



Legislative Assembly of Alberta

The 30th Legislature
First Session

Standing Committee
on
Public Accounts

Health
Alberta Health Services

Tuesday, February 11, 2020
10 a.m.

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**Legislative Assembly of Alberta
The 30th Legislature
First Session**

Standing Committee on Public Accounts

Phillips, Shannon, Lethbridge-West (NDP), Chair
Gotfried, Richard, Calgary-Fish Creek (UCP), Deputy Chair

Barnes, Drew, Cypress-Medicine Hat (UCP)
Dach, Lorne, Edmonton-McClung (NDP)
Feehan, Richard, Edmonton-Rutherford (NDP)
Guthrie, Peter F., Airdrie-Cochrane (UCP)
Hoffman, Sarah, Edmonton-Glenora (NDP)
Nixon, Jeremy P., Calgary-Klein (UCP)
Renaud, Marie F., St. Albert (NDP)
Rosin, Miranda D., Banff-Kananaskis (UCP)
Rowswell, Garth, Vermilion-Lloydminster-Wainwright (UCP)
Stephan, Jason, Red Deer-South (UCP)
Toor, Devinder, Calgary-Falconridge (UCP)
Turton, Searle, Spruce Grove-Stony Plain (UCP)
Walker, Jordan, Sherwood Park (UCP)

Also in Attendance

Shepherd, David, Edmonton-City Centre (NDP)

Office of the Auditor General Participants

W. Doug Wylie	Auditor General
Eric Leonty	Assistant Auditor General

Support Staff

Shannon Dean	Clerk
Stephanie LeBlanc	Clerk Assistant and Senior Parliamentary Counsel
Teri Cherkewich	Law Clerk
Trafton Koenig	Parliamentary Counsel
Philip Massolin	Clerk of Committees and Research Services
Sarah Amato	Research Officer
Nancy Robert	Research Officer
Michael Kulicki	Committee Clerk
Jody Rempel	Committee Clerk
Aaron Roth	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications
Jeanette Dotimas	Communications Consultant
Tracey Sales	Communications Consultant
Janet Schwegel	Director of Parliamentary Programs
Amanda LeBlanc	Deputy Editor of <i>Alberta Hansard</i>

Standing Committee on Public Accounts

Participants

Ministry of Health

Aaron Neumeyer, Assistant Deputy Minister, Financial and Corporate Services

Lorna Rosen, Deputy Minister

Dean Screpnek, Assistant Deputy Minister, Health Standards, Quality and Performance

Alberta Health Services

Deb Gordon, Vice-president and Chief Health Operations Officer, Northern Alberta

Verna Yiu, President and Chief Executive Officer

10 a.m.

Tuesday, February 11, 2020

[Ms Phillips in the chair]

The Chair: Well, good morning, everyone. I would like to call this meeting of the Public Accounts Committee to order and welcome everyone in attendance.

My name is Shannon Phillips. I'm the MLA for Lethbridge-West and chair of this committee. I would ask that members, staff, and guests joining the committee at the table introduce themselves for the record, and then I will go to the members on the phone lines. However, I believe that today we do not have any. I'll double-check that.

Please.

Mr. Gotfried: Good morning. Richard Gotfried, MLA for Calgary-Fish Creek and deputy chair.

Ms Rosin: Good morning. Miranda Rosin, MLA for Banff-Kananaskis.

Mr. Barnes: Drew Barnes, MLA, Cypress-Medicine Hat.

Mr. Jeremy Nixon: Jeremy Nixon, Calgary-Klein.

Mr. Turton: Good morning. Searle Turton, MLA for Spruce Grove-Stony Plain.

Mr. Walker: Good morning. Jordan Walker, MLA, Sherwood Park.

Mr. Stephan: Jason Stephan, MLA, Red Deer-South.

Mr. Guthrie: Peter Guthrie, Airdrie-Cochrane.

Mr. Toor: Good morning. Devinder Toor, MLA, Calgary-Falconridge.

Ms Gordon: Good morning. I'm Deb Gordon with Alberta Health Services.

Dr. Yiu: Verna Yiu, president and CEO of AHS.

Ms Rosen: Lorna Rosen, Deputy Minister of Health.

Mr. Neumeyer: Aaron Neumeyer, Alberta Health.

Mr. Screpnek: Good morning. Dean Screpnek, Alberta Health.

Mr. Leonty: Eric Leonty, Assistant Auditor General.

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

Mr. Shepherd: Good morning. David Shepherd, MLA, Edmonton-City Centre.

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora.

Mr. Feehan: Richard Feehan, Edmonton-Rutherford.

Ms Renaud: Marie Renaud, St. Albert.

Mr. Dach: Good morning. Lorne Dach, MLA for Edmonton-McClung.

Dr. Massolin: Good morning. Philip Massolin, clerk of committees and research services.

Mr. Roth: Good morning and happy 2020. Aaron Roth, committee clerk.

The Chair: I'll note that we do not have any members teleconferencing today, and we do not have any substitutions today.

The microphones are operated by *Hansard*, so you do not need to do anything. Please set your cellphones and other devices to silent for the duration of the meeting. The committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and video stream and transcripts of the meetings can be accessed via the Legislative Assembly website.

We'll now move on, committee members, to approval of the agenda. Are there any changes or additions to the agenda?

Seeing none, would a member like to move that the agenda for our February 11, 2020, meeting of the Standing Committee on Public Accounts, the morning meeting, be approved as distributed? I have a mover, Mr. Barnes, I believe. Are there any discussions on this motion? All in favour? Okay. Any opposed? Thank you. That motion is now carried.

We will move on to item 3, approval of minutes. Do members see any errors or omissions to note in regard to the previous meeting's minutes?

If not, would a member move approval of the December 3, 2019, minutes?

Mr. Turton: So moved, Madam Chair.

The Chair: Okay. Mr. Turton. It is moved that the minutes of the December 3, 2019, meeting of the Standing Committee on Public Accounts be approved as distributed. Is there any discussion on this motion?

Seeing none, all in favour? Any opposed? Thank you. That motion is carried.

We will now move on to Health and AHS. I would like to welcome our guests from the Ministry of Health and Alberta Health Services, who are here to address the office of the Auditor General's outstanding recommendations as well as the ministry annual report for 2018-19.

I would like to invite officials from Health and AHS to provide opening remarks not exceeding 10 minutes. Thank you.

Ms Rosen: Thank you, and good morning, everyone. We appreciate the opportunity to return to the committee and continue our discussion on Alberta Health's 2018-19 annual report and the Auditor General's outstanding recommendations.

At the outset I want to once again reiterate our thanks to the office of the Auditor General for its desire to improve the health system for all Albertans. We take the Auditor's recommendations very seriously and work hard with our partners and stakeholders to implement them.

The department currently has 14 outstanding recommendations. Three recommendations relate to user access management for electronic health records, oversight for seniors in long-term care, and improving that conflict-of-interest processes are fully implemented and ready for a follow-up audit. The department has continued to address its six outstanding recommendations related to chronic disease management. These recommendations are fully implemented, and we are working with the office of the Auditor General and AHS on determining the best approach to their follow-up. And we continue to work towards implementation of the remaining five outstanding recommendations. For example, we have entered into a contract with Meyers Norris Penny to develop a process for reconfirming that all Alberta personal health card holders continue to be eligible for health coverage in Alberta.

I'll take the next few minutes to recap some of the department's key accomplishments from 2018-19 before turning it over to Dr. Yiu. Looking at the first outcome in our annual report, to improve

Albertans' health outcomes, home care services were expanded to increase access, reduce reliance on acute care, and enable Albertans to stay at home longer. The government supported the development of about 1,200 net new continuing care spaces, including designated supportive living and long-term care.

Work was done with Health and community partners to strengthen mental health and addiction care for Albertans. Some examples of achievements include the elimination of wait-lists for primary and mental health services from the Calgary urban partnerships society, the delivery of mental health first aid training to over 250 seniors and their caregivers as well as government staff working in disability services, and the hiring of additional school-based community mental health supports.

Turning to our second annual report outcome of supporting Albertans' well-being through population health initiatives, ongoing projects within the ministry include working with the community partners to promote healthy living and eating. We continue to address the opioid crisis through actions such as training emergency room staff as well as primary care providers to treat patients with opioid use disorder. As of March 31, 2019, there were approximately 550 PCN providers prescribing opioid agonist therapy to their patients. More than 90,000 naloxone kits were distributed in 2018-19. New opioid dependency treatment clinics were established, and the virtual opioid dependency program was expanded, which helped treat Albertans with opioid use disorder in 136 communities across the province.

The government continued health service improvements for indigenous Albertans by collaborating with indigenous communities, AHS, the federal government, and other partners to address health priorities and support culturally safe programs and services.

The ministry also provided an additional \$1 million in 2018-19 to support enhanced sexually transmitted infection outreach services by AHS.

In relation to the third outcome in the annual report, ensuring Albertans receive care from skilled health care providers working to their full scope of practice, work continued to improve the delivery of primary health care services, and scopes of practice were expanded for registered nurses, nurse practitioners, and midwives. Support for emergency medical services was increased by \$25 million, including support for the community paramedic program.

In regard to our annual report outcome of a high-quality, stable, accountable, and sustainable health system, we continue to support the pan-Canadian efforts to reduce generic drug prices, which realized more than \$30 million in incremental savings for Alberta in 2018-19.

In addition, Netcare enhancements were made to improve care co-ordination, and the MyHealth records portal was successfully launched in March 2019. The government worked with AHS to improve communications for referrals between primary care providers and specialists to shorten wait times through initiatives such as e-referral and the Alberta referral directory.

With that, I'll now ask Dr. Yiu to provide her comments.

Dr. Yiu: Great. Good morning, and thank you for the opportunity to be here with you today. As you know, the results of the AHS review were released last week. The review really recognizes the successes that AHS has achieved over the last decade as the largest integrated health care system in Canada. It has given us an objective look at where we are today. It has also pointed out many opportunities to evolve and do things differently, all with a goal of being more efficient and providing more effective patient care. We are a change-ready organization, and we are making progress on what matters the most, building a sustainable system that is here for Albertans today and in the years to come.

In the past decade Alberta's health care system has become more efficient, more sustainable, and more integrated. There is less duplication of services, a leaner administration, and we are able to adopt best practices quickly and effectively province-wide. There is still work to be done, and we are putting more focus on high-priority areas such as surgical wait times, addiction and mental health services, and treating patients in the community rather than in the hospital.

We are currently reviewing the report's recommendations to determine our priorities for action. Our goal is to ensure that Albertans receive the best care both now and in the future. Obviously, fiscal stewardship is central to this, and we take that accountability seriously.

I share this background on this report because it's a relevant foundation for me to discuss our annual report and the recommendations relating to the Auditor General's report on health. I'd like to also thank the office of the Auditor General for his work over the years to help improve patient care, efficiency, and safety in our health care system.

As of February 2020 AHS has 10 outstanding recommendations from the Auditor General. We have advised the OAG that we've implemented seven of these recommendations. Those related to expense claims, IT disaster recovery plans, chronic disease management, mental health services, and seniors' health are prepared for a follow-up audit. In seniors' care and mental health there is more to do, but AHS is working to implement the OAG's recommendations. We are also committed to our work improving the health system and delivering high-quality care that meets the needs of all Albertans.

Of our performance measures available in the report, 10 are better than or the same as the year before. We hit the target on one of the measures, people placed in continuing care within 30 days, showing improvement from a year earlier.

10:10

We acknowledge that we still have much work to do to achieve the target on all 13 performance measures, but we are focused on making improvements on those targets. Three other measures also showed improvement: percentage of alternate level of care patient days, timely access to specialty care e-referral, and the disabling injury rate in the AHS workforce. In addition, we are seeing stability in six important measures: patient satisfaction with hospital experience, wait time for addiction outpatient treatment, unplanned medical readmissions, hand hygiene compliance, and childhood immunizations.

We continue to work towards seeing improvements in nursing units achieving best practice efficiency targets and perinatal mortality amongst First Nations. As we head into our second decade, I'm proud of what we have accomplished, and I'm excited about what the future holds. We are committed to bringing down the costs of care, including reducing the average cost of treating a patient in a hospital. We're increasing the quality of health care we provide across the system, and we are working every day with our partners to transform how health care is delivered now and in the years ahead.

I hope today's meeting is an opportunity for us to continue to work together to do what needs to be done to deliver positive health outcomes and experiences and do so in a financially sustainable way. Thank you.

The Chair: Thank you.

I will now turn it over to the Auditor General for his comments. Mr. Wylie, you have five minutes.

Mr. Wylie: Yeah. I turn my time back over to the committee.

The Chair: Okay. Well, thank you, Mr. Wylie.

Our time allotment format for questions from committee members has been revised for today's meeting. The first rotation will now be 15 minutes each for the Official Opposition and the government members, beginning with the Official Opposition. Mr. Shepherd.

Mr. Shepherd: Thank you, Madam Chair, and thank you to all the members of the committee and everyone who is here to join us today. I appreciate the opportunity to join in on this discussion of the ministry's annual report, the outstanding recommendations from the Auditor General.

Off the top, I just have a few questions related to some of the activity levels that occurred during the fiscal year 2018-19 at a number of AHS locations. I appreciate that some of these questions might be fairly substantive. You might not have all the numbers at your fingertips, but for anything you don't have available now, I would appreciate it if you could follow up quickly in writing. Thank you.

I'll start. I'm just wondering. I understand, of course, that AHS is currently looking at reducing what they deem to be procedures of limited clinical value, which amounted to roughly 50,000 procedures. Some of those procedures involved breast reductions, tubal ligation. I was just wondering if officials from AHS could provide this committee with a list of all AHS locations in 2018-19 that provided those services and how many procedures were done at each of those facilities in terms of breast reductions and tubal ligation.

Dr. Yiu: Yeah. Absolutely, we can provide some of that information to you. We just don't have that available to us right now.

Mr. Shepherd: Of course. I understand. Thank you.

Well, moving on, then, of course, AHS also operates, to my understanding, about 85 small or medium hospitals that have 24/7 emergency departments, approximately 83 of those being in rural Alberta, serving about 830,000 rural Albertans. Now, those sites were identified in the recently released Ernst & Young report into AHS. I was wondering if officials could provide a list of those 83 hospitals and provide us with some data on the activity levels in each of those emergency departments. In particular, I'm curious about how many patient visits there were on average per day, per month, and for the year in the fiscal year 2018-19.

Dr. Yiu: Yeah. I mean, I think we can also provide that information to you.

Mr. Shepherd: Fantastic. Thank you, Dr. Yiu. I appreciate that very much.

One of the other things I was curious about. I've been doing a lot of reading recently of the EY report. There's some discussion in there of long-term care, and I was wondering if officials from AHS could provide a list of all of the long-term care beds that are currently operated by Carewest and CapitalCare during the fiscal year 2018-19, including the location and the number of those beds.

Dr. Yiu: Again, we would be happy to provide that to you.

Mr. Shepherd: Excellent. Thank you, Dr. Yiu.

Along the same lines, there is some discussion there regarding the provision of certain nonprescription medications in those facilities. I know that currently AHS does not charge long-term care patients for nonprescription medications such as Tylenol, at a cost

of roughly, I understand, about \$2 million if I'm reading the report correctly. I was wondering if officials could provide a list of all the long-term care facilities, the number of beds in each facility, and an estimate of the costs at each facility for the use of nonprescription medications for the fiscal year 2018-19.

Ms Rosen: We can provide that from a perspective of the reimbursement of the drug costs, yes.

Mr. Shepherd: Excellent. Thank you, Ms Rosen. I appreciate that.

I'm also interested in getting a better understanding, I guess, of some of the capital purchases regarding diagnostic imaging during the fiscal year 2018-19. I was interested, in reading the EY report, to note that there's been no provision of capital funding to look after some of the badly needed work of replacing and repairing some equipment. I'm just wondering if officials can identify the total sum that was spent during the fiscal year 2018-19 on capital purchases related to diagnostic imaging and, as a supplementary to that, if we could get a list of all the equipment that was purchased and which AHS sites that equipment went to.

Dr. Yiu: Yes, we can provide that to you also.

Mr. Shepherd: Okay. Did you want to provide any comment at this time, I guess, about your thoughts on the amounts that were invested towards the diagnostic imaging equipment in 2018-19? From what I'm reading, it sounds like we have at least, if I recall my numbers correctly, about 30 per cent of the equipment that was nearing the end of its useful life and quite a few others that were needing to be replaced. Were we able to make progress on that during the '18-19 year?

Dr. Yiu: We'll have to get back to you on that. I just don't have the details on that. I would have to say that we have sort of a high-level, strategic approach to equipment replacement, of which diagnostic equipment would fall into overall equipment maintenance, but we can get back to you on that.

Mr. Shepherd: I understand. Certainly. Thank you, Dr. Yiu.

I have a question, then, about how Health and AHS are estimating what's usually referred to as unavoidable growth pressures, so things like population increase, demographics, inflation, et cetera. Now, I was just wondering: what was the ministry's assumption in 2018-19 in terms of what the costs would be for unavoidable growth pressures in total? That is to say: what was your estimate on the combination of population increase, demographic changes, and inflation in percentage terms as it applies to the Ministry of Health budget and the AHS budget, assuming roughly flat levels of service?

Ms Rosen: So, Mr. Shepherd, did you want that broken down between those component parts: population, inflation, and demographic changes?

Mr. Shepherd: Certainly. If you have those as separate amounts, that would be appreciated.

Ms Rosen: We do, but I do not have it broken down here. Can we get back to you with respect to that?

Mr. Shepherd: Sure. Would you be able to provide a general summary and then the details later?

Ms Rosen: In terms of a general summary I would suggest to you that we were working towards an overarching increase of approximately 3 per cent because that was manageable given those

pressures and without what I would call significant structural change required in order to achieve those pressures. It was, I believe, 3.3 per cent, but I would like to check that and get you the component parts.

Mr. Shepherd: Thank you very much. I appreciate that, and I look forward to reviewing that information.

Along similar lines, the recently released EY report notes that there are some unavoidable growth pressures in the system, and they're predicting that they will average about 1 and a half per cent per year over the next four years. Now, given that you were just talking about 3 per cent, that number strikes me as a bit low, and I think that Budget 2019 estimated that population growth alone, excluding any demographic changes and inflation, would be about 1.6 per cent in 2020, 1.7 in 2021, 1.9 in 2022, and 2 per cent for 2023. Can you help me understand – I'm just trying to get a sense here: how can these growth pressures be less than our actual population growth?

The Chair: Member Shepherd, I will just take this opportunity to remind all MLAs present that Public Accounts is focusing on money that has already been spent and assumptions that have already gone into previous years and previous annual reports, just for everyone's context.

Mr. Shepherd: Thank you, Madam Chair. Are you asking me to rephrase my question, then?

The Chair: Yes, I am.

Mr. Shepherd: Certainly. Well, thank you, Madam Chair. Given your instruction, perhaps I could put it this way. I mean, I appreciate that we're looking back at 2018-19. The current administration may have some different views on this, but looking back at 2018-19, then, perhaps: can officials tell us what the ministry assumption was for the combined inflator for population growth, demographic changes, and inflation for the next four fiscal years? I assume it's part of 2018-19 that that work was done. Those considerations were baked in as part of how that budget and spending were applied. I'm just trying, again, to understand what the ministry's planning assumptions were during 2018-19 for growth pressures for those three variables when they're combined in percentage terms.

10:20

Ms Rosen: As I stated earlier, the assumptions were that we would capture any efficiencies that were possible without making what I would call foundational or structural changes and without doing some program review with respect to either Alberta Health or Alberta Health Services. It was more what I would call a summative approach to the different pressures and then using some modelling to determine what might actually be achievable with respect to controlling growth.

Mr. Shepherd: Excellent. I guess that'll be evident, then, in some of the other . . .

Ms Rosen: Yes.

Mr. Shepherd: . . . written information you'll provide, that'll demonstrate what that was. Well, thank you very much.

I had a question just along the issue of lab services. Now, again, in reading the EY report, it refers to some costs regarding lab services, I believe, going back to 2018-19. It states that when comparing similar tests within the hybrid model, that being in Alberta south, where in the Calgary region we have mainly public provision; in the north we have the hybrid provision, some private,

some public. The EY report, based on data from APL that I haven't found publicly available but which they refer to, compares similar tests within the hybrid model and claims that there's a cost differential of about \$1.29 per test between APL and the private provider. I was wondering. Would you be able to provide to the committee, I guess, any information you would have on the differences in costs in the 2018-19 year on similar or identical tests performed between the private provider and the public providers within the province of Alberta?

Dr. Yiu: Yeah. I would say that right now what we're doing is trying to validate some of the EY, I would say, assumptions that they made around that piece. It's very hard to actually get the pricing from the private companies. They're private entities, so you don't necessarily have all the information, but we can try to provide you with our best guess. It is part of our evaluation as we look at that recommendation from EY.

Mr. Shepherd: Thank you, Dr. Yiu. I appreciate that. Just to clarify, is this just the way the contract is structured with the private provider such that we don't have a clear idea of what we're paying per test?

Dr. Yiu: Well, you know, we're not comparing apples with oranges because we do tests, for example, that the current private provider doesn't do. So when you try to lump everything together, it's not necessarily comparable because we do more expensive tests, we do more complex tests, so there's that complexity in there. I wish it was easier to compare, but it's not. But we can try to provide you with what we have as best as we can.

Mr. Shepherd: Well, thank you, Dr. Yiu. I guess that's something we need to keep in mind, then, when we're reviewing the Ernst & Young report.

Ms Rosen: Maybe if I could just supplement a little bit.

Mr. Shepherd: Certainly.

Ms Rosen: I don't think that it's our place to comment on the methodology that EY may have used in terms of their calculations. They did what they did independently. They provided us with some results, and as Dr. Yiu has said, we now have to figure out what that means for us in terms of their assessments and then moving forward. There will be an implementation plan with respect to that. So I wouldn't suggest to you that we could replicate their results, but we can give you whatever information we do have that's available.

Mr. Shepherd: Absolutely, and that would certainly be all I would ask. I certainly recognize that EY was independent in conducting this report, but I think it's important on behalf of Albertans and, indeed, our job as legislators to ensure that we're hearing from the folks on the front lines who are applying these services as well as the accountants who might be reviewing them from the outside. I appreciate the opportunity to ensure that we help Albertans have the validity on that.

At this time I believe that my colleague MLA Hoffman has some questions.

Ms Hoffman: Thanks. Madam Chair, I would like to begin just by asking – I know AHS just reached its 10-year landmark, I guess, milestone anniversary during this fiscal year, and there's been discussion about how there haven't been reviews of AHS. I feel differently, so I'm hoping that AHS can talk a little bit about some of the reviews that have been ongoing in those 10 years to ensure optimum outputs for the people of Alberta.

Dr. Yiu: Well, I would say that we've been continually reviewed by the office of the Auditor General in that I think that we've been working with the OAG on sort of trying to improve health outcomes for Albertans. All the recommendations that the OAG has come out with are ones that we've accepted and adopted and are trying to fully implement. Now, there's a complexity in terms of some of the recommendations, which is why it's taking us a bit longer for some of them versus other ones, but I would say that we've been very much on a journey where we've had the OAG provide us with sort of an overview for improving the outcomes piece.

I think where we have not had sort of a detailed review is really around the financial pieces of that, and I think the EY review, for me, was an opportunity to look at our fiscal picture and look at the very specific aspects of sustainability from that perspective. For me, there were three things I kind of wanted to get out of the review. One was to kind of validate where we are as a health system, the second one is to really affirm the direction that we're going, and then the third opportunity for me was to really learn about things. We consider ourselves a learning health care organization, and if there are new things that we should be doing that we're not, then I'm really anxious that we continue to progress towards, you know, a high-performing health care system.

Ms Hoffman: Through you, Madam Chair, if Dr. Yiu would feel comfortable elaborating on some of the other reviews. I know that there's an audit committee within the AHS Board itself. Thinking back again on the fiscal year we're reviewing, I know that there were some students who raised concerns around long-term care outcomes in one particular facility: what types of reviews and what outcomes were achieved through the review. I'm speaking specifically about Lacombe, but I'm sure that there are other facilities that we've done similar types of audits on over the years.

Dr. Yiu: Yeah. I would say that we're constantly reviewing ourselves, again, in an effort to continually improve. I mean, we are not a status quo organization; we're not a stand-alone organization. We're always wanting to improve on clinical processes.

The Chair: Well, thank you, Dr. Yiu.

We will now move over, as part of our first rotation, to the government side for 15 minutes. I have MLA Guthrie to lead off, please.

Mr. Guthrie: Thank you. Thank you for making a second trip. We do appreciate your being here and your time. In October 2015 there was a recommendation from the Auditor General, number 13 to be precise, that recommended that the government improve processes to verify billing of physicians, and according to an update that was provided, the department has an implementation plan, but it is not ready yet for a follow-up audit. I hope that the department can execute on this as soon as possible as I do believe that checks and balances for potential overbilling is an issue that we owe the taxpayers some due diligence. Can the department advise us on the extent of overbilling and its cost to taxpayers over the last five years? Then, additionally, can you advise us if there have been any recovered expenses over that same time period?

Ms Rosen: Can you just give me a minute here?

Mr. Guthrie: Yeah. No problem.

Ms Rosen: The binder is too big.

Over the last five years the average amount returned to government annually has been \$3.7 million.

I'd like to talk a little bit, though, with respect to the process and improvements that are required. One of the challenges that we have

from a billing perspective is that the volumes are actually quite significant, as you can imagine, because we're talking about physician billings for a customer base of 4.3 million people, and our systems are actually quite old. In fact, when I came into the department, I was surprised to hear the word "mainframe" applications bandied about. We do actually overlay with respect to the existing systems that we have some applications to actually demonstrate where we have outliers with respect to billing, et cetera, but it's not the same as if you have an up-to-date, perhaps a little bit more modern application, which we are in the process of developing. So the delay in terms of us saying that we fully implemented this relates to systems renewal. We anticipate that we will have fully implemented this by 2022 because we are working on improving our systems in that period of time.

10:30

Mr. Guthrie: So by 2022. Okay.

Sorry. Pardon me. What was the figure for recovered?

Ms Rosen: It's \$3.7 million a year on average.

Mr. Guthrie: Okay.

Ms Rosen: When you think about the base, because our physician billings in a year are approximately \$4.5 billion, \$3.7 million can either suggest to you that we're not doing an adequate enough job with respect to capturing or that we don't have significant problems. I think the answer probably is somewhere in between there, that we need to have more robust approaches and practices, hence the Auditor General's recommendation and, hence, us working to improve our systems to ensure that we are capturing the outliers and that we are doing analysis on a reasonable basis.

Mr. Guthrie: Okay. Great. Thank you.

On page 33, performance indicator 4(a) reports the per capita provincial government health expenditures, and the number has continued to grow year after year, as you can see. It also states that "there are opportunities to streamline cost [through] improving efficiency and effectiveness." Can you go into a little bit of detail as to what those opportunities are and give us some examples?

Dr. Yiu: What I can do is talk about at least the AHS component of that.

Mr. Guthrie: Sure.

Dr. Yiu: We've actually been very cognizant about the high cost of health care in Alberta, just to say that our expenses within AHS since '15-16 have averaged about 2.6 per cent per year versus the first six years of AHS when our expenses increased on average about 5.7 per cent. We've actually done a lot of work bending the cost curve downwards.

We've been very focused on the cost per standard hospital stay. From '17-18 to '18-19 we've actually reduced the cost of that per capita by \$167, which doesn't sound like a lot, but when you multiply it by all the beds that we have and the cost of a stay, it amounts to a reduction of about \$32 million in in-patient costs. The way that we've done that is really primarily through our work which we call operational best practices. This is the work that we've done around making sure that we have best standard procurement practices. For example, you know, in the past we maybe had, let's say, 100 contracts for rubber gloves; we really only want to have, you know, one or two because that's when you get the critical mass and the most savings that you can generate.

Other aspects of OBP are to make sure that we have as appropriately low overtime usage as possible and to say that we

actually are one of the best in the western provinces when it comes to overtime rates; sick time, making sure that we maximize our attendance management program, making sure that we have the right processes so that we actually have an optimal staff mix within our units. We spend a lot of time working on this OBP work and have actually generated about \$178 million in savings over three years since we started that work. That's sort of our approach to trying to increase our efficiencies.

Mr. Guthrie: Okay.

Ms Rosen: I'm going to speak a little bit more about the primary care system as Dr. Yiu has referenced predominantly the acute care system. I believe that the Auditor General's recommendations around PCNs and complex patients also speak to a drive towards what ultimately results in efficiencies. If you actually have better care plans, and if you actually have Albertans that have wellness programs starting with primary care, what happens then is that you actually generate efficiency because you have healthier people, and you thereby have fewer costs.

One of the areas that we have worked hard on is around the PCNs and also, I would suggest to you, around better integration with respect to care, better handling of complex patients. Certainly, Alberta Health and Alberta Health Services have worked hard with respect to increasing integration because through that integration you actually then wind up doing better by patients, and anything that you can do to increase the health of patients actually improves the efficiencies and sustainability of your system. I think that that is notable as well.

Mr. Guthrie: Yeah. That's great to hear.

On page 33 once again it also states that the government is working to control the three largest cost drivers, and those are physician compensation, pharmaceuticals, and hospital services. What exactly is the government working on to control those particular cost drivers?

Ms Rosen: I just would like some clarity if we're talking about '18-19 and the things that were done in '18-19 to work on controlling those costs. Is that the member's question as opposed to a forward-looking perspective?

Mr. Guthrie: I'm just referencing what's on page 33 from the 2018 result.

Ms Rosen: Okay. I'm going to start with pharmaceuticals. In 2018-19 there was a significant effort as a member of the Pan-Canadian Pharmaceutical Alliance to work with other provinces and territories to increase access to drug treatment options and to achieve lower and consistent drug costs, which actually, I believe, in '18-19 wound up saving us \$30 million over what we had previously forecast, predominantly through the use of lower priced generics. I think that that was a significant accomplishment in '18-19.

With respect to physician compensation I would suggest to you that there are two components. There are the rates that we pay for particular services or activities that physicians undertake, and then there's the volume of those services. I would suggest to you that we had some success on the first part, which was around the rates that we pay, where we actually held the rate increase to zero in '18-19. We didn't have as much success with respect to volume, but we did reduce, then, the overall increase in physician compensation costs because we did have a zero per cent rate increase.

With respect to hospital services I believe that Dr. Yiu has already spoken to that. I don't know if there's something else that you want to add.

Dr. Yiu: Maybe I'll just add that another really important strategy that I think globally every other jurisdiction is trying to achieve is to really try to make sure that we provide care where Albertans really want it because, at the end of the day, no Albertan really wants to be in the hospital. So in '18-19 we developed a program called enhancing care in the community, which is really about: how do we actually reallocate services so that Albertans can get the treatment at home?

A really good example of that would be the expansion of our community paramedics program, where we actually have paramedics who are able to start intravenous, give medications, all either through the guidance of their own physician or it could be the physicians within our systems. It really has shown that we can actually not only prevent admissions from going to hospital, but we can prevent them from going to emergency, and they can actually stay at home.

Those are some examples of where we're trying to invest in actually making sure that we enhance the services at home. That actually has allowed us to keep up with some of the capacity and growth questions that came up earlier about what the strategy is for dealing with that.

Mr. Guthrie: Ms Rosen, you had mentioned the agreement to hold the compensation rate at zero, but it's my understanding that the actual compensation had gone up 4 and a half per cent in each of those years. Can you just elaborate, then, on why, if it was supposed to be held at zero, we had a 4.5 per cent increase in each of those years?

Ms Rosen: There are two components that determine what your total compensation cost is, the rate and the volume. So what we did was control the rate, and there was a zero per cent increase in 2018-19, but we did not have a mechanism to control volume. Volume increases would occur for a number of different reasons, perhaps more patients, so more doctors in Alberta, therefore, seeing more patients.

10:40

The volume of activities is actually quite complex to analyze and to actually determine where, perhaps, there could be some changes. I think that we've focused on the rate first, with a view to then look at continuing on to do things that would help us with volumes. We did have a number of committees with the AMA to explore options around physician volume, et cetera. That kind of committee work often takes quite a bit of time. Between '17-18 and '18-19 physician compensation went up by \$242 million. That would have been mostly due to volume growth – right? – because there were no rate increases in that year.

Mr. Guthrie: Was it volume increase, or were there changes in complexity within the billing?

Ms Rosen: I understand what you're asking. In terms of categorization we throw into volume anything that actually results in more billings being put through, but there could also have been a change in mix with respect to the kinds of activities, where there were perhaps billings for more complex patients. This is an area that we were exploring, that we are still exploring to determine whether or not the way that we categorize a complex patient and therefore compensate for a complex patient is appropriate.

Mr. Guthrie: Thank you.

The Chair: Thank you, Deputy. Before we move on to the Official Opposition rotation, I just wanted to provide an opportunity for Mr. Rowswell to introduce himself for the benefit of the committee.

Mr. Rowswell: Garth Rowswell, MLA, Vermilion-Lloydminster-Wainwright.

The Chair: Thank you.

We will now move on to our second rotation, which is a 10-minute per side rotation. We will begin with the Official Opposition. Please go ahead.

Ms Hoffman: Thank you very much, Madam Chair. We were touching on long-term care very briefly. We often see an attempt to compare apples and oranges again when it comes to long-term care or even assisted living between private and public sector or nonprofit sector. Two examples of facilities that were being built in this fiscal year were, of course, Bridgeland and Norwood. I'm hoping that AHS can elaborate a little bit. Are those patients able to be accommodated in other facilities anywhere in the province, and if so, what types of facilities would they be in if they weren't in these two facilities that are under construction in the fiscal year that we're reviewing?

Dr. Yiu: I think that one of the intentions with the two that we had actually put on the table to be built was really to make sure that we have appropriate housing for seniors with complex illnesses. I would throw addictions and mental health into that mix. There is no question that, as with most things, when there's an increase in complexity, it's actually harder to make sure that we have the right type of facility and the right types of supports to actually provide care for those individuals. Those two facilities are meant to actually help address some of that.

Ms Hoffman: Just to elaborate on that: patients who would be a good fit for those two facilities, where would they be today, and what would be the cost difference between the kind of care they're receiving today and the kind of care that they would be receiving in these new facilities once they're completed?

Ms Gordon: Some of them might be at home with home-care supports that they and their families are managing, and some of them might be temporarily in one of our facilities that might have lower utilization in acute care and waiting for an opportunity to come up in one of those facilities.

Ms Hoffman: Yeah.

Ms Gordon: An Edmonton example of that would be that we took the Hardisty facility, which was aging, and we have created some temporary residency there for individuals with temporary programming to support them so that they have good quality of life while they wait.

Ms Hoffman: Thank you. Part of how I'm connecting this to what we were discussing earlier around the Ernst & Young report is that there was discussion around alternate levels of care and cost savings. While I agree that everyone should get the right care in the right place by the right provider at the right time, I might add, I don't know that we have the capacity within our current care structures to meet the needs of those ALC patients. I'm wondering if you can elaborate on: if there was room to place these with appropriate supports, wouldn't they already be placed somewhere else? If not,

what are the strategies to ensure that we are achieving the greatest cost-efficiency for those patients and the best health outcomes?

Ms Rosen: Maybe I could start just by saying that I think this is a challenge that's been recognized for some time and that there have been programs and was a program in '18-19 and '17-18 with respect to adding continuing care spaces, and there was actually some success with regard to that. I believe 1,200 spaces were added, so we did make some progress, I would suggest to you, in the time frame that we're talking about.

As we have examined things more closely, though, I think we realize that our efforts need to be multiplied as opposed to waned off because we have more people that need continuing care or alternative service levels. Even though we made some progress in adding some continuing care spaces, it didn't do as much as we had hoped for the ratio because we still have growth in the need. So vigilance is required for us to keep on top of that, to keep providing those appropriate spaces and to have people taken care of in the best possible places.

Ms Hoffman: Would it be possible to get some write-up after around the cost-effectiveness of, you know, what today's cost would be for a typical patient in an ALC bed versus what it would be for a complex care patient in these two new facilities, those types of things?

Dr. Yiu: Sure. Yes.

Ms Hoffman: Thank you very much.

I wanted to touch on a few other things, around overdose prevention, for example, or harm reduction initiatives around opioids, which I know were mentioned in the opening remarks. How many lives were saved during the fiscal year that we're referring to, and how many referrals were made as well? That can be in writing.

Okay. A few other things I wanted to touch on that I know were executed in '18-19. Would the table be able to expand on the midwifery expansions that happened during those fiscal years or that fiscal year that we're referring to, which communities they were expanded to, and how that relates to overall initiatives with regard to right care, right place, right provider?

Dr. Yiu: Maybe I can answer that, on the midwifery. As of August 2019 we've got 135 registered midwives within the province that are staff appointments with Alberta Health Services. Since '15-16 the number of midwifery courses of care provided by AHS has increased by more than 50 per cent to more than 4,000 annually. As a result of the increased funding, we've expanded midwifery services to Medicine Hat, Cardston, High Level, Lac La Biche, Okotoks, Airdrie, Canmore, Brooks, Fort Saskatchewan, and Grande Prairie. Additionally, we've got full midwifery services which began at Chinook regional hospital on October 7, 2019, and there's planning right now under way to do further expansion.

Ms Hoffman: Thank you very much.

Maybe I'll take an opportunity to ask a few other questions around some other areas. During this fiscal year I know there were some increased capacity pressures – increased demand as well, but also capacity pressures increased – and I'm wondering if you can expand on what was done in terms of breast cancer surgeries, hip fracture repair surgeries, and some of the others where there was a particular emphasis to ensure that wait times were reduced. Of course, capacity demand goes up even more than the number of procedures often. What were some of the strategies, and how did those benefit patients?

Dr. Yiu: Yeah. In '18-19 we actually spent \$40 million in new investment money to sort of support more cancer surgeries. About \$12.5 million of that went into increasing cancer surgeries; \$11 million went into cancer care outpatient treatments, because you can't do the surgery without making sure you've got the appropriate outpatient therapies; \$6.6 million went into cardiac surgery; \$3.8 million went into ortho; and then the remainder went into cataracts. We did spend some funding to actually improve the quality improvement initiatives and to expand what we call the NSQIP program, which is a quality assurance program. We expanded that program from five sites to the 16 big sites within the province. We can get you the detailed numbers around the specifics, as you've requested.

10:50

Ms Hoffman: That would be great.

I'm happy to share my time with my colleagues.

Mr. Feehan: Thank you. Dr. Yiu, I would like to ask you just a little bit about some of your comments about the perinatal mortality in First Nations communities, that you mentioned. I wonder if you could just start by identifying some of the concerns that you may have had about that and how those numbers compare to nonindigenous perinatal mortality rates.

Dr. Yiu: I would say that in Alberta – I can't speak for the other provinces, obviously – one of our major challenges is, really, ensuring that we've got optimal health outcomes for indigenous peoples, and it's a real challenge for us. It does require more entities to be involved than just Alberta Health Services. There are major social determinants of health, as we know, where indigenous people may be disadvantaged. We do know that the perinatal mortality rate for indigenous and First Nations is much higher than for nonindigenous people.

Mr. Feehan: Do you know how much higher? Can you provide that later?

Dr. Yiu: I would have to get the numbers for you.

Mr. Feehan: I'd love to have some comparative numbers. Thank you.

Dr. Yiu: Sure. You bet. Absolutely.

Mr. Feehan: Please, go ahead.

Dr. Yiu: Just to say that we've been working on this for quite a few years, around really trying to improve our partnerships with indigenous communities. We're very cognizant of the fact that we need to be very respectful when we work with First Nations and to really, I would say, make sure that they invite us into their community to work with them.

We've actually got a really neat partnership, that was funded through the Merck program, which is called Merck for mothers, and it's a program where we've been partnering with I think three First Nation communities to really work with them on how to actually improve maternal health.

Mr. Feehan: Thank you.

The Chair: Okay. We are now moving over to our second rotation on the government side. You have 10 minutes. We will begin, I believe, with Member Stephan.

Mr. Stephan: Thanks. Thank you to the members of the Health ministry for attending. You have such an important stewardship.

The focus of my questions is going to be on health care process, control deficiencies identified by the Auditor General in his October 2015 report, number 13, page 102. This was referenced earlier by my colleague, but I'm going to read what it says. It says that the Auditor General recommends

that the Department of Health enhance the processes it uses to check whether:

- patients received the medical services for which physicians billed the department
- payments are being made in accordance with the provisions of the Alberta Health Care Insurance Act.

What I find really troubling is that in the report of the Auditor General dated November 2019 – and my understanding persists today that these processes are not ready. The annual report, as I understand it, for the Ministry of Health states that the largest cost driver is physician compensation. So my question is this: if physician compensation is the largest cost driver, then why over the past five years did the government fail to protect taxpayer dollars by instituting the internal control processes requested five years ago by the Auditor General?

Ms Rosen: MLA Stephan, I think that in terms of systems and process improvement there is, particularly when systems are involved, a cost to that systems improvement, and we tend to prioritize systems around what I would call corporate service provision – you know, billing, procurement, et cetera – perhaps a little bit less highly than we would prioritize actual clinical systems or clinical equipment, those that can be demonstrated to actually produce health care results. I'm not suggesting to you that that is an appropriate prioritization; I'm just suggesting to you that that is perhaps what has happened in the past . . .

Mr. Stephan: Okay. Sorry. I just want to make sure I continue with the rest of my questions.

Is it fair to say that in terms of priorities it wasn't a focus over the past five years?

Ms Rosen: I'm going to suggest to you that perhaps it wasn't a priority five years ago; it became a priority, I would suggest to you, in the last three years, where there was actually, after the recommendation was made, consideration given to how to implement. There was an emphasis then around what systems improvements were required, and there was a considerable amount of work done in terms of going out to industry, to the provider community to determine: what would be an appropriate approach to actually re-engineering our systems? That work was done over the last two years. That culminated in us being able to go forward.

If I could be allowed to just talk a little bit future oriented, that culminated in us receiving approval in Budget 2019 to do systems improvement, which we're now implementing, which will take two and a half years to actually implement in total. These changes, particularly for big systems that have hundreds of millions of transactions going through them on an annual basis, do actually require quite a bit of time to improve. We started the process about four years ago: that is what I would say to you in terms of improving the system. I can't speak really knowledgeably about why the three-year delay before we started, but we did start about four years ago to really look at what it would take to improve the systems.

Mr. Stephan: And this is the largest cost driver in Health?

Ms Rosen: It is, yeah.

Mr. Stephan: And we have not yet addressed the internal control deficiencies and our largest cost driver since 2015?

Ms Rosen: No. I don't think that's fair to say. Things that we've put into place sort of in terms of interim measures – as I indicated previously, we have applied some applications that actually allow us to do more of what I would call exception testing within the billing system that actually then raised things for consideration that we then pursued and analyzed – “audited,” if you prefer the term – to determine that those billings were actually appropriate, and we then actually made recoveries with respect to that. It's just not the most efficient way to do it.

Mr. Stephan: Sure. Can I ask a question about that in terms of the interim measures?

Ms Rosen: Yes.

Mr. Stephan: I know that we're looking to be better, and we always need to look to be better. My understanding is that annual physician compensation is about \$5.4 billion. You had mentioned that, on average, there was about \$3.7 million every year in audit recoveries. Just a quick calculation on that: that is less than one-tenth of 1 per cent. What I'd like to know, actually, is: how much was spent on the audit function? Do we know the answer to that question?

Ms Rosen: I can provide you with that, but I don't have it with me.

Mr. Stephan: Okay. I'd like to speak to determining whether or not there's a culture of accurate compliance in billing submissions. In the event that there was an audit discovery of an overbilling, what monetary penalties were imposed in those cases?

Ms Rosen: To the best of my understanding, MLA Stephan, the focus is on recovery of any overbillings as opposed to penalty, but I stand to be corrected on that. Could I get back to you with respect to that? I don't believe that we issue penalties. I believe that we just do the best that we can to recover any overbillings.

Mr. Stephan: Okay. Can I ask a question, then? What disincentive is there to overbill?

Ms Rosen: I don't want you to think that I'm trying to avoid the question, and I am sincere with what I'm about to say. Professional ethics, I think, with regard to physicians would suggest to me that – this is a profession on the whole that we trust with some of the most important things that we as a public service deliver, and I do believe that they actually do have for the most part a very solid understanding of their obligations with respect to their professional ethics, which includes only billing for services that they've actually delivered.

11:00

Now, you're always going to have outliers. Absolutely. You're always going to have problems. One of the things that I believe that the Auditor General has taken pains to point out to us is that it's okay for us to trust to a certain degree, but we also have to verify. So our verification processes have not been, perhaps, as robust as they would, could, should be, and we are actively working to improve that. It's just that when you're talking about something that is so big – \$4.5 billion is a very significant amount of money; it's generated through a very, very significant number of transactions – it's actually complex, so it takes a little bit of time once you've actually made a decision to make the change. We're working hard to implement that.

Mr. Stephan: Sure. I appreciate as a professional myself that there are ethics, and the vast majority of professionals are honest and

upright in the discharge of their professional duties. But, of course, we need to balance that with respecting and making sure that we protect taxpayer dollars to ensure the sustainability of our health care system.

Since 2015, when the Auditor General identified the process deficiencies – and I know I'm almost out of time – has physician compensation grown at a faster rate than population growth?

Ms Rosen: Yes.

Mr. Stephan: Okay. Would you be able to provide us with those comparators in terms of looking at physician compensation growth versus population growth? Of course, as population grows, then you'd have a logical relationship there, but it'd be very important to understand those comparators and to see if internal controls are a factor in that.

Ms Rosen: Yeah. Just looked at that information this morning. We have a chart for the last 10 years. If that's sufficient, we can provide that.

The Chair: All right. Thank you.

We'll move on to our third rotation now with the Official Opposition for 10 minutes. It looks like Mr. Feehan, please.

Mr. Feehan: Thank you. Dr. Yiu, I think we were just beginning a conversation about maternal health in regard to perinatal mortality in First Nations. You indicated at the time you were speaking that it isn't just simply an issue of addressing the death of infants and so on but, rather, addressing maternal health. I know that previously Deputy Minister Rosen had suggested that wellness programs were actually part of our efficiency programming, such that if we have good maternal health and reduced infant mortality then, of course, we will have reduced costs to the health system. I just wonder if you could elaborate on that and continue what it is that you were saying.

Dr. Yiu: Yeah. As I was saying, with the program Merck for mothers, that we've been working with the three First Nations around, just to give you an example, part of the funding goes to supporting educating young mothers who are, obviously, expecting around nutrition. They actually provide sort of supports around how to, you know, make sure that they get good sources of nutrition. They have a community garden. I mean, it's a really, really good program that enables those young mothers and young women to really be able to look after themselves. I think all our efforts around trying to make sure that we provide the supports for indigenous people when they come into our facilities: it's really something that we're very cognizant of, some of the sensitivities of that. We've heard that they don't like to come into our facilities, that they feel intimidated when they do come in. It's an area or an environment that they're not comfortable with. So we've been very purposeful around mandating cultural competency and indigenous awareness for all of our employees.

Mr. Feehan: So are you identifying that as part of your response to reducing infant deaths, you are actually designing programs specifically for indigenous community members so that they don't have to come in to regular settings?

Dr. Yiu: We're trying to partner with them so that we can provide as much support as we can where they are at. So yes. For example, when we've been up to visit Saddle Lake, we actually work very closely with that community in terms of providing some of our addictions and mental health supports, some of our counselling,

other allied health. Same, I would say, for Siksika, down south. We've got a very good partnership with them. What we really want to do is to maximize the partnership to where they are at. The Blood Tribe is another example.

I do have to say that, you know, our latest statistics when we looked at perinatal mortality, when we first identified it to be an issue back in 2016: we have reduced the gap, so we do feel that we're making some progress. We can get you the specific information about what the gap reduction is. But we do feel that we're making progress overall.

Mr. Feehan: Great. That reduction in the gap is largely due to wellness programs that focus on social determinants of health and maternal care, with a specific focus on indigenous programming separate from programming for the general public. Is that fair to say?

Dr. Yiu: Yes.

Mr. Feehan: Do you have some thoughts or concerns about what would happen if specific programming for First Nations people was eliminated and they were told they had to go to generalized programming?

Dr. Yiu: Well, we haven't approached that. I mean, for us it's really important to provide that support for indigenous communities. This is something that is a priority for us, and we are continuing on that journey.

Mr. Feehan: So your strategic plan moving forward, based on the evidence that you have just described to me now, is to continue a focus on indigenous-focused programming because we have a serious problem of infant mortality as compared to nonindigenous statistics. Is that correct?

Dr. Yiu: I would agree with that. Yes.

Mr. Feehan: Thank you. You've also indicated that it really is about wellness programming and maternal health and that it isn't just about the medical practice but the larger context in which that occurs. I'm just wondering. Are there any plans to reduce the number of programs that would refer these parents into these kinds of programs in terms of health care, like they're doing in social services by the elimination of the parent link centres?

The Chair: Member Feehan, I'm wondering if you can maybe rephrase that to be more of a question about either the 2018-19 annual report or OAG recommendations.

Mr. Feehan: Was there an increase in funding put into programming to ensure that First Nations people had appropriate access to medical care directed toward their particular needs in the '18-19 year?

Dr. Yiu: To be honest, we would have to get the information for you in terms of comparison with '17-18.

Mr. Feehan: I would certainly like to see that. Thank you.

I'd like to move on to another question. There was an incident in the last few years, what we would consider a racist incident, in the Blood Tribe area, where Ramona Big Head, unfortunately, heard comments about her made by AHS staff, and I know that you had to respond to that. I'm just wondering about what kind of responses you put in place to ensure that racism has decreased in the medical services in this province.

Thank you.

Dr. Yiu: I would say that that was probably one of the most difficult times that I've had in this role. It was a really shameful experience from our context, and even though the two AHS employees were working as independent consultants at the time that the incident happened, it doesn't really matter because when you work for AHS, you need to reflect the values of the organization.

As you may or may not be aware, we went very public with that. We connected with Ramona Big Head and the Blood Tribe. We went out to the community, offered our apologies in person. It really was a catalyst for us to embark on sort of an overarching indigenous health strategy but more so to actually ensure that we provide the appropriate supports and training for our people to make sure that they don't have that conscious or unconscious bias. We actually embarked on at that time, as I said earlier, and mandated a cultural competency program that we've actually shared with other ministries. It is a program that currently about 68 per cent of our employees have taken the first module, which I'm really pleased about, but we actually want 100 per cent. We feel that that's a really important first step to building awareness towards reconciliation.

Mr. Feehan: Do you have some mechanism of keeping track of racist incidents and how you're responding to them?

Dr. Yiu: Well, we keep track of all complaints or all issues that come forward to us, so absolutely we do track that, we track how we deal with it, and we track the outcomes of that. That is definitely something that we monitor.

11:10

Mr. Feehan: Thank you.

In your planning for the last year, I'm wondering if you could tell me about any work that you've done across the province in terms of including First Nations people as practitioners in the system.

Dr. Yiu: Understanding that this is beyond '18-19, but I'm happy to answer the question.

Mr. Feehan: Well, I'm happy to, you know – if we need to keep it within that: were there some plans that were implemented or strategies put together during the year that we're speaking about?

Dr. Yiu: Yeah. We actually started an indigenous strategic clinical network. I think for many of the members here strategic clinical networks are sort of grassroots networks of front-line practitioners that bring best practices to the forefront for not just our practitioners but also for patients and families. This indigenous strategic clinical network is actually co-led by a very well-known, I would say, indigenous physician, Dr. Esther Tailfeathers, as well as Val Austen-Wiebe. They've been working very closely with our indigenous health program to develop an indigenous health strategy that is in alignment and working with the ministry.

We're quite pleased with the work that they've actually embarked on. Obviously, as part of that work we can't do a health strategy like this without the input of elders and healers. We've been using our Wisdom Council, which is a council of basically elders and healers, to actually inform this health strategy, and we're quite pleased with the report and happy to share that if it's of interest.

Mr. Feehan: How do you determine the effectiveness of this? You're talking about being very happy about where it's going and, obviously, being very sensitive to the needs of the First Nations community and the protocols involving elders and therefore being able to develop a very appropriate set of programming, but how do

you know that that's actually reducing things such as infant mortality or other medical procedures?

Dr. Yiu: That's why we actually follow the perinatal mortality and, as I said, you know, we seem to have reduced the gap. That ultimately is what is most important to us. Actually having those kinds of clear outcome metrics, as you had mentioned, is very important.

The Wisdom Council, to be absolutely frank, is actually very good, I would say, feedback for us. They represent the whole province. They come from all different bands and reserves, and they are a really good source of information for us as to whether we're heading in the right direction or not.

Mr. Feehan: So you would suggest that kind of a program, like there was . . . [Mr. Feehan's speaking time expired]

Thank you.

The Chair: All right. Thank you.

We will now move on to MLA Turton for 10 minutes on the government side.

Mr. Turton: Thank you very much, Madam Chair, and thank you very much for coming before us today. I have a couple of quick questions that I just want to ask that definitely pertain to the youth of my riding, and they have to do with vaping and smoking. On page 16, performance indicator 1(b) to be exact, of the annual report, it indicates that there has been an increase in the reported smoking rate among Albertans, specifically ages 12 to 24. Although there was no indication as to whether the rise in these rates are long term or short term, it is suggested in the report that a rise in smoking rates may be related to an increase in youth vaping. Can your department please explain their plan to reduce the youth smoking rate, specifically when it comes to regulating vaping among youth?

Ms Rosen: MLA Turton, you're right. Alberta has experienced a rapid rise in youth vaping. Teen vaping rates have risen from 8 per cent in 2014-15 to 22 per cent in 2016-17 among students in grades 10 to 12, and, of course, the legislative framework for tobacco control does not govern vaping. Within the time frame that we're talking about here, in 2018-19, I think in that and the preceding years is when vaping actually started to escalate dramatically and started to become a significant problem.

The Tobacco and Smoking Reduction Act has an automatic review period in it, and that period came up this year. So as a result of that sort of legislative agenda or structure that's been built into the legislation, the review has come up this year. There was no decision made to review it earlier. I would suggest to you that it's just in the last year that it's really become quite alarming and that there have been other effects associated with vaping that have caused not just Alberta but all provinces to turn their minds to this here more recently. When there are new threats, sometimes it takes a little bit of time for not just Alberta but the nation to turn its mind to it. It has been increasing steadily, and we are, post 2018-19, now looking at the legislation and will be doing something about it, but that's sort of forward looking as opposed to past.

Mr. Gotfried: Okay. On that note, just a reminder to the members to direct their questions with respect to the past reports and the '18-19 past expenditures, please. Thank you.

Mr. Turton: Okay. Thank you.

Based upon the report and kind of some of the wording that was in there, are there any other risks that the department has identified that might help us to address the challenges around increased

smoking rates among youth which, obviously, will lead eventually to the current date?

Ms Rosen: Well, we do have a number of tobacco cessation programs, you know, prevention and health promotion activities. We do spend several million dollars on that, did in 2018-19 spend several million dollars on that. I think that we do monitor these programs on a regular basis to see which ones are most effective.

From my previous experience in Treasury Board and Finance, I have to tell you that one of the most effective programs for reduction in smoking is actually taxation. You make things unaffordable for people, and it does help. I would suggest to you that we use a basket of goods. We currently spend – or we're spending in this year – \$6.3 million on these cessation programs and these, I guess, wellness strategies, and we will continue to do that. We'll continue to monitor that for impacts. We were seeing smoking going the right way in most categories with the exception of youth, and now we have vaping, that's sort of taken over from that.

Mr. Turton: In the '18-19 report are there any other demographics that have been identified as a higher risk of smoking addiction outside of the youth component?

Ms Rosen: Not that I have information on right now. I can certainly check that out and get back to you if that's appropriate.

Mr. Turton: Okay. That would be.

I defer the rest of my time to MLA Rosin. Thank you very much.

Ms Rosin: Perfect. Well, thank you so much to everyone a second time for being here today. My first question, I guess, is from one Ms Rosin to the other Ms Rosen in the room. It's very well known that Alberta has quite a young population in comparison to other provinces, primarily due to our resource economy and the typically good job market and high standard of living. But when we look at the costs, our health system is extensively more expensive compared to other provinces despite the fact that we should have a fairly healthy population. I'm wondering if you can talk to us about why that is, why our health care system is so expensive.

Ms Rosen: There are three primary cost drivers that actually cause us to be a more expensive system. As with all health systems, it needs a lot of people, a lot of physicians, a lot of health care workers, and our compensation costs tend to be higher than any other province for both physicians and our health care professions and by a considerable amount in most cases. There are some exceptions to that. We have more hospitals than other provinces on a per capita basis, and hospitals are an expensive way to provide care. We have one of the most generous drug programs in the country as well. On those three big pieces, which absolutely represent the majority of our spend, we tend to be higher than other provinces.

Ms Rosin: Okay. Thank you.

Just to follow up, would you say that even though we have such a young and typically healthy population, we are going above and beyond in providing care for Albertans compared to other provinces?

11:20

Ms Rosen: I'll ask Dr. Yiu.

Dr. Yiu: Yeah. I absolutely agree with what the deputy said but would just say also that because we have a younger population, we also have more labour and delivery. When we compare ourselves

to some of the other jurisdictions like British Columbia, Saskatchewan, Ontario, we have about 39 per cent higher labour and delivery. Labour and delivery are actually one of our highest costs in the hospital system. We also consequently have higher costs for newborn care because of the fact that we have more labour and delivery. As a province we also have more trauma and injuries and poisonings because of the younger populations. I think that when people think that just because you're younger, you're going to be healthier, in fact that's not necessarily the case. You just have different issues.

Ms Rosin: Thank you.

One more question. On the inverse, Alberta's senior population is expected to double in the next 10 to 15 years. I'm just wondering: what have we learned in the past with respect to our investment in seniors' health services, specifically long-term or continuing care, and what types of partnerships have we discovered have been proven most effective, especially when it comes to leveraging costs? Just because we know that this population is going to double in the next 15 years, I'm wondering if you have discovered any best practices or if you guys are planning for that increase.

Dr. Yiu: We're absolutely, I would say, worried about that aging tsunami, as people often say, and I think that's why we're trying to do things differently. The enhancing care in the community program is a really important program for us, because sometimes when you're elderly and you're sick and you end up in hospital, you don't necessarily get the same, I would say, rehab care in order to get you back home. Sometimes we just make the assumption that maybe they should go into long-term care when the reality is that maybe we can get them healthy enough to actually go back home. We're trying to change how we actually sort of deal with seniors who are acutely ill and really work on the strategy to say: maybe you can go home, but we need to make sure that you have the right supports at home to do that. You know, the community aspect is a really, really critical part for us and making sure that we have the right type of supports around seniors to make sure that they can actually get into rehab.

We're looking at day programs. For example, one of the strategies that we have on the community basis is doing what we call virtual hospitals. We don't actually admit people into hospital. We actually pretend to admit them, but they actually receive the care at home. We've got a program in Calgary and one in Edmonton. It's called sort of a virtual hospital. Instead of seeing a patient as though you're in the bed within the university site, you're actually skyping with the care provider team with the actual patient at the home setting. The feedback that we've gotten from Albertans who've actually experienced these programs is quite impressive. I mean, they can't say enough how good it feels that they can actually receive the care at home versus actually being in the hospital.

Ms Rosin: Thank you.

The Chair: All right. Thank you.

We'll now move over to the fourth rotation, the Official Opposition for 10 minutes, please.

Mr. Dach: Thank you, Madam Chair. I have questions about a specific project that's very close to my constituents in Edmonton-McClung, in the west end, and of course that reference I make is to the construction of a new emergency department at the Misericordia hospital, which planning is under way for. It's not only my constituents in Edmonton-McClung but the wider Edmonton area who are pretty concerned about making sure this project is completed on time because, of course, in light of the southwest

Edmonton hospital being pushed down the road to an unknown time frame, all the more importance is placed upon the construction of a new emergency department at the Mis. The planning is under way – and I think that is identified in the 2018-19 report – on that \$65 million project to build a new emergency department at the Misericordia hospital. So would you give a bit of context to define the need? How many visits per day was the existing emergency department designed to serve?

Ms Rosen: MLA Dach, we don't have that information here with us. Can we provide that to you in writing?

Mr. Dach: Sure thing.

What is the current expectation for the new department as far as ability to serve the patient need that's there now? Is it anticipated to meet the demand that's current or future demand that will grow?

Ms Rosen: My understanding is that the expected demand that we are planning to meet is 65,000 visits a year.

Mr. Dach: Okay. Now, as far as the time frame for this project, I'm understanding that in 2018-19 a significant amount of planning money was spent. Can you say how much money has been invested so far in the planning for this emergency department construction at the Mis?

Ms Rosen: We just need a minute, so perhaps you could ask another question, and we'll get back to you on that.

Mr. Dach: I should do that. Basically, based on what your response might be, you could determine perhaps whether the planning process is on schedule or not. Of course, people are very concerned about this happening and actually getting construction under way.

Ms Rosen: That piece I can answer. It is on schedule. In terms of the planning stages, it was determined early on that one of the clinics there had to be moved in order to facilitate the construction of the new emergency department, but it is on schedule when you consider the demolition of that clinic. It looks to be, at this early stage, on time and on budget, very promising with respect to concluding positively.

Mr. Dach: All right. Well, I appreciate that report. I know that the chapel has also been moved in anticipation of construction, so the wrath of a higher power might also intercede if we end up getting behind schedule.

Certainly, we'll keep an eye on that because not only my constituents but the whole of the city of Edmonton is really relying upon that upgrade and future contemplated new additions and renovations to that hospital. It's an exciting, complex, new sort of rebuild. The emergency department is going to be the first really big element of it, and people are anxiously awaiting that time to completion.

Ms Rosen: Unfortunately, we don't have the amount that's been spent on planning so far. We'll have to get back to you in writing if that's all right.

Mr. Dach: All right. Thank you. I appreciate the report that you're on time and on budget and that we're full steam ahead.

I'll defer to my colleague.

Ms Renaud: Sure. Thank you. I just had a general question about disabled Albertans and complex care. I think that it's pretty easy to understand that a lot of people who have disabilities have some pretty complex needs and frequently perhaps end up in hospital

because there isn't another place to go, because there isn't sufficient home care to deal with the complexity of their needs, whether it's accessible, affordable housing. I'm just wondering if you could speak to any investment or programs that have been made to sort of address this problem.

Dr. Yiu: Thank you for the question. I absolutely agree with you, and I think that I had commented before on how we have to do different things with seniors. I'm just going to be fairly specific about some of the things that we've done, just to give you a sense of our sort of overarching strategy when it comes to seniors.

For example, as I said, we're trying to look at things to support seniors where they don't actually have to be in hospital. Day programs are actually very important for seniors. They really allow them to stay strong and healthy. Really, it's about wellness and prevention, as we had commented on. For example, we've got a seniors' day program at Medicine Hat regional hospital, where we really work with seniors who have gotten mental diagnoses of depression or other mental health disorders. Again, it's really making sure that they can stay outside of the home.

We've also been working on a program called the CHOICE program. I don't know if you've heard about that, but CHOICE stands for comprehensive home option of integrated care for the elderly. Again, it's really meant to actually assist seniors so that they can actually continue with independent living. It's been a program that we've had in place for more than 20 years, but what we are doing is refreshing the program, really optimizing the expansion across the province to make sure that it's available to all seniors no matter where they live.

Then, obviously, we're really trying hard to sort of push in the community to make sure that we get more supportive living. An example of that would be in Vermilion, where we're actually, again, working with the community on that.

Ms Renaud: Thank you.

Maybe I could just go a little further. Specifically for people with disabilities – whether or not they're seniors remains to be seen – specifically for somebody with the label of developmental disability or physical disability, brain injury, whatever it might be, are there programs, I guess, specifically targeted to reduce the frequency of their needing to stay in hospital because there is no other place for them? Are there any numbers available to us about the number of people with disabilities that are required to be in long-term care because there aren't any viable community living alternatives?

Dr. Yiu: Again, I would say that the same applies. We've been really trying to think outside the box for this in terms of trying to develop programs that actually support them better in the home setting.

We've recently opened a unit in Norwood to actually support these types of individuals. We've partnered, actually, with supportive housing to provide some of these group home settings for individuals so that they don't have to be, you know, institutionalized, so again working with communities. It is really important to make sure that you work with the communities and with the individuals involved.

11:30

Ms Renaud: Just based on the information that was used to put together the reports and the audits that we see, in your experience or with your expertise, is it wise to invest in community living supports for people with disabilities that would contribute to eventual savings in terms of a reduction in hospital stays or the number of days they're staying in hospital?

Dr. Yiu: Well, I would say that any time we can keep people out of hospital is a good thing. As I said, I think it's a multipronged approach when it comes to how we do that because I would say that there's a certain component where it's quite individualized.

Ms Renaud: Okay. Thank you.

I will turn over my time to Mr. Feehan.

Mr. Feehan: Thank you.

Dr. Yiu, I'd just like to follow up a little bit on your comments earlier about labour and delivery in the province of Alberta and indicating that one of the realities of having a young province is that we have increased costs in labour and delivery. I have a number of questions, but first I'd just like to get some basic information. Perhaps you need to provide it to me later.

I would like to know about the number of labour and delivery events that occur, particularly outside of the major city areas, so outside of Edmonton, Calgary, Grande Prairie, Red Deer, Lethbridge, for example. I'd like to know something about the type of delivery. For example, are they scheduled C-sections or emergency C-sections or vaginal births or whatever other alternatives may be medically defined, just so I have a bit of a sense about the demand around the province and whether that's increasing or not. Is that something that can be provided, I'm assuming, at a later date?

Dr. Yiu: Yeah. We can definitely provide that, but just to give you a sense, I think that, on average, there are about 50,000-plus deliveries . . .

Mr. Feehan: That's throughout the whole province but not in the rural areas.

Dr. Yiu: We can give you that breakdown. Absolutely.

Mr. Feehan: Great. Thank you. I appreciate that.

One of the other things that you indicated is that sometimes there are complex needs around labour and delivery, if things don't go well, and that as a result we have some pretty comprehensive NICUs, neonatal intensive care units, in the province. I'm just wondering: has there been an expansion of those services throughout the province, and are they outside of the major centres? I know, for example, that people in the north frequently have to fly in to those units because they're not available. Can you tell me if they're expanding or if they were?

Dr. Yiu: Yeah. We've done some purposeful expansions. For example, we recently opened an NICU at the Sturgeon. But I would say that one of the things that we've done is actually trying to promote telemedicine . . . [A timer sounded]

Mr. Feehan: I'll get back to you the next time. Thank you.

The Chair: All right. We now have a 10-minute rotation for the government members. We have Member Rosin to lead off, I believe. Go ahead.

Ms Rosin: Yeah. Perfect. I have one final question before I pass it off to my colleagues, and it is with reference to performance indicator 1(c) on page 17. This shows that year after year fewer people are being hospitalized in Alberta, primarily due to the successes within our primary care system. While this is really good news – we want people to be getting proper treatment within our province in the most local and immediate situation – I'm wondering if your ministry can square this improvement with the fact that hospital care is still the leading cost driver in our system despite the fact that hospital numbers are going down.

Ms Rosen: The reason that hospital care, though, is one of the most significant drivers is because we do still have a fairly high appropriate level of service, so we have too many people in hospital that could actually be taken care of at home or in the community either in terms of designated supportive living or continuing care. I would suggest to you that that's probably the biggest reason. We also do have some small facilities where perhaps – and maybe Dr. Yiu can speak to this a little bit more thoroughly – the mix of services that are offered in those smaller facilities is not necessarily meeting the needs of the community, where perhaps there could be a shift in the type of bed that they have in those facilities, where in a smaller community you don't have to stick to, say, for example, just acute care in those facilities. You could actually have a mix of acute-care and continuing care kinds of beds.

Dr. Yiu: I would say that culturally as a country and as a province we've been very dependent on hospital care. It's the way the system has been built over decades, so it's no surprise that, you know, Albertans are very dependent on that concept. It's going to be challenging. There's going to be a need for change management and the expectations of Albertans about what they really need going forward, but one of the things that's going to be really important for us is really going to be understanding: what does the community need?

We talk a lot about patient- and family-centred care, we talk about provider-centric care, but what we really need to do is provide community-centric care and to really engage the communities about what it is that they need in order to make sure that their residents are best looked after. It doesn't always mean that you need to have an acute-care bed, so I think it's really important to have those dialogues and conversations. I think the smaller communities are very dependent on their hospitals, not just because it's a hospital to them, but it, in fact, is an economic engine for their community, and we totally respect that. We understand why it is that they want the hospitals, but I think we can use hospitals in a different way that can actually serve them better.

Ms Rosin: Okay. I'm trying to follow up because I actually feel like the answer sort of contradicts the numbers. I'm not sure it actually addresses the question I asked. I mean, you said that we still have lots of people in hospitals, but the numbers show that the numbers of patients being admitted to hospitals are continually going down. I feel like those numbers sort of contradict the answer. I'm just wondering if you could really explain why the numbers of patients in hospitals are going down but the costs of hospitalization in Alberta and operational costs in hospitals are continuing to go up.

Ms Rosen: If you're referring to performance measure 1(c), it speaks to a particular kind of patient, ambulatory care sensitive conditions. Those actually have gone down because we actually have made some progress with respect to getting more care in the community, particularly primary care with regard to the seven conditions that are actually articulated there. In terms of our hospital costs, just like all of the costs in health care, they continue to go up because our population increases, because our rates of compensation increase. So it's not one thing. It's a basket of things that actually cause our costs to rise, and you have to take, then, an overarching approach.

This particular performance measure is about understanding that there are things being treated in hospital that don't need to be treated in hospital, and can we do a better job of getting them out of hospital? It demonstrates that by 2018, compared to 2014, we were doing a little bit better job, I think.

Ms Rosin: Okay. Thank you.

With that, I'll pass off to my colleague Mr. Barnes.

Mr. Barnes: Okay. Thank you, and thank you to all of you for your work for Albertans and being here today. Hospitals and emergency department wait times I want to ask about, please. Performance measure 3(a) addresses exactly emergency department wait times for the 17 busiest sites in Alberta. Measures that were taken in 2014 and '15 seem to have had success in reducing wait times the following year, but then, when we compare it to 2015, it appears that wait times in two of your categories have seen time increases of nearly 10 per cent. Why is it that given all the money spent on hospitals, a leading driver of costs, as we've determined, wait times are still above 2015 levels?

Dr. Yiu: Wait times in emergency in major centres continue to be a challenge for us. We are meeting our target of eight hours from the time the patient arrives to the decision to admit. With the volume of patients using emergency departments combined with overcapacity issues in the facilities, to move patients through the system is a challenge. Emergency room wait times are really a reflection of the flow of the hospital, and if the flow of the hospital is not optimal, then the backup happens to be in emergency.

We've been working for I would say 10 years or more around really trying to try multiple different strategies about how we can actually improve wait times. We've done I would say more than 250 different types of initiatives all over the province to try to address that, and I would say that we've been pretty successful. What we've shown is that although the capacity keeps going up in terms of the number of patients being seen, the wait times have remained more or less stagnant or pretty well status quo. We're actually trying our best to deal with the overcapacity issues.

11:40

I think one of the things that's very challenging for us is, really, making sure that the right type of patients go to emergency. I know that we've been working really hard with the primary care networks around making sure that we optimize. The patients who really don't need to be seen in emergency should really be seen in the primary care offices. In working with the ministry and with the College of Physicians & Surgeons of Alberta and AMA and the PCNs, I think we actually have seen some improvement in that to make sure that there are opportunities for patients to see their primary care physicians when they need to so that they don't end up in emergency.

We've tried different strategies around emergencies, having sort of what we call rapid-flow access, where, you know, the less severe patients get seen in a different stream whereas the sicker ones go through another stream. At the end of the day, it is challenging, especially in our big sites.

Mr. Barnes: Thank you. Eight hours almost doesn't seem like an emergency. Is the cost to the system, is the cost to the taxpayer the same when a patient is seen in emergency as compared to a different type of clinic?

Dr. Yiu: Well, we can get you the detail on that, but for sure I would say that it would be less expensive to be seen as an outpatient than it would be to be seen in an emergency department.

Mr. Barnes: Thank you. Slow movement in the emergency speaks to bottlenecks in our whole system, as you just outlined. That's part of the reason why I'm so concerned with the escalating costs and how much of our provincial budget health care is taking now. Based on the fact that the emergency room is a symptom, that means that our entire health system slowed down since 2015 and has not

recovered. Can you speak to the impact throughout the entire health system and why patients are not moving through fast enough and comment specifically on the impact of these increasing and overall costs?

Thank you.

Ms Rosen: I think that one of the things that we do need to point out – and, actually, this is something that the OAG has pointed out to us in the past – is that when we’re looking at that particular performance metric, it’s really just an indicator. It’s an indicator, in terms of emergency department wait times, that they are increasing, but in order to actually determine why that is, you have to do a deeper analysis, and I do believe that we have some breakdowns with respect to that that we could share. To conclude from these results that there has been any particular trend with regard to emergency departments, this would belie what Dr. Yiu just said, where she has indicated that she actually thinks that we’re improving, and that’s from her actual observations of how things are working on the ground. It’s really important for us to look at performance metrics and say: “You know what? We don’t like the way this is going. We need to look at this a little bit more carefully and perhaps not draw conclusions that would be unwarranted or oversized given the small measurement that we actually have in front of us.”

Now, having said that, it’s absolutely an issue, and we do have to have people know their options better. We have to have people staying out of emergency rooms to the degree that we can. It’s not just about one thing; it’s about a number of things.

The Chair: Okay. Thank you, Deputy.

We will now move to the final rotation, which provides a three-minute time slot for opposition members, followed by government members. The rotation provides members the opportunity to read questions into the record for follow-up answers provided by the ministry and AHS.

I will now open the floor to questions from members. Member Shepherd, please.

Mr. Shepherd: Thank you, Madam Chair. A few final questions, then, for the record. Thank you again for coming today. Mr. Guthrie and Mr. Stephan were talking about physician compensation. In terms of physicians’ complex modifiers I’m wondering if you could provide us a bit of information on how many physicians were indeed using those complex modifiers in ’18-19, what the ancillary costs were from that, and any numbers that were involved in that regard.

They were talking about physicians and compensation and asking about outliers and the amounts that are applied there. If you could identify the number of physicians that were indeed a part of that \$37 million that you mentioned was recovered and any numbers you would have in regard to how many physicians you feel are in fact overbilling and related numbers and dollar amounts with that.

There were questions about compensation versus population growth. I appreciated the answers you provided. I was wondering if you could give us any idea of: in ’18-19 what demographic shift would there also have been amongst the population that might have also driven those factors?

In terms of diagnostic imaging for ’18-19 how was the additional funding that was provided for diagnostic imaging applied, and what was the effect on the wait-list numbers for ’18-19? Were there any efforts made or consideration given to physician costs for radiography and how those might be addressed in ’18-19?

In regard to some of the comments earlier regarding the operational best practices helping to reduce costs, part of that, of

course, involves changing staffing mixes and ratios in different kinds of care: acute, long-term care, et cetera. Could we get any numbers that you would have, then, on changes in ratios or staffing in acute care, long-term care, all other forms of hospital care?

What amounts were invested in improving community care in rural areas? So in regard to rehabilitation – you referenced that – and the need to move more people into that level of care, were there any additional investments or any work done towards improving access to allied health care professionals – physiotherapists, chiropractors, others – who are incredibly important as part of that recovery process? And then just if we could get information on the number of Albertans under 65 who have developmental disabilities who may be in long-term care.

Lastly, Dr. Yiu, you were talking about the EY report and about how you just got it, how you’re working with it. If we could get a sense of when you anticipate or if you anticipate you will be able to come up with that implementation of this plan within the next hundred days, just to get a better sense of when the PAC committee might want to follow up with you on some of the outstanding questions and things that were involved here.

I believe that Mr. Dach could have some questions.

Mr. Dach: Yes. One quick question. Thank you very much. For fiscal 2018-19, how many full-time equivalents does AHS have allocated for rural mental health? As a follow-up to that, I’m wondering if you could provide data showing the number of agricultural producer suicides in Alberta over the last five years.

Mr. Feehan: Thank you. I’d like to just ask a question following up from when we were talking about the NICU, but I’ll just ask . . . [A timer sounded]

Jeez. I have been beat every time.

The Chair: Three minutes is not very long.

I will now turn it over to the government members for their three minutes of reading questions into the record, please.

Mr. Walker: Thank you so much. Thank you all so much for being here. I’m deeply grateful that you’re here, recognizing what happened last time – that juvenile theatre was absolutely unacceptable – so thank you, guys, for being here. I deeply appreciate your time. I know our side does.

Okay. I’m going to quickly read in one question and then pass on my time to Member Stephan. On the opioids: key strategy 2.3 on page 19 of the annual report brings up harm reduction associated with opioid use. Can you shed light on how much it costs for the distribution of more than 137,000 naloxone kits and if these kits and their costs have proven beneficial in addressing opioid-related overdoses? Some specifics and consolidated statistics would be helpful.

Thank you. I’ll pass my time on now to Member Stephan.

Mr. Stephan: My question is this: if this was your business, your money, and your largest cost driver lacked appropriate internal controls, unaddressed for five years, what steps could you take specifically to accelerate the timetable to put in the internal controls requested by the Auditor General for physician compensation?

I’ll pass on the time.

Mr. Jeremy Nixon: I understand that First Nations life expectancy is based on small samples. Given how unreliable the data is, how effective is this performance measure, and what is the ministry doing to make sure that it better understands First Nations life expectancy so that we are in a better position to improve it?

Mr. Gotfried: Can I have one question? Given the focus on expanded scope of practice with respect to emergency room visits, what are you doing to ensure that practitioners such as optometrists, pharmacists, PCNs, including the use of the 811 line, reduce emergency room visits?

The Chair: Okay. You have another minute, government members. If there are no more questions to read into the record . . .

Mr. Walker: I can read in another one.

The Chair: Okay. Please.

Mr. Walker: Thank you, Chair. Page 14 of the annual report has a performance measure for clients placed in continuing care within 30 days. I noticed that the results steadily declined year over year from 2014-15. Why did this decline occur, and what is the department doing to rectify this situation for Alberta's seniors?

How much time do I have, Chair?

The Chair: Twenty-five seconds.

Mr. Walker: Okay. Off to the races.

I'd also like to know how performance declined for continuing care while, according to page 49 of the report, the continuing care budget was overspent by \$18 million.

Another question. Again on page 49 of the annual report, administration was \$12 million over budget for 2019 and support services over budget by \$51 million. Can the department explain these specifically and comment on the examples of overspending for the most recently reported fiscal year?

Thank you.

11:50

The Chair: All right. First of all, I would like to thank officials from the department of Health and Alberta Health Services for attending today and responding to our questions. We ask that any outstanding questions be responded to in writing within 30 days and forwarded to the committee clerk, who sits to my left.

Are there any other items for discussion under other business today?

Seeing none, we will move on to the date of the next meeting, which is, in fact, today. We will meet again this afternoon at 1:30 with the Ministry of Education, the Edmonton public school board, and the Calgary board of education. There will be a premeeting briefing for members at 1 p.m.

Now we'll move on to our adjournment. I will call for a motion to adjourn. Would a member move that the meeting be adjourned? Member Feehan. All in favour? Any opposed? That motion is carried, and we will see one another in approximately 100 minutes' time.

[The committee adjourned at 11:51 a.m.]

