Legislative Assembly of Alberta

The 28th Legislature
First Session

Standing Committee on Public Accounts

Alberta Health Services

Wednesday, May 15, 2013
8 a.m.

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Standing Committee on Public Accounts

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Alberta Health Services
- Duncan Campbell, Executive Vice-president and Chief Financial Officer
- Chris Eagle, President and CEO
- Robert Hawes, Vice-president, Financial Reporting
- Stephen Lockwood, QC, Board Chair
- David Megran, Executive Vice-president and Chief Medical Officer
- David O'Brien, Senior Vice-president, Primary and Community Care
- Deborah Rhodes, Senior Vice-president, Finance
- Ronda White, Chief Audit Executive

8 a.m. Wednesday, May 15, 2013

[Mr. Saskiw in the chair]

The Acting Chair: Well, good morning, everyone. I think we'll get started. It is around 8 o'clock. We do have some people on the line. I'd like to call this meeting of the Standing Committee on Public Accounts to order. My name is Shayne Saskiw. I'm the MLA for Lac La Biche-St. Paul-Two Hills, and I'm here today substituting for the chair, Mr. Rob Anderson.

I'd like to welcome everyone in attendance. We'll go around the table to introduce ourselves, starting on my right with the deputy chair. Please indicate if you are sitting in on the committee as a substitute for another member.

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

Dr. Massolin: Good morning. Philip Massolin, manager of research services.

Mr. Amery: Good morning. Moe Amery, MLA, Calgary-East.

Mr. Goudreau: Good morning. Hector Goudreau, Dunvegan-Central Peace-Notley.

Dr. Megran: Dave Megran. I'm the chief medical officer for clinical operations at AHS.

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

Mr. Lockwood: Steve Lockwood, board chair, Alberta Health Services.

Mr. Campbell: Duncan Campbell, chief financial officer.

Ms Dawson: Mary-Jane Dawson. I'm a principal with the office of the Auditor General.

Mr. Saher: Merwan Saher, Auditor General.

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

Mr. Hale: Jason Hale, Strathmore-Brooks.

Mr. Stier: Pat Stier, MLA, Livingstone-Macleod.

Mr. Donovan: Ian Donovan, MLA, Little Bow riding.

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

Mrs. Towle: Kerry Towle, MLA, Innisfail-Sylvan Lake.

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

Mr. Tyrell: I'm Chris Tyrell, committee clerk.

The Acting Chair: Just some housekeeping stuff before we proceed. The microphones are operated by the *Hansard* staff. Audio of committee proceedings is streamed live on the Internet and recorded by *Alberta Hansard*. Audio access and meeting transcripts are obtained via the Legislative Assembly website. If everyone could make sure to speak directly towards the microphones and not lean back in your chairs while speaking, that would be appreciated. Please do your best to keep your cellphones away from the microphones and on vibrate or silent.

If there are people calling in via teleconference, could you please introduce yourselves as well?

Mr. Khan: Good morning. Stephen Khan, St. Albert.

The Acting Chair: Welcome.

Is there anybody else? Okay. Great.

We have the agenda that has been distributed. After reviewing that, could I have a member please move that the agenda for the May 15, 2013, Standing Committee on Public Accounts meeting be approved as distributed? Mr. Ian Donovan. All those in favour? Opposed? Carried.

We do have materials that have been distributed. Obviously, we're meeting today with Alberta Health Services. The reports to be reviewed are the Alberta Health Services annual report, April 1, 2011, to March 31, 2012; reports from the Auditor General of Alberta for March, July, and October 2012 and February 2013; the consolidated financial statements of the government of Alberta, annual report 2011-2012; and the Measuring Up progress report on the government of Alberta strategic business plan, annual report 2011-2012. Members should all have a copy of the briefing document prepared by committee research services.

Joining us today, of course, are the board chair, Mr. Lockwood, and the president and CEO, Dr. Eagle, as well as several other representatives from Alberta Health Services.

I'd like to now invite you to make a brief opening statement of no more than 10 minutes. Thank you.

Mr. Lockwood: Thank you, Mr. Chairman. As I indicated, I'm Steve Lockwood, and I'm the board chair of Alberta Health Services. I'm pleased to be here with the committee today and look forward to our discussion. We're here to focus on the 2011-2012 fiscal year for Alberta Health Services, a year characterized by progress and improvement in the health care delivery system.

Let me give you a quick example. The lives of more than 21,000 Albertans were touched by telehealth in 2011-2012, an increase of about 20 per cent from the previous year. This technology bridges the distance for patients, especially those in remote areas, and allows them to connect to multidisciplinary teams of clinicians, who then manage and support them through their care. In 2011-2012 a new program was added to telehealth through which members of First Nations communities in northern Alberta can meet with health professionals via telehealth to get help monitoring diabetes and nutrition.

This was year 3 of operations for Alberta Health Services, and we used this year to continue building upon the foundation we established in the first two years. In 2011-2012 we began to move towards a model of health care delivery in which decisions about patient care are made closest to where care is actually provided. This movement included creating five provincial zones, which resulted in more direct contact between Albertans and local health leaders, and encouraging a stronger role for our health advisory councils.

We continue this evolution today, creating more opportunities for local decision-making. At Calgary's Rockyview general hospital we're examining the benefits of a self-managed operating unit. This pilot combines the best of our integrated provincial system, with a strong emphasis on local leaders making decisions tailored to the community they serve.

In 2011-12 we also focused on responding to our highest health care priorities: strengthening primary care services, offering more continuing care options, and improving access to the health system. For example, in the primary care area we increased the role of nurse practitioners by piloting clinics in Edmonton and Calgary in which nurse practitioners managed the care provided to patients. This initiative offered patients comprehensive primary care while fostering improved access to the health system.

Another made-in-Alberta program that addressed all three of the high health care priorities was our CHAPS program. Through this community health and prehospital support program emergency medical services staff are able to identify patients at risk of having their health deteriorate while living at home due to a lack of support or hazards. Patients such as seniors are then connected to existing programs and services like home care to help them maintain independence while living safely at home. Mr. Chairman, this program clearly shows the benefits of our single Alberta integrated system.

Our total operating budget for 2011-12 was approximately $11.7 billion. Total operating expenses increased by 8.7 per cent from the year prior and were lower than the budgeted amount by .8 per cent. Health care dollars were directed to priority health needs such as providing more home care services, adding continuing care spaces for seniors and adults with disabilities, and improving wait times for surgical and emergency care.

A number of our performance measures showed steady progress in 2011-12. These performance targets were intentionally ambitious and in some cases would take years to achieve. Going forward, we intend to work closely with Alberta Health to establish new performance matrices that can be benchmarked both nationally and internationally.

Let me highlight a few examples of performance measures that showed progress. The length of time for patients waiting to be admitted to hospital from an emergency department improved. This is in reference to our top 15 urban and regional emergency departments. Forty-five per cent of patients were admitted within the eight-hour target compared to 41 per cent in the previous year.

To help reduce demand for hospital beds and ease congestion in our emergency departments while adding capacity to our system overall, we opened just over 1,000 net new continuing care beds. We also opened more than 100 net new acute-care beds and nearly 100 net new beds to support patients in need of mental health and addiction care.

We had an improved response to immunization efforts. Seniors' flu immunizations increased from 59 per cent to 61 per cent, and children's flu immunizations increased from 27 per cent to 30 per cent. These numbers, while showing progress, are still not acceptable. We aim to increase the number of vaccinations through such efforts as the Alberta access improvement measures program, or, as we refer to it, AIM. This is a made-in-Alberta initiative to improve quality and access for patient care. Already we are making changes in how vaccination clinics are set up and how patients move through the clinic from checking in to actually receiving the care.

The number of cataract surgeries performed increased by 8 per cent. Wait times for this procedure improved by 25 per cent, to 35 weeks from 47 weeks in the prior year.

Alberta Health Services also continued to provide Albertans with more options for health care services and information. In May 2011 phase 1 of the MyHealth.Alberta website was launched as a single place to find health information and useful health tools. Today the website has approximately 100,000 visits per month from Albertans looking for health information.

8:10

In July 2011 we launched emergency department wait times for the Calgary zone on our external website. It was the first phase of an effort to post estimated wait times for emergency departments and urgent care centres. It was followed a year later with emergency wait times for the Edmonton zone. The wait times initiative is a tool to help Albertans see what is happening in local emergency departments and to help them get the care they need when they need it.

We recognize that seniors and adults with multiple chronic illnesses and disabilities want to remain independent at home and in their communities for as long as it is safe to do so. That is why in 2011-12 we continued to invest in home care, helping nearly 105,000 Albertans with home-care services such as medication management, an increase of 4,400 patients, or 4.4 per cent from the previous year.

With the creation of Alberta Health Services and our continued effort to build a sustainable, patient-focused health system, we have without a doubt achieved some early synergies. We're making better use of shared technology and corporate services and working to streamline support functions. Personally, I'm very proud of what Alberta Health Services has accomplished since amalgamation in 2008. The history of our organization is characterized by one particular thing. We meet the challenges head-on in order to deliver care to the 3.8 million Albertans we serve.

This is an interesting time for Alberta Health Services, and in my personal opinion we're at a crossroads at which we can choose to continue doing the same things in the same way as in the past or we can choose to do things differently. We plan to move towards the health and wellness of the people of this province. It is unequivocally our first and highest priority. As I said earlier, we've laid the groundwork for growth and transformation. Our successes and challenges of the past are lessons we have learned from and that we can and will use to accelerate transformation of the health system.

I believe the path ahead is one of change, where we shift our focus on acute hospital care to a new model for the health system where services are predominantly provided in the community setting. We will simplify the health system while improving patient outcomes and satisfaction. We will respond to the health needs of all Albertans through primary and community care and, above all, eliminate waste, reduce bureaucracy, and give our health leaders the freedom and accountability to lead. That's how we will improve patient satisfaction and outcomes and build the sustainable, patient-focused, and responsive health system Albertans want and deserve.

Fundamentally our accomplishments in 2011-12 and the changes we have made and will continue to make allow us to do what we as a health system do best, taking care of Albertans and their families when and where they need it most. Thank you.

The Acting Chair: Thank you very much, Mr. Lockwood.

There are some other MLAs that have come into attendance. I'd start with Ms Fenske. If you could just introduce yourselves.

Ms Fenske: Thank you. Jacquie Fenske, Fort Saskatchewan-Vegreville.

Mr. Jeneroux: Matt Jeneroux, Edmonton-South West.

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

The Acting Chair: Thank you very much for joining us.

Oh, we have one more here, last but not least. Just go ahead and introduce yourself.

Ms Pastoor: Bridget Pastoor, Lethbridge-East. Forgive my tardiness.

The Acting Chair: No problem.

I'd like to now invite Dr. Saher, our Auditor General, to make an opening statement on behalf of the office of the Auditor General.

Mr. Saher: Thank you. I'm very happy with that title.

Good morning, everyone. Mr. Chairman, my comments are on material included in our October 2012 and February 2013 public reports. Our audit of primary care networks reported in July 2012 was discussed by this Public Accounts Committee on October 24, 2012. Starting on page 24 of our February 2013 report we recommended that

> Alberta Health Services tighten its controls over expense claims, purchasing card transactions and other travel expenses by:
>
> - improving the analysis and documentation that support the business reasons for – and the cost effectiveness of – these expenses
> - improving education and training of staff on their responsibilities for complying with policies
> - monitoring expenses and reporting results to the Board.

In our October 2012 report we made five new recommendations arising from our financial statement auditing. We made recommendations on data conversion testing, payroll accuracy monitoring, goods received not invoiced, fees and charges revenue, and journal entry review and approval. In that October '12 report we reported satisfactory progress on information technology control policies and processes and the recording of deferred contributions. We also reported that AHS had implemented our recommendation on supplementary retirement plans.

We were able to issue an unqualified audit opinion on the 2012 Alberta Health Services consolidated financial statements.

Our list of prior outstanding recommendations for Alberta Health Services begins on page 172 of our October 2012 report.

Thank you, Mr. Chair.

The Acting Chair: Thank you very much. I appreciate that.

With that, we don't have much time, so we definitely want to start with some of the questions. We'll start with the deputy chair, Mr. Dorward, and proceed from there.

Mr. Dorward: Thank you, Mr. Lockwood, particularly for coming. Thank you all for coming. You have some individuals behind you, I'm sure, from Alberta Health Services, and we thank them for coming, too. It doesn't go unnoticed, Mr. Lockwood, that you would come as the board chair, and we're thankful for that commitment to the committee.

Through this committee you're reporting to all the people of Alberta, and we could call Alberta Health Services often, given the dollars that are involved in the province in the health care area. We look forward to the discussion. If we cut you off, Mr. Lockwood or Dr. Eagle, it's not because we don't care about the answer. It's because we have a whole bunch of questions. I have lots of colleagues who have questions. Certainly, it's permissible any time to put on the record that you'll get back to us in writing, and that can be done through our committee clerk.

My first question is relative to what the Auditor General said regarding journal entry review processes. As a chartered accountant this is an area that I find weakness in often, actually, with corporations or organizations. Has the recommendation regarding journal entry review process been reviewed, and do you have any comments on that?

Mr. Campbell: Yes, we have reviewed the journal entry process, and we have followed the recommendations fully. This is a very important area, an area which is part of our compliance function. This is an area which as a chartered accountant myself I take very seriously, including the signing of the accounts and the statements.

Mr. Dorward: Good. Thank you.

I wanted to get into the statement of financial position a bit. If I could refer you to the annual report, page 111. When I refer to a number, it'll be the Health and Wellness report rather than your own consolidated financial statements. I noticed the amount of cash and investments you have and on the flip side the accounts payable and other liabilities. Could you make a comment on the extent to which you have a significant treasury operation in your organization so that those short-term assets and liabilities are managed correctly?

Mr. Campbell: Yes. I certainly can report that we have a very good treasury function. We also have very good board oversight in terms of making sure that we have the appropriate risk profile for the assets under our control. In fact, we are currently expanding that to include an investment subcommittee of the board.

Mr. Dorward: Thank you.

I would also refer you to the income that you receive, the revenue, page 110 of the consolidated statement of operations. In the revenue section there's a line item of just less than half a billion dollars for fees and charges. What I've heard is that you have different fees given to different hospitals, that if somebody comes in and they say that it's an uninsured situation, they are charged a different fee in one area than they are in another, Royal Alex versus Foothills or something. Could you comment on that? Are fees consistently applied? Have you spent time making sure that these fees are an all-in cost of service delivery? Those kind of things.

Ms Rhodes: With fees and charges for uninsured residents or residents from other provinces or out of country those rates are set through the ministerial directive. Those are based on case costs from the different facilities. So they are different by facility, but we do follow the ministerial regulations around them.

Mr. Dorward: Thank you. We're getting the kind of quicker answers we like to get.

Obviously, within your consolidated financial statements there likely weaves an internal audit process. Can you describe to me your internal audit process and whether that is fulfilling the need right now. Is that an area that needs to be bolstered and strengthened? It seems to me that the Auditor General provides a function, but internal audits are a key part of that as well.

8:20

Ms White: We've grown from the previous practice, from the previous health region, so we have a large group, about 25 auditors. We look at both internal audit and controls across the organization as well as risk-management practices. We are continuing to grow and evolve, but we cover a wide variety of operations: financial and IT as well as service delivery areas.

Mr. Dorward: I take it you're happy with the job you're doing.

Ms White: I'll leave that answer to Duncan and Dr. Eagle.

I'll just give you some context. I think we're covering the major risk areas currently. There are always areas to improve, but we are covering those major risk areas for the organization.

Mr. Campbell: I'd like to add to that if I may. There's a broad enterprise risk-management framework, and our internal controls and our enterprise risk team are together. So we're actually looking at our risks and our internal control work through the same lens, through the area of risk. I would say that our internal control team is doing a great job.

Mr. Dorward: Thank you.

You know, operational audits are a really good tool for ongoing investigations of areas where simplicity and efficiencies can be found.

I will now turn the time back to the chair, who will turn the time to my colleague Ms Pastoor.

The Acting Chair: Thank you very much.

We do have another MLA attending here. Would you please introduce yourself?

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

The Acting Chair: Thank you very much.

That was a very enlightening discussion on audit procedures in the morning.

Ms Bridget Pastoor, you're next.

Ms Pastoor: Thank you very much, and good morning. I want to make it very clear up front that I have no idea what chartered accountants do. I have a problem balancing my own bank account. However, I have many years of experience as a front-line geriatric specialist RN, so I'm going to come at it from a little bit of a different angle.

What I'd like to get from the board – well, no. Let me back up a bit. This is always something that I say, and this may not be the appropriate place to say this. When I want to talk to someone about health care and health delivery, my first question always is: have you ever wiped a bum, and have you held the hand of someone who died? That's my first question, and when I get a good answer, then I continue the conversation. However, it's okay; you don't have to answer.

What I'd like to see – and I can't kind of pin it down – is an org chart of AHS, of the departments and what kind of numbers are in each department. Clearly, that can't be answered here. It has become such an octopus out there that I'd like to try to get a handle on exactly what's going on.

Another thing. I hear the word "risk" all the time, but I think that's a risk for money. I'd like to know what kind of risk assessments are done for the people that you actually are supposed to be looking after. One of the risks that, in my mind, is huge is that of moving seniors a hundred kilometres away to get them out of the hospitals.

If I could just have some comments on that, I will turn it over to someone else, and I'll perhaps come back later when I hear more of the conversations that are going on.

Dr. Eagle: Thank you for the comments about the org chart.

Ms Pastoor: You're going to answer "yes," I know. But those other guys . . .

Dr. Eagle: The org chart has been a real challenge. I mean, there are few organizations of a hundred thousand employees where we try and put everything on the web pages. I think the public found that very, very confusing. It looked vast. It is vast. There are a hundred thousand people in there. You know, some of our front-line leaders: a nursing manager typically will have 120 direct reports. So it's a complex thing to represent. I think it led to a view that Alberta Health Services has nothing but administrators, and people are perplexed because the CIHI data says that we're a pretty efficient operation, you know, in terms of administrative to operating costs.

In terms of risk we spend a lot of time looking at risk from a clinical perspective. We have a very, very active quality and safety committee of our board. When we bring on new programs and we make clinical changes, we do a safety risk assessment. A lot of our briefing notes, when we're looking at clinical changes, include an overall risk assessment. You know, the risk isn't just about money. The rigour, which comes from having people like Ronda in the organization, of how we look at risk has improved. We're putting more and more effort into our clinical risk management. Whether it's implementing a clinical IT system or changing the staffing on a nursing unit, there's very intense interest in risk.

The 100-kilometre program: I think I would ask Dave O'Brien to just talk briefly to that.

Mr. O'Brien: Good morning. I think that our 100-kilometre policy is one which we wish we didn't have. It unfortunately is highly necessary in an environment where we have insufficient community capacity in order to support. It is very much about risk management as well. Acute care is not a place for seniors. We need to have them placed urgently into a community setting, which is more appropriate, where they can receive the safe and quality care they need. The 100-kilometre policy actually is a standardization for us. Where before many former health entities did not have a stated limit, by implementing the 100-kilometre policy, we are actually able to expedite placement of seniors into the community, where they need that care.

Ms Pastoor: Thank you, but I'm so sorry; I couldn't possibly disagree with you more. It's inhumane.

I'm sorry. I just thought of one more. You have something in human resources, and I don't have the name in front of me because I forgot my notes. It's about staffing, E something.

Mr. O'Brien: EFT?

Ms Pastoor: And that stands for?

Unidentified Speaker: No. It's e-People.

Ms Pastoor: Thank you. E-People. Thank you very much.

Clearly, that is province-wide, so let me describe a scenario for you. I could use myself as an example. There I am, a little bit long in the tooth, and I know what I'm doing and, you know, kind of minding my own business, doing my thing. Fortunately, I had a boss that understood, and I didn't have to work in a humongous organization, where you're really just kind of a little minion. But here I am doing my thing, and along comes Miss University with her clipboard. Clearly, we are going to have, perhaps, words. Now that goes on my chart, and I decide: okay; I've had enough of working in city X because I'm not happy and I'm getting a hard time and God knows what all. You know how people can intimidate so that they can get rid of you, that sort of stuff. So now I want to go to another city. How much of that incident has travelled with me all over the province because it's flagged?

Dr. Eagle: Just to clarify a little bit what e-People is all about, e-People is basically a payroll and HR system. Instead of having, you know, 12 different payroll systems, we now have one.

Ms Pastoor: And that's good.

Dr. Eagle: So e-People has been a really good cost saver for us. We are probably the only organization in the country to have a hundred thousand people on a single payroll system, so it's been a huge . . .

Ms Pastoor: No. Actually, you're the sixth-largest corporation in Canada.

Dr. Eagle: With a single payroll system.

Ms Pastoor: Sorry. Yeah.

Dr. Eagle: You're right about the scale of AHS in Canada, though.

Individual employee records, you know, aren't as transparent. They're not as available across Canada.

Ms Pastoor: That red flag doesn't follow you?

Dr. Eagle: It increasingly will follow people. You know, as we become more and more an integrated system, the red flag will follow you. It's not only employees who are concerned about this. It's surgeons and physicians and anaesthetists. You know, in the old days if you didn't like how you were working at the Calgary General, you could move to Foothills, and that would be kind of a whole new beginning. One of the downsides of having a large organization is that, you know, we are one organization, so a lot of the records of an employee will follow them from one side of the province to the other. So you're right on target.

8:30

Mr. Dorward: Ms Pastoor, we do need to move on to some other colleagues. I'll get back to you if we can. We also have the opportunity at the end to have some time for written questions.

Go ahead, Mr. Lockwood.

Mr. Lockwood: Just a clarification. Would you like us to present an org chart? If so, could I ask that we provide this type of an org chart? As we've indicated, we're in the process of reviewing all of the management positions in the organization. That's a project that will be completed, I would think, sometime near the end of the summer, early into the next quarter. To me, that would be the more relevant chart to provide because that will show you where we're going to be going forward as opposed to where we are today, but we can do whatever you wish.

Ms Pastoor: Could you give me a time frame on that, then? The end of September?

Dr. Eagle: End of September would be good.

Ms Pastoor: Thank you.

The Acting Chair: Thank you very much.

We'll now proceed to Mr. Moe Amery.

Mr. Amery: Well, thank you, Chair. Thank you very much for being here this morning. My question, Mr. Lockwood, is going to focus on your opening statements, and that has to do with access and waiting times. There isn't a day that goes by without hearing something about our health care system in the media. In most cases, unfortunately, it's negative stories, complaints, criticism. However, I still think that we have one of the best health care systems in the world. I say that because I have seen other health care systems.

I know that we are talking about our 2011-12 budget, but I would like to just briefly give you some historic effects. About 20 years ago our total government budget was about $11.9 billion. Our population was 2.7 million people. Our health care budget was $3.1 billion. We had about 4,500 doctors in the province.

Today we have 3.7 million people, our spending is $17,020,489, and we have over 7,500 doctors. The issues and the complaints and the criticisms are still the same: long waiting time at the emergency room, so many months and sometimes years to see a specialist.

It seems to me that it doesn't matter how much money we spend; the problem still exists. I know it's causing a lot of frustration, and this is the question and these are the complaints I have been getting from my constituents for the last 20 years. Sometimes I hear that people get so frustrated at that emergency room. They take a sick child there, and after waiting for six, seven, eight hours, they leave without seeing a doctor. I think, you know, it's about time that we deal with this situation, with this problem. Can you give me some thoughts on this and what is being done to deal with it?

Mr. Lockwood: Well, I think I've been very consistent since my appointment in September 2012 that pouring and giving more money to the system will not necessarily improve things. We've tried that. Your statistics just proved that out.

What we are working on today is a decision-making change that I believe, that my experience leads me to believe may provide the answer, and that's what I referred to as our Rockyview pilot project, that's going on right now. What we want to do is that we want to take all the benefits of a consolidated system that we created by virtue of the amalgamation of the nine regions, three programs. Since then we've added to that the jail system. We've added to that EMS. We've added to that fixed wing. So we've got everything in this one big bundle.

In 2011-12 we geographically moved some decision-making powers down into our five zones. Now what we need to do is that we need to get decisions being made in relation to facilities and in relation to patient care as close to the patient as we can get it. That means putting more decisions with local people in hospitals. It's not necessarily the leadership dyad at the hospital. It flows right from them down throughout the wards. We need to make sure that the services provided in the head office groups are services that the people on the front line want. If the services that head office group provides are not wanted by the people on the front line, then we won't need those services anymore.

We've got the one pilot project going. It's my hope that by some time in June or July we'll have been able to identify upwards of 30 to 40 different operating units throughout the province, and we'll then proceed to get the local decisions made.

Let me give you a couple of examples of what happens. A couple of years ago we were down in Medicine Hat, and we had one of our health advisory council leaders there. At the end of the presentation we asked, "Is there anything we could do to help you today?" Her response was: "Yes. We've been trying for two years to get a parking pass for each of our seniors living in the hospital because they don't have a long-term care facility yet, and we haven't had an answer." As Dr. Eagle has pointed out many times, what happens is that the request comes like a horseshoe. Your request is here, it goes through our bureaucratic system, and it comes down at the other end of the horseshoe. But the other end of the horseshoe isn't connected to where the request came. There didn't seem to be much surprise that there wasn't an answer. Well, that can't happen. There are a multitude of things like that.

What I can say today is that we've been working with the Rockyview for a few months now, and the change in the people there is to me noticeable, the excitement of the people being able to, first, have accountability, responsibility, and the power to make changes without having to ask through Edmonton or Calgary head office: can we do this? The system I want to get to is one where we've got local decision-making with a local budget and an incentive that if you can perform better than budget, some of the

savings will come back to the head office group to be reallocated to where the highest needs in the province are, but some of those savings stay with you in your self-managed operating unit to perform even better and to place those funds into the care you think your community or your region needs. I think, as everybody in the room would know, every region is not the same in this province.

The Acting Chair: Thank you. If you don't mind, Mr. Lockwood, we have limited time.

Mr. Lockwood: That's fine.

The Acting Chair: Mr. Allen has joined us.
If you'd like to introduce yourself.

Mr. Allen: Thank you, Mr. Chair. Mike Allen, Fort McMurray-Wood Buffalo.

The Acting Chair: I know that the deputy chair, Mr. Dorward, would like to ask a few questions right now.

Mr. Dorward: I'm just itching to get after another financial question on the statement of consolidated financial position. Note 15 on the financial statements from last year has almost $6 billion of unamortized external capital contributions. I certainly would take a written response to this one. It goes to note 15. I see a number that floats around $5 billion. When I see a number like that on note 15 and there's not that much relative activity happening there, I wonder if I could just have a comment on if it's possible to answer what makes up those kinds of balances. If not, then we can take a written response on that.

Dr. Eagle: We'll have Robert Hawes, who's one of our vice-presidents of finance, answer that. Thank you.

Mr. Hawes: The balance you referred to is referred to as unamortized external capital contributions, and what that represents is funding that Alberta Health Services has received in the past and has spent on capital assets. From a revenue recognition perspective, it's referred to as deferred revenue. As the asset that was funded is amortized – and those expenses are flowing through the statement of operations as an expense – we also recognize, of course, the amount of revenue that relates to the extent to which that asset was funded externally.

Mr. Dorward: Good. Thank you.
I asked the question particularly because I had a constituent who actually asked me why you have $5 billion in debt. Does it represent debt owed to a bank or anybody else?

Mr. Hawes: No. It represents funding that we've already received, and it's deferred revenue, so eventually it's all going to flow through the statement of operations as revenue.

Mr. Dorward: Okay. Thanks very much.
We'll go back to the chair.

The Acting Chair: Well, thank you very much.
We'll now proceed to the Official Opposition and the Health critic, Heather Forsyth.

8:40

Mrs. Forsyth: Thanks, Chair. My colleague Mrs. Towle, who's our Seniors critic, and I are going to do a little bit of tag team if you don't mind, and we're going to be asking questions.

Before I start with the questions, I want to share a personal experience if I may. I spent about five weeks in the hospital with my mom. I want to, from the bottom of my heart, thank the people in your association, and those are your health care workers, your docs from the emergency room to the docs that were taking care of her on the medical floor, the RNs, the LPNs, the NAs, and even the cleaning staff at the new south Calgary hospital, who did a fabulous job, which made our journey a lot easier. There is no question that these people are dedicated and working as hard as they can to take care of the people that are entering into your hospitals. I think it's important for me to thank the dedicated employees in the front line that are taking care of the patients that they're working with on a day-to-day endeavour.

If you could please pass that down to all of your front-line workers. I think that's something that they need to hear because I truly believe – and I've said this over and over again – they're the people that are keeping the health care system running, and they're the people that need to be thanked. If you could pass that on.

I want to start off, if I may, please, with the Auditor General's report, and it's not what I consider a good read, considering the criticism that is put forth not only in the recent Auditor General's report, but it goes back to the Auditor General's report in 2008, it goes back to the Auditor General's report, I believe, in 2009, and it continues in regard to the criticism of the expenses.

The Auditor General cited issues in expenditure policies and approvals in 2009. AHS has been up and running since April 2009, and the recommendations are still outstanding. Specifically – this applies now like it did then – there wasn't a clear and comprehensive expenditure approval policy. Why is this recommendation still outstanding? When will the recommendations be fully implemented, and can you please tell me what your policy is now on expenses?

Mr. Campbell: Yes. I'd like to say that we have implemented the hosting policy, and we've got the strictest policy in Canada. It was implemented in October 2012. In fact, all the recommendations from the Auditor General's report will be completely finished by the end of June this year. We've taken this very, very seriously. I know, coming from British Columbia, that the systems and the controls we have in place are superb and the best in the country.

Mrs. Forsyth: Can you explain to me, then, so I can understand why it took three Auditor General reports for an organization this large and you're just now implementing a strict criteria and policy?

Mr. Campbell: To answer that, the policies were improved, and they've been improved since then. We have taken that very seriously. Also, the implementation of our systems has helped us really get control over there. Having a system that we can actually line up with all our delegation of authority and workflow has really helped us to make sure that the right people sign off the right expenses and has really helped us in this. We're in a very good place now to be able to sign off a compliance certificate around expenses.

Dr. Eagle: We have learned a lot from the Auditor General reports over the years, and we've gradually improved the level of our policies to deal with things. I think that at this point in time some of the things we've dealt with are sort of the training of our staff, you know, so that they actually know how things are supposed to be approved, so that they know what could be approved, who can sign off, the attestation. When something gets signed, you have to say: I have read the policy; I know this. Then

there's secondary review, to make sure that all of the expenses are properly dealt with. Then there are, finally, audits. We've got now a very, very intense process to look at expenses. It's taken time to put that into place. The time may have been too long, but it's in place now.

Mrs. Forsyth: I don't want to hammer on this issue continuously, but for me, as an Albertan, it's quite embarrassing when I see some of the criticism that has come out of the Auditor General and some of the expenses. I mean, we talk about one of your employees using their own plane, some of the expenses that there has been no rationale behind, some of the travel expenses without looking at how things are done, some of the hotel expenses. I'm having trouble with this. Mr. Lockwood, as a businessperson who runs a very, very successful business yourself, how can this go through without any whistles or bells going off in somebody's mind about checks and balances?

You talk about your organizational chart, which is huge – the Member for Lethbridge-East brought it forward – and you talk about how you're changing that organizational chart. I mean, your current organizational chart is pages and pages and pages of executive vice-presidents, vice-presidents. For goodness' sake, you have a vice-president of linen. Truly, I'm having trouble comprehending how this is happening. The checks and balances aren't in place.

Mr. Lockwood: Well, let me address the organization that you just mentioned. The organization as it exists today was put in place by a prior management team, and it was a very hierarchical one, where if you were the CEO, everyone reporting to you had the title of executive VP, and then everyone reporting to them had the title of senior VP, and everybody reporting to them had the title of VP, and everybody reporting to them had another title that was standard. In the last six to eight months Dr. Eagle and I have been looking at that, and we've determined that that's not the way to have an organizational structure.

What you need to do is to look at each individual person and determine what the job is that they're doing and what's the appropriate title for the person. I don't get too hung up on the titles, but we've got to simplify it so that people understand who's responsible for what. As I indicated, by the end of September we're going to have that job done, and we're going to have a clear, concise, crisp org chart so that you can understand what people are responsible for. Let's not worry too much about the title. To me, the title is important when it comes to pay and the band that you're in. We're going to make sure that, if that's the way it's got to be with the pay band, the job deserves a pay band that's appropriate, not the title. We don't pay by title. We pay by job value.

With respect to the expenses in the Auditor General's report there were a number of instances – you've alluded to the plane. Okay. When you go to examine that instance, that plane was fully justified by the physician from a cost perspective. What he hadn't done properly is document why he had chosen that mode of transportation and why there was value from a clinical perspective in doing that. Okay. So what we've learned is that we are under immense scrutiny. When you're under immense scrutiny, you've got to have not just golden-type processes; you've got to have platinum processes to ensure that every box is ticked off. That's what we've moving to do.

Hotels. Sure, in the past we've had people stay at the Fairmont. Well, there's a government rate at the Fairmont, so there must be other government employees staying there because you don't get a government rate unless you stay there enough nights. We don't stay at the Fairmont. I checked in last night for 154 bucks at the Westin. Am I unhappy about that? Absolutely not.

We fully understand and appreciate that every dollar we are provided with is not our money; it's Albertans' money. Every decision on an expense has to be made by every individual, all 100,000 or the number that are making expense decisions, as if it's your own money. We will get people doing that. It's a complicated system of expense reporting and expense checking and expense auditing – yeah, that is – but that's going to give our board comfort. A certificate will be required from our CFO that, from his perspective, the controls are in place to ensure that the expenses are appropriate, business oriented, and in accordance with policy.

Mrs. Forsyth: I'm going to ask my colleague the critic for Seniors to ask a couple of questions now, please.

Mrs. Towle: Hi. Thank you very much for coming. I appreciate the opportunity to have a moment of engagement with you. In the interest of full disclosure I want to let you know that I used to work for the health region, and I worked for Alberta Health Services for nine years. I want to put that out there.

I also want to put out there that I am one of the everyday Albertans who took care of someone in long-term care. My brother passed away from Huntington's in a long-term care facility. I think that each and every one of you at this table needs to understand that your processes for long-term care, for placement, for how you make those decisions are not – not – good. For the people who are actually on the front line, the people who actually have to deal with that process each and every day, it is a terrible, terrible position to be in. I want to put that out there so that you understand the context from which I'm coming forward here.

8:50

I also take care of my father, who had a massive stroke in January of 2011. I care for him. Between my mom and I, we financially care for him and physically care for him with no supports from Alberta Health Services because there are none available. So you need to understand that as well.

The perspective which I'm coming from is that I need to go on record to help you understand your 100-kilometre policy. I share the comments of the member across the way who talked about this policy. This policy is detrimental to families. We know that there is a negative health impact when you move people away from the community, away from their family. Then when you do a secondary move, especially for those with Alzheimer's, dementia, it can actually hasten their death. When you're that family member who has to undergo that policy – and I was one of those – that is a terrible policy. It needs to be removed from Alberta Health Services' policy. Albertans want it removed. It is unnecessary.

Going on from that, looking at page 65 of your Alberta Health Services report, you talk about home care being a priority initiative. I can appreciate that. There are a couple of things. The home care services guideline that you mention for rural areas is 120 hours per year, so long-term home-care clients are getting 120 hours per year. That's 10 hours per month, or one hour every three days. I don't know how that's a priority, one hour every three days for home care. I'd like you to talk about that.

The other part of it is that at the bottom you talk about performance measures, and you talk about the number of unique home-care clients, and you talk about it increasing by 3 per cent. The number of unique clients has increased by 3 per cent. Have you increased the resources to service those clients by 3 per cent?

If so, has that gone directly to front-line staffing? Has it gone to direct patient care of 120 hours, increasing that at all?

Dr. Eagle: Thank you for your comments around the 100-kilometre rule. I think we're going to have to go back and look at that again. Obviously, it's having impacts that are, you know, quite severe in terms of the profile of Alberta Health Services and the care of patients.

I would like Dave O'Brien to talk about our home care approaches.

Mr. O'Brien: In terms of the 120 hours per year, it is just used as a proxy, a performance gauge. It's the average number of hours that are delivered in the community to clients, so obviously there's a great deal of variability within there. We use it as a measure to determine that we're moving in the right direction in terms of adding more hours to home care in the community, in particular in rural areas where they have been underfunded compared to urban areas.

To answer your question about resources, over the past three years our home care expenditures have increased from $385 million per year to around $530 million per year. These resources have all gone directly to the front line.

Mrs. Towle: Thank you very much for that.

If we can go on even further, when we talk about the number of people waiting for continuing care placement and the wait times for those continuing care placements, I'm noticing that you're always talking about 1,000 continuing care beds. I can appreciate that we need more continuing care beds. There's no question about that. The downfall I see is that there never is any mention of long-term care nursing beds. How many of the people waiting for beds in community and in acute care are actually requiring long-term care nursing beds?

Dr. Eagle: I think that's a really good point. If you look at the people waiting, say, in hospital for discharge, the minority of those people, when you use a standard assessment tool like interRAI, require long-term care placement. Many are capable of going to supportive living. Many people are fine with home care. We have roughly 14,500 long-term care beds in the province, and we're basically finding that that's the right number.

What we're trying to do is increase the amount of supportive living and home care. It gets people closer to their home and in better environments. The acceptability of home care seems to be very high with the public, and we're expanding home care because of that. Home care is where we really believe the future is. Also, it's cost-effective because we don't have to build capital facilities to house people.

Mrs. Towle: You know what? I'm excited to hear you say that because I actually do believe the future of saving taxpayers money in health care is shoring up home-care resources, and we know that keeping people in their homes longer certainly improves the quality of life. That's fantastic.

Going along with that, if you're a person who truly needs long-term care nursing beds – and I'm one of those people; my brother was not able to stay at home – they're not available. The government's talk all the time is, "We're expanding beds. We're getting a thousand net new continuing care beds," but what we're talking about is long-term care nursing beds, 24-hour nursing beds that are required for that unique need. They don't fit into the continuing care system. They truly need long-term care nursing beds. How many long-term care nursing beds, not continuing care beds but long-term care nursing beds, have been added to the system, and how many specifically to rural Alberta, where this need is truly, truly acute at the moment?

Dr. Eagle: I think there are a couple of things. I'll ask Dave to respond in more detail. There's an issue of building new long-term care capacity. There is also a significant issue of replenishing the current long-term care capacity. If you look particularly at lodges, which aren't part of our system, and also the long-term care centres, many of them need substantial investment to maintain the current 14,500.

Mr. O'Brien: We do track our long-term care beds annually, and we show a number right around 14,500, but that unfortunately does not describe the amount of change that's occurring behind the scenes. There are a number of long-term care beds that are old and decommissioned and a lot of new long-term care beds that are being brought up. We're doing this with government in a strategic way to ensure that we're bringing up the capacity in communities where it's required. Our current wait-lists have about 25 per cent of clients waiting for long-term care, and placement into long-term care occurs significantly quicker than it does into supportive living.

Mrs. Towle: What are your projections, then, over the next three to five years for long-term care nursing beds, not continuing care?

Mr. O'Brien: Projections in terms of what we plan to do to increase them?

Mrs. Towle: How many beds are you looking to increase for long-term care nursing?

Mr. O'Brien: We're not planning to increase long-term care nursing beds. We are planning to ensure that the right capacity is available in the communities where seniors need them.

Mrs. Towle: If that's actually accurate and we're not keeping up with home-care clients that are currently on the list, and we know that that's going to increase, and if we're not going to increase long-term care nursing beds going forward and even your 1,000 continuing care beds that you're building – your projected targets are 900 people waiting in community and 375 people waiting in acute, sub-acute, so that's 1,275 people. So you're not going to meet them on the continuing care side, you're not going to meet them on the home-care side, and you're not going to meet them on the long-term side. I just want to know where my dad goes to die. That's what I'd like to know.

Mr. O'Brien: Currently we have sufficient long-term care capacity in the system. That's our belief. You know, we can prove that through the assessments of the clients who are on the wait-list and who are currently in the facilities. In addition to that, we are adding a thousand net new supportive living beds per year. These are environments that clients desire and require. In addition to that, we are growing home care. While we did put a target of 3,000 home-care clients per year, we're far exceeding that target. We're adding significantly larger numbers of clients to home care. We've committed once again to another 3,000 net new clients in the coming fiscal year. Home care is a high priority for us in terms of growth and having that environment between home care and long-term care. We're growing supportive living, and we feel that long-term care has sufficient capacity currently.

Mrs. Forsyth: I want to go back to the Auditor General's report and the recommendations he did on page 8 of his report, recommending that AHS tighten its controls over expense claims,

purchasing cards, transactions, and travel expenses. He talked about improving the analysis and documentation to support the business reasons, et cetera. Can you tell me what cost control methods you have implemented and how you are controlling them right now?

Ms Rhodes: As we said earlier, we've improved the policy. We've implemented training and educational materials. On the expense claim we actually require staff to attest and the approver to attest. We have set limits for hotels and airfare. If they exceed those limits, they must specifically document the reason for which they have exceeded those. Those go through a compliance review.

So we've done those types of things, and we're now in the process of providing by the end of June our first set of more comprehensive reporting on expenses. We have been reporting to the board on executive expenses for the last number of months, but we're now taking that reporting down within the organization.

9:00

Mrs. Forsyth: How many employees of Alberta Health Services currently have credit cards? We're hearing 1 in 4. How are you controlling those?

Ms Rhodes: We have about 1,900 P-cards that are out there. Those are procurement cards. The majority of those procurement cards are used by what I would call maintenance and facility staff and other staff that buy and use it for supply purposes. That's the majority. About 52 per cent of the expenses on the P-cards are related to the purchase of supplies.

Mrs. Forsyth: On the auditing control, if you have an expense, are they going to be putting on those expense accounts what the business purpose was for using the cards? Previously you've been criticized on that.

Ms Rhodes: Yes.

Mrs. Forsyth: I just want to talk a bit – I know our time is about five minutes – about your org chart if I may, please, again, Mr. Lockwood, and the pages and pages. You said that titles are irrelevant; you weren't going to get tied up on that. Last year's middle management grew from 3,450 FTEs to 3,800 FTEs. Why?

Mr. Lockwood: What was the number again?

Mrs. Forsyth: Middle management: 3,450 to 3,800 FTEs.

Dr. Eagle: I think we'll get back to you with a written response to that, but management is described as a number of different things. I mean, the staff who have brought in this e-People program, for example, have been classed as management. You know, the people who are doing quality assurance are classed as management. We've increased some areas. I don't know exactly what the driver of the number is, so I'll give you a written response.

There has been some increase in the number of management staff, but if you take a look at the overall management structure of Alberta Health Services and compare it to what the equivalent would be in Ontario – you know, we looked at how many executive leaders you would expect in Alberta based on the Ontario model. We used to have 140 VPs and CEOs. We now have approximately 80.

The Acting Chair: Thank you, Dr. Eagle. We'll take your written response on that. We just have very limited time.

Mrs. Forsyth: Let's briefly go to page 68 of the annual report, talking about physician engagement, which is notably low. I'd like to know, if you could please tell me, what physician engagement you have had in regard to physician concerns. I hear about intimidation and bullying, et cetera. If you could please in a written response tell me how you're proceeding on that. I can tell you that as of yesterday I'm still hearing about that.

Dr. Megran: We have taken that very seriously. After the report was commissioned along with the survey results, we undertook a number of initiatives. With respect to intimidation in particular, we established a confidential line in association with our medical staff associations and the AMA whereby physicians could call simply with questions about "How do I get heard?" or "How do I get a decision made?" or "I feel I've been intimidated or bullied" or "No one is listening," the entire spectrum.

We've made further adaptations to that . . .

The Acting Chair: Sorry to interrupt you here. The time is up for the Official Opposition. We'd very much appreciate a written response on that.

Next up we have the Liberal Party. Dr. David Swann.

Dr. Swann: Thanks very much, Mr. Chair. Thank you, all, for joining us today. One of the recurring themes around health care today is the ratio of management to front-line staff. Could you help us understand what that ratio looks like, how it compares? I think Dr. Eagle started to talk about Ontario. I'd like to hear more about that. The Minister of Health talks about a 3 per cent management investment. I'm not sure that he's ever explained that, but I'd like to hear something about how this compares to the ratio of management to front-line workers in the previous nine regions, for example. We talk about financial savings as a result of consolidation. Help us understand how that ratio looks today and how it compares to the former regions.

Dr. Eagle: We have taken, you know, repeated looks at how we're stacking up compared to other organizations, and we've looked into the private sector. We've looked at Exxon, for example, and we've looked at other health systems in Canada as to how we're doing. We've basically tracked how many senior leaders we have to the total head count, and we're running at about one senior leader, which is an executive leader, to about 1,300 staff. That's very similar to the percentage in the Vancouver Coastal health authority. It's very similar to many other health systems in the country.

It's not best in class, you know, so what we're doing in the work that Mr. Lockwood talked about is: how do we make this a leaner administrative system overall? I think there are some significant ideas about how we can bring that about, and we're working on it actively. But if you look at the most efficient ratio systems, it's about one senior leader to 1,800, so we think we can make a pretty good move on that. I've sort of tasked the organization with bringing down our administrative executive ranks by about 10 per cent per year over the next three years. So we're really committed to making this a lean organization.

I think the 3 per cent that you're referring to, that Mr. Horne talked about, is really related to the CIHI costing. Partly it's the way CIHI measures costs, but partly it's because we are quite efficient. Three per cent is a pretty good number, and it's one that we are going to hold as a benchmark . . .

Dr. Swann: Explain that 3 per cent to us.

Dr. Eagle: What CIHI does is it takes a number of lines out of our management information system which they define as expenses. They add them up, and they compare it to your total budget. They do that for health systems across the country. I think they actually have an updated financial report coming out in the next few weeks, so there will be further CIHI information. It's a very standard national comparator, and there are, as you know, very, very few strong national comparators. You could argue the appropriateness of the lines that they take from this management information system, but it is a standard that's done across the country.

Dr. Swann: Now, when you say one manager per 1,300 staff, you're talking about a senior manager.

Dr. Eagle: I'm talking about executive management.

Dr. Swann: I'm talking about entire management versus front-line caregivers, patient-contact caregivers. What is that ratio?

Dr. Eagle: I can't give you the ratio off the top of my head.

Dr. Swann: Maybe you could get back to me.

Dr. Eagle: Will do.

Dr. Swann: With respect to past reports of the Auditor General on delays in pension fund transfers from Alberta Health Services to the pension fund manager: a significant amount of interest payments, penalties, and delays in pension fund transfers. Hundreds and hundreds of employees were identified in a past – and I don't have the exact reference here. Can you explain what has happened about those delays in pension fund transfers and how they've been addressed in subsequent years? I haven't heard a follow-up, in other words, from either the Auditor General or from Alberta Health Services about those pension fund penalties, interest payments, and delays in transfers, the employer portions of the pension funds.

Mr. Hawes: I believe I can respond to part of your question. The Auditor General's recommendation is referring to a process where at the end of every calendar year Alberta Health Services and other employers are required to report to the pension board with respect to employee pensionable earnings, pensionable service, and it also indicates contributions. Then that's reconciled back to their records, and there are audit checks. The recommendation is related to that process of reporting. I don't believe it's related to the actual transfer of cash. It's a reporting issue.

With the amalgamation of a number of payroll systems the reporting is a little bit complicated. It's better now, going forward, that we're on one system. The recommendation relates to what are referred to, I believe, as turnaround documents. When we submit our electronic file – we actually submitted an incorrect file – it produces a number of error reports, and those are the turnaround documents that we're required to file. We weren't able to resubmit our file, so we had to go through a fairly manual process to submit. At the end of the day – I can't remember how long it took afterwards – all the turnaround documents were submitted and cleared all the errors that were logged as a result of that process.

9:10

Dr. Swann: Are you saying that there were no interest payments and penalties and delays in the actual transfer of dollars from Alberta Health Services to these staff pension funds? That was my understanding of this.

Ms Rhodes: To my knowledge, there was no interest or penalties. There were delays in issuing statements to members. The 2011 turnaround documents were cleared by January 31, 2013. We're in the process of doing the 2012 turnaround documents, and the plan is for those to be cleared by June 30, 2013, a significant improvement from last year. The 2011 member statements have now since been sent out to employees.

Dr. Swann: My final question is about the amalgamation of the nine regions. My understanding is that still at this point we haven't managed to consolidate the financial and staff data, and it's been an ongoing process of bringing them under the single management IT system. It's been almost five years. When can we expect to see the full integration of these nine regions into a single?

Mr. Campbell: I'm very pleased to report that as of April all our staff were on the same single payroll system, and we do have the same system for our account side. Everything is on one system, so it's good news. A lot of hard work by a lot of people.

Dr. Swann: If I have more time, I'll ask a question about how you make decisions on investment in prevention programming in Alberta Health Services. Is that a decision that comes out of Alberta Health? My understanding is that less than 5 per cent of our budget is involved in primary prevention programming. How do we get that up? How are we ever going to address the burgeoning costs of health care if we don't invest more in prevention, and who's making decisions around where we put prevention dollars?

Dr. Eagle: I think you've raised a really good point. You know, prevention is sort of a shared responsibility between Alberta Health and Alberta Health Services. If you look at what needs to be done with an aging population, with increasing amounts of chronic disease within that population, prevention, primary and secondary, is where we need to be spending resources.

We spent a fair bit of time over the last year and a half creating what we have called strategic clinical networks, where we bring groups of clinical experts together to look at best practice. A lot of the work that they're doing, you know, spans the continuum of care from primary prevention to death. We've asked them to pay particular attention to ways that we can prevent unnecessary care, how we can make sure that care is offered in the right place and that there's appropriate prevention. It's not only a cost-effectiveness issue; it's really about a quality of care and a quality of life.

Dr. Swann: Who's going to make the decision to start shifting more dollars, more time, energy, and investment into prevention?

Dr. Eagle: Well, it comes through our health plan, and that's approved by the board, and the board submits it to the minister.

Dr. Swann: And who's lobbying for that? Which group of people on your staff is working at that level?

Dr. Eagle: Well, we have our medical officer of health, Gerry Predy, sitting on our executive team. You know Gerry personally. He's a very effective leader in population health. I think that across the medical community as a whole there's a sense that we have to be working differently and doing far more on the prevention side. You know, issues like pediatric obesity and the impact that's going to have five and 20 years out have really had an

impact on how people are seeing what needs to be done today to look after the health of Albertans, to prevent illness tomorrow.

Dr. Swann: I'm hearing a lot about child mental health issues not being identified early: huge costs throughout the system, delays in seeing caregivers, complications of their chronic mental health conditions because they're not being identified early. That's another area where I think there's a tremendous need for investment.

Dr. Eagle: Wait times for child mental health are actually part of our tier 1 measures, and it's one of the areas that we spent a lot of time looking at. You know, one of the areas of mental health of children that concerns me greatly is the gap between adolescent services and adult services. The transition there is very difficult and need not be. It should not be difficult for patients and their families to make that transition. That entire issue of mental health for the young is something I think we need to spend a whole lot more time and effort on.

Dr. Swann: Thank you.

The Acting Chair: Next up we have Mr. Bilous from the NDP caucus.

Mr. Bilous: Thank you. I just want to begin by thanking all of you and your staff for being here. I'm going to get into mental health in a second, but a couple of quick questions. How many VP positions are there in total within the AHS?

Dr. Eagle: As of today 80.

Mr. Bilous: Eighty. That includes all VP positions or only the executive VP positions?

Dr. Eagle: That includes all.

Mr. Lockwood: So there would be VP, senior VP, executive VP, CEO.

Mr. Bilous: Okay. Thank you.

I'd like to know: in last year's budget how much was spent on executive salaries, bonuses, and severance? If you need to get back to me in writing . . .

Dr. Eagle: It would probably be more efficient to get back to you. We can certainly provide an accurate number.

Mr. Bilous: Thank you. I appreciate that.

Can you tell us why there were no targets available for the performance measure related to patient satisfaction for addiction and mental health services in the March 2013 AHS quarterly performance report? Have targets since been developed, and if not, why not?

Dr. Eagle: What we try to do with targets is to look where we can have comparator targets, you know, where there is a national benchmark, where there is some hard measure where the clinical experts say that your satisfaction or your wait times should be so much. Where it gets into more subjective areas like satisfaction, it's really hard to know what the satisfaction level should be. I mean, you'd want everybody to be 100 per cent satisfied all the time, but that's obviously an unrealistic expectation.

We've had trouble coming up with objective targets. When we have that type of problem, we tend to just look at what the trending is. What we wanted to see is that, you know – recently there was a Health Quality Council report, the report on patient satisfaction. We would want to see that to be a positive trend. It is. Is it fast enough? It is not. So we'd look at what information is out there year over year for things like satisfaction and see where we can go to improve the services that we offer for Albertans.

Mr. Bilous: Okay. The medical director for child and adolescent mental health and addiction services in Calgary, Dr. Chris Wilkes, has been very public and vocal in recent months with respect to the inadequate mental health services in Calgary, which is refreshing, to see a high-ranking official in AHS talk about the problems within the system in a very frank and candid manner. He said that the demand is outstripping service provision capacity because services haven't grown proportionally with population growth in Calgary in the system, which in his words is really a patchwork of services and is totally underfunded. Some children in Calgary spend up to three days in an emergency ward waiting for a bed. Some families report waiting lists of up to nine months for mental health treatment, which forces them to turn to private psychologists, which they have to pay for out of their own pocket.

I'm wondering what performance measures are in place to keep track of that patchwork of mental health services. Is it only the performance measure listed as children receiving community mental health treatment within 30 days on page 48 of the June 2012 AHS annual report, or are there additional measures that aren't necessarily published and made public unless we ask for them?

Dr. Eagle: We have a variety of measures that support the publicly reported ones. Obviously, each program has some measure of what its activity is, what the volumes are, what the wait times are. Right down to an individual clinic level they will have that information. We just don't roll it up. We could provide further information on the current situation for children's mental health in Calgary. We recognize that it's an issue.

You know, if you look at not just mental health, just looking at the growth in the use of the Children's hospital in Calgary, we're having overcapacity issues that we've never had before across all services. The number of visits to the emergency department is way up over what it has been before. I don't have the exact number, but that ability to provide services in Calgary to children is obviously of growing concern, growing day by day concern. We obviously have to adapt to it. We're working with the Children's hospital site and the programs that they run for Calgary but across southern Alberta as well and also looking maybe at options for capital development at the site to relieve some of the capacity pressures there.

Mr. Bilous: Okay. Continuing on this, one of the Legislature committees, the Standing Committee on Families and Communities, also heard in the last few months that the mental health system in the province is in shambles. The department is currently having a professor conduct a gap analysis so the government can get some sense of what services are actually being provided. They don't even know where the cracks are, let alone who's falling through, so I'm wondering: in your view, what are the obstacles to increasing the percentage of children referred for mental health services who actually receive a face-to-face scheduled assessment with a mental health therapist within the 30-day period? As of March 2013 we were 12 per cent below our targets, and that's on page 48 of your quarterly performance report.

9:20

Dr. Eagle: I can only say that we, you know, recognize this is a problem. We're working with our clinical teams. The tier 1 measures have a very effective way of focusing your attention on

making improvement. We are focused on it. We'll work on it. We're held accountable for the services that we deliver.

Mr. Bilous: You spoke earlier, when Dr. Swann was asking briefly about child mental health and the gap between adolescents and adults, and I'm wondering: what initiatives are you taking to close that gap? What is being done other than identifying that that's an issue?

Mr. O'Brien: I think your statements are fair. There is a current patchwork of services available, particularly to teens, adolescents, and children. The system that is in place for children does have some lessons for us for the adult world, where the case management is more system-wide. Really, it wraps around the client and enables them to transition from and to different care providers. This is something that we are working on. It is one of the objectives that we've listed in the creating connections addiction and mental health strategy that we're working on with the eight ministries as well.

Mr. Bilous: I can appreciate that you've identified it as an issue or an area where there needs to be work, but I'm wondering what kind of either targets or – you know, in a year from now or even six months from now, when this committee brings you back before us, what kind of benchmarks will we have at that point in time so that we don't hear, "Well, we're still working on it"? I mean, what are the tangibles that we can actually see?

Dr. Eagle: I think that that's a complicated question to answer, and I would like to give you an answer in writing to that. Thanks.

Mr. Bilous: Okay. Sure. Thank you.

On page 16 of the March 2013 performance report I'm a little concerned when I see that in the Edmonton zone only 61 per cent of children are receiving community mental health treatment within 30 days of referral. The target is 92 per cent. Again, for Edmonton it's currently 61 per cent, so that's quite a significant difference between the target and the actual. I'd like to know what the problem is. Why is the number so low in the capital city? What are the reasons, and what's being done about it?

Dr. Megran: We'll ask Dave to comment in detail again, but clearly you're quite correct about Edmonton at 61 per cent. That was of concern to us. Since then we've opened services and expanded services through our Leduc location.

Maybe I'll ask Dave to give us some details as to whether we have other initiatives and what the impact has been so far.

Mr. O'Brien: Yeah. Thank you. Dr. Megran is correct. What we have been doing is trying to understand better at a local geographic area the service need and trying to increase services available within the local geographies in order to address the problem. In addition and key to it, I think, is really involving the primary care networks and primary care physicians, in particular, in assisting to identify and to guide Alberta Health Services and the clients in terms of seeking the appropriate treatment in a timely way.

Dr. Megran: If I could just add, a number of the questions – and Dave's answer emphasizes this – speaking to care in the community, to prevention, all of the things that we are moving towards and need to move towards to make a sustainable system and to make a healthier Alberta require very close relationships and integration and interaction with other providers like primary care physicians and other primary care providers in clinics. They are critical partners. For care in the community, for prevention, and all of those things this must be a team effort, and we need to continue to direct our effort in building those relationships and making it a team and a solid, not haphazard, and well-functioning patchwork of many providers.

Mr. Bilous: I'll move away from mental health here, but I just want to make sure that this should be and hopefully is a priority. Again, I mean, there is a committee that's focusing on children's mental health. It's great that you've identified some of these things, but when we come to the next time we bring you in front of us, I'll definitely be following up to see what concrete actions have been taken.

I'm going to change gears here in my last couple of minutes. Last week the Alberta NDP opposition learned that AHS was privatizing a host of laboratory services currently done in Wainwright, Westlock, and Vermilion. In particular, general microbiology, immunochemistry, hemoglobin A1c are to be moved from Wainwright and Westlock and general microbiology from Vermilion to DynaLife. This privatization of services will mean that up to five AHS employees could lose their jobs. I'm wondering if you could give us any details on how much money you expect to save in moving these services to DynaLife.

Dr. Megran: We could give you a written response about the money.

I think two points are important. This is about efficiency in making sure that we're doing appropriate volumes of tests and maintaining the quality of those tests. As you know, there is a correlation between how many tests you do and how good you are at them.

I think, with all due respect, that the term "privatization" is perhaps not entirely accurate. As I think most people know, in providing many laboratory services in the Edmonton area and the northern part of the province as well as some parts of the central zone, DynaLife is a very important partner for us, and they are privately owned. This change in the three communities that you talked about was about efficiency and bringing testing into a more efficient pattern. It turns out that in this part of the province that means the testing will be absorbed into DynaLife and our relationship with them. Had it occurred in the southern part of the province, then it would have been absorbed into Calgary Lab Services, a subsidiary and publicly funded. So it's not a privatization decision, but it turns out and happens that we have a very important private partner in the provision of lab services.

The Acting Chair: Unfortunately, time flies when you're having fun, so we're now going to go to the deputy chair, Mr. Dorward.

Mr. Dorward: I refer you to page 130 of the Health financial statement and your financial statement, note 11. We're into the area of talking about supplemental executive retirement plans. I'd just like to read into the record the comments in the second paragraph of your note 11.

> During 2012, the AHS Board approved amendments to the defined benefit SERPs,

which are supplemental executive retirement plans,

> which will freeze SERP service accruals and earnings projections for all active plan members over a 3 year period. Once individual plan members' SERP service accruals are frozen, these plan members will be enrolled and accrue benefits in the new defined contribution SPP.

The SPP is not described a lot there. Could you describe the SPP and talk in general terms about who's in those plans, what it means? Could you start there, and we might take that line of questioning a little ways.

Mr. Hawes: The different retirement compensation arrangements related to pensions are described in the policies and a note to each, I think. The supplemental pension plan is a defined contribution plan, which is different than the SERP, which is a defined benefit plan. Basically, the individual's earnings that are in excess of the standard tax threshold that limits the benefit received under LAPP is subject to the supplemental pension plan. Ten per cent of those earnings are added to a defined contribution, sort of like our group RRSP plan. For example, if an individual was earning $200,000, the threshold is approximately $150,000, the excess earnings are $50,000, so 10 per cent of that, $5,000, would be the benefit that would accrue to that individual.

Mr. Dorward: Okay. Good. That area of pensions is a good launching point for me to make a comment. The annual reports you'll see, especially in the corporate world, have moved more to an informative document rather than an analytics document, which typically annual reports were in the past. Performance measures are good, but I even find performance measures not to be necessarily user friendly. Descriptions of things in meaningful ways are important parts of annual reports. I look forward to Alberta Health Services annual reports in the future being very user friendly and perhaps a document that regular Albertans can go to to actually find answers to some of the questions that we've heard today. Any comments on that at all, on your annual report? How important is it that you tell Albertans the real story of what's happening over there at Alberta Health Services?

9:30

Mr. Lockwood: Well, I think if you look at a public company, almost all of the public companies in Canada have eliminated the circulation of annual reports. They're limiting their disclosure to their financial statements and their management's discussion and analysis, so their MD and A. I think our annual report really serves to tell Albertans about some of the programs that we're dealing with. The financial statements are what they are, but I think we could get more into what I would call an MD and A type of document where it is verbiage explaining what the financial statements mean as opposed to just throwing out 30 pages of numbers. We'll take that under consideration and look seriously at that type of a document and not only create the document but use user-friendly language.

Mr. Dorward: Back to you, Mr. Chair.

The Acting Chair: Mrs. Sarich.

Mrs. Sarich: Thank you very much, Mr. Chair. I'd like to open by saying thank you for your presentation today and for the hard work by you and your board, all the allied health professionals, all your workforce throughout the organization and for your tireless commitment not only to the organization but in working really hard on behalf of Albertans to try to provide them the best health care system.

I come from the lens of the private sector. You know, Albertans often talk about their money being invested in the health care system, the approximately $17 billion. From my lens I would say that you're quite a health care conglomerate. I've often said that to see the full force of all of the changes that are occurring, it will be 10 years out from amalgamation, 10 years forward in hearing some of the information shared today.

I'd like to take you back to the October 2012 report, pages 172 to 176, where the Auditor General has provided recommendations on outstanding and not ready for follow-up audits; in particular, the recommendations that have been identified that are outstanding three years or more. Usually organizations experience that when they do have an Auditor look, they give you that three-year cycle to get your re-alignment and get things in place, so I wouldn't expect that you would give a response today. But I think what would be very valuable for this committee is a status update which would describe the processes, like your operational processes that you have undertaken to put in place, to address all of these outstanding issues, three years or more, contained in pages 172 to 176.

I also would like to go back to the inquiry by colleagues on the organizational chart issue. There is something that we can have a look at today. I appreciate that you have addressed an effort to streamline, flatten, maybe not so much vertical but to go in a different style, given a different management look at the organization. I think we need to be able to see: what does it say today in terms of our organizational chart? When you complete that work, what does it look like?

I have to ask this. When you make that move, it costs the organization money to make a change. Have you ever calculated for every action that you've taken what the actual cost of the change has been to the organization? Coming from the private sector, Mr. Lockwood, you would know exactly the context of this question. I think it's very incumbent on the organization of Alberta Health Services to examine that very question and what the final impact financially will be because we're talking about a $17 billion organization. You could provide a written response for that. I'm happy to hear a little bit about the quality improvement an organization with the complexities would be working alongside.

I have to ask this question as well. Sometimes fresh eyes looking at the situation given the governance, given the hierarchy of your organization – are you working with any external organization to help you identify strengths and weaknesses and streamlining to bring the level of standards that you're looking for and that you're proposing as an organization? Sometimes when you internalize, you can't see as well as an outside organization looking in to help you. Are you working with a consulting firm to help you with any of the organizational changes that you have in place or in mind as you move forward?

Mr. Lockwood: Well, with respect to the local decision-making, no, not at this stage. With respect to a refreshing new set of eyes on, for example, the finance and accounting world, absolutely. We've recently appointed a new board member, a CA from Calgary, and he will sit on audit and finance. I've appointed a committee member from Albertans at large who's not on the board but will also sit on that committee. As we look at each committee of the board, we're looking to refresh and get new ideas all the time, and we're constantly on the look for new board members to add.

Mrs. Sarich: Thank you for that. I guess maybe I wasn't clear. The appointments that give you an internal look: those people bring expertise to the table. Are you working with any external consulting group so that they can provide a fresh set of eyes about your organization, called Alberta Health Services, to provide you with a different perspective, something that would challenge and would perhaps make you a little bit more robust and nimble to respond to the demands of the health care system?

Mr. Lockwood: Not from a structural, organizational perspective; we're not.

Chris, other areas where we do have consultants?

Dr. Eagle: Yeah. We do a fair bit of, you know, benchmarking. We are looking at organizations that are like us, you know, and have spoken to and will probably be visiting Kaiser Permanente later this year. We formerly had a pretty brisk conversation with an organization called Geisinger in central Pennsylvania, which has one of the stronger health systems in the U.S. We've had a lot of back and forth with Intermountain Health. So we've looked at that.

We certainly use consultants to help us deal with things like remuneration and what's appropriate policy for remuneration for health care executives. Obviously, you know, we can come up with an answer, but it doesn't have much credibility. You have to have someone else say that it's reasonable or it's not. So we do a fair bit of that back and forth. We haven't done it comprehensively.

We are very much aware of the cost of change. You know, I've been through every design of health care system in Alberta since 1982. The cost of change to my career in terms of where energy has been taken, and taken away, has been fundamental. The effort to avoid pointless change is really critical. The move to devolving AHS from a single monolith down to five zones and then to more local decision-making is stuff that people have asked for. Our foundations have asked for it, our health advisory councils have asked for it, and many, many people in the public wanted a more responsive organization. These aren't radical steps; they're necessary steps.

Mrs. Sarich: If I could just interject.

The Acting Chair: Sorry, Mrs. Sarich. We just have limited time.

Mrs. Sarich: Oh, sorry. Thank you.

The Acting Chair: Ms Fenske.

Ms Fenske: Thank you. Following where MLA Sarich was going, I know we spent a considerable time the last time Alberta Health and Alberta Health Services were here on the PCN accountability. I know that that's not a three-year outstanding recommendation but, certainly, a quick update on how that's moving along.

I have another question, so I'll ask them both in case there isn't time. The other is on page 85 of the annual report, and it talks about emergency and outpatient services, for one. One of the lines that I've underlined is the "difficulties in recruiting staff, thereby creating vacancies." What are we doing to alleviate that problem? If you look under that bullet and also the bullet above about in-patient acute nursing services, increased overtime costs are mentioned twice. To me that's a scheduling issue. I mean, if we're always going into overtime costs, we need to change the staffing levels. If you could comment on those things, please.

9:40

Dr. Megran: With respect to the PCNs these are really combined recommendations from the OAG. Obviously, Alberta Health Services and Alberta Health have been working together. There is a draft accountability and evaluation framework, if you'll recall, and as you know, those recommendations were focused in large part on those two pieces, accountability within the PCNs and to whom, within government and AHS, as well as how we evaluate and measure. So those frameworks are there.

The current negotiations with the Alberta Medical Association, which we hope are coming to a very successful conclusion, will be an important step. During this time period since the release of the OAG report and the nature of the negotiations, really, it's very difficult for Alberta Health to engage PCNs and the Alberta Medical Association in any kind of review and joint operationalization of the accountability and evaluation framework. So we expect that to go forward. Obviously, you can't do this without the PCNs and their partners.

In the meantime I would just stress, though, that we are doing other things. AHS has started a measurement capacity initiative with 13 of the 39 PCNs, really working with them to say: how do we measure access in a meaningful way, and leading to improvement, how do we measure patient outcomes? Things of that nature. So we are moving forward on some initiatives despite the fact that the overarching frameworks really need to go forward in an environment with a signed physician agreement, where the role of the AMA in these processes and in the governance of PCNs is clear and where we can do that effectively.

Dr. Eagle: On the issues related to staffing, I think, you know, workforce is our number one concern at this point in time. It's not only where we spend our money; it's the heart and soul of our organization. I think there have been some earlier comments about the importance of our front-line staff in how Alberta Health Services is perceived and how patient care is delivered.

Overtime is a particular issue for us. It relates to an impact of having a very part-time oriented workforce. You know, the average RN in Alberta is working about .6, if I remember the numbers right, so that means that a nurse who's working three days a week can designate two days a week as sort of designated days off. If they're called back on those days, which happens frequently, that's at two times the rate in overtime. That's an expensive proposition.

What we've undertaken is a very major initiative to look at our scheduling and to work with the unions to increase the percentage of full-time staff. It's not only an issue of expenditure; it's an issue of safety. There's tons of evidence that says that when you have many handovers of care between care providers, you know, less safe care is provided. We need to make sure that we have as much towards a full-time workforce as we can get just to deliver high-quality care.

The Acting Chair: Thank you, Dr. Eagle.

Next up is Mr. Jeneroux.

Mr. Jeneroux: Great. I just have a quick question for you, hoping for a quick answer, but we'll see. Databases. We talked at length about the payroll system and the benefits of having one payroll system. I'm curious as to outside of the payroll system how many databases are in Alberta Health Services. I imagine in terms of streamlining these types of things, that the target isn't to have as many as what you currently have. I've heard through rumours that there are a lot. What would be your target for coming back to this table next year?

Dr. Eagle: Unfortunately, we have inherited many, many different clinical data systems, and I can't even hazard a guess as to how many there are. But on the plus side we're creating with Alberta Health sort of an amalgamated database. We can actually do real-time analytics on, you know: what are the services now, what do we need to provide them, how do we impact sort of chronic disease management, or what would a prevention program do to outcomes of health? By having an information system that looks at our Alberta Health Services activities, the information that comes from Alberta Health in terms of more the population demographics and some of the data that comes from other more socially oriented ministries, we can do much better in projecting the health needs of Alberta. While we have many, many different clinical systems, we also have this growing central repository of information that we can use for a sophisticated analytic. That's where the money is, actually, knowing your population and being able to analyze what the future trends are. I think, you know, that

almost any private-sector company of note is investing in analytics these days for exactly that reason. That's where we need to be.

The Acting Chair: Thank you, Dr. Eagle.

Mr. Jeneroux: Could I just clarify?

The Acting Chair: Be very quick.

Mr. Jeneroux: Are we talking about a million, or are we talking about 50? I guess just a round kind of number. I'm kind of looking at Stephen, thinking he might have an idea.

Mr. Lockwood: Well, just by way of example on the financial side, simply the financial records, we started off with somewhere in the neighbourhood of 15 different systems. In a typical amalgamation in the corporate world you'd have a robust system that all of your other companies that you buy fit into. We had a situation of 15 systems, none of which was robust enough for the entire system. We've taken 15 to one, so there's an example of the savings.

The Acting Chair: Thank you, Mr. Lockwood.
Next up is Mr. Dorward.

Mr. Dorward: Just in an attempt to tie this into the financial statements, on the consolidated statement of operations there are expenses. One of those expenses has got to be for the primary care networks. I did want to comment that the primary care networks, in my opinion, are doing great work. In my constituency we've often talked with people that are involved with them. However, the number of people that know about them, quite frankly, is way lower than I thought. I had two meetings recently, one with a hundred seniors and another one with 60. Of the hundred, eight put their hands up that they even knew about it. In the 60, there were four who put their hands up. So we're at less than 10 per cent of knowledge of what a PCN even does. Just as a comment, can you tell me, really fast, the future of PCNs?

Dr. Megran: That's a hard one really fast. I think that tied in with the OAG recommendations as well as the realization that things need to evolve and go further, you're quite right that PCNs have accomplished a lot. They do vary in their scope and breadth and what they've done. Alberta Health has embarked on what is affectionately called PCN 2.0, really an enhanced PCN.

What have we learned? How do we go further? How do we take the improvements further? How do we take into account the OAG issues that were raised? That process, again, was difficult and delayed with respect to negotiations with the Alberta Medical Association and the primary care groups within the AMA but in the last two months is gaining momentum again. My understanding is that there is a fourth or fifth version of what the future and what enhanced PCNs will be that has come out of the Alberta Medical Association and the Primary Care Alliance and is being considered by Alberta Health. Alberta Health Services is a part of that feedback process and development process.

The Acting Chair: Thank you very much for that brief answer. I know Mr. Dorward put you on the spot there.

Obviously, this is a very large organization, and we have limited time. At this point there are some remaining questions from each caucus, so we're going to allow them roughly a minute and a half each to get them on the record and, hopefully, in some cases get written responses from you if you're willing.

Heather Forsyth.

Mrs. Forsyth: Thank you. I'm going to be brief, and I would like a written response.

I want to go to page 26 of the Auditor General's report about the questionable expenses in regard to the Flames tickets, the gate admissions for the Stampede, et cetera. Have those questionable expenses been paid back? Have you paid Mr. Merali a severance yet?

I want to talk about schedule 2. I talked about the middle management, and you said that you didn't have that in front of you. It's in schedule 2 of the annual report under the management category, where it went from 3,500 to 3,800 and from $447 million to $500 million in one year. I'd like to know how many millions of dollars you have put into putting more front-line staff in place instead of middle management. Where we really need to focus is on the front lines.

I want to refer to the Auditor General's report of October 2012, page 173, about the mental health gaps that still have not been dealt with from October 2008. We had some questions on mental health. "We recommend that Alberta Health Services reduce gaps in mental health delivery services by enhancing," and they go on. Could you please update me on that?

Thank you.

Dr. Eagle: We'll get you written responses on all of those.

The Acting Chair: Great. Written responses. That's excellent.

9:50

Mr. Bilous: Okay. I'll read these in as quickly as I can.

Going back to concerns with the Westlock privatization, they revolved around the fact that eliminating laboratory work within the hospital might actually increase costs in the long run. I understand that whenever Westlock hospital, for example, sends a patient to Edmonton for tests, when the patient returns, they're put in a private room, and extra safety precautions are taken until that patient can be tested for superbugs that exist in Edmonton's hospitals but not in Westlock's. Having an immunochemistry lab right inside the hospital means that patients can be tested within a short period of time. Once the hospital has to start sending these tests to DynaLife, patients will have to stay in private rooms, with staff taking extra safety precautions and taking up some of their time, and incur greater costs on the health care system.

A couple of questions. Can you confirm if DynaLife is the only private service provider for lab services in the province? Can you tell the committee the dollar amount relative to how much was paid to DynaLife for any and all services in 2012? If you can, comment on whether or not you're concerned that by removing lab services from rural hospitals, new doctors might be less inclined to practise in those locations due to fewer available services.

The Acting Chair: Thank you.
Written responses?

Dr. Eagle: Yes.

The Acting Chair: Okay. We've gotten confirmation from Dr. Eagle that they'll provide a written response.

Next up is Dr. Swann. Do you have any remaining last questions?

Dr. Swann: A couple of general questions and comments. You indicated a significant increase in home-care services, which is good news. What I'm hearing, unfortunately, from the field is that the quality of home-care services is not what it could and should be, and there are a number of factors in that: the education of the

staff, the attitude of the staff, the English skills of the staff, the lack of continuity of the staff. It's creating, certainly, complaints to my office.

Relating to another, more general issue, the palliative home-care cuts that we heard about yesterday are really a shift, as I understand from the minister, between RNs and LPNs, and that may be okay if you're dealing with uncomplicated palliative care clients. What I'm hearing is that in some cases these are critically ill clients at home, and the shifting from an RN to an LPN means a serious, increased risk of failing to identify problems early and treating them appropriately and referring them as necessary, meaning that we're going to end up with more emergency room visits from some of these palliative care clients, more hospitalizations, more deaths in waiting rooms instead of deaths at home, where they want to be. Just feedback that's coming to my office.

Employee sick leave. I haven't heard and seen much about it, and I'm not sure whether . . .

The Acting Chair: Dr. Swann, sorry to interrupt. Maybe if you have a question that they can provide a written response for?

Dr. Swann: I'd love to see some data on morale and sick leave. To me, they're connected. You've done some surveys of staff morale. How is our sick leave relating to other health care organizations, the rate of sick leave and absenteeism among staff?

Dr. Eagle: Again, we'll get you a written response.

The Acting Chair: Great.

Thank you very much, Dr. Swann and Dr. Eagle.

Next up I just want to see if Mr. Khan, who's online, has any burning questions that he'd like to get in here.

Mr. Khan: Thank you, Mr. Chair. Dr. Swann, thank you for bringing up the issue of home care.

Dr. Swann touched on a number of the questions I had regarding addressing the challenge of finding staff for home care. Again, this is a question that perhaps is best dealt with in a written response. I'm just curious to know from a budgetary standpoint if there have been any projections or cost-benefit analyses done as to: would there be some tangible savings to AHS with increased home care?

Dr. Eagle: Again, a written response will be forthcoming, Mr. Khan.

The Acting Chair: Great. Thank you, Mr. Khan.

Mrs. Sarich, very, very briefly.

Mrs. Sarich: Primary care networks collect a lot of data. What have you requested in terms of data sharing from primary care networks so that they have their place along with family care clinics and to support their investment like the dollars that are being allocated to them and the service and programs that they provide? I think that Albertans need to understand these two places where health care delivery is occurring. In Edmonton-Decore the Edmonton North primary care network is an example. Lots of people don't even know it exists.

Thank you.

The Acting Chair: Thank you.

As the chair and representing this committee, we obviously thank you very much, the folks from Alberta Health Services, for taking the time and for thoroughly answering our questions. At this stage we have business that we're going to proceed with, so you're free to leave the room. Thank you so much again.

Folks on the committee, we just have some business that we'll get done in about 10 seconds, some really quick business. The working group met last week and agreed that a presentation by the CCAF surrounding reporting practices would be a good idea for the committee. They are the same organization that came and gave us that day-long orientation last September, and they have indicated their availability. The meeting would be scheduled for September 12 as this committee is currently booked every week until June 5. Because the meeting would be out of session, there would be a half-day meeting with them similar to the orientation back in September.

I was wondering if a member could move that. I'll read the motion, and Mr. Amery has indicated he would move that

> the Standing Committee on Public Accounts authorize the committee clerk to contact the Canadian Comprehensive Auditing Foundation for the purpose of scheduling a presentation to the committee on September 12, 2013, and that the responsibility for any necessary scheduling be delegated to the informal working group.

Mr. Amery: I so move.

The Acting Chair: Mr. Amery has moved that. All those in favour? Opposed? Carried.

There is a Canadian Council of Public Accounts Committees conference coming up, that this committee traditionally participates in. This year's conference is scheduled from August 25 to 27 in Regina, Saskatchewan. It would be a great type of holiday to have there. Delegations are typically comprised of the chair and deputy chair of the Standing Committee on Public Accounts as well as the committee researcher and committee clerk. I would suggest that we nominate two backups just in case one of the attendees outlined is unable to participate.

The committee clerk has informed me that in the past we used a lottery system, where names are picked out of a hat by the committee clerk and added to a contingency list. If a member is unable to attend, the first name on the list would have the first opportunity to take their place. If they're unable, the second person is contacted. Would any members be interested in putting their names forward as an alternative? If they do, please e-mail the committee clerk. The deadline for these submissions is Friday, May 17, at noon. The draw would occur at 1:30 p.m. sharp in committee room B for any who would like to be present, and those members would be informed via e-mail.

Does anyone have any questions on that process? If not, I'd like a member to move that

> the chair, the deputy chair, the committee clerk, and a committee researcher for the Standing Committee on Public Accounts be approved to attend the 2013 CCPAC-CCOLA conference in Regina, Saskatchewan, in August and that the selected members be identified as alternatives in the event that any of the approved delegates are unable to attend.

Mr. Amery: I so move.

The Acting Chair: Mr. Amery moves. All those in favour? Any opposed? Carried.

The next meeting date is at 8:30 in committee room A with Alberta Agriculture and Rural Development on Wednesday, May 29, following the constituency week. The prebriefing will occur from 8 in the morning till 8:30 in committee room B.

Mr. Dorward: Thank you, Mr. Chair. Just a comment that we anticipate meeting for the next two. There is one after this one, on

June 5. We do not anticipate changing those, whether the Assembly is sitting or not.

The Acting Chair: A very important motion that I'd like someone to move, that the meeting be adjourned.

Mr. Amery: I so move.

The Acting Chair: Mr. Amery has so moved. Thank you, everyone.

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

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