Second Session, 40th Parliament

REPORT OF PROCEEDINGS
(HANSARD)

SELECT STANDING COMMITTEE ON

PUBLIC ACCOUNTS

Vancouver
Tuesday, September 30, 2014
Issue No. 11

BRUCE RALSTON, MLA, CHAIR

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SELECT STANDING COMMITTEE ON PUBLIC ACCOUNTS

Vancouver
Tuesday, September 30, 2014

Chair:	*	Bruce Ralston (Surrey-Whalley NDP)
Deputy Chair:	*	Sam Sullivan (Vancouver–False Creek BC Liberal)
Members:	*	Kathy Corrigan (Burnaby–Deer Lake NDP)
	*	Marc Dalton (Maple Ridge–Mission BC Liberal)
	*	David Eby (Vancouver–Point Grey NDP)
		Simon Gibson (Abbotsford-Mission BC Liberal)
		George Heyman (Vancouver-Fairview NDP)
	*	Vicki Huntington (Delta South Ind.)
	*	Greg Kyllo (Shuswap BC Liberal)
	*	Mike Morris (Prince George–Mackenzie BC Liberal)
	*	Linda Reimer (Port Moody–Coquitlam BC Liberal)
	*	Selina Robinson (Coquitlam-Maillardville NDP)
	*	Shane Simpson (Vancouver-Hastings NDP)
	*	Laurie Throness (Chilliwack-Hope BC Liberal)
	*	John Yap (Richmond-Steveston BC Liberal)
		** denotes member present*
Other MLAs:		Lana Popham (Saanich South NDP)
Clerk:		Kate Ryan-Lloyd
Committee Staff:		Ron Wall (Manager, Committee Research Services)

Witnesses:

Carol Bellringer (Auditor General)
Rod Frechette (Ministry of Health)
Jessie Giles (Office of the Auditor General)
Bill Gilhooly (Office of the Auditor General)
Jeremy Higgs (Ministry of Health)
Russ Jones (Deputy Auditor General)
Lisa Moore (Office of the Auditor General)
Stuart Newton (Comptroller General)
Ted Patterson (Ministry of Health)
Carolyn Rogers (CEO, Financial Institutions Commission)
Heather Wood (Ministry of Finance)

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SELECT STANDING COMMITTEE ON PUBLIC ACCOUNTS

Tuesday, September 30, 2014
9:00 a.m.
West Meeting Room 111 and 112, Vancouver Convention Centre
1055 Canada Place, Vancouver, B.C.

Present: Bruce Ralston, MLA (Chair); Sam Sullivan, MLA (Deputy Chair); Kathy Corrigan, MLA; Marc Dalton, MLA; David Eby, MLA; Vicki Huntington, MLA; Greg Kyllo, MLA; Mike Morris, MLA; Linda Reimer, MLA; Selina Robinson, MLA; Shane Simpson, MLA; Laurie Throness, MLA; John Yap, MLA

Unavoidably Absent: Simon Gibson, MLA; George Heyman, MLA

Officials Present: Carol Bellringer, Auditor General; Stuart Newton, Comptroller General

Others Present: Ron Wall, Manager, Committee Research Services

1. The Chair called the Committee to order at 9:01 a.m.

2. The Committee reviewed the agenda.

3. It was moved by Kathy Corrigan, MLA, that:
Mr. David Loukidelis and Mr. Graham Whitmarsh be requested to appear before the Committee with respect to additional questions relating to the Committee's continued consideration of the Auditor General's report titled *An Audit of Special Indemnities*. The motion was defeated on the following division:

Yeas (5)	Nays (7)
Corrigan	Dalton
Eby	Kyllo
Huntington	Morris
Robinson	Reimer
Simpson	Sullivan
	Throness
	Yap

4. The following witnesses appeared before the Committee and answered questions relating to the Auditor General Report: *Credit Union Supervision in British Columbia* (March 2014).

Witnesses:
Office of the Auditor General:
- Russ Jones, Deputy Auditor General
- Bill Gillhooly, Assistant Auditor General
- Lisa Moore, Executive Director, Financial Audit

Ministry of Finance:
- Carolyn Rogers, CEO and Superintendent, Financial Institutions Commission (FICOM)
- Heather Wood, Assistant Deputy Minister, Financial and Corporate Sector Policy, Ministry of Finance

5. Resolved, that the Committee meet *in-camera* to discuss additional questions relating to the report. (Kathy Corrigan, MLA)

6. The Committee met *in-camera* from 11:39 a.m. to 11:51 a.m.

7. The Committee continued in public session at 11:52 a.m.

8. The Committee recessed from 11:54 a.m. to 1:01 p.m.

9. The following witnesses appeared before the Committee and answered questions relating to the Auditor General Report: *Oversight of Physician Services* (February 2014).

Witnesses:
Office of the Auditor General:
- Russ Jones, Deputy Auditor General
- Jessie Giles, Manager, Performance Audit

Ministry of Health:
- Ted Patterson, A/Assistant Deputy Minister, Health Sector Workforce Division
- Rod Frechette, Executive Director, Compensation and Negotiations, Health Sector Workforce Division
- Jeremy Higgs, Executive Director, Workforce Research and Analysis, Health Sector Workforce Division

10. The Committee recessed from 3:10 p.m. to 3:20 p.m.

11. The Committee discussed the agendas and schedule of future committee meetings.

12. The Committee adjourned to the call of the Chair at 3:57 p.m.

Bruce Ralston, MLA
Chair

Kate Ryan-Lloyd
Deputy Clerk and
Clerk of Committees

TUESDAY, SEPTEMBER 30, 2014

The committee met at 9:01 a.m.

[B. Ralston in the chair.]

B. Ralston (Chair): Good morning, Members. I'd like, first, to introduce the new Auditor General of British Columbia, who is here at the committee today for the first time. Briefly, by way of introduction, there are many members on this committee who formed part of the Committee of Selection, so many of you will be familiar with her background.

She is the former Auditor General of Manitoba, two different stints, and has an extensive background, as one might expect, in conducting financial statement audits, performance audits and investigations. She's a member of the board of the International Federation of Accountants and the Auditing and Assurance Standards Board.

She's been two weeks in the job — a bit of a whirlwind tour over there in the office — and is here before the committee for the very first time. Would members join me in making the new Auditor General of British Columbia, Carol Bellringer, welcome.

We have an agenda that's been circulated. I propose to deal with item 1 at this point.

Work of the Subcommittee on Agenda and Procedure

S. Sullivan (Deputy Chair): I just wanted to make a comment about the agenda, which has brought up a situation.

First of all, welcome, Auditor General. It's great to have you.

And thank you, Russ Jones, for your capable support and leadership.

Basically, under the guidance of our Chair, the committee has been working very well. But recently the issue of the agenda has brought up a topic for me that I think the committee should consider. Perhaps now is not the time but in the future.

First of all, we do have…. One of the very first decisions of the committee was to create a subcommittee of agenda and procedure. The committee has worked quite well. The process that we use is very collaborative. For example, in the last determination of these meetings here, the Chair offered two of three days — either the 30th, first or second. I suggested we might be able to pull off all three days, and he considered that the ideal was to meet two days.

That worked very well, but on the issue of this agenda, this very topic here, I did suggest that we had pretty fully discussed it the last time. We had about two hours' discussion. This topic has been discussed in the House at least two times that I know of and has been discussed thoroughly in the media — very sharp journalists onto it. I felt that we could use our time better by dealing with some of the other reports.

When I look at the functioning of this subcommittee, I think it's worked very well, in general. I was looking for a kind of measure of how the subcommittee has worked, and the best rough measure I could come up with is the number of hours that the committee has agreed to meet.

[0905]

When I looked over the past number of years, typically a public accounts committee will meet between 14 hours and 30 hours, and 2010 was the highest number of 30 hours. Last year, despite only having half a year, we met for 28 hours. This year it looks like we will have a record in terms of hours met, so in that way it's working well.

I did object to this item at the beginning, because I felt it had been sufficiently dealt with. I am very open to discussing it further, but at the last meeting it was decided that the member who wanted to discuss this would send a letter. I didn't receive that letter. I believe the Chair did. I didn't have enough information to deal with….

In the future the committee may want to give direction as to how this subcommittee would function. Would it be based on a collaborative approach? Would it be based on the Chair making decisions with some advice from the Deputy Chair, or would the Chair just make the decision? In this case, the Deputy Chair not having all the information to deal with….

I wanted to make that comment. Mr. Chair, thank you for your guidance and your leadership, but I think it was an issue that I would like to ultimately have discussed at some other time.

B. Ralston (Chair): As far as I'm concerned, we are going to proceed, but just maybe let me make a few comments.

First of all, the letter that you refer to was circulated. You received it two weeks ago, on September 15, I'm advised by the Clerk. Secondly, it was discussed. Page 57 of the transcript, the *Hansard* of Tuesday, June 24, is where it was discussed by the committee. At that point — this was over three months ago — I said that MLA Corrigan was going to submit a written application, we would adjourn the session, and, subject to that motion, we would continue. That was voted on and approved by the committee.

As far as I'm concerned, the committee considered that and sanctioned this step, subject to a letter being provided, which it has been.

Secondly, you are, I think, partially accurate in your recitation of what's happened with the subcommittee, but you will recall that in setting the dates for the first part of 2013, I began discussion with you in early December 2012 and did not get your agreement to four days — two full days, which turned out to be at the end of June, and two days while the House was sitting. That process of coming to agreement took some four months.

There were a number of objections that you raised to proceeding more quickly. You were unavailable. You were unwilling to circulate proposed dates by e-mail. You insisted on meeting with members of your committee personally, although when you met in Prince George at the end of January, you were unable to find any time.

If we want to go in to air the laundry of the operations of the subcommittee, I can say that I've been very dissatisfied with the way in which it's functioned and found that your willingness to engage in the simple process of agreeing to dates is a very protracted and torturous one.

In my view, our subcommittee hasn't functioned well in that respect. Doubtlessly we can make improvements, and I note that in the recent exchange that we had there was more prompt agreement, although you would not agree to meeting at any point during the six weeks of session. That's very unusual for any legislative committee in the country, but apparently that's your view.

I don't think the committee functions well, because it seems to me your goal is to prevent the committee from meeting rather than to facilitate it meeting. Really, I think the business of the committee is to address the reports and the public accounts of the province rather than to spend our time quarrelling about when the committee is going to meet. In many committees, I note…. I was at a conference in Newfoundland. I think MLA Yap was there. [0910]

The committee in Alberta — Wildrose has the chair of the committee, and the Tories are the government there at this point — has made some very innovative steps and set out a more or less fixed calendar, with some advance agreement on committee meeting dates. So there are lots of opportunities to look at other jurisdictions and see how they do it.

I don't think the proper judgment of the efficacy of the committee is the number of hours it sits. Presumably, the public and those who would hold agencies accountable would look to the quality of the debate and the regularity and the frequency of the debate rather than simply the total number of hours. Certainly, I'm willing to discuss it. I'm willing to seek improvements, and I look for your cooperation on that. But since you've raised the issue, I feel it's important for me as Chair to put my view forward fairly clearly.

With that, I'm going to turn to the first item on the agenda and MLA Corrigan.

Auditor General Report: *An Audit of Special Indemnities*

K. Corrigan: I appreciate the opportunity. Just on the inclusion in the agenda, I would also point out…. I believe that all members of the committee got the letter perhaps the same day, I would say, or within a day of when it was sent to the Chair. So if there's any concern about the timing, it's certainly not intentional. Everybody received the letter within a day of when — I think it was the same day actually — the Chair got it. That's when it was completed.

S. Sullivan (Deputy Chair): Can I respond to that?

K. Corrigan: Yeah, sure.

S. Sullivan (Deputy Chair): What I was told by the Chair on September 5 was that he had the letter in his possession. This was an e-mail I received. I objected, saying that as a member of the subcommittee, I think it is proper that as this letter has to do with the setting of the agenda, the other member of the subcommittee should also have the information so that I could help to make a decision or help to provide advice to the Chair. That letter did not come to me until well over a week later. I believe I received it the same time as all the other members. As a member of the subcommittee on agenda, I expect that the committee expects the subcommittee on agenda to set the agenda or to at least give advice on the agenda. I did not have that letter.

B. Ralston (Chair): Well, I don't think there's any question that members have received the letter in a timely way sufficient for them to consider it prior to the committee meeting today.

K. Corrigan: Just on that, the final letter, on the letterhead — the appropriate one for distribution — I believe was September 15, and everybody received it on the same day.

I also want to say that I've been on this committee for quite a while now, pretty well since I was elected in 2009, and it's been my experience that issues have been dealt with regularly where members have said: "Look, I have more questions. The amount of time that we've allotted is simply not enough." I think we've dealt with some reports for several hours when people have had a lot of questions. So I don't think that's unusual. But anyway, I'll leave the rest to the Chair, and I will…

B. Ralston (Chair): Please, if you could just get to the substance of the motion.

K. Corrigan: …just continue on.

I also want to note that I did give notice that I was going to move a motion, so maybe I'll go ahead with that. I move the following motion. It is: "That Mr. David Loukidelis and Mr. Graham Whitmarsh be requested to appear before the committee with respect to additional questions relating to the committee's continued consideration of the Auditor General's report titled *An Audit of Special Indemnities*."

The reason I have done that, why I have moved that motion, is that I certainly found that after we had fin-

ished our discussions on June 24, 2014, towards the end of it I felt there were many questions that were unanswered by the report and issues that had been raised by the report and by discussion of the report that I felt could only be answered if we could have the appearance of Mr. Loukidelis and Mr. Whitmarsh to ask questions.

[0915]

I'm not going to read that whole letter. It's fairly extensive. It's five pages long. But I think what I'd like to do is just highlight a few of the reasons so it's on the record.

The first thing that I want to point out is that I do recognize that the Public Accounts Committee has an independent role and that we are to act in a non-partisan way. I hope that the reasons that I've given in this letter for requesting Mr. Loukidelis's and Mr. Whitmarsh's appearance are in the spirit of being non-partisan and saying: "What is good for the people of British Columbia? What best serves the people of British Columbia?"

I also note that Mr. Loukidelis and Mr. Whitmarsh, who are central to the discussions in the report about special indemnities…. Although they provided a written statement on October 20, 2010, they've never been questioned in any kind of legislative or legal form.

In addition, the circumstances under which Mr. Basi's and Mr. Virk's legal fees were paid for by the taxpayers of British Columbia were unique. It is my understanding, and I guess that's been confirmed by further information that we received as a committee subsequent to that hearing, that this is the only example of indemnities being paid where there have been criminal convictions.

I think that the consideration of whether we request Mr. Loukidelis and Mr. Whitmarsh to appear has to be considered in the context of whether or not the payment is consistent with the overall rationale for special indemnities, which was a policy designed to ensure fundamental justice as summarized in the Auditor General's report. The gist of it is that individuals should be protected when they act in good faith.

That was very clear from the report. It's very clear as the principle upon which special indemnities are paid. But it's not clear enough from the general principle or from the report. We know that the Basi-Virk indemnity agreements contained very specific provisions for repayment if there was a conviction, and in fact a conviction occurred.

I think the fact that there was a significant departure from policy and an exercise of power that was very different than what was contemplated in both the policy and the agreements themselves — the appropriateness thereof as well as the consideration of the precedent that was set — means that this would be very worthy for further examination by the Public Accounts Committee.

I also point out in the letter that the magnitude of the indemnities is unique. The $6.2 million payment by the government represents well over half of all special indemnities ever paid for by the provincial government. While there was some content in the report that talked about that, we don't know why…. I think members might have more questions about why those payments were so high. There was a 25 percent holdback initially, but those amounts were released in 2008, and it's not clear why.

I would note also that since that time, as I point out in my letter, there has been a change to the regulation. That change to the regulation…. How could it be that this special indemnity was paid, yet later it was determined that this was inappropriate? Questions were asked about that, and we didn't, frankly, get, I think, a very sufficient answer on that. But it's very clear now that the decision is that those kinds of indemnities are wrong. It's another reason, I think, why we need to look back and say: "Okay, if it's wrong now, why were these special indemnities paid or forgiven at the time?"

Another area that we didn't deal with extensively in the committee but I think is also very critical is that the Auditor General's report is very clear that the release from repaying the indemnities was contingent or dependent upon a guilty plea.

[0920]

This raises many legal and ethical questions, including whether, for example, the deal could be considered an inducement to plead guilty. I don't believe that this issue has been discussed again in any legal or legislative forum.

I would also point out that the statement by the deputy ministers on October 20, 2010, didn't include or allude to the fact that guilty pleas were a condition of the deal. I also think it's appropriate for this committee to test the assertions about the level of independence of the two processes — i.e., the decision to forgive the legal fees and the guilty plea — particularly as we now know that the two processes were contingent upon each other, which required a certain level of entwinement of discussion between the parties.

I would also point out that while the report said it found no evidence of political involvement with regard to the decision to release Basi and Virk from their liabilities, the Auditor General's report does not address the issue of whether there was political involvement in the plea bargain.

In fact, Ms. Dodds of the Office of the Auditor General told our June 24, 2014, Public Account Committee meeting: "Our focus was on looking for any inappropriate involvement in the decisions around the administration of the indemnities. We intentionally did not look at the issue of any allegations of involvement around decisions involved in the legal proceeding and the role of the special prosecutor." That's not to suggest there was political involvement, but questions were raised, and I think Mr. Loukidelis and Mr. Whitmarsh are perhaps the only people who can answer questions around that.

I don't think we want to forget, even though we want to remain non-partisan, that the context of the payment is important. I remember that there were, for example,

media stories suggesting that the two processes were intertwined and, secondly, that ministers were involved in negotiating the deal.

Finally, the Auditor General's report itself notes that there were limitations in its report because of its inability to access information.

In summary, the decision to relieve Mr. Basi and Mr. Virk of their obligation to repay their legal fee was unique. It was contrary to stated policy governing eligibility for special indemnities. The indemnification was contingent upon guilty pleas. The public expressed concern about the appropriateness of the decision, but there has never been an opportunity to ask questions of Mr. Whitmarsh and Mr. Loukidelis. I think it's in the public interest for this committee, as the watchdog committee tasked with ensuring that taxpayer money is spent appropriately and effectively and in a transparent manner, to have that opportunity by requiring Mr. Whitmarsh and Mr. Loukidelis to appear as witnesses to the committee.

Finally, one of the hallmarks of the whole issue of the Basi-Virk indemnities was a suggestion that there were attempts throughout the process to suppress information. I think that this committee should stand for just the opposite. This committee should be interested in making sure that all information that is relevant should be made public. For that reason, I have brought this motion, and I hope that there is support for it.

B. Ralston (Chair): Further debate on the motion?

M. Morris: I don't support the motion, Mr. Chair. It has been clear throughout the Auditor's report and through all the other reports that have been generated as a result of this that there's been nothing illegal occur, that the policy was complied with and that everything that needed to be done was done in order to arrive at the decision that these gentlemen made.

I'm sure Ms. Corrigan knows — and others with a legal background in here — that a lot of the discussions that happen between the accused in this case, Basi and Virk, and their counsel and the special prosecutor and whatnot, are privileged information. We will never have the other side of that story. No matter how much you want to dig into this to find out what happened on the criminal side of things, we will never have that information within this forum here to assess whether or not there was any kind of a departure from policy.

[0925]

For a number of reasons, I think that this motion is groundless and that there's no need to have these gentlemen appear before this committee.

D. Eby: In response to MLA Morris's comments, certainly it's very clear that policy was not followed by these bureaucrats. The policy was to indemnify where people acted in good faith, and I think the taxpayers of B.C. would certainly understand that if you're working for the government and you do something in good faith and you're sued for it, that yeah, sure, we'll cover your legal expenses.

In this case, obviously, Mr. Basi and Mr. Virk were convicted, yet they were still indemnified. It was clear that the bureaucrats involved here did not follow policy. In fact, they did not follow policy, and that decision, we're told, did not go up to cabinet.

In such a scenario I think it's entirely within the realm of this committee to bring those bureaucrats here and ask them what they were thinking, what happened that allowed them to spend $6.2 million without oversight in a manner that caused, frankly, outrage among the public — so that we can prevent it from happening in the future, prevent it from happening again. I don't agree that policy was followed here.

In addition, MLA Morris, as a police officer, would have…. Certainly, it would have been an unusual scenario where someone was arrested, put forward for prosecution and then threatened with a $6.2 million fine if they didn't plead guilty, which was essentially what happened here.

These individuals were told that if they did not plead guilty, if they went to trial — which their lawyer had signalled he was inclined to do because he thought there was a reasonable prospect that they wouldn't be convicted — they would face a $6.2 million fine and their lives essentially, financially, would be over. So of course they pled guilty.

I think the question of the government using its resources in that way to compel — which I believe this was — a guilty plea is another question that should be addressed. Did Mr. Loukidelis and Mr. Whitmarsh consider the impact of that decision on the ability of the accused to make a free decision about pleading guilty?

Again, not squarely on this issue, but for future decisions in similar situations, will we be again telling people that they'll be facing millions of dollars in legal fees if they don't plead guilty? And is that the kind of policy that the government of British Columbia wants to advance?

For the prospective view of decisions being made by bureaucrats in difficult situations, are we providing them with the guidance that they need? How do we avoid this kind of breach of policy in the future? Also from the prospective view: how do we make sure that we don't compel guilty pleas in situations where people have a reasonable prospect of not being convicted, where they have a reasonable defence and they wish to go to trial but where that trial may be damaging to the government?

I think these are critical questions, Mr. Chair, and they are entirely within the realm of this committee and the ambit of this committee. I hope that we are able to address them. I hope all committee members recognize that and vote for that.

B. Ralston (Chair): Any further speakers? Okay, can you read the question again, then, please?

M. Morris: Perhaps I'll offer a couple of other comments on this. Contrary to what members opposite are saying, there is no policy breach in this entire matter. They are making presumptions in this particular case that perhaps there was. The reviews show that there was no policy breach and that the individuals that were navigating this file had the discretion under the existing policy to make the decisions that they did in order to facilitate the outcomes that we got here.

I think, to David Eby, that assumptions are made that this $6 million was used as an inducement to plead guilty. We don't know the discussions that took place between counsel and the special prosecutor in this case, and they're the ones that negotiated the guilty plea. We will never know what those discussions were all about.

[0930]

As a former police officer, I've been intimately involved in plea bargaining in the past. A lot of it, a lot of the outcomes, I didn't agree with, but under the circumstances that we were faced with at the time, they were the best decisions that we could make under those circumstances.

We have some very qualified people in the public service that make those decisions on behalf of the people of British Columbia, and I have complete faith in those individuals and the background that they have and the ability for them to make the decisions under the existing policy of the day.

We had a review of that policy. Mr. Stephen Toope made the review of that. As a result of that, the policies were changed with respect to the discretion that these positions held. But at the time that this occurred, policy was followed to the letter.

S. Sullivan (Deputy Chair): This event took place quite a while ago. The two individuals that you are asking to appear don't actually work for the province of B.C. anymore and actually don't even live in the province. I assume that it would be at the cost of the committee to bring them in. We really have to ask for what purpose. What do we expect to get out of that?

I can't support that motion either.

S. Simpson: I think that MLA Morris is just simply wrong here.

B. Ralston (Chair): Through the Chair, please.

S. Simpson: Through the Chair. The reality is that there was a policy, a policy that said that you needed to act in good faith and that if you're convicted of a criminal offence, you don't get your lawyer's fees paid. Clearly, that's what happened here — and a major fee, $6.2 million.

This was very much a departure from what the practice has been, to make this decision. The people who made the decision…. I don't think there's a question about whether they had the authority to do this, but they made this decision. There are legitimate questions as to why they made that choice to make that decision.

It is not clear whether there was a discussion around the plea bargain itself with any ministers at all. And the deputy made that pretty clear in his testimony to this committee when he presented to this committee. He said that he couldn't answer that question. He didn't know, and fair enough. But it's a legitimate question about what happened around the plea bargain here. We simply don't know that.

We do know what happened around the special indemnity. The Auditor General was very clear that their office, the Auditor General's office, was looking solely at the question of the indemnity and was not considering the other question appropriate — not a problem. But those questions are in fact linked.

This committee…. It's $6.2 million on this indemnity — publicly, a very major concern for people as to how that decision came.

As to the comments of MLA Sullivan, the reality is that we have a responsibility to get to the bottom of this if we have the ability to do that. We can sort out the logistics of the questions around Mr. Loukidelis and Mr. Whitmarsh. We can find a way to deal with that. If the committee needs to go do some kind of tele-thing, we can do that. We can arrange that. We don't need to be flying them from wherever they are in order to get them to testify.

The fact that they've left the employ of government does not excuse the fact that they were there. They are the only people who have the ability to answer a number of the questions that were raised when this matter came forward in June. If the deputies that were here at the time could have answered all of those questions, we wouldn't be having this conversation today. They acknowledged that a number of the questions of the committee could not be answered by them and could probably only be answered by Mr. Loukidelis and Mr. Whitmarsh. It leaves as many questions unanswered as were resolved by the session that we had the last time we came together in June.

I think it's absolutely appropriate. The logistics can get worked out. People want to have an answer to the question as to how this happened. How did $6 million get paid out to two convicted criminals to pay their legal fees?

The question that my colleague MLA Eby raises about the pressure point of saying "You plead guilty or you pay" is a legitimate question in terms of the process of how plea bargaining goes forward and what kind of pressure is put on people who are facing those kinds of situations.

[0935]

I think it's absolutely the kind of work that this committee should be doing, and I support the member from Deer Lake.

B. Ralston (Chair): Closing, then.

V. Huntington: Let me say firstly that I am quite uncomfortable with this discussion. As much as I am interested in it — and I think it has been put forward very clearly by the proponent of the question — it is, unfortunately, fundamentally partisan in its pursuit. I find that difficult because I have always said to this committee that we owe it to the people of this province to be as nonpartisan as we can be.

Further, the discussion is pursuant to a report from the Auditor General that was very specific — perhaps specifically crafted. I think it was a very thorough report. Undoubtedly, the Auditor General's office did an enormous amount of work.

It was with a narrow question in mind, however. It did not pursue the relationship between the plea bargaining and the lifting of the indemnity — or the indemnity — and thus leaves open the questions that are being pursued right now.

All that being said and my discomfort that this committee would be pursuing it in this manner, I do think there are issues here that have never been explained to the public that the public is deeply concerned about — always have been and still bring it up if the issue arises in any way, shape or form, at least to me.

I think there is an issue of transparency here that if we can resolve would be to the benefit of the public. As difficult as the decision has been to me, I will support it — the motion — because I believe the public deserves the transparency that this discussion might provide them.

With that being said, I'd also like to take just a moment, Mr. Chair, to reserve my opportunity to speak to the earlier discussion about agendas. I would like to know when I might be able to speak to that, at your convenience.

B. Ralston (Chair): I'm going to ask Kathy to close, but Mike wanted to say something.

M. Morris: I just wanted to bring the attention of the committee to a comment from the Auditor in his report. It's on page 6 of his report. He said: "The public servants tasked with approving and administering special indemnities were diligent and fair in exercising their responsibilities. Their practices were principled and responsive to each situation, and they were kept separate and distinct from the proceedings for which the indemnity was provided."

They did look into that, and they gave fair measure to the process itself.

B. Ralston (Chair): In closing, this will conclude debate.

K. Corrigan: Vicki, I appreciate your comments. I think we all wrestle with…. It's always very important that we are acting in the public interest.

There are times, I believe, that the public interest demands that we take steps that may be seen as partisan. But I always operate on what I believe is in the public interest, and I think it is in the public interest for us to have these two gentlemen before us. I think the public would probably agree, and maybe we'll see about that.

I don't have the report before me today, but the comments by the Auditor General are within the context of the fact that the Auditor General acknowledged that the investigation was limited partially in scope — we have to act within that scope in this report, I suppose — but also with regard to the information that the Auditor General was able to accumulate. Part of this is that I think there's far more information that is relevant that we could have gained by having Mr. Loukidelis and Mr. Whitmarsh appear before us.

[0940]

Going back to a point that's been made earlier — two points. First of all, the policy was very clear. These gentlemen may have had the power and the ability to make the decision that they did, but it is very clear from the report itself that it was contrary to policy. I think you have to separate the two. They had the power, and they did it, but the policy was very clear. And not only was it…. Well, I won't get back into that. But I think the policy was very clear.

It sounds like we probably won't have them. My suspicion is that probably all the members on the other side of the table will….

B. Ralston (Chair): Let's not presume what people are going to do.

K. Corrigan: Let's not presume anything. Thank you, Chair.

I believe that it is in the best interests of the public of British Columbia that we do invite them to come before the committee.

B. Ralston (Chair): That concludes the debate, then. Could the Clerk read the motion, and then we'll vote.

K. Ryan-Lloyd (Deputy Clerk and Clerk of Committees): Good morning, Members.

The motion is moved by Kathy Corrigan. It reads as follows: "That Mr. David Loukidelis and Mr. Graham Whitmarsh be requested to appear before the committee with respect to additional questions relating to the committee's continued consideration of the Auditor General's report titled *An Audit of Special Indemnities*."

Motion negatived on the following division:

YEAS — 5

Simpson	Corrigan	Huntington
Eby		Robinson

NAYS — 7

Reimer	Morris	Sullivan
Yap	Dalton	Kyllo
	Throness	

B. Ralston (Chair): We'll move to the next item on the agenda, which is credit union supervision in British Columbia. Perhaps we can just take a moment to enable the staff to set up for our consideration of that report. We'll stand down just briefly.

[0945]

We're going to be considering the Auditor General report *Credit Union Supervision in British Columbia*, dating from March 2014. I'll introduce the witnesses from the Office of the Auditor General. I think I see everyone here — Carol Bellringer, Auditor General; Russ Jones, Deputy Auditor General; Bill Gilhooly, assistant Auditor General; and Lisa Moore, executive director, financial audit.

Representing the auditee and the government: Stuart Newton, comptroller general, from the Ministry of Finance; Carolyn Rogers, the CEO and superintendent of the Financial Institutions Commission, known by its acronym, FICOM; and Heather Wood, assistant deputy minister, financial and corporate sector policy, Ministry of Finance.

If the Auditor General would like to open, I'd welcome that.

Auditor General Report: *Credit Union Supervision in British Columbia*

C. Bellringer: As is the case with all of the reports on today's agenda, as you know, I was not in the office when the audits were conducted, but I'll be pleased to provide, if I'm able to, my position on certain general matters. Russ Jones, who issued these reports as Auditor General — and, I must say, I'm discovering has done a fabulous job within the office — will provide our opening comments on the report and then have the other staff of the office go through the detailed presentations for each one.

I did have, if you'll permit me, a short message to relay to the committee from Malcolm Gaston, who actually asked me to please thank you all for the kindness that was shown to him just after his accident in June. He said that your card arrived at a difficult time and provided a great deal of strength to him. So thank you on behalf of Malcolm.

Just a quick few words on this particular audit, having gone through the report. Credit union supervision is certainly a critical area. I saw that the office's report emphasized the importance of maintaining depositor confidence across the credit union system. I thought it was interesting and important to note that we did the audit to contribute to strengthening the system and prevention — to prevent problems as opposed to reacting to problems that have not but could always, it's possible, occur, as we've seen certainly at the international stage.

Over to you, Russ.

R. Jones: Good morning, Chair, Deputy Chair, Members. Just to follow up on Carol's remark from Malcolm, he is back at work now, which is very good. He's been back for about two and a half weeks and is gradually getting up to full-time. Yes, it's great to have him back.

I'm pleased this morning to be able to provide some opening comments on the report *Credit Union Supervision in British Columbia*.

The strength of the credit union deposit insurance system depends on how well it's supervised. The goal of supervision is to promote the stability and soundness of credit unions and, through the use of early intervention and problem-resolution efforts, reduce the probability of any failures. The Financial Institutions Commission's mandate is not to prevent all failures but to reduce the likelihood of failures and, if one should fail, minimize the negative impact on the financial sector.

Credit unions have evolved to become as sophisticated and complex as banks. For this reason, they require the same oversight. The province is working towards meeting international industry standards for supervising financial institutions to ensure the supervision of credit unions is at the same level as other major banking institutions in Canada. These global standards and best practices encourage identifying potential problems early to enable proactive intervention.

Problems in even a small deposit insurance system can spread feelings of uncertainty and a loss of confidence in the system. My report includes recommendations to improve the effectiveness of the credit union monitoring program, including completing an appropriate plan for insurance payments to depositors. The plan would facilitate orderly and timely insurance payments and maintain depositor confidence across the system.

I hope the recommendations we have provided will assist FICOM and the government in furthering what is already an appropriate supervisory framework for monitoring B.C. credit unions.

Today with me I have Bill Gilhooly, assistant Auditor General, and Lisa Moore, executive director, who led the work in this report. They're going to take you on a small journey through the slides.

[0950]

L. Moore: Credit unions offer a full range of financial services, just as Canada's chartered banks do. Unlike the banks, though, credit unions are owned by their members. These institutions play an important role, particularly in smaller or remote communities where big banks are reluctant to establish branches.

As of June 30, 2013, there was over $50 billion in insured deposits held by almost 1.9 million members of the 43 credit unions in British Columbia. Government regulates and supervises the credit unions in B.C. and administers the deposit insurance fund. There is no limit on the amount that is insured. The previous limit of $100,000 was removed, as part of government's response to the global financial crisis in 2008.

There are four main participants in our report: FICOM, the ministry, the commission and CUDIC. The Financial Institutions Commission, otherwise known as FICOM, is part of the Ministry of Finance. The regulation and supervision of credit unions is just one of its responsibilities — other areas, for example, being real estate, mortgage brokers and pension plans.

In our report, FICOM's external oversight panel is referred to as the commission. The commission is only involved in the regulation of financial institutions, including credit unions, trust companies and insurance companies, and is not involved with FICOM's other areas of responsibility. The Credit Union Deposit Insurance Corporation of British Columbia, or CUDIC, administers the deposit insurance fund.

We undertook this audit to determine whether the method and extent of the supervision of the province's credit unions are appropriate. We looked at whether FICOM has an effective credit union monitoring program, if the deposit insurance fund is adequate to cover a significant credit union failure and if there is a full plan to ensure that the payments from the insurance fund can be made to depositors promptly should a credit union fail.

Looking at the monitoring program. Although international industry standards were developed mainly for regulators of the big banks, the majority of the standards are applicable to B.C.'s supervision of credit unions.

FICOM has progressed as far as it can in adopting some of these standards within the existing legislation. For example, the standards require that responsibilities, objectives and powers in monitoring authority and the operational independence and accountability supervisor, which is FICOM in B.C., be prescribed in legislation.

The current legislation reflects a primarily compliance-based approach as opposed to the principled and risk-based monitoring approach. As well, although the commission has overall regulatory oversight, FICOM is part of the Ministry of Finance's operations. It is required to follow government's financial policies and procedures and adhere to government's human resource management policies and framework.

Industry standards recommend having a limit on the amount of an account balance that is insured. The limit should be set so that most depositors are fully covered and ensure that a significant portion of the total deposits are not fully covered. In B.C., there is no limit on the amount insured.

With the mandatory review of legislation in 2014, government has an opportunity to determine whether and to what extent it wants to fully adopt the industry standards. We recommend that the Ministry of Finance consider the industry standards when they do this review.

At the time of our audit FICOM had 25 staff vacancies — approximately 35 percent of the positions in their financial institutions division. As of the summer of 2013 it posted 17 of these positions, and by the end of our audit it still had been unable to fill any of them.

Supervisory work such as on-site review has been scaled back. FICOM completed only seven of the 17 planned credit union reviews for 2012-13, and for 2013-14 the initial 16 planned reviews had been scaled back to three.

On-site reviews are important for determining the composite risk rating, which is a risk factor that is determined for each credit union, which allows FICOM to focus its monitoring efforts on those credit unions that it needs most. At this rate, it will take three years to complete on-site reviews for the ten largest credit unions and over 14 years to do all of them.

In addition, the team responsible for monitoring credit unions does not have all the expertise and competencies it needs. FICOM has been using contractors to fill some of these areas, but this is only a temporary solution.

Looking at deposit insurance. There is no worldwide standard as to the optimal balance for a deposit insurance fund. Guidance is currently under development.

[0955]

In B.C. the target fund size was set in 2008 by recommendation from an actuary. In late 2013 an actuary was once again engaged to review the target fund size. However, FICOM and the commission should review the fund size annually in light of changing economic conditions such as interest rates and the growth of credit union deposits.

Similar to any other emergency preparedness scenario, a plan is needed ahead of time so that the people involved know what to do if a credit union should ever fail. A plan is in the works, and we have recommended that an agreed-to date be set for its completion.

As well, to comply with industry standards and be transparent for depositors, the public must be regularly informed about the benefits and limitations of the deposit insurance system.

There are 11 recommendations in the report. Please see the summary recommendations on page 7 and 8 of the report for the complete list.

In summary, the report makes two recommendations to the Ministry of Finance and three to FICOM to improve the effectiveness of the credit union monitoring program, as well as three recommendations to the commission concerning the insurance fund and three concerning a plan for making payments to insure depositors.

This concludes our summary of the report.

B. Ralston (Chair): From the auditee, then.

C. Rogers: I think you introduced both of us, but Heather, my colleague here, and I will handle most of the presentation.

Thank you, Lisa.

I have to start, unfortunately, by making an apology because I think our slides note that there are 12 recommendations from the Auditor General. Lisa is actually right; there are 11 recommendations. That's why she's the auditor, I guess.

Two of the recommendations were directed towards the Ministry of Finance. The balance of nine were recommended to either FICOM, the management of the operating body, or the oversight body, the commission.

Today I'm pleased to present progress on those recommendations directed to FICOM and to the commission. The commission's chairperson, Helen del Val, would have liked to attend today but is out of the country. She asked me to provide her regrets and to update you or respond to any questions you might have on those recommendations directed to the commission.

My colleague Heather here will update and respond to the question related to the first recommendation directed to the Ministry of Finance, and that is the one related to modernizing the current legislation. Heather, as she was introduced, is the assistant deputy minister of financial and corporate sector policy, so this fits clearly in her area of expertise and responsibility.

On the second recommendation that was directed to the Ministry of Finance — that's the one relating to addressing the staffing capacity at FICOM — I'll be pleased to update you and take questions on this recommendation. While it was directed to the Ministry of Finance, it was subsequently referred to the Public Service Agency. The Public Service Agency has been working with myself and my management team on a plan.

Overall, I think it's important to note that all of the recommendations — all 11 of them — were supported by government. I would add that from FICOM's perspective the exercise was a very good one. I often remark to my staff that it's useful every once in a while for an organization like ours, that's in the business of doing our own examinations, to be on the other side. We found the exercise to be worthwhile.

In broad terms, and for the purposes of developing our action plan and our presentation to you today, we categorized the Auditor General's findings and recommendations into five key areas. The first is modernizing the legislative framework for financial institutions. The second is increasing the staffing capacity at FICOM.

The third is around approving supervisory practices. "Supervision" is the term that FICOM and other regulators around the world use to describe a collection of programs and activities that we use to provide risk oversight of regulated financial institutions.

The fourth category is modernizing deposit insurance funding policies. The fifth, as noted, was about making sure there's an operational plan in place in the unlikely event that we need to deploy funds from the deposit insurance fund.

I'm going to turn the presentation over now to Heather, who will speak on the first recommendation.

H. Wood: Good morning. The first recommendation in the report is directed to the Ministry of Finance. The recommendation is that the Ministry of Finance ensure that in its review of the Financial Institutions Act and the Credit Union Incorporation Act, it also reviews the standards set in the core principles for effective banking supervision and the core principles for effective deposit insurance systems.

[1000]

The ministry agrees with this recommendation. The Financial Institutions Act, known as the FIA, and the Credit Union Incorporation Act, known as the CUIA, contain provisions that require those acts to be reviewed every ten years. Section 294 of the FIA and section 109 of the CUIA provide for the following: "Every 10 years, the government must initiate a review of this Act to determine what changes, if any, should be made." As the last review of these statutes was completed in 2004, government is required to initiate a review of them by the end of this year.

As indicated in the ministry's response to the report, it is normal practice for a review of this nature to consider the changing landscape, including new and emerging standards, such as those set out by the International Association of Deposit Insurers and the Basel Committee on Banking Supervision.

The review will consider how the standards set by these bodies should apply to the B.C. credit union system as well as any legislative amendments that are required by policy decisions triggered by the consideration of new industry standards.

But I want to emphasize the review will also include other components as well, such as requests from and issues raised by industry, consumers and the regulator itself for changes to policy, and legislative frameworks that govern the regulation of financial institutions in B.C.

The ministry will lead the review, including consultations with industry and consumers, as well as policy research and analysis that will be required for the review. I expect, however, that FICOM will actively participate in the review with the ministry and that the ministry will draw on the considerable operational expertise of the staff at FICOM and the research undertaken to date to benchmark B.C.'s current financial legislation and regulation against international standards.

I would note that a number of other provinces have recently announced similar reviews. Ontario indicated in its 2014 budget that it will launch a review this fall of

the Credit Unions and Caisse Populaires Act, 1994, which will "provide an opportunity to update the legislation and regulations." Alberta indicated in its 2014 budget that it will be reviewing how it regulates the financial sector in Alberta and that the review will "ensure we continue to be a leader in the regulation of pensions, insurance and financial institutions." So while the FIA and the CUIA both explicitly require the B.C. government to launch a review of the legislative frameworks, the review appears to be particularly timely at this point.

C. Rogers: The second finding relates to an ongoing challenge at FICOM, and that is maintaining an adequate complement of staff with the right skills and level of experience to meet our mandate. The Auditor General noted that FICOM's framework for supervision was appropriate, and that framework includes the process for planning on-site reviews as well as the tools and systems used to analyze risk.

He also noted — and I apologize, Ms. Bellringer; at the time the report was done, it was a he — that FICOM was not meeting its annual supervision plan and was unlikely to be able to do so going forward, given the number of vacant positions, particularly at senior levels in the organization.

The Auditor General noted that the staffing constraints were not budget-related but rather stemmed from other constraints outside FICOM's direct control, and that's why the recommendation was directed to the Ministry of Finance and not to FICOM or the commission. Government supported the recommendation, and as I mentioned earlier, the Ministry of Finance subsequently requested that the Public Service Agency work directly with me and my management team to address the issues and develop a plan. Some work has been done in this area over the summer.

Concurrent to this work, though, my management team and I have recently put in place a series of contracts with external firms who will add capacity to our supervisory work over the next 24 to 36 months. This is intended to be a temporary solution and was one we saw as necessary to reduce the significant backlog of supervisory work.

We acknowledge the Auditor General's comments about FICOM's overreliance on contractors, and we agree that this should not be a long-term solution. However, we see it as the best and potentially only solution available to us in the near term.

The Auditor General also made two recommendations targeted at improving FICOM's supervisory practices and, in particular, increasing the degree of rigour around our documentation. His report noted that FICOM staff regularly adapt our processes and tools to the range of credit unions that we supervise. If the committee is familiar with B.C.'s credit unions — and I know the Chair certainly is — you know that we have credit unions ranging in size from $12 million to $18 billion in assets.

[1005]

The Auditor General's advice was that FICOM needs to ensure that we clearly and consistently document the adaptations we make and how they impact our assessment of risk.

We absolutely agree with these recommendations. We believe that adapting our tools and processes to the size and complexity of the range of institutions we supervise is important. In particular, it's important to small credit unions to ensure that we don't apply a system designed for an $18 billion organization to a $12 million organization. However, we also agree that where we adapt our tools and processes it's very important that we document them. So we're supportive of this recommendation.

Some intensive work has been done since the Auditor General's report was issued, but we expect this will be an ongoing improvement that we need to make. If we are able to address our staffing capacity, we believe this will further improve our consistency on documentation.

The fourth category of recommendation is related to the funding policies for deposit insurance. FICOM maintains and administers a deposit insurance fund in support of the unlimited deposit insurance provided to depositors in B.C. credit unions.

During the financial crisis in '08 and '09 some deposit insurance companies and organizations found — and they found out rather the hard way — that their funding models were inadequate and their programs to deploy funds were not operationally effective. As a result, the standards and best practices in this area have since been updated and are significantly more thorough and robust.

FICOM has been tracking these changes, and we're gradually modernizing our own policies to be compliant with these new standards. In our response to the Auditor General's report, we noted that we expected to have all of these recommendations addressed in a series of policy recommendations to the commission by the end of the year. We're tracking slightly behind schedule on this project, but we still think we'll hit the deadline.

The final category of recommendations also focuses on deposit insurance. Here again the Auditor General is encouraging FICOM to pay close attention to the lessons learned by other deposit insurers during the financial crisis.

In this case the recommendations focus on ensuring that we have a clear plan in place that can be readily mobilized in the unlikely event that we need to deploy funds held in the deposit insurance fund. We note, and we feel it's important to stress, that the Credit Union Deposit Insurance Corporation has never been in the position of having to pay money directly to depositors resulting from a credit union insolvency in B.C.

We also note that B.C. credit union depositors have never lost a dollar on deposit in B.C. credit unions. We want to continue that record, though, so we also acknowledge that having a clear plan in place is prudent, and it

will contribute significantly to our mandate of protecting depositors and also to maintaining confidence in the credit union sector in B.C.

We also believe it's important to consider, as part of this overall planning process, that other resolution strategies should be included in this planning exercise, and consideration needs to be given to which strategies would be deployed in which situation. As a result, this is a very complex project. It involves multiple stakeholders and requires specialized skill.

Again, in our original report back to the Auditor General, we committed to complete this within 12 months. There are some senior staff positions leading this work at FICOM that are vacant right now, so the work is moving slowly. We do expect that we will be able to have a plan in place in a 24-month period, though. So we may not have it done when the Auditor General visits us again in a year, but we do expect to have it done a year subsequent.

In summary, I hope it's clear from my short presentation that government is supportive of the recommendations made by the Auditor General. The report was very timely for FICOM, given the significant amount of change we've made to our practices since the financial crisis. As Heather noted, it was timely for the review of the legislation as well.

Work is well underway in addressing the recommendations, and we expect to demonstrate considerable progress when the Auditor General does follow up in less than a year from now.

That concludes my remarks. Thank you. I'm happy to take questions.

[1010]

K. Corrigan: Thank you for the presentation from the Auditor General's office and also for the information from the ministry and FICOM.

I'm interested in the 35 percent vacancy rate. Just to be clear, in the report in the response from the Ministry of Finance, the FICOM and the commission, where it says that the ministry and FICOM were partially exempted from the public sector staffing management strategy in 2012 and '13, essentially what we're talking about is a hiring freeze.

It seems like the problem was created by a hiring freeze by government as well as…. I note the staff shortage is noted by the OAG. This is a quote in its audit: "…are primarily in more senior and specialized roles, and difficulty attracting and retaining people to these roles results from a range of factors, including a highly competitive environment for skills and financial sector risk management."

It looks to me like the problems are created by a combination of a hiring freeze and either pay or working conditions, which is concerning.

To my question. Since FICOM and the ministry have, as an admittedly temporary solution, said that they're going to contract out this work, I'm concerned about what the impact of that is, particularly because there is a comment about not having the continuity at the senior levels and where the expertise is — that that's being lost or is not there sufficiently in FICOM.

My understanding of the companies that mainly do the kinds of work — the audit, the internal audits, and so on — for the credit unions are companies like…. There are some specialized companies like Grant Thornton and PRA and KPMG. I don't know whether Pricewaterhouse…. But I know those three do for sure.

I'm very concerned about whether or not we're setting up something, real issues, of people moving back and forth. It suggests conflict. I'm wondering whether we could get some answers about that and how it's being resolved and then what companies it is that have been contracted to do this contract work with the credit unions.

C. Rogers: Well, you listed them. The three that you listed — Grant Thornton, Peter Reimer and Associates and KPMG — are the three firms that we have awarded contracts to specifically for on-site examination and monitoring. In addition, we have a series of other contracts in place with individuals or firms who are conducting other specialized work or supplementing our management team right now. The contracts put in place specifically relating to examination work are with those three firms.

I can assure you that management at FICOM share your concern around the issues of conflict. It's always difficult, I think, in a regulatory environment to be working with private firms, but we put an enormous amount of work and thought into this issue.

In structuring the contracts, we were very, very careful to ensure that the firms are required to disclose any potential conflicts, real or perceived, and we do have the right to terminate the contracts at our discretion if new business arrives in those firms that we think has either a real or potential or perceived conflict. It is something we are highly attuned to, and we will stay that way.

K. Corrigan: Can I do a follow-up, another question, just one?

B. Ralston (Chair): Just one.

[1015]

K. Corrigan: That is concerning. It's not just the issue of whether or not there's a potential conflict for those companies vis-à-vis their work for government, and I'm not suggesting that at all. I think these companies are highly ethical and that they do understand their roles and they do understand the issue of conflict of interest. But it's also then, potentially, a problem for those credit unions who have used those companies over time. They

are going to be put in a situation that they no longer can use the companies that have that particular expertise to do that kind of work.

I'm wondering. My second question — I may get a chance to ask some more questions later — then is: where are we in terms of those contracts? I know that it was mentioned in March of 2014. That's when the report was, so it was prior to that that it was expected these contracts were going to be in place. Are these contracts out, and are those people working in the field now with the credit unions?

C. Rogers: Yes, the contracts have been issued to all three firms. The work in the field is just now getting going. The contracts were put in place just in the last month.

There was a considerable ramp-up period. We needed to put processes and procedures in place, to your point, to manage conflict. There were also a lot of other procedures around protecting information, establishing protocols and policies for the staff to deal with the contractors and for the regulated credit unions to deal with the contractors.

There was also…. We spent a month training and orienting the contractors on FICOM's supervisory framework. So the process to put these contracts in place was in itself a big piece of work. We also needed to do some internal restructuring to put a team of management in place to manage the contracts. It's quite an administratively complex process.

It took us quite a long time to get all that in place, but the contracts were finalized early in September, and we expect the fieldwork to start in a matter of weeks.

L. Throness: I have a few questions about unlimited insurance. As I understand it, about $50 billion of assets are insured by a fund of $428 million, which is less than 1 percent of the total 88 basis points. When I think of the insurance on my car, in over three or four years it'll amount to 40 percent of the value of my car.

Why is the target so low? I'm not sure who I ask that to.

C. Rogers: That would be me.

The insured assets in B.C. as of June of this year are $60 billion. As the credit union system grows, the rate in growth increases. We're growing at about a $10 billion pace a year. The fund is now — you're correct — at 88 basis points.

That may seem counterintuitive, but like any insurance company, we work with an actuary, and we create a model based on probability of a default and the loss that would result as a default. The model's quite complex, and it includes historical data. Given that there has not been a failure of a credit union in B.C., that has a large impact on the model, as you can imagine.

The other thing that affects the model is the robustness of the supervisory practices and the legislation, because those are things that are considered to reduce the probability of a failure or a default.

Those all feed into the model. We use the model and our own judgment to assess the risk, and that is how you get to a number of 88 basis points against the size of insured deposits.

L. Throness: A follow-up question. Why did the credit unions go to unlimited insurance? Was it to attract depositors from the chartered banks?

B. Ralston (Chair): There was actually a pronouncement by the Premier in October of 2008 as one of his ten points responding to the financial crisis.

L. Throness: As I understand it, they gave the approval to raise the insurance level, but it was the credit unions' decision to do so.

H. Wood: No. The Chair is correct. The decision was made by the government in October of 2008 in response to the economic crisis. A number of other provinces at the same time, or very close to the same time, moved to unlimited deposit insurance as well.

[1020]

L. Throness: Okay. Given that on page 16 it says the Basel Committee and the International Association of Deposit Insurers discourage unlimited deposit insurance, would it be more prudent to limit the deposit insurance levels?

H. Wood: I think that the issue needs to be reviewed in this review. The issue of unlimited deposit insurance is that there is an assumption that consumers, whether they are individuals or institutions, will be less concerned about the financial strength of a particular financial institution if the government is perceived as being there to hold consumers whole should there be a problem with a financial institution because of unlimited deposit insurance. That is the theory. That is the assumption that underlines the concern that international standards articulate about unlimited deposit insurance.

I think it is a valid policy issue that needs to be considered on a periodic basis, and I think this is the right time and the right forum in which to review it.

L. Throness: My final question, if I might: how are the funds distributed in case of a default, particularly in the case of unlimited liability?

C. Rogers: Well, I think one of the recommendations that the Auditor General makes is that a very specific and operational plan needs to be in place. One of the reasons that the deposit insurers are encouraged to have a very detailed plan for what is considered to be a very

remote possibility is that these situations really rely on the deposit insurer, the regulator, being able to maintain confidence.

One of the standards that the Basel Committee sets out is that a deposit insurer, in the event of a default, should be in a position to pay depositors within 48 hours. Unlike a normal failure or bankruptcy situation, you're asked to deal with creditors — that is essentially what depositors are — very, very quickly in order to maintain confidence and prevent a situation from spreading. In order to be able to do that, there are, you can imagine, a lot of decisions and lot of details that need to be taken care of in a very short amount of time.

L. Reimer: Thank you, to the Auditor General, for this report. It certainly opened up my eyes to credit union supervision.

When I read the report, I was concerned about some of the things in it. I'm just wondering what other provinces are doing with respect to some of these things. Are there best practices that are happening in other provinces that can assist you in meeting the recommendations of the Auditor General?

C. Rogers: FICOM works closely with our regulatory colleagues across Canada. In fact, at this moment and until the end of this year I currently chair the Canadian Council of Insurance Regulators and the Canadian Credit Union Prudential Supervisors Association. We not only participate; we play a very active and lead role. I think we regularly work with our colleagues to glean any amount of learning and any amount of best practice from them, and that's something we'll continue to do.

D. Eby: My question relates to page 19 of the detailed report in relation, again, to — this was raised by MLA Corrigan — the hiring issue. I was just trying to square the circle of why FICOM would be under the government hiring restriction regime when in the last paragraph it's noted that it's funded entirely by credit unions. It's got surpluses in that funding. Do we know why it is that they're captured by the hiring restrictions and why this has been imposed on them, given that they're independently funded?

C. Rogers: I just want to make one careful correction, that FICOM is funded by all of the industries it regulates, not just credit unions. I wouldn't want credit unions to think they're funding the supervision of insurance companies and pension plans.

[1025]

To your question, though. I think FICOM has long been a…. I often use the term "one foot in, one foot out." We're not a Crown agency like the Securities Commission. The Securities Commission is a full Crown agency, and it is outside of government. It sets its own human resource policies, its own financial management policies. It has to comply with the direction of the minister, but it's its own agency, and it's not included in the Public Service Act.

FICOM is an agency, so we have more operating independence from government than a core department within a ministry. But broadly, we are still inside the Public Service Act, so we have the same compensation and human resource policies and structures that any other part of the Ministry of Finance has. So when policies, such as the managed staffing policy, come down, the hiring freezes you referred to, generally we are captured in those types of decisions.

D. Eby: If I may follow up. Our surpluses, which are accumulated within FICOM, then — do they offset the provincial debt? Is that one of the reasons…? It's certainly something that I noticed in the university sector, where universities had accumulated surpluses and those surpluses could then offset the provincial debt picture. Might that be one reason why?

S. Newton: FICOM was set up as part of a ministry. It's just a creature of how it was created. It's part of the Ministry of Finance, voted under the Ministry of Finance voted appropriations, so that's how they end up there. Any surpluses, deficits in relation to FICOM end up as part of consolidated revenue fund, as would any surpluses in any entity that's in our entire consolidated financial statements. A Crown entity that has a surplus is included in the bottom line for government. Any and all of that is taken into account in determining what cash flow government needs and then what borrowing they may need in order to be able to meet other program requirements.

D. Eby: I just, in closing, want to note how much I appreciate the role that B.C.'s credit unions play in our provincial economy. I mean, 75 years without a single loss to depositors is a remarkable and enviable record, and I know from my own credit union, Vancity, they do exceptional work across the province in local communities. I just wanted to recognize that on the record because I am certainly appreciative of the work done by credit unions in B.C.

V. Huntington: Just one quick question. Well, I have two or three, but the first one. Do you think, given the nature of the financial situation globally, that a ten-year review of the legislation is appropriate or whether that should be brought down to, say, five years or even less?

H. Wood: It's a very good question. The Ontario legislation actually has a requirement for a review every five years, but I can tell you — my colleagues in Ontario may not be pleased with me for doing this — that the ministry simply finds it doesn't have the time in a five-year cycle to

actually do a full review of these pieces of legislation. The Financial Institutions Act is 160 pages. The Credit Union Incorporation Act is 100 pages. These are the most complex pieces of financial corporate sector legislation that we manage within the Ministry of Finance.

I think that ideally — you're correct — it should be less than ten years — perhaps a seven-year window, for example.

V. Huntington: Do you need to have a legislative change recommended by this committee in order to bring it down to, say, seven years? Or does the department or the ministry have a capacity to react quickly if it thinks there needs to be a change?

H. Wood: In terms of bringing down the timeline from ten to seven?

V. Huntington: The timeline or reacting quickly to a legislative requirement, should there be a situation that needs it.

H. Wood: Well, the ministry can always elevate urgent issues to the minister that require immediate legislative attention. As you know, there is a process for doing that. It isn't as immediate sometimes as some would like it to be, but certainly, on an annual basis I have found that if there are urgent issues, we can elevate them to the minister, and they tend to be given high priority, I would say, within the overall legislative priorities of government.

V. Huntington: Would it be worthwhile if an additional recommendation came out of this committee to consider moving the review back to seven years? I know you would rather not, but perhaps it would be worthwhile and advisable.

[1030]

H. Wood: I don't know that I could say whether it would be worthwhile, because I feel that we would have opportunities, for example, to make recommendations to government and that the advice would be well considered and well taken. If during the course of this review industry, consumers, the regulator consistently said to the ministry that the time frame should be shorter than ten years, I think we would be quite successful in being able to provide that advice and have it strongly considered.

V. Huntington: Could I ask the Auditor General if she would care to comment on that — whether it would be more advisable to look at a review of seven rather than ten? Or Mr. Jones. Whichever.

C. Bellringer: I see that as walking into the policy area.

V. Huntington: Yeah, I guess so. Okay.

C. Bellringer: Having said that, the process of going about it by looking at international standards and looking at practices in Canada certainly will give you a bit of an answer to it. I have to admit I was thinking: "Ten years — that's several Auditors General worth."

V. Huntington: Yeah. I'm not sure I understood the answer there, but….

B. Ralston (Chair): So is that a good thing or a bad thing?

Interjections.

V. Huntington: Sorry, were you going to make another comment?

C. Bellringer: The quick answer was that we're not going to make a policy comment on it.

V. Huntington: All right. Thank you.
Could I follow up?

B. Ralston (Chair): Sure, one more.

V. Huntington: It's slightly longer. Well, I didn't intend the other one….

As I understand it, FICOM's primary mandate — or at least initially — was to minimize the negative impact of failure on the financial sector. Is that correct?

C. Rogers: I think I would consider that part of our mandate, yes.

V. Huntington: Okay, part.

One of the things in looking at a review of the credit union situation is that I think, from the perspective of the public, the credit union is seen as sort of the people's banking system. I wanted to explore a little bit some of the comments, particularly on page 16 at the bottom, related to the prevailing versus the new view, where we've already discussed…. The initial review was that unlimited deposit insurance was to discourage risk-taking among the financial sector primarily, I guess, and latterly the public — into a new view where now insurance is looked at as promoting confidence and stability within the system. I think it's what is commented on, on 16.

Then there were the comments that the deposit insurance is intended to cover fully most but not all deposits and to ensure "a significant portion of the value of the deposits are not fully covered" — which I found almost contradictory. That's the last sentence. I wondered. Is that the case — to ensure that "a significant portion of the value of the deposits are not fully covered"? Or is that a typo in the paper? You can answer that first, and then I can carry on.

L. Moore: It is not an error. It is what's intended. Canada is actually an example of that for the federal banks. They have insurance that estimated about 97 percent of their eligible depositors are covered, but it's only about 35 percent of the total deposits that it covers. They are viewed by the Financial Stability Board as an appropriate or a model system to be following.

V. Huntington: Okay. So in that respect, I need to understand….

B. Ralston (Chair): This is your last question, Member, because then…

V. Huntington: I beg your pardon.

B. Ralston (Chair): …we'll come back to you. Just finish this one, and then we'll come back to you. Go ahead.

V. Huntington: In that case, I need to understand how this then plays out on the ground in terms of the non-financial depositor. How does the public…? Does this protect the public deposits, or is it looked at protecting the 97 percent protection ratio for the financial sector? How is this going to play out on the ground in terms of a potential failure?

C. Rogers: If I might, Chair.

I think it might be helpful to understand this issue if I use two terms that regulators or deposit insurers tend to use. One is market discipline, and the other is moral hazard.

[1035]

Market discipline is a concept that says that in addition to the regulators' oversight and the legislative framework that are in place to ensure that financial institutions act prudently, you ideally want the marketplace, which are their customers which fund their business….

Depositors are what fund any financial institution. You want them to care as well. You want them to decide where they deposit their money, based on their assessment of whether that is a sound and prudent financial institution. When you have an unlimited deposit insurance regime in place, you basically remove the incentive for that market discipline to occur.

As Heather mentioned, what happens is that instead of relying on an assessment of whether you're depositing your hard-earned money at a very sound and prudent financial institution and maybe doing a little bit of your own due diligence, you'll just say: "Well, I don't need to worry because if it does fail, I'm covered."

The moral hazard comes in, in terms of management inside financial institutions and even community-oriented financial institutions. The theory goes…. The reason you regulate is that management always has an incentive to grow and to be profitable and to take risks. That's the business they're in. When management knows that a failure of their organization would not affect the funders, the depositors of their organization, they also don't have that extra discipline in place to be that much more careful.

The moral hazard and market discipline are eroded by virtue of an unlimited deposit insurance scheme. That is really, I think, what underlies the Basel Committee and the conventional thinking around the wisdom of limited versus unlimited schemes.

The last point I would make…. I think this is maybe specific to your very specific question. The way the math works is that the average depositor in a financial institution is unlikely to have millions of dollars. They tend to have around $100,000. CDIC, the federal deposit insurer, is currently reviewing that limit to make sure that it keeps pace with inflation and that type of thing.

Generally, what you want to aim to do is insure the average depositor, the average person who deposits their money, and not insure the large institutional investors who might park money in an institution. The theory is that those depositors have the resources and the wherewithal to exercise that market discipline more than the average depositor does.

Hopefully, I've answered your question.

V. Huntington: Somewhat. If I could just quickly follow up….

B. Ralston (Chair): We'll come back to you, but I'd like to move to other members.

V. Huntington: I just wanted to finish the thought here.

B. Ralston (Chair): Go ahead, Shane.

S. Simpson: A couple of questions. The first is the staffing question — just to get back to that a bit. It seems to me that the limits, the sufficiency of the staffing levels and the challenges in filling those positions, underlie a lot of the ability to do the work. You've got to have the bodies there, the people there, to do the work.

I would assume that the challenges we're seeing here as they relate to credit unions— and you could correct me on this — probably also impact the staffing levels and also impact the ability to do the work with the other sectors that you work with and you help regulate. It's not just credit unions. It's the brokers, and it's everybody out there that you have responsibility for, so it's a more complex problem.

Is the challenge here the revenues that you receive from industry? It was pointed out by my colleague here that you're, essentially, funded by the people that you oversee. Is the challenge in the staffing and getting your staffing up primarily around the freeze? Or are their other issues that are creating the problem for reaching your staffing levels?

C. Rogers: I don't think it is primarily about the hiring freeze. As we noted, as the Auditor General noted, we were given a partial exemption from the freeze, and we have been subsequently given a full exemption from the freeze. We are at the same staffing levels as when the Auditor General visited.

[1040]

I think that mathematically it would be difficult for me to argue that it was the hiring freeze that affected our staffing situation.

S. Simpson: What is it?

C. Rogers: Our current vacancy rate is 33 percent.

S. Simpson: I mean, what are the issues? If you have the capacity and you have the resources, what are the challenges you're facing to ramp that up and get the people in place with the skill set to do the work you need done?

C. Rogers: Primarily, it's an issue of our compensation framework. We compete with other regulators and with the broader financial sector — the firms that we've contracted out to and industry itself. These are skills for which the market pays more than we pay, particularly at the senior level.

At our entry level and our mid-management level, we are reasonably competitive, and we are reasonably staffed at that level. But as we develop those people and get their skill level to a certain point, typically they can command a higher salary on the market, and we lose them. As some of our staff in those positions retire after long careers in government, we haven't been successful in replacing them.

S. Simpson: At the more senior levels.

C. Rogers: Yeah. There are some other small issues — limitations around how we can advertise and recruit and stuff — but I think those are second-order issues.

S. Simpson: So your ability…. The compensation packages that you can put on the table are regulated, presumably, by the public service and that. Or do you set your own standards?

C. Rogers: We're part of the Public Service Act. We use the same framework as core government. We do not have the ability to set….

S. Simpson: You're not the investment corporation.

C. Rogers: No. Or the Securities Commission or the other regulatory bodies.

S. Simpson: And they have that ability to set compensation packages that are over and above what the public service…?

C. Rogers: That are different.

S. Simpson: That are different. That's a fair comment.

The question around — the comment that was made I believe by the comptroller — resources, dollars, that come in to FICOM that are surplus to the operation. They then go back, as with other departments, into general revenues of government.

I believe that's what you said, Mr. Newton.

Could you tell us how much money we're talking about here? What kind of money flows from fees, from the numerous people who help fund FICOM, that aren't used by the commission and then go back to general revenue?

S. Newton: At this time, with me I wouldn't have the number of the surplus. I don't know if Carol knows.

S. Simpson: Would you know, Ms. Rogers?

C. Rogers: Yep. Our overall budget at FICOM annually has ranged the last four or five years to between about $13 million and $14½ million. The surplus that has been returned back to government in that same period has ranged between $4.7 million and $5.8 million.

S. Simpson: So you're spending about $14 million on your operation, give or take.

C. Rogers: No, we budget.

S. Simpson: You budget about $14 million on the operation, and you're spending less than that because you're not staffed all the way up. And you're giving about $5 million to the government as surplus.

C. Rogers: Yes.

S. Simpson: So the revenue that's coming in is about $15 million, and you're only spending about $10 million. Is that fair? Then the rest is going back, give or take?

C. Rogers: Yeah. Give or take.

B. Ralston (Chair): I put myself on the list next.

Just to follow on this question about staffing. The federal regulator, OSFI, I think is well known — certainly under the previous CEO — for very tight and effective and detailed regulation of institutions across the country. It seems given that basically one-third of your staff is not there…. What do you think is the impact on the regulatory environment, or is that something that you consider?

[1045]

Certainly, it does create additional risk, and that's sometimes factored into consideration of the strength of financial institutions, if the regulator isn't doing their job. Given these constraints that you say are not finan-

cial but are, as I think you referred to, other constraints, what's the impact on the risk environment given that failure to regulate?

C. Rogers: Are you directing that to me?

B. Ralston (Chair): Oh yeah. You're the one.

C. Rogers: I agree with the Auditor General's comments about timeliness being a significant issue.

The supervisory framework that we use is the same one that OSFI uses. We work closely with OSFI. They've been generous in lending support in the form of training and advice. Our staff meet regularly with them. Their framework, and FICOM's framework, is based entirely on being proactive.

To the member's earlier comment about: how can 88 basis points support $60 billion? It's really because the theory is that we are not going to find ourselves in a situation of resolving a failure because we will have identified and rectified a problem much further upstream. All of that relies on a very proactive, very early intervention model of regulation. So timeliness is a key factor.

Expertise is a key factor. Reputation is a huge factor. One of the reasons I believe that OSFI is as effective a regulator as it is, is because it has such a strong reputation that when it makes a recommendation to its regulated institutions, they listen. It has that close working relationship. Having staff that have the expertise that provides them the credibility and the respect from financial institutions is critical, and having them regularly interacting in a proactive way with institutions is also critical.

I agree with the Auditor General's remarks that the timeliness and the capacity are limiting our ability to do what we're there to do.

B. Ralston (Chair): I'm going to raise the example of OSFI, just because, as you say, they're well known. Any experience I've heard indirectly about their operation is that financial institutions live in a certain level of fear of them just because they are so effective. I don't think, given your staffing constraints and on the three things that you say — timing, expertise and reputation — that FICOM is anywhere near that. That's not a personal slight upon your ability to run the organization. It's just that it seems to be where it's at, given the lack of a proper staffing.

Can you give an example, then? For a senior position like a financial examiner — I'm not sure what the titles would be — what would be the compensation at FICOM, and what would be the payment for an equivalent position at one of the private firms — say, an accounting firm — for someone who would be capable of doing, at a senior level, a detailed examination of a major credit union, for example? Just to get a sense of what the…. You're talking about a salary gap. It all sounds a little bit theoretical without some hard numbers.

C. Rogers: If I may, Chair, we did do some benchmarking. I think an appropriate benchmark might perhaps be OSFI or another regulator rather than a private firm. I think generally, on principle, government agencies try to avoid benchmarking with the private sector. What is probably a more appropriate benchmark would be our neighbour credit regulator or our federal counterpart, as you mentioned, OSFI. That information I would have….

B. Ralston (Chair): Okay. Comparisons are made with the private sector all the time, and usually it's a good thing to compare with the private sector, in some political lexicons. A comparison with OSFI, then, would be probably appropriate.

[1050]

C. Rogers: Okay. A managing director would be a senior supervisory role. Relative to OSFI, there is about a 50 to 60 percent gap. With our provincial counterparts in western Canada it's slightly smaller, about a 30 to 40 percent gap.

B. Ralston (Chair): No, no. What's the salary at FICOM, and what's the salary at OSFI? Just so people can understand it. A 60 percent gap doesn't mean very much to anyone.

C. Rogers: Okay. A managing director at FICOM when this research was conducted would be making between $75,000 and $90,000, depending on their level of experience. In other provinces they would make 35 to 45 percent more; in OSFI, 50 to 60 percent more than that.

B. Ralston (Chair): Okay. Just to avoid people having to convert it and for those of us who are not….

C. Rogers: I'm the financial regulator. I should do the math.

B. Ralston (Chair): Fifty to 60 percent more would be what? What would be the range at OSFI, then?

C. Rogers: A managing director would make probably about $130,000 to $150,000 at OSFI.

B. Ralston (Chair): And have, in your requests…? You're apparently freed from the hiring constraint. You don't have the discretion to set salaries at that level. Is that what you're saying?

C. Rogers: No, I don't.

B. Ralston (Chair): Have you asked?

C. Rogers: Yes.

B. Ralston (Chair): And it's been specifically declined.

C. Rogers: Yes.

B. Ralston (Chair): What was the reason given?

C. Rogers: I think the environment right now, broadly, in government around compensation in the public sector…. It's a bad time to be asking.

I think, generally, all parts of government are being asked to show restraint in this area. Ultimately, FICOM is inside the Public Service Act, and the Public Service Act has a framework in place. We, like everyone else, need to adhere to the framework.

B. Ralston (Chair): Okay. One more question. On page 17 it says: "Legislation review is due in 2014." I believe it's…. Heather Wood used the words "was going to initiate" a review, but the Auditor General uses the language: "The last review was completed in 2004, so another one is due in 2014."

The difference between "due" and "initiate" seems to be substantive, because these kinds of reviews can take a long time. In fact, would you agree — my question is to Heather Wood — that this review is now overdue?

H. Wood: No, I don't agree that the review is overdue. The last review was initiated in 2002. It was completed in 2004. In conducting the next review, in order to ensure that there is no perception that the government feels there are concerns with the sector that need to be addressed, we wouldn't normally initiate the review until 2014.

B. Ralston (Chair): Well, I thought the legislation required to initiate a review. So in order to be complete this year, you would have had to initiate it — if it was going to take two years — two years ago. It seems to me to be a nuanced difference of grammar, but the result seems to be that it will be 12 years before you've completed a review rather than ten, and that seems to be in contradiction to the legislation.

H. Wood: Well, the actual sections of the legislation say: "Every 10 years, the government must initiate a review of this Act to determine what changes, if any, should be made." But of course, the completion of the review cycle and the determination of changes, in my view, does not complete until legislative changes are enacted. In the last review it took approximately two years from the start of the consultation process and the policy analysis and development phase, moving through to the actual legislation development and introduction.

Based on that standard, to initiate the review would be at ten years from the end of the last review, which was when the decisions about changes would have been made — 2004.

B. Ralston (Chair): I can't agree with that interpretation, but thank you for it. Does the Auditor General have any comment on that passage in the report?

[1055]

C. Bellringer: I haven't read the actual words in the legislation, but to me a ten-year period is…. If something needs two years to be completed, then you have to factor that in. It's sounding like 12 years to me, as opposed to ten. I think ten years means that it should be completed in 2014, which is what we put in the report.

G. Kyllo: Just quickly, the 88 basis points that's currently established for the fee. Had you had a full complement of staff for the last five years, do you think that the rating would have been any less? Would that have resulted in increased confidence and maybe a reduced rate?

C. Rogers: To be clear, 88 basis points is the reserve. In insurance terms, it's the pool of money held to offset a loss, and as recommended by the Auditor General, it's a number that is under review. The Auditor General's advice was that we broaden our model that we use to determine that number, using the new standards that are published by the International Association of Deposit Insurers, which is what we're going to do.

One of the things the new standards recommend that a deposit insurer use is the degree of compliance with supervisory best practices — so whether or not your regulatory and supervisory environment meets best practice — because it's considered to be one of your risk mitigators.

We have factored that — our degree of compliance — and some of the things noted by the Auditor General into our recommendation that will go to our commission, hopefully by the end of the year, and it will have some impact on the reserve target, on the 88 basis point target. I apologize. I've not taken the recommendation to my board, and we've not released it to the industry, so I'm a little cautious in terms of being more specific than that.

G. Kyllo: I guess where I was going to go with the question is that all of the different inputs that affect the amount set aside in the reserve could likely be or will likely be impacted by the frequency of the actual audits that are being conducted. So if all the audits weren't being conducted in a timely fashion, we could see, potentially, a greater reserve being established, which would potentially cause additional cost, I guess, for financial institutions.

C. Rogers: Yes.

G. Kyllo: Okay. Just one other question. With respect to the contracting out that is done, have you guys done

any determination on the actual cost of completing an audit using internal resources versus contracting out? And with the contracting out, is that a fixed fee-for-service, or is that based on an hourly basis?

C. Rogers: I'll answer the last question first. The way we've structured the contracts is that they will be fixed fee. My experience with these firms, though, is that at the end of the day, they'll find a way to limit the work to make sure that we'll pay, one way or another.

We have looked at the cost of an examination internally relative to what we're paying externally. That was part of our due diligence in ensuring that the contracts that were put in place were appropriate. The cost is roughly a little more than twice as much to contract it out — about 2.3 — relative to an internal cost, which, my understanding is, is about the norm for an internal versus contract-out ratio in government.

G. Kyllo: And the internal rate would take into consideration overhead costs and all the other…?

C. Rogers: Yeah.

S. Robinson: I, too, want to follow up a bit, and I'm quite concerned about the short-staffing situation. I'm just trying to understand what the impact is of not being able to complete the number of audits or the number of on-site visits that normally get carried out.

Just based on the report, it looks like 16 or 17 is usually the number that FICOM likes to do every year. It looks like that's the pattern. So historically, before 2012…. It just says for the last two years you haven't been able to complete them. What's been the number before then?

[1100]

C. Rogers: You're correct. We'd basically take all of our regulated entities — insurance and trust companies, everything. What we used to do, I would say prior to about 2011 or '10, is we just divided them by a 24- or 36-month cycle, and we did that many every year, or we intended to do that many.

We were keeping pace better prior to 2010 because we used a very simple, rudimentary compliance-based approach. What we did in 2010, following the financial crisis, is we started to transition to a more risk-based framework. We started to try and benchmark against accepted practice, incorporate all of the learnings that came out in the financial crisis.

As a result, the process is quite a bit more intensive, and we had some increased turnover of staff as we transitioned to a new skill set. The combination of factors meant that we started to do quite a bit fewer examinations as a result.

S. Robinson: If I may, Chair, just one follow-up question.

What's the overall impact of not getting through enough of these each year? What's the real risk to depositors?

C. Rogers: I guess I would go back to my earlier comment about early intervention. Everything that I know in my role as a regulator about being effective at avoiding problems that have enough of an impact to affect depositors or to affect the financial system as a whole is about finding them, figuring them out early and then having the type of relationship with the organizations that allows you to solve them in a manner that doesn't flow down to depositors.

Again, I would come back to: early intervention relies on early detection, and early detection relies on regular contact and frequent examination.

S. Robinson: In other words, it's just increased risk.

C. Rogers: Yes.

M. Dalton: Just on the topic of the reserves, how does it compare with our credit unions as opposed to the Canadian chartered banks — the percentage of the basis points for our reserve? Also, if you can make a comparison with maybe some of the American banks. I know there are a lot more there. But just how does that look?

I'm just wondering if less of a reserve can indicate also perhaps more confidence and compliance. I'm sure there's quite a bit involved in that, but if you can make some comments on that, I'd appreciate it.

C. Rogers: I guess the first comment I would make is that every deposit insurer that I know in the U.S., Canada and globally is doing what we're doing, which is figuring out what happened in the financial crisis, what we thought was true that may not have been true in practice and incorporating all of that into our policy. Almost every deposit insurance fund CEO that you would talk to would tell you: "We're currently reviewing our target fund size." That would include CDIC.

We're a little bit behind our colleagues across Canada in the credit union sector, but most of them have very recently completed a review. B.C. has one of the lowest target fund sizes across Canada, but I would say that that is in part because of that lag in the timing of our review. I'm showing my hand a little bit here in terms of our recommendation to our fund size that's coming, but I would think that, subsequent to that recommendation, we will be more in the mid-range, relative to our colleagues across Canada.

CDIC is currently reviewing their target. Their target is slightly lower than ours. Their deposit insurance scheme is different than ours, though, as well.

I don't have enough detail that I could make specific comments on the U.S. What I would say is that in the U.S.

there are a number of funds who are in the process of replenishing their deposit insurance funds, so their targets are impacted by that factor. FDIC, for example, ran out of money and borrowed money to fund its deposit insurance during the crisis.

M. Dalton: So you're looking at how much of a difference? How many basis points? Just kind of a range.

[1105]

C. Rogers: In Canada I would say our difference between our provincial colleagues ranges from…. We're 88 basis points. I think the highest fund is two basis points — 200, so very significant — down to about 100. I think the next highest would be 20 basis points more, and then it would go all the way up to more than double.

J. Yap: You referenced the financial crisis and learnings from it. Going a bit further back in history, leading up to the financial crisis of '08, there was the situation with the sub-prime mortgages and kind of excessive lending on inflated values and all of that, which made its way into the investment assets, which I think you referenced — you know, one of the values for the assets.

Does FICOM, as part of its early warning work and proactive work, do sector analysis? The mortgage lending sector is such an important part of the credit union portfolio. What I'm thinking of is that from time to time we hear pronouncements at the federal level, whether it's the Bank of Canada or the Finance Minister, expressing concern about the state of the real estate market. Let's focus on that. I think it's generally viewed that in Canada and in B.C. we've got a very buoyant market.

Does FICOM, as part of your proactive work, do any forward analysis? If you do, what are the outcomes of that? Then do you provide guidance to the credit unions on perhaps reviewing their lending? What sorts of outcomes come from that?

C. Rogers: Yes, we do that kind of work. We have a small team of people at FICOM that do risk surveillance and analytics. They are the folks that tend to look forward at the next problem or the risks that are emerging. We regularly look at the data that we receive from credit unions on a regular basis. We do additional data calls. We do something called stress testing, a technical term for looking at worst-case scenarios. Most recently, we have a practice of issuing guidelines, which are basically our way to articulate to our financial institutions what our expectations of prudence are.

On the specific topic that you are asking about, residential mortgage underwriting, we have a guideline out in the sector right now for consultation. It's available on our website. Really, it is the product of us looking at what's happening federally, what's happening in the housing market specifically in our province and what we're seeing from our own examination work in our regulated entities.

K. Corrigan: Essentially, what we have in terms of staff, then, from what you've said…. I appreciate your analysis and coming with the information. It's really appreciated that when somebody asks questions, we have somebody come here who has anticipated what possible areas of questions are and has come with the information. I do really appreciate the extra work and preparation that goes into that.

[1110]

What you've essentially said is that the fact that there are caps for compensation has resulted in staff shortages and also increased risk and weaker oversight, and that what is being done in order to temporarily remedy that weaker oversight and the concerns associated with that is that instead of paying an extra 35 percent to 50 or 60 percent for internal staff, we're paying 230 percent more to have the work contracted out.

Would that be a fair evaluation of where we are?

C. Rogers: Yes.

K. Corrigan: Thank you. That's succinct.

So really, it's the issue of…. Putting in artificial caps on compensation for governments can have unintended consequences and end up actually costing government more, so you have to be really careful about inflexibility, I think.

I wanted to ask a couple of questions just about the number of reviews that are being done now. I notice that on page 19 again, there was reference to only…. FICOM only completed seven of 17 planned on-site reviews in 2012-13. Four more were rolled over to 2013-14, and for 2013-14, 16 planned on-site reviews have been reduced to three to focus on the larger institutions.

Then I think on another page there was…. Well, I'll stay with that one. I can't remember where the other one was. So this is the impact.

Where are we right now in terms of…? You've put some contracts in place. Has the catch-up started yet, or are we still falling further and further behind? How many reviews behind are we right now? How long is it taking?

C. Rogers: Well, at this exact moment we are a little bit further behind, and the reason is because we did…. In order to put the contracting process in place, I mentioned earlier that it was in itself quite a rigorous exercise. There was a lot of work to be done, and we ended up needing to move some of our staff into a business unit that will now oversee the contractors.

That's because — I should make this clear — the contractors can't actually make the regulatory decision. We still need a team of staff that will make the regulatory decisions associated with those institutions. We need-

ed to move some staff over to handle that, and then we needed to take some additional staff to get all of those processes in place.

Those folks came from the same team of people that do the examinations, so for a short period of time, for a four- or five-month window, our examination work actually became a little bit more backlogged. We completed one large credit union examination. We also shifted some staff because we have a similar situation for our insurance and trust companies, and we needed to send some examiners to an insurance company.

Right now we are a little bit more behind, but having put the contracts in place, we are hoping that we will start to really catch up more quickly now.

K. Corrigan: I know we haven't had a failure, and that's a great thing. We really generally love our credit unions, I think, in this province. But one of the impacts…. My understanding is that if there isn't a review done for a considerable amount of time, and a credit union — which should be reporting if there are problems, I guess, anyway…. Nevertheless, if there are problems beginning, there's a rating scale for credit unions — sort of one, two or three or something like that. The fees for those credit unions go up significantly if their risk assessment rates them more poorly — correct? — I mean, to the tune of three or four times, $100,000 to $400,000 or something, depending on the size of the credit union.

C. Rogers: I think their fees don't change depending on their risk rating. What does change is their deposit insurance assessment. Again, CUDIC, the deposit insurance fund, uses best practice in our assessment framework, so like any good insurer, we risk-rate institutions as part of their insurance assessment.

If a credit union has a higher-than-average risk rating, they pay a higher-than-average premium. The idea is that credit unions that are low risk pay less insurance than credit unions that are higher risk.

[1115]

K. Corrigan: Potentially, if a credit union has not been reviewed for a longer time than would be best practice, what could happen is that the risk could not be determined as early, and therefore, the premium could go up, which would then put that credit union behind the eight ball more. Then they would be at a higher risk even, because it'd be more difficult to pay those premiums. Is that correct?

C. Rogers: We don't adjust a credit union's risk rating simply because we haven't done an on-site exam for a long time. A risk rating is adjusted using a very rigorous process, and there needs to be clear evidence that the risk profile has changed. Typically, that evidence is gathered as part of the examination process.

Inside of our framework, there would not be a situation where just purely by virtue of an institution not having had a recent exam, they pay more. That would not happen. But if your point is that if we're not on site regularly we don't catch the problem soon enough to have it affect the risk rating, that is a possibility, yes.

K. Corrigan: That was what I was referring to.

In terms of FICOM itself…. I'm trying to understand whether or not there would be other bodies that would take a look at FICOM. It sounds like it's not the fault of FICOM at all but the fault of the problem with staffing, in terms of being able to provide the oversight that FICOM wants to provide.

FICOM has, I would assume, guidance and standards. But does FICOM have its own regulator that it is answerable to that would evaluate whether or not it's able to do the work that it needs to do in terms of oversight of credit unions?

C. Rogers: What's often referred to as the regulator of regulators, or the standard-setter of regulators, is the Basel Committee. The Basel Committee releases guidance and standards, and the Auditor General will use that guidance and those standards as its benchmark in order to evaluate FICOM. That is the benchmark we tend to use too. Some of the reports that the Auditor General relied on were assessments that FICOM commissioned from external firms who specialize in benchmarking regulators against the Basel standards.

We did this partly in preparation for the upcoming FIA review too, so we could understand where we could make improvements outside of a legislative change and where we needed to work with Heather's team on legislative change. We had an external firm benchmark us against the standards for insurance supervision, the standards for banking or credit union deposit-taking supervision and the standards for deposit insurers. Those three very detailed reports were done within the last 18 months.

That's what the commission uses and my management team and I use to plan out our operations and our improvements to our practices.

K. Corrigan: I know there was reference to the standards, and I may have missed something in the report, but can you quickly tell us what the results were and what kinds of issues were raised in those reports?

C. Rogers: As I said, the Auditor General relied on those reports — particularly on the deposit insurance and the banking supervision one — as part of their review, so you would have seen similar comments in their reports as you saw in the Auditor General's report. The report on insurance, which is not an area that the Auditor General looked at, was also consistent. So they tended to cite some of the same things.

I would make the comment, in fairness, too…. You can appreciate that the standards for regulators and the standards for legislation for regulators have all been updated in a flurry of activity since '08-09. So it's not unusual.

[1120]

I think any regulator right now who's benchmarking themselves is going to identify some gaps. That's true also for legislation, right? There's been a lot of updated thinking in this area.

Those reports were prepared. They've been shared with the ministry, and I know that Heather's team and our team will consider them as part of the FIA review. There are also things within those reports that FICOM can address without necessarily waiting for legislation, and we're working on those.

B. Ralston (Chair): In recommendation No. 5 it talks about documenting the work processes to be used in supervising smaller credit unions. I think it's well known that through a process of mergers over the last 20 years, the number of smaller credit unions has steadily diminished. I think the total number of credit unions is now 43, and it was above 100, I think, not so long ago.

Is your sense that…? Historically in the past — I'm not suggesting anything about the existing smaller credit unions — there were a number of regulatory and supervisory problems that emerged from smaller credit unions, whether difficult economic circumstances in their market area, weak or poor leadership at the CEO or board level or just straight dishonesty and fraud at the executive level. Would you say that by the process of consolidation, the risk in the whole system has been diminished or not?

C. Rogers: If I may, Chair, I'm very attuned to the fact that this is a business of confidence, and I'm pleased to share some of my insights as your superintendent, but there are certain things I'd prefer to do in camera, if I might.

B. Ralston (Chair): Okay. You're asking that we move in camera to share that, then?

C. Rogers: With questions specific to the risk profile of our regulated institution — that would be my preference.

B. Ralston (Chair): Okay. Sure.

Is there a motion, then, to move in camera?

Interjection.

B. Ralston (Chair): The Clerk is suggesting to me, probably quite prudently, that we perhaps do that at the end.

C. Rogers: Sure.

B. Ralston (Chair): I'll reserve that question.

Secondly, then, I had a question about — and this may fall into the same category that we may deal with at the end — credit unions in British Columbia. Some of them have expressed interest and taken some steps to make interprovincial connections with credit unions in other provinces. I'm wondering: is that something — it would seem your answer would likely be no — that you have the capacity to examine?

Secondly, what's the risk profile that emerges from that potential of interprovincial credit union connections? Because then you may be taking on or assuming not only the assets of your partner but also the liabilities of your partner.

C. Rogers: We do have some interprovincial role as it stands now. In 2009 — I think it was — our Central 1 Credit Union, which was formally Credit Union Central of B.C., assumed the assets and liabilities of what was formerly the Ontario Central. Subsequent to that, Central 1 assumed responsibility for the payments and clearing system for all Canadian credit unions outside of Quebec.

So FICOM already has a national oversight role by virtue of it being the primary regulator of Central 1. Central 1 is now effectively a clearing and payments house for Canadian credit unions, and it is the central bank to both Ontario and B.C. credit unions. In that sense, we have inherited an interprovincial role.

You may know that FICOM designated Central 1 as a systemically important financial institution for the credit union sector about a year ago, which is, again, regulator language for "this institution needs very close and careful oversight because its failure would create a systemic problem." So we already have that role.

[1125]

The possibility for credit unions to move outside of provincial borders right now…. While there is a legislative framework through the interprovincial trade agreement, the name of which escapes me right now….

B. Ralston (Chair): Is it TILMA that you mean, with Alberta?

C. Rogers: TILMA, yeah.

B. Ralston (Chair): Or the new west partnership?

C. Rogers: That's the one, yeah.

B. Ralston (Chair): I thought these people would be quicker to say those ones, but apparently not.

C. Rogers: That framework allows for credit unions in B.C. to seek out interprovincial partners. But it needs — as any trade agreement needs — the other partner, the other province, to also have that enabling legislation. So that varies still.

The other option that's available to credit unions now, which also has not yet resulted in any change, is that a credit union can now apply to become a federally chartered credit union. If it did that, they would move to being regulated federally as well. But to date, there isn't a B.C. credit union that I'm aware of that has any near-term intention to make that application.

B. Ralston (Chair): Just arising from that, then, what's your assessment of your capacity to examine and assess the risk, given what you've said about Central 1 being, I think, a strategically significant financial institution? What's your sense of your capacity to properly examine and regulate it such that the confidence that's required in it is there?

C. Rogers: I would say right now we don't have that capacity. We have been outsourcing that. We've been heavily using contractors for that role for two years now. We are recruiting right now, hoping to fill some staffing positions, but in the interim we're still very reliant on contractors.

B. Ralston (Chair): It's the same constellation of contractors that you spoke of earlier?

C. Rogers: No, different ones.

It's a very different organization. It's not a retail financial institution. It is basically a central bank and payments and clearing. It's a financial utility, basically.

B. Ralston (Chair): Can you just explain: what's the relationship, then, between the 43 B.C. credit unions and Central 1 in terms of allocation of capital or spillover of risk?

C. Rogers: Maybe we'll move that one in camera, too, if we could.

B. Ralston (Chair): Okay. I didn't mean to bring up all these delicate questions.

I had one final question, then. On page 20 there was a reference to the documentation of composite risk ratings. In the second paragraph there's a note that commercial lending is often a significant line of business for a credit union and that the presence or absence of commercial lending wasn't documented in assessing the risk profile of a credit union.

Now, as it turned out, they didn't do a lot of commercial lending, so it didn't really matter. But it wasn't documented. Given that, certainly, the smaller credit unions and, to a lesser extent, the larger ones focus more on retail lending rather than on commercial lending, I suppose it's not a great concern. But can you explain why that happened and what steps have been taken to avoid that in the future?

C. Rogers: I think in this case…. Credit unions' lending caps or limits are basically a function of how large they are — their own asset sets. Typically, the larger the credit union is, the larger the loans. It's generally the larger credit unions that get into commercial lending in any material way.

That's kind of an accepted fact amongst our staff. They would typically go into a small credit union, and they would know just by how large that credit union is whether or not they would need to spend a lot of time examining the commercial loan portfolio in that credit union.

I think sometimes what our staff do is they skip the step in our framework where we write all that down, where we say: "This credit union is this large. Their lending caps are this large. The largest loan they make is this. The proportion of assets that is lent commercially is this. Therefore, I've decided to not include commercial lending as a significant activity in my oversight process."

[1130]

What the examiner did, I think, was looked at the risk assessment and didn't see the documentation of that thinking in establishing the risk rating — just saw that it was not identified as a risk area — and had to go back and ask a lot of questions and subsequently found out that that was the case. So it did make sense that our examiners did not spend a lot of time on commercial lending in that credit union but had to go ask the questions. It wasn't documented in the file.

I don't know, Lisa, if you want to….

L. Moore: That's a fair assessment.

C. Rogers: So I think the recommendation is: you might have made the right decision, but every auditor will tell you it's very, very important that you document how you got there.

V. Huntington: Thank you. I'd just like to complete the question I had earlier, and that's to try and determine in my own mind what I see as a gap between the new view and the old view and what the policy pronouncement of the former Premier was — i.e., that the deposit insurance should fully cover the deposits. I'm assuming that would represent the new view that stability and confidence in the system is critical versus what I seem to be hearing, which is that the financial supervisory sector still holds onto the old view where you want to discourage risk-taking and, therefore, not cover the deposits fully.

I'm wondering if you could discuss what I'm seeing as a bit of a contradiction between the new and the old, what the obvious policy inference was when the former Premier made that decision and why we still find ourselves with a policy of 35 percent coverage — that whole different approach or the old approach to covering those deposits and what the deposit insurance is intended to do.

C. Rogers: I'm not entirely sure I'm understanding your question.

V. Huntington: Well, I guess I'm trying to uncover, too, what I see as language here saying that there was the old view of discouraging risk-taking — that was why the deposit insurance was generally not 100 percent — versus the new view that we want to encourage stability and confidence in the system.

I'm assuming that when the Premier said that there will be no limits on deposit insurance, he was moving toward that stability-and-confidence point of view. Yet it seems to me that the system itself has not moved to that point of view — i.e., there is no intention of covering deposits fully. So I'm just wondering….

C. Rogers: Deposits are covered fully in B.C. right now. We have an unlimited deposit insurance scheme.

V. Huntington: When I go back to that 97 percent versus 35 percent, that's where I'm having trouble understanding what that means.

C. Rogers: There's a difference between covering depositors and deposits. In financial institutions often a large amount of the deposits are held by a small number of depositors if you attract a lot of what we often call institutional investors or large depositors.

I think what the Auditor General was trying to capture here is that the policy guidance that has emerged encourages policy-setters to set their deposit insurance in a way that covers most depositors but not necessarily most deposits. In other words, protect the 97 percent of us that have our RSPs and chequing accounts but not the 3 percent that have our $8 million deposit. Is that clear?

V. Huntington: Yes, that's much better for me. Thank you. Probably everybody else understood that, but thank you very much.

[1135]

L. Reimer: I just wanted to ask you about contractors versus internal staff. I think MLA Corrigan had mentioned that the amount we're paying contractors…. She used the number 230 percent or something like that, and you said yes in the end. Can we really compare contractors to internal staff? When we pay contractors…. When we hire internal staff, we probably are providing them benefits in addition to their salaries. Therefore, are we really comparing apples to apples when we're talking about contractors versus staff?

C. Rogers: When we do the math to give you those ratios, we're using the full cost of running the operation.

L. Reimer: Including…. Okay, thank you.

C. Rogers: There's a ratio that we can use to gross up a salary to include benefits as well as overhead, training and all of those things.

M. Dalton: On the contracting out, are the contracts year to year? Are they, like, for six months? What types of time periods are we looking at?

C. Rogers: Because we're conscious of and we agree with the Auditor General's comment that we are overreliant on contractors and need to build the capacity internally, and it is our hope and our intention that we will find our way to do that, we put the contracts in place in a way that gives us an annual renewal by institution.

There is a total of, I think, about 45 institutions that we've outsourced, because there are not just credit unions — some insurance and trust companies too. Those are spread over three contractors, but we've structured the contracts so that FICOM can choose to terminate the whole contract or pull only one or more than one institution out of the contract. There's a window each 12 months to do so.

It gives us an opportunity, on an annual basis, to look at our capacity and bring more of the work back into FICOM if we are able to.

M. Dalton: How long has this been going on? For quite a few years now? Has it been increasing — the use of contractors?

C. Rogers: We've been using contractors heavily, as the Auditor General noted, for the last two years increasing…. What we've done more recently in terms of completely outsourcing the examination process is new, though. That hasn't been how we've done it in the past. We used contractors more…. We would hire a specialist to come in and help us with an examination, but the work was all retained in-house.

What we've done now, actually, is taken the complete monitoring and examination work for a large number of our regulated entities and outsourced it through an ongoing contract.

B. Ralston (Chair): Anyone else?

Okay, given that that appears to complete the questions, I'm going to suggest, then, that we move in camera.

Before we move the motion, I'm advised by the Clerk that observers will have to take a walk in the sunshine and won't be here while we engage in that process. Nothing personal, of course. We'll be breaking for lunch at 12, and you're welcome back by then.

MLA Lana Popham is here. It's up to the committee. If people object to her continuing to be here, I will ask her to go. But given that she's an MLA, I think that's fine.

You might as well stay, then.

Is there a motion, then, to move in camera?

Motion approved.

The committee continued in camera from 11:39 a.m. to 11:51 a.m.

[B. Ralston in the chair.]

B. Ralston (Chair): We're back on the record. Are there any concluding questions, now that we're back in the regular session?

V. Huntington: I guess a bit of direction from the Chair. If this committee wants to propose a recommendation beyond those of the Auditor General, how do we do that?

B. Ralston (Chair): Well, at this point there's no consensus of the committee that the committee should indeed adopt the recommendations of the Auditor General, let alone put forward its own recommendations.

It is the policy and the practice of other public accounts committees across the country, notably the Public Accounts Committee in Ottawa, to craft its own recommendations and put those before the committee. Usually there's staff support for that. At this point I think that's a direction that we should be moving in.

The other direction that is fairly common in other public accounts committees is a formal follow-up process by the committee as opposed to by the Auditor General. I know Russ Jones had worked on that and was attempting to bring that before the committee. With the new Auditor General in place, perhaps that's a discussion we can have in the future.

I think it's important not only that we receive the reports and have the discussion…. We have the option of making separate and independent recommendations, if members agree, and secondly, the capacity to follow up on those recommendations and see whether recommendations that are made, after careful analysis and debate, are actually followed. That's something that the committee should have the capacity to do as well.

At the moment there's no consensus. That's something I've discussed with the vice-Chair, and we haven't got agreement on that either.

V. Huntington: Could I then say, Mr. Chair, that I'd also like to have that question referred to the committee at some point, as I did earlier about our agenda setting?

B. Ralston (Chair): Right.

Okay, any further questions? Otherwise, we can recess a little bit early.

We'll just declare a recess, and we'll be back at one o'clock for our next report.

Thank you very much, and thank you for all those who presented. I think that was a very thorough discussion.

The committee recessed from 11:54 a.m. to 1:01 p.m.

[B. Ralston in the chair.]

B. Ralston (Chair): We're going to deal this afternoon with consideration of the Auditor General report entitled *Oversight of Physician Services*, dated February 2014.

Just let me briefly introduce the staff who are here. We have Carol Bellringer, the Auditor General; Russ Jones, the Deputy Auditor General; and Jessie Giles, the manager of performance audit. On the government side, Stuart Newton is the comptroller general. For the Ministry of Health, Ted Patterson is the assistant deputy minister, health sector workforce division; Rod Frechette is the executive director, compensation and negotiation, health sector workforce division; and Jeremy Higgs, executive director, workforce research and analysis, health sector workforce division.

The deputy minister was invited at my request to attend, but apparently he is at a federal-provincial Health Council meeting. I think it's a meeting of all the health ministers across the country which is taking place today, tomorrow and Wednesday in Banff, Alberta, so he was unable to be here for this particular session.

This is an important topic. I think 9 percent of the provincial budget is what we're talking about here, so we'll look forward to the report and the discussion that ensues.

I'll turn it over at this point to the Auditor General.

Auditor General Report: *Oversight of Physician Services*

C. Bellringer: Thank you, Mr. Chair.

On this report, I was struck reading the audit report on the oversight of physician services that the audit sets out to find what I saw to be some pretty basic answers that should be available to legislators. Appreciating that health care delivery and outcome measurement is a complex area and a cost driver of the provincial budget, I do think that legislatures need to have this basic accountability information provided to them to allow you to make informed decisions around the budget vote.

I also noted that the examples provided in our report of jurisdictions that have established performance management systems for physicians are outside of Canada — England, Salt Lake City, Ohio, Australia, New Zealand. What we are envisioning may be something somewhat new but, I would suggest, is feasible within the health care system in Canada.

I'll allow Russ to do the summary, and then Jessie will do the more detailed presentation.

R. Jones: Thank you, Carol.

Chair, Deputy Chair and Members, good afternoon and welcome to our discussion of the report titled *Oversight of Physician Services*.

Just to start off, I'd like to clarify for members that this audit focused only on the quality and cost-effectiveness of physician services and not the overall health care system. It also focuses strictly on the oversight of physician services, not whether physicians provide quality or cost-effective care.

That said, government has the challenge of ensuring that our health care system will remain strong and affordable for generations in an environment with limited funding and continual demand. To succeed, government must prioritize the funding available by making informed choices about health care service delivery now and into the future.

[1305]

Physicians play a major role in providing health care services. They contribute to promoting, maintaining and restoring our health, and their services often save lives. At the same time, these services are a major cost to the system. To make informed choices, government needs to know whether the services provided offer the best value and the highest quality for the money spent. We don't believe they do.

To explain how we came to that conclusion, I will have Jessie Giles, manager in our performance audit, give you an overview of the report.

J. Giles: Anyone who has had an illness or been affected by illness in their family understands the value of physicians. Because of how valuable physician services are, it can be difficult to determine an appropriate cost. This is government's responsibility. It has to manage health care spending. Our audit looked at the oversight of physician services.

The cost of paying for physician services is quite high. In 2011-12, B.C. paid its 10,346 physicians over $3.6 billion, approximately 9 percent of the entire provincial budget. Almost all B.C. physicians receive their income from public health dollars.

Given the limited amount of funding available for health care and government's duty to protect and enhance the health care system, government must make evidence-based funding decisions. To be successful, government must understand and ensure that all health care services, including those provided by physicians, are high quality and offer good value for the money spent.

This audit examined whether the Ministry of Health, the six health authorities and the Medical Services Commission are ensuring that physician services are achieving value for money. We examined the oversight of the quality and cost-effectiveness of services provided under the fee-for-service and alternative payments program models, the two largest physician-funding models in B.C.

We concluded that government does not know if physician services are high quality and offering good value for the money spent. Government cannot demonstrate that physician services are high quality. Government cannot demonstrate that compensation for physician services is cost-effective. Systemic barriers in the province's health care system are hampering government's ability to achieve value for money with physician services. Our findings question government's ability to make informed decisions regarding physician services.

Government does not have a consistent overall system for assessing and managing physician performance. For example, health authorities grant privileges to physicians annually to permit them to practise in their facilities. However, performance reviews are not done consistently as a condition for privileged reappointment. This means government does not know what quality of services is being provided by individual physicians and whether it is getting the quality it expects for the money being spent.

We also found that entities are working in silos and have different opinions regarding who is and who should be responsible for the oversight of physician services. This is resulting in gaps in the oversight.

Government is also unable to demonstrate that compensation for physician services is offering the best value because it has not defined what "value" or "cost-effective" means as it relates to physician services. In addition, government's current physician compensation models and processes limit its ability to ensure value for money. This is specifically a concern, given that the Minister of Health is accountable for ensuring the best possible value for taxpayers.

Government has two main models to pay physicians: fee-for-service and the alternative payments program. Both models are common throughout Canada and internationally.

The majority of B.C. physicians receive funding through fee-for-service. Although this model encourages providing a high volume of services, which increases access, fees are not linked to patient outcomes, and there's a potential incentive to provide services that are not necessary and/or most appropriate based on patient needs. We were unable to determine if this is an issue because information on appropriateness of services is not collected consistently.

We also found that government is not regularly reviewing existing fee-for-service fee codes to ensure that fees are appropriately matched with the service being provided, with the exception of laboratory fees. Advanced technology can decrease the complexity and the amount of time needed to provide a service, thereby making an expensive fee less appropriate.

[1310]

APP, on the other hand, pays for a range of services through contracts — standard rates for half-day services — or by fixed compensation.

APP was specifically put in place to support physicians seeing patients who require more clinical time. We found that government is not reviewing or adjusting APP con-

tracts to ensure that they are cost-effective. Half of the APP contracts we reviewed exceeded agreed-upon compensation ranges or were so unclear, we could not reach a conclusion.

The report also identifies several systemic barriers that make it challenging for government to ensure quality and cost-effective physician services. These include: the data needed to assess the quality of physician services at the individual level is either not available or is fragmented; aspects of work culture are impeding constructive engagement with physicians; and current legislation is not adequately supporting entities overseeing physician services.

Some of the issues in our report were identified by Dr. Douglas Cochrane in his 2011 investigation regarding the quality of the interpretation of CT scans and obstetrical ultrasound readings in the province. Government has taken steps to address some of the issues Cochrane identified. However, progress has been slow, and significant work is still needed. Government must continue to resolve these barriers to ensure its effective oversight of physician services.

We had a total of six recommendations. Recommendations 1 and 2 propose the need for improvements with respect to performance management of physicians as well as clarification of roles, responsibilities and accountabilities. Recommendations 3 and 4 propose improvements related to current physician compensation models. Recommendation 5 proposes that government identify and address work environment barriers to physician engagement. Recommendation 6 proposes that improvements are necessary with respect to legislative and regulatory framework governing physician services in B.C.

That concludes our presentation, and I will now turn things back to Russ.

B. Ralston (Chair): I'll now call upon the representatives of the auditee, the Ministry of Health. I'm assuming it's Ted Patterson.

T. Patterson: Yes. Thank you to committee members for the opportunity to be here with you this afternoon. As the Chair reminded me, it wasn't optional for me as well, but I am pleased to be here, of course.

You were introduced to both Rod and Jeremy. I will say, aside from their titles, that Rod is responsible for the alternative payments program, and he has a long history in physician human resources management within the ministry. Jeremy is, among other things, responsible for analytics in my division. He's actually responsible for the Medical Services Plan payment schedule, or fee-for-service, as it's commonly referred to. He has long experience in physician economics for the ministry. I'm quite pleased that they're here with me to answer some of the more detailed questions that you might have today.

First, I'd like to acknowledge and welcome the new Auditor General in her role and acknowledge the work of the Deputy Auditor General and staff of the Office of the Auditor General on their report. I thank the Auditor General for her opening and the idea that some of this is complex, and you'll hear that repeated by me a number of times in my presentation. Some of it is new, but it's feasible. They're improvements that we need to work toward.

Thank you for that, and I give full credit, as I believe we say in our response, to the Auditor General's staff for the work they did on this report. It's worthwhile, and the recommendations are important, and we take them seriously.

I would say, though, back to the complexity, that we are making progress on most of the recommendations in the report. We'll walk you through some of the activities that are underway.

I would add a general caution or caveat here. As I'm sure you're all aware — and you'll see it laid out in my slide deck — health care is complex, and change in health care can be extremely difficult.

[1315]

We have long history, organizational and professional culture and a multiplicity of often competing interests that we have to consider in managing change. It's not a bad thing. It's just a fact. It's reality.

At times this complexity can make even seemingly small, commonsense changes seem challenging, and then significant or radical change, which I think is actually suggested by a couple of the recommendations, is quite another matter.

What I would say is that how we manage change in health care, from our perspective, is every bit as important as what we intend to change. That's been a lesson at the ministry over the past seven or eight years that I've been at the ministry. It's a theme that you'll see in our planning guide document, *Setting Priorities for the B.C. Health System*, which is available on our website. It's basically a refresh of our innovation and change agenda from a number of years ago.

In our view, given the challenges that we have with change in the health system, we have to be focused, opportunistic and strategic in terms of our approach. Most importantly, we need to be constructive and collaborative in terms of how we engage our health system partners.

I would put it to you that some of the recommendations in the report speak to changes that we should be working on in effecting change in the short term, but there are some recommendations that require a longer-term approach to change.

I don't want to leave you with the impression that it's too hard. We're alive to the fact that there are significant opportunities for change, and we're working hard to make those.

I'd like to mention, as well, that I think we've got some willingness and energy on behalf of some of our partners

in the health system to work with us collaboratively and constructively on that change. I'll mention the Medical Services Commission, the health authorities, the College of Physicians and Surgeons of B.C., the Doctors of B.C. — formerly the B.C. Medical Association — and many others which I will reference throughout this presentation.

The slide that's up right now is really just of passing interest. When I wrote a presentation on infection control a number of years ago as a junior policy analyst, I managed to weave Aristotle into the speaking points, and you get stuck with Jeffrey Simpson today.

Interjection.

T. Patterson: There you go. This is a quote from our planning guide document. It's from Jeffrey Simpson's latest book on….

Interjection.

T. Patterson: That's right. There you go. I hope there's not a quiz at the end. I'm partway through the book. I hope my boss doesn't read *Hansard* here.

That's just for your interest. I mean, it summarizes how we are thinking about change and why we think it's so important that we take a collaborative and constructive approach to managing change in health care.

What I'd like to do is walk through the six recommendations in the report and describe for you some of the activities that are underway to address each recommendation. Broadly speaking, the first recommendation deals with physician performance management. There are a number of activities, both existing and new, that we believe at least begin to address this recommendation. I'll speak about these in terms of two streams of activity: quality assurance activities and quality improvement activities.

In terms of quality assurance, quality assurance is about regulation and oversight. It's about setting the bar, if you will, establishing a general set of standards that physicians are expected to meet in order that patients and the public can be assured they're receiving care from a qualified and competent health professional.

Quality assurance for physicians is the responsibility of a number of agencies at the national and provincial levels, including the Ministry of Health, and spans the entirety of a physician's career, from his or her medical education through to retirement.

For example, at the national level the Medical Council of Canada assesses over 11,000 medical graduates every year through its examination process. Also at the national level, the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada establish competencies and certification requirements for physicians to practice in various specialties.

They accredit medical residency and training programs, and they accredit the continuing professional development programs required for physicians to maintain certification throughout their careers, and that's a key point. I'm advised — I was at a meeting yesterday — that these organizations are actually looking to increase the number of hours of assessment required of physicians on an annual basis in order to maintain their certification.

At the provincial level the College of Physicians and Surgeons of B.C. is the organization created under the Health Professions Act, as you know, for the purposes of licensing, investigating and disciplining physicians who practise in this province. The college, as well, fully endorses the principles of the national organizations with respect to continuing medical education and professional development.

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Each year at the time of licence renewal, registrants are required to attest that they're compliant with the medical education requirements of either the Royal College or the College of Family Physicians of Canada. Additionally, the College of Physicians and Surgeons of B.C. has a range of quality and performance enhancement programs to support the ongoing quality of physician practice, particularly in community and private settings.

Also at the provincial level, health authorities, of course, represent another layer in terms of regulation and oversight of quality assurance through their annual process to grant privileges to physicians who wish to practise in health authority programs and facilities, as we've just heard.

This process occurs within the context of a broader governance framework for medical staff established under the Hospital Act and Hospital Act regulation. This framework requires the creation of medical staff associations and structures, bylaws and policies that govern the medical staff affairs within a health authority, including requirements for physicians to participate in quality assurance and quality improvement activities as required by a health authority.

Quality improvement, on the other hand, is obviously related, but it's about continually raising the bar in terms of professional practice, I would say. It's about continuous and ongoing professional development at individual, team and system levels. At the level of the individual physician, there's a strong cultural emphasis on professional obligation and self-direction, with respect to practice improvement.

There's a sense in which performance activities must be by us and for us among the physician community, if they're to be successful. There are a range of quality improvement and performance enhancement activities that take place throughout the health system.

I've just mentioned the national and provincial requirements for continuing medical education and professional development. There are various quality improvement

initiatives underway throughout the health system, led by the ministry, the health authorities, the B.C. Patient Safety and Quality Council, for example.

In particular — we'll reference this later on — there's a tremendous amount of collaborative activity going on through a number of joint clinical committees that have been established under the physician master agreement. There are four of these: the General Practice Service Committee, the Specialist Services Committee, the Shared Care Committee and the Joint Standing Committee on Rural Issues. Each of these committees has a quality improvement agenda and contributes to and supports quality improvement or physician performance enhancement in various ways.

I'm spending a fair bit of time on the quality slide here, but I promise I'll move more quickly through the rest. Aside from all of this activity that goes on in the normal course, we are doing some important work that was, I believe, referenced through the Physician Quality Assurance Steering Committee that emerged after the Cochrane report a number of years ago. We're doing some work to make improvements on both the quality assurance and quality improvement side and to wed both of those — the various activities.

The PQASC, or the Physician Quality Assurance Steering Committee, is a collaborative and multi-stakeholder committee that includes the ministry and health authorities, the college, the B.C. Patient Safety and Quality Council, Doctors of B.C. and the various joint collaborative committees that I just mentioned. There are a number of other organizations that are involved in various initiatives as well, so it's quite the enterprise.

Specifically, in terms of quality assurance, we are in the process of implementing a provincial credentialing and privileging system that will ensure a consistent, standardized approach to the privileging process across all health authorities. It'll include a single-standard, web-based credentialing and privileging system, including standardized business processes for health authorities. It will include consistent, objective, criteria-based standards for physicians, dentists, midwives, nurse practitioners and other health professionals who wish to have privileges to practise in health authority programs and facilities.

These criteria will be set out in privileging dictionaries, they're called, for each medical specialty, and health authorities will then use these dictionaries to assess individuals wishing to practise in a health authority. In other words, a general surgeon in Vancouver Coastal will be required to have the same core set of competencies to have privileges as a general surgeon in Fraser Health or Vancouver Island, and there are sets of non-core competencies, as well, that may be locally based or applied in certain local situations as appropriate.

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This initiative will also include training and support for medical staff leaders that are conducting annual performance reviews, and we heard a comment about the, I guess, inconsistent performance reviews that take place now. We recognize that, and this initiative is intended to address that.

So there will be training to support medical leaders conducting these interviews. These interviews may include discussion of, for example, physician self-assessments; compliance with health authority bylaws, rules and policies; patient care management practices; qualitative data; multi-source feedback, and there are a number of tools that can be used for that purpose; team relationships; patient and student satisfaction; currency of practice; continuing medical education; scholarly activity; and so on.

We expect the new system to be in place early in 2015, and we've received interest from a number of other provinces that are quite interested in the model.

Supporting that, on the QI side, I'll say that we're doing work on a provincial performance enhancement framework, which is referenced in the report, to support both community- and facility-based physicians meeting their professional obligation to continuous professional development and the enhancement of their practice.

As I said earlier, there are a lot of quality improvement activities going on throughout the system in various venues. One of the things that we're trying to do through the Physician Quality Assurance Steering Committee is better coordinate and build on those activities, to build them together — as I said earlier, wed QA and QI, if you will.

Again, there's a long list of stakeholders participating in that, and we expect to have discussions about establishing metrics, expectations, deliverables and accountability on a more systemic basis than is the case at present. This is a key priority for the steering committee in 2014-15.

I should note, as I did earlier, that this is one of those pieces of work that is going to take some time. But I think it's excellent work, and it's well worth it.

I will summarize just on the quality side. There is a lot of good work underway. There's a lot of activity to improve quality in terms of physician services — quality assurance and quality improvement — and we'll continue to carry on with that work.

Quickly, recommendation 2 suggests that there's a need to clarify roles, responsibilities and accountabilities among the various stakeholders responsible for ensuring quality and cost-effectiveness in physician services. We agree, and we believe we're moving forward on a number of fronts to improve on that issue.

Our *Setting Priorities* document sets out that we'll be creating a clear performance management and accountability framework built on public reporting and grounded in a clear understanding of roles, responsibilities and accountabilities of various stakeholders and organizations involved in the delivery of health care, including

the ministry, the Medical Services Commission, health authorities, the colleges and physicians themselves.

We've been doing some work over the past year to improve governance and accountability between the ministry and health authorities in particular, and we have in fact developed the performance management and accountability framework I just referenced. It's in this *SettingPriorities* document. We're sharing that widely with stakeholders so that they're aware of how we're evaluating health services, broadly speaking.

I will also say that the work referencing the long list of stakeholders that participate in the Physician Quality Assurance Steering Committee…. Working with that group of people has pushed us to try and achieve clarity in terms of our respective roles. I think we're making some progress through that steering committee.

As well, in terms of physicians understanding and accepting their role, I think there are signals both nationally and provincially, I would say, that physicians recognize that the nature of their role in relationship to the health system is evolving — it's not what it was 20 or 25 years ago — and that they have to be accountable and participate in a different way in the health system.

Both the Canadian Medical Association and the formerly B.C. Medical Association have released papers on medical professionalism — what it means to be a doctor and be accountable and responsible and all those things. From our perspective, that's welcome news. They acknowledge that there's an evolving role for them in this as well.

Recommendations 3 and 4 both deal with physician compensation models — in particular fee-for-service and alternative payments — although as the report notes, there are a number of other payment mechanisms for physicians in B.C. Specifically with respect to recommendation 3, there's a great deal of debate in various jurisdictions about physician compensation and physician compensation models.

[1330]

I would suggest to you that there are no perfect compensation models for physicians and that every jurisdiction, or every province in Canada at least, faces similar challenges with respect to some of the issues in this report. There are advantages and disadvantages to any and every compensation model.

I would also suggest the idea of…. And I don't want to imply that this was what was intended by recommendation 3, but the idea of a wholesale rebuilding of physician compensation models in the short term is perhaps unrealistic. These models — in particular, fee-for-service — have a long historical and cultural significance for physicians. I'm advised, for example, that the tariff committee process that was established to create and amend fees for doctors is rooted in 50 or 60 years of history, created at the onset of public medicine in the province here.

We agree that significant change is necessary, and we're quite interested in moving in that direction, but I would suggest that this won't happen easily or quickly, either through negotiation or otherwise. However, that's not to say we cannot or should not pursue significant change to these models. In fact, I'll put it this way. I think we've got a generational opportunity, as a result of changing physician demographics in the province, to start to think about fundamentally shifting the way we think about physician compensation and build new models for the future over the next several years.

Just to elaborate on that, for the most part, physicians at present day enjoy the freedom to determine where, when and how much they work. Physicians entering the workforce today think differently about how they want to work and where they want to work. There's been a shift, I'm told, in the literature over the past ten, even 20, years about how physicians are trying to achieve a balance of work and lifestyle, as I would suspect most of us are. Fewer physicians today want to work 60- to 70-hour weeks and run a business, so to speak. You may have read a little bit about that in the paper recently.

Younger physicians, we're finding, increasingly want to focus their time on clinical work and aren't necessarily interested in opening their own clinic independently and running a business. They're also interested in, to put it this way, practice niches — addiction medicine, walk-in clinics, hospitalist programs in hospitals, for example.

I think what that tells us is that at the same time, some of these physicians are looking for new payment models and gravitating away from fee-for-service models. That includes overhead to alternative payment and contract arrangements.

As I said, I think we have a real opportunity to start working with medical residents, physicians and others on developing the models for the future now and start taking these steps. As I said earlier, that's a discussion we hope to engage them in soon, and I would say that that will take a few years.

On recommendation 4, fee-for-service and alternative payment arrangements, this is about improving existing compensation models. I'll say simply that we recognize many of the challenges that the Auditor General raised in the report, and we are taking steps to improve our management of both fee-for-service and APP. Importantly, I think we are doing it with a commitment of collaboration and support from the Doctors of B.C. and health authorities thus far.

In 2014, specifically, we intend to establish a payment schedule review working group to review the MSC payment schedule, with the objective of identifying adjustments to fees and billing rules to reflect changes in knowledge, skills, time and technology required to deliver a service; fees for elimination that are no longer necessary or in accordance with the standard of care; and adjustments to fees based on evidence-based outcomes data.

This will be a labour-intensive exercise and, again, will take time. But after we have completed our work, we will take our findings through the tariff committee in the Medical Services Commission processes to effect change with respect to the payment schedule and, hopefully, bring better value for money.

We also will be working collaboratively with the Doctors of B.C. through the Medical Service Commission's guidelines and protocols advisory committee and the Patterns of Practice Committee, to support the goal of high-quality patient care and effective utilization of physicians' services.

[1335]

With respect to the alternative payments program, we believe the time is right for a more fundamental policy review, which we will be undertaking in consultation with the health authorities and Doctors of B.C. in 2014-15. This is actually identified from a budget perspective as a key priority in the ministry's *Setting Priorities* document.

I will take a bit of issue with part of the report here. It references the fact that…. It suggests we've not done any demonstrable work in aligning physician compensation with patient population health needs and makes specific reference to expectations that fees for complex services that significantly improve a patient's quality of life would be higher than fees for less complex services.

As the report suggests, I think we would agree with respect to the payment schedule. We have problems in terms of relative value of fees. We agree with that.

However, we have done a great deal of work over the past ten years to align patient needs and compensation — in particular in labs, as was mentioned, but also more broadly through the joint collaborative committees that I mentioned and, I think most importantly, through the General Practice Services Committee. Specifically, I would add that we've created numerous incentives and fees for chronic disease management in complex patients for family physicians and specialists.

We expect that, following our current round of negotiations with Doctors of B.C., we'll be able to provide those joint committees with a new mandate to create further incentives and programs aligned with patient populations, priority patient populations. My point here: we have been working and will continue to work with Doctors of B.C. to create these new incentives that we think make improvements for patients in the province.

Slide 8. The next recommendation is about physician engagement, and I think we're actively addressing this issue on a number of fronts. With respect to community-based physicians, the General Practice Services Committee has been working on improving physician engagement in the community for close to a decade now. I would suggest that family practice in the province has…. Physicians would tell us, and they do tell us, that there is a marked improvement over the past — roughly — ten years since they started a number of their initiatives. The GPs are more engaged.

The focus of our efforts over the next several years will now turn to engagement of facility-based physicians. We've been in discussions with Doctors of B.C. and health authorities for a number of months now about ways to improve relationships at provincial, regional and local levels within the health system.

At the provincial level the ministry and the health authorities are committing to working together more closely with the Doctors of B.C. at the senior executive level of our organizations — for example, though the leadership council for the health system, which is chaired by the deputy and includes all the health authority CEOs.

At the regional and local levels there is some important work to do, and health authorities and physicians will be working closely to improve the structures and processes that I referred to — the medical staff structures and processes through which the physicians interface with health authority medical leaders and administrators.

This is a significant undertaking, and there are organizational and cultural issues that we will need to work through over the next several years. This will not happen quickly, but we're all committed to doing it and to putting focus and energy into improving engagement for physicians. Through this process we will be discussing engagement surveys for physicians and reporting our progress to the Minister of Health and through the leadership council as well.

Very quickly, the next recommendation, 6, refers to legislative and regulatory barriers to oversight for physician services. This is a key piece of work that is being undertaken by the Physician Quality Assurance Steering Committee. We have conducted a legislative and regulatory review, and the ministry is presently reviewing the results and determining the next steps in terms of addressing some of these regulatory barriers.

In summary, the ministry, the MSC and the health authorities appreciate the Office of the Auditor General's report on the oversight of physician services. The report identifies a number of opportunities for improvement to ensure that dollars spent on physician services provide maximum benefit to patients and maximum value to taxpayers. We believe we're working to address the recommendations, and we'll continue to work with our health system partners to do so.

I thank you again for the opportunity to be here.

B. Ralston (Chair): Okay. Questions.

[1340]

S. Robinson: Well, I certainly appreciate the complexity of all the various stakeholder groups and the tensions between them all in terms of who is taking responsibility and oversight and how to actually tease that apart.

I guess, first, I want to just acknowledge the Auditor

General and the work that's gone into trying to sort that out and help us understand who's doing what. I suspect my colleagues have lots of questions, so I'm going to start off with just a couple and then come back around.

My first one has to do with this generational opportunity that you mentioned. It was actually part of my notes that there is a shift. I'm really curious about how you're taking advantage of that, because a cultural shift is really hard to do. I think collectively we've seen that happen in British Columbia around seatbelts, for example — getting people to wear seatbelts, which is now culturally accepted — or even drinking and driving.

It takes a lot of effort to move a whole body of people to change behaviours. This is just a subset of that group. Given that there is a shift, I'd like to hear a little bit more about what specific steps are being taken to capitalize on this opportunity.

T. Patterson: Thank you for the question. I would say maybe I'll set some context here. All of this, physician compensation, from my perspective…. My portfolio is health human resources. One of the things that's set out in the *Setting Priorities* document is that we need a strategy for health human resources, which we're developing, that supports the service delivery goals that we have at the ministry to target certain patient populations and improve health care for those people.

We presently don't have what I would call a robust health human resources strategy, and we're working to develop that. Over the next, I'd say, six months, we'll be working to develop that, and that will, I think, from a policy perspective, surface a number of the issues that we need to be thinking about three, five, ten, 15 years down the road in the health system. It'll allow us to have a policy discussion with some of these people representing different generations of physicians and how we manage change.

Then we look to engage those folks in a discussion about policy in the future. I would say we're in the policy development stage, and we're not yet having those discussions — other than, I would say, sporadically we'll get people coming into the ministry saying: "I've got a brilliant idea. Help me get here." They are brilliant ideas, and we try and facilitate that and build on that and take the opportunities where they come. But we're doing quite a bit of work on a health human resources strategy at present.

S. Robinson: It sounds like it's just contemplative right now rather than into action….

T. Patterson: We're in the initial stages of thinking about this.

S. Robinson: If I might, Chair, I have one other question that has to do with the physician engagement. I think around this table most of us are always concerned with citizen engagement. If you have 10 percent of the population voting, you think that's terrible. Then you get to 20 percent. It's still terrible, but you say it's an improvement. I'm really curious about: when you talk about physician engagement, what is it that you're measuring, and what does good physician engagement look like?

T. Patterson: What I would say, generally, is there's a focus…. There's an understanding in health care — and you'll see that reflected in our health human resources strategy; I think it goes for any organization — that engaged staff bring results in terms of improvements in patient care. The literature points that out.

We do measure engagement for, I'll just say, the non-physician health care employees in the health authorities right now. We haven't done extensive work measuring engagement for physicians working in health authority programs and facilities, and that's something that we need to work on.

The Doctors of B.C. has surveyed its members, and that was clear in their last survey before negotiations that the top non-monetary priority for physicians was engagement, that they are feeling they don't know who to talk to locally, in facilities or which regional department head or whoever they're supposed to connect with. They're feeling disengaged.

That's apparent, so we are taking steps, as I mentioned. The health authorities are working locally with Doctors of B.C. to create new structures and processes to make sure that physicians feel like they can inform health authority decisions about resource allocation before decisions are made rather than being told about them after the fact, which may be a little bit unfair to my health authority colleagues.

[1345]

As I said, we have been in discussions for several months about taking a more systemic approach to this. But it's got to be done locally, I think — site by site, region by region, health authority by health authority — because it's really locally about the relationships between physicians and the health authorities that they work in.

S. Robinson: Can I ask one last question on this engagement piece, just around engagement? What does successful engagement look like? How do you know that people are successfully engaged in the process?

T. Patterson: Part of that will be…. I mentioned surveys, conducting engagement surveys, and that's probably a longer-term measurement — improvement in surveys, for example. But I think problem-solving locally — simple things like physicians attending medical advisory committee meetings and participating effectively in those, physicians engaging in quality improvement initiatives locally and feeling like they're contributing. They

want to contribute.

There are, actually, examples of where things are working very well, I'm told. It's not as though there are engagement problems everywhere, but certainly, there are places where work is needed. I think we'll hear less about physicians and, working on teams, some of the issues — the growing pains, challenges with respect to compensation and negotiation issues — can be managed more effectively locally — those sorts of things.

L. Throness: I wanted to talkabout doctor shortage. I have a riding of some 10,000 square kilometres. There are about 30 place names in my riding. In the rural areas particularly, there are problems with access.

A few years ago I was able to work for the Minister of Health in Ottawa. I was told, by someone there who knows, that we really don't have a doctor shortage in Canada. We have doctors who have a new lifestyle and who work fewer hours. They talked about a doctor in particular who worked in an emergency department in a hospital for two shifts a week, made $10,000, no overhead, no administration. He had a very nice life. But that does not necessarily serve the needs of our population.

Can you tell me about the changing ratio of doctors to population? Is the ratio changing? Is it declining? Is it increasing? What does that ratio look like?

T. Patterson: I'll turn things over to Jeremy to give you the exact figures, the scientific approach. But my understanding is, and he'll confirm this, that the number of physicians in the province is increasing per population. Some of the discussion we have from time to time is precisely that: do we have a physician shortage, or are physicians working differently? Perhaps we have more of a distribution problem and a productivity problem than an actual shortage of people.

J. Higgs: If I may, to answer your question, the physician-to-population ratio or population-to-physician ratio has grown in a way that can be expressed simply by saying that the number of physicians has grown from the period of '01-02 to '12-13 by 29 percent. That's 8,234 physicians in '01-02 to 10,628 in '12-13. At the same time, our population grew by 13.4 percent. So the rate of increase for physicians is more than double the rate of increase in population over that same period of time.

L. Throness: Okay, another question. There are about 251 working days in a year, and the average physician is now billing on 179 days. What kinds of tools can the ministry bring to bear to encourage physicians to work more?

If I was a person who owned a business, I could say: "I want to hire you because you're going to work full-time, and I don't want to hire you because you're going to work part-time." Doesn't the public have the right to a full-time physician? I understand that they're independent actors and so on. But what influences, what tools, does the ministry have to change the behaviour of physicians or to encourage, stimulate behaviour that is in the public interest?

T. Patterson: I would suggest that that's something we need to work on, frankly. We've got contractual and other arrangements, but the reason I think physicians are practising that way is because we may not have the incentives, the structures right, the compensation models right. So we do need to do some work in that area.

[1350]

L. Throness: In particular, a few years ago there was a court case on billing numbers — I think about 20 years ago now — where they wouldn't give billing numbers in B.C. to people who didn't move to certain areas. That was overturned by the Supreme Court.

What is the extent to which the government can use the assigning of billing numbers?

T. Patterson: There are a number of specific things that we do, I should mention, for certain types of medical residencies. If they're international medical graduates, I believe we require a return of service, and we try and target those to underserviced communities.

I am familiar with that case, and it was long before my time. I know that there are a number of jurisdictions that actually do. New Brunswick, I think, is one example that restricts the use of billing numbers and targets those in certain communities. So a new physician who wants a billing number must practise where there's a billing number available to practise.

I am told that the success of that type of approach depends on robust and comprehensive physician resource planning. New Brunswick as been able to justify, as I understand it, in court that this is grounded on a solid approach to human resource planning.

There are examples out there of that approach. It's something that we could look at and, frankly, I think we should look at. But it has to be grounded, as I said, in a solid approach to human resources planning.

L. Throness: I would just point out, Chair, as a final comment that I haven't heard about many tools that are available to the ministry. That, I think, should be a matter of concern.

D. Eby: A couple comments directly related conveniently to MLA Throness's comments. I would be very hesitant to blame, Mr. Chair, doctors in British Columbia living a relaxed lifestyle for the shortage of physicians in the province. The doctors who I know and have worked with are exceptionally hard-working and remarkable people and as concerned as anybody else about the shortage of physicians, especially family physicians.

My question on that point is related to the government's tools and one of the tools that they potentially have available to them that was discussed in this report, which the Medical Services Commission discussed on page 25 of the report — which does not have any full-time staff.

In the report it notes that the purpose of this commission is to ensure reasonable access to medical care across the province and that this shortage of staff on this commission results in there being no entity in B.C. measuring specialist wait times, no entity ensuring reasonable access to medical care and, in addition, no entity measuring the actual implementation of the much-vaunted GP for Me program, which was part of the June 2014 mandate letter for the Health Minister.

My question is both to the representative of the ministry and to the Auditor General. Is there any reasonable explanation for there not being any full-time staff dedicated to ensuring access to physician services across the province?

J. Higgs: If I may, as long as I've been in the ministry, the Medical Services Commission has relied largely on the Ministry of Health to provide its support for its agenda — to support the materials that show up on the agenda. It relies on people like me right now for updates on budget management and expenditure reports. It relies upon representatives from various committees, such as the advisory committee on diagnostic facilities, the billing integrity program. It's not been a model of having direct staff for a very long time. So I, myself, can't say when and where that decision was taken.

The commission has varied over time from being a single person to being, for about 20 years now, the tripartite setup that it is now, with the government members, public members and members from the Medical Association. It has people that do a lot of work for it, but there has never really been a structure for having dedicated staff.

The Medical Association does a little bit to provide updates to the chair, as well, once in a while. But really, the commission has long relied on ministry staff, whose job is split between doing some work for the commission and doing its ongoing program area work as well.

[1355]

D. Eby: Thank you for that. I have just a follow-up question. I'm curious, because the report's language is not ambiguous. It says that there simply is no measurement of specialist wait times, that the commission as it is structured — whether tripartite, staffless or otherwise — cannot fulfil the mandate of ensuring reasonable access to medical care and that there is no measurement of the GP for Me program. It's unambiguous.

How do I square the wording of this report with what you've just told me — that the commission is working properly and there is measurement of these things?

J. Higgs: I would say that actually there is…. The commission itself, the Medical Services Commission, oversees the Medical Services Plan budget. Where we see wait-time management and measurement is actually in another part of the ministry, where they're looking largely at the acute care system. That's largely where we have wait-time measurement, largely for procedures — surgical procedures, a few diagnostic procedures.

The commission itself does not have, has never undertaken, a wait-time measurement on their own. They are overseeing the Medical Services Plan budget. I would say that their reply to that is that they're trying to provide reasonable access through having a payment schedule that has reasonable fees and provides reasonable compensation for physicians — linking that back to the Canada Health Act, whereby reasonable access actually is linked back to reasonable compensation for physicians.

That's where the Medical Services Commission would be looking to do its work regarding access. It's to make sure that the compensation for physicians is adequate to provide access for things like primary specialists and diagnostic care.

D. Eby: Do you disagree then? It sounds to me, in your answer…. I was listening carefully, and I didn't hear you disagreeing. I just want to be clear. Is there anybody measuring specialist wait times from the point of referral? Is there anybody measuring the implementation of the GP for Me program? Is there anybody fulfilling the Medical Services Commission mandate of ensuring reasonable access to medical care?

J. Higgs: There are people who are looking at wait times. The wait time you've referred to, from referral to specialist — that's something called wait 1. That's a very difficult thing to measure in our administrative data. A particular patient-physician interaction that leads to a specialist consultation is a somewhat imprecise date at times in our data. There are some quality issues. We have to rely upon the claims data to actually have the necessary information.

What we measure is…. We tend to measure from specialist consultation to surgical booking, which is essentially the wait 2. So I won't disagree. Nobody…. We're still working on wait 1, and there's a pilot project that's underway through the Specialist Services Committee to try and do that. There have also been some efforts in the ministry to do it, but it hasn't reached a provincial spread yet.

The GP for Me is one whereby what they have is a measure that is, I think, best called an estimate at the moment. They have an algorithm for measuring attachment. Technically speaking, it's a pretty good algorithm. But measuring attachment in administrative data in the physician world is really difficult because we don't have a flag for a person's regular medical physician.

We have algorithms and we have estimates to be able to say: "This person gets the majority of their care from a particular practitioner." What that tells us is that we can make an assumption that that is the primary relationship. What we're able to do, and the big advance that we've been making over the last few years…. It's to be able to look back in time.

We're not just looking at a particular year. We're looking back five, ten years to see what those relationships are, then making an estimate of how many people are in relationships like that, and then being able to judge the improvement between those who have that kind of relationship and those who don't over the time that we have our GP for Me program.

B. Ralston (Chair): Russ, did you have something to add?

R. Jones: I was just going to mention I'll let Jessie explain to the members how we came up with our conclusion.

[1400]

J. Giles: We had a similar discussion with the Medical Services Commission, and it came down to a couple of things.

The key argument that they use was because — and we note on page 22 — they are responsible for some rural program amounts, so by enabling these rural program funding incentives, they are helping to ensure accessible services. They use that argument in terms of how they're able to meet their mandate.

Really, what it came down to and what we heard is that the exception comes with the committee on diagnostic facilities, which monitors the accessibility of lab services. They are doing work in terms of what's happening with lab services, but when it comes to everything else, they're not.

K. Corrigan: I think it's interesting that in the response from government to the Auditor General's report, the words "collaborative" or "collaboratively" are used seven times, which I think is a good thing. But I think back to recent negotiations with teachers, for example, and it's a very different kind of relationship.

I'm wondering whether maybe what's really being danced around here is that it's a challenging relationship with doctors. My sister is a doctor — just recently retired this week, actually — so I love doctors, and I love my family doctor. But the reality is, is it not true that at the basis of all the challenges here is the fact that physicians consider themselves as independent contractors, essentially, and professionals who should have the right to decide what they do and how they do it and how it's measured and how they're accountable?

Maybe I'll just start with that very general question.

T. Patterson: I would say that we do have a positive relationship with our physicians. I think we've been able to do some excellent work over the past…. Before my time, it started, frankly, in particular starting with the general practice community. So there's some excellent work out there. The word "collaborative" in that context means something, and they are quite serious about it. It's important that we work collaboratively with physicians.

I wouldn't say that we don't have a good relationship. I think quite the opposite — that we do have a good relationship. Perhaps with any relationship there are times where you disagree, but we're able to work constructively with each other on areas where we have mutual interests. So I would just say that.

The idea that physicians are independent practitioners, or sometimes we hear the word "contractors," for example. Physicians that I speak to…. I don't know if it's the committee's experience, as well, but some physicians adopt or accept that characterization, and some can't stand it. Actually, they resist it. I wouldn't want to make general comments about that.

The long history of what it means to be a medical professional — there's a culture that's involved here. As I said earlier, I think there's a recognition among the profession where in the past, maybe, a physician would set up a practice in some corner of a community on her own or his own and have a practice individually. That's not the way physicians think about things. Physicians are looking on their own to be part of the health system and to practise differently.

Physician autonomy and physician independence are starting to mean something else. They're quite eager or excited about working in team-based practices and team-based models with other health professionals. I hope that answers your question.

K. Corrigan: As a follow-up, yes, I do believe that the relationship traditionally has been a good relationship. My point is rather a bit the other way.

[1405]

Because the physicians and the B.C. Medical Association are a very powerful group, trying to ensure that we have accountability in a system where people simply get paid for reporting that they've provided a fee…. I mean, it's really quite unique, the payment system for doctors. I think perhaps that government needs to push more in order to ensure that accountability.

I want to use just one really quick example. On page 18 there's discussion about the physician practice enhancement program, which was also referenced in the presentation, and the fact that assessments happen regularly. It's done through the college — 332 peer practice assessments. Yet the information that is gathered does not include any performance measure for quality, and the college doesn't report on the outcomes of the peer assessments to the public or to the government, even at

an aggregate level.

Why would it be…? Could this kind of information and a requirement that peer reviews be rigorous and that this information be made available to government…? Could that not be a requirement — simply a requirement by government?

T. Patterson: It could, and one of the things that we will be speaking about through the physician performance enhancement work that you referred to is precisely that: what metrics ought to look like for different physician groups, what our expectations are from those physician groups, what their accountabilities are and the role and responsibility of the different organizations.

I think at this point we're meeting, trying to understand what information exists. We have a rich repository at the Ministry of Health, as well, of clinical and administrative data that I think we can make better use of to establish measurement and monitoring for physician services.

So yes, but I would not want to take the approach to make it mandatory, I guess, straightaway. I think we need to be clear about what our objectives are and what we're looking for in terms of measurement and monitoring from various organizations and then work with them to get there. I think that's the approach that we'd like to take.

K. Corrigan: I also wanted to ask a question about fees. On page 30 of the report it says that fees "are not linked to health needs of the general population. Historically, fee increases have been the result of efforts by sections advocating for higher pay, an approach that can create tension among the sections when there is a limited available amount of funding."

I'm just wondering what is being done about that, because that seems like a fundamental flaw with the system.

T. Patterson: Jeremy will jump in, in a second here, because he actually participates in the tariff process through which these fees are set.

I guess what we would say is that one of the things we're doing when we go into negotiations, for example, is rather than sending money toward the available amount…. We've actually come to an understanding with the physicians that instead of price increases, we can send funds to the joint collaborative committees in order to allow them to work with us, work in government and with the health authorities, to create new fees or new incentives that fall outside of the payment schedule arrangements. Nevertheless, they end up in physicians' pockets, but they're targeted in a different way to patient population health needs.

That's one approach we're doing, and we've been relatively successful in doing that.

J. Higgs: I can add that I will agree that the report gets this right. Historically, most of the ideas for fee changes — be they increases through negotiated settlements where money is granted and then the sections go and divide it up and decide where they want to put their fees but also just changes within the fee schedule on a routine basis — are mostly generated by the physicians themselves, by the sections themselves.

[1410]

They are saying: "Well, we want to just do an across-the-board increase, for example, on all of our fees. So we'll take all of it and just make a 3 percent increase" or "What we'll want to do is put it all, if it's a specialty, on a consultation. We haven't put any money on our consult for a long time, so let's just put it all on the consult."

What we've done over the last several years is a couple of things. One of the things that the ministry has done a lot more of is pay an awful lot more attention to the actual allocations that come in for negotiated fees. Several years ago, for example, the section of general practice wanted to put a whole bunch of money just sort of across the board in their areas. What we had observed in the ministry was that they really needed to put more money into hospital fees, because physicians weren't coming to the hospitals so much.

Over a period of a few weeks of discussion back and forth, which my colleague Rod was very instrumental in handling, we ended up actually shaping that allocation. We ended up having a bit more influence than we normally would have because we really pressed the point and said: "Look, we really need to have not a general increase on office visits. We need to try and get docs back into the hospitals. So let's put some of your money onto fees." It took a while, but they did agree to that after a bit.

The other thing that's happened over the last few years is that we have put very little money into just general fee increases. What we've put in since fiscal year '10-11 has been a 0.5 percent general fee increase, which is around $11 million to $12 million a year that gets split between the GPs and the specialty sections.

What we've done with other money, though, is we've put money into specialist recruitment and retention. So there's been a process for interested sections to come forth and make arguments for a pot of $20 million. That resulted in money going to geriatrics, psychiatry, pediatrics, general internal medicine, which all tend to be at the lower end of the average annual income. You can see that in the report here.

We've done that. We've also had what we call disparity money, which has also been targeted at physicians. We had a total of $20 million for that in '06 and '07 that was there to try and narrow the gap between the higher-level specialties, as you'll see in your report — ophthalmology, for example — and some of the lower-end ones. Again, groups like general internal medicine were successful. Pediatrics was successful, obstetrics and gynecology.

To come back to the question, these are some of the efforts we've been making. We're going to continue that.

We're really going to continue that.

The other thing, if I may, is that on a day-to-day basis with the tariff committee…. When sections come with suggestions to change their fees, we are trying to do a much better job, particularly over the last couple of years, of really taking a good hard look at what these procedures are for, what the benefit is to the patient, what it's going to cost, trying to hold them accountable for what they say it's going to cost and what it ultimately is going to cost. That, of course, requires a higher level of monitoring on our part.

Those are just a couple of broad examples of how we're trying to do better in this area.

K. Corrigan: Just a final question on that area. On the same page at the bottom it says: "Without the ministry or the Medical Services Commission systematically assessing cost-effectiveness, there is no incentive to initiate changes to fees to ensure cost-effectiveness is maintained."

It's difficult, actually, in this report, because it is such a complex subject, to jump back and forth between the response and the report itself to see exactly where each of the issues is addressed. It looks to me like there is not a system in place to…. I mean, that's the comment of the Auditor General. Do you have any response to that comment?

T. Patterson: Well, I think that's one of the things that I mentioned earlier. We recognize the challenges with the payment schedule, and we will be doing some work this year to have a look at the relative value of fees and see if we can take some proposals forward to the commission to revalue some of those fees or eliminate fees where we don't think they're doing the trick. Part of that…. It's our responsibility to undertake that work and to bring better management to bear on the fee-setting process.

[1415]

S. Simpson: Just a quick question. I don't have a lot here. What we know when we look at questions around physicians is that the B.C. Medical Association is a pretty powerful organization. It's an organization that has had the ability to push back against governments of all stripes for a long time in terms of defending the interests of its members.

The kinds of discussions that are incorporated in this report and in the response…. I guess the question I have is: what discussions have been had with the BCMA around these issues? While individual physicians may or may not have views about how to approach this, the BCMA, I'm sure, has views about how to approach this.

Without some willingness on their part to be involved in a discussion about the rethink of physician services and what that means, people who will replace us somewhere down the road will be having this discussion again. So where have they been involved in this discussion, and how does that relationship unfold to get to a solution?

T. Patterson: As you can imagine, as I said earlier, I think we've got some willingness and commitment to talk about the future and what physician compensation models could look like. So we do have a good foundation, a good relationship, to start from.

Having said that, I do recognize, and I'm sure all of you recognize, that it's very difficult for the Doctors of B.C., the B.C. Medical Association, to participate in processes — revaluation of fees — or to be seen, I would suggest, defending what could be compensation adjustments for certain groups of physicians, certain sections of their membership.

That's tough for them, because there are 30-plus different sections within the BCMA. Other than, I guess, the idea of levelling everyone up to address value, the alternative is that some sections might see their compensation or certain fees decrease if we were to really take a hard look at value. So it is challenging for them. I don't dismiss that at all. But there is a recognition — on the part of physicians even, not just the Doctors of B.C. — that they're interested in quality and cost-effectiveness. They don't want to be seen as wasting taxpayers' money.

It has to be artfully done, but it can be done. It's feasible.

S. Simpson: So what's our reality in terms of the assessment of the ministry about how we get there and how this conversation happens? How's it going to happen? How are we going to have this discussion with the key players? On the physician side it's the BCMA, presumably, as their representative in this discussion. How does this discussion unfold so that we actually make some progress and we're not back having a discussion about a subsequent Auditor General's report in ten years that tells us the same thing is occurring?

T. Patterson: It's an important point. The foundation is a good relationship and being able to work through tough issues. It doesn't mean that there may not be pain in certain places, but I think you need a good relationship to manage those sorts of things.

S. Simpson: I'll leave it there. I think I heard the answer.

B. Ralston (Chair): Just to go back to page 30, I had this page flagged as well. I think sometimes the power of an example is more illustrative than some more general explanations. There is an explanation there about cataract fees. I'm just going to read it.

> "When cataract fees were first introduced, the average duration for cataract extraction and lens implantation was one hour. By 2011 the procedure had decreased to approximately 15 minutes. Improvements in technology — specifically phacoemulsification, where the eye's internal lens is emulsified with an ultrasonic

> hand piece and aspirated from the eye — made cataract surgery easier and safer to perform. The ministry, therefore, proposed reducing the fee, but it took six years to obtain approval and implement the change. The fee was reduced from a combined total of $533.87 to $420."

[1420]

I'm not sure that this addresses the issue of cost-effectiveness, but certainly it does deal with the issue of a legitimate argument that perhaps the cost should be reduced. I'm sure some of us have had the experience of being in hospital for a procedure where the attending physician has stacked up a number of people, kind of airport-style circling around the control tower, all to get the same procedure, one after another.

Can you explain why it would take six years to make that change? That might illustrate some of the challenges that you face.

J. Higgs: It took six years in total, largely because for the first four years of that, the ministry wanted to make a change — it was very obvious that a change needed to be made — but we weren't able to coalesce on a really good argument, and we weren't able to overcome the section of ophthalmology. The section of ophthalmology has to be given a lot of credit for their ability to defend their interests. They are very intelligent people, and they really, really know what they're doing when it comes to billings and their payment schedule.

What we ended up doing in the last two years was actually formulating an argument that really just got to the nub of what the value of the service was. Essentially, what we did was that we just picked off several arguments, and they all ended up in one place. That was that the fee was higher than it needed to be in order for it to be performed. This is called the concept of economic rent. That means that with the technology in that procedure that had taken it from an hour long to 15 minutes, ten minutes in some cases, all of the benefit had accrued to the provider.

What the argument really got down to, the conclusion, was…. Looking at a base year of '94-95 and where we were, we figured out how much technological benefit there was, and then what we did was we went in arguing that the fee should rightly be set at this. Then the discussions came, for the next little while, about where we would land.

In addition, one of the reasons why it took two years is that we sent a letter to the tariff committee in March 2011 that said: "We want to change the fee." We actually suggested a 66 percent reduction at the time. The chair of the tariff committee asked us to meet with the section first, before actually bringing it to the tariff committee. "See what you can do with the section," he said. It took five months to do three meetings with them, where in every one of them they said: "The fee doesn't need to be changed. It's fine." We just couldn't agree.

Ultimately he said: "Well, now we're going to go to tariff." We started in March of 2011. We didn't get to tariff to make our argument until January of 2012. We made our case, did the great big, long argument, and then they came back with something — actually right away. They came back with a recommendation to go to $441, which at the time was equivalent to Ontario. We said: "That's not good enough. We want it to go down lower than that."

What that triggered, as per the master agreement, was something called the ad hoc joint review panel. That joint review panel didn't meet until October. What happened is that they got our materials in July, but then we couldn't get a meeting arranged until October. A lot of that was because "Well, the ophthalmologists aren't available" or "People aren't available." So it just dragged and dragged. We got to the ad hoc joint review panel. They reduced it to $420.

At that point, if either party had not agreed with that, they could have taken it to the Medical Services Commission. But what we ended up doing in that case was that we agreed to it, and the change was enacted in January of 2013. Really, the big thing is that we had four years of "Now, what's the argument going to be, besides 'you really should change this'?" to actually come up with an argument that was persuasive enough for the tariff committee and for the section to say: "Okay, we'll agree to a change."

[1425]

B. Ralston (Chair): Well, it certainly illustrates the difficulties. Maybe you should hire Peter Cameron.

Looking at page 7, there's another question that I have.

> "We also found that government is not reviewing or adjusting APP contracts to ensure they are cost-effective. In fact, half of the APP contracts we reviewed exceeded agreed-upon compensation ranges or were so unclear we could not reach a conclusion. Sometimes the ministry and health authorities agree to pay more than established ranges and rates — i.e., to obtain a sought-after specialist — which sets the precedent for negotiating higher rates."

Could the ministry respond to that?

That seems certainly to be a problem if you're not following the contracts that are negotiated, because I think the point that you were attempting to illustrate there was that you were bound by the agreement between the government and the BCMA and that there were a number of procedures to follow in order to get to agreement.

T. Patterson: On the alternative payment side, Rod might have something to add. What I would say is that the alternative payments program is newer than the fee-for-service program — the payment schedule, if you will. But there are a number of contracts out there, ones where there are payments over the rates and ranges that are negotiated in the PMA agreement.

Some of these are historical legacy contracts that simply get renewed and carried on year over year. So there are a number of arrangements that are in place. We don't deny that. They exist.

B. Ralston (Chair): What's the solution, then? I mean, I'm not sure that it's directed to the question. I don't

get the sense that you're answering the conclusion that the Auditor General came to: "The government cannot demonstrate that compensation for physician services is cost-effective." But I suppose we are talking about costs, so if you are paying more than the contracts say, how is that…? I mean, at the very least, that's not very business-like and doesn't seem to me very effective.

T. Patterson: What I would say is that for those arrangements that are historical or legacy arrangements, there are opportunities for the health authorities. The contracts are between the health authority and the physician, so there are opportunities from time to time for them to open up those contracts.

However, we do have provisions in the physician master agreement where contracts that are above rates and ranges are actually red-circled in some cases so they don't receive general increases that other physicians on alternative payments would receive.

B. Ralston (Chair): I think it said in the report that you're paying on these APP so-called arrangements $408 million. You made a reference to an exception for what you call legacy agreements. What percentage of the $408 million are legacy agreements? And in the case of a legacy agreement, is that for the lifetime of the physician? I mean, if someone negotiates something in 1995, does that continue above the tariff until the physician retires from practice or dies?

R. Frechette: Well, as you can imagine, when we're talking about reducing compensation to physicians in any sense — the ophthalmologists were an example just used — there is consideration of whether they will find alternatives to the existing alternative under which they're contracted.

In many cases, we don't want to disrupt the service to the public, and therefore we have agreed to slowly deal with these arrangements, as Ted already mentioned, by not providing increases to these arrangements that are over the range.

B. Ralston (Chair): Essentially, they tell you that "if you reduce that, we'll walk, and I'll go somewhere else.

R. Frechette: Yeah, that's often the response.

B. Ralston (Chair): I see. Okay, those are my questions at this time.

[1430]

S. Robinson: I have a couple of questions. I have one, actually, for the Auditor. It has to do with recommendation 4 — 4.2, specifically — where the recommendation is that "fees and contracts are adjusted on a regular basis so physician compensation reflects changes in the knowledge, skills, time and technology required to deliver a service."

I'm always curious about what "regular" means. Regular as in every decade, every five years? Is there something more defined than regular that the Auditor would recommend?

R. Jones: I would say that regular is not every month, but it shouldn't be every ten years or 20 years either. You should be looking at all of these factors when trying to determine whether or not the fees are appropriate. When you see changes in some of those areas, that might be regular — once a year, twice, every other year, but not every month and not every ten years.

S. Robinson: So somewhere between. I understand that "regular basis" is ongoing, so it's not just when we think of it. It's built into some sort of systematic review of some kind, and it's built into the overall system.

R. Jones: Yes.

S. Robinson: If I might, Chair, carry on with some of the other questions that I have.

It has to do with the report that talked about legislation and some of the concerns related to the communication of physician performance at the aggregate level. One of the queries that comes out of the report is that because we don't have anyone overseeing the performance measures for quality, we don't have any information on overall performance or trends over time. And there's comment that the legislation does not prevent the college and the health authorities from sharing physician performance information on an aggregate level.

What recommendations can the ministry make about how to bring that forward? Is that something that legislatively we need to be looking at? I guess I'm looking for some direction about how we make that a possibility in terms of getting a sense of value for money and making sure that the public is being well served.

T. Patterson: Is the question for me?

S. Robinson: Yes.

T. Patterson: Well, as I mentioned, we are undertaking a review of the legislative and regulatory framework for oversight for physician services. I think, more broadly, one of the other pieces of work that we are doing at the ministry is the policy around what an updated health information management model would look like.

A number of other provinces…. This isn't my file, so I apologize to my colleagues who may be listening, but we're one of the few provinces left that doesn't have a unified legislative approach to health information management that would enable the sharing or the flow of in-

formation between the various bodies who right now are covered under one piece or several pieces of legislation. That would go some way to address some of the barriers that are identified in this report.

We are doing policy work right now on that, and we're also looking at the tools that are available to the various parties, the health authorities and their medical staff — bylaws, the college, the Health Professions Act, and so on. What I would say again is we're at the policy stage of looking at some of these issues.

S. Robinson: It sounds like it's more than contemplative — that it's maybe into action, that there's some action happening.

T. Patterson: We are working on it, yes.

S. Robinson: Is that the kind of thing that we would see, perhaps, in the next year or so — that there would be some policies developed over the next 12 or 18 months that would help facilitate this?

T. Patterson: In 12 to 18 months I can say that the work in my division…. We are actively working on those things, but as I said, some of this falls outside of my division, so I don't want to run afoul of some of my colleagues here in terms of their workload.

M. Dalton: I'm just looking at some of the appendices in the report. In appendix A we see that in 2001-2002 we had the highest per capita that we were paying for physicians — $545 per person for a physician. It was the highest in Canada. Now in 2012-13 we are less than the average, at $863 or something like that. It's still a significant increase, about a 50 percent increase. But I just want to….

[1435]

Even though we've been restraining, if you want to call it that in spite of the fact there's been a significant increase, it doesn't seem to have impacted the number of GPs. We've seen a 26 percent growth in GPs. That's one thing.

I'm wondering if you can comment on that and, also, how that applies to specialists. That's my first question, and then there are two more.

J. Higgs: The figures I quoted earlier were for all physicians. GPs in total have grown. Both GPs and specialists have grown quite a lot. We actually tend to have fewer specialists per capita than other provinces and more GPs per capita than other provinces. We've really emphasized primary care in the last decade, so that actually has grown a bit.

To your question regarding this graph under appendix A, B.C. was number one for several years after 2001-2002, so our figure of $800 didn't really…. That grew, and it really only started to fall behind right around the turn of the decade.

Really, what I ascribe it to is the fact that other provinces — and I have some information that I brought with me — put so much money into physicians relative to both their health investments and their GDP growth.

We still put in more money to physicians and health than our GDP growth. It's just that other provinces really, really went a lot higher. Where we were in a situation of putting, say, 4 percent per year into physicians, other provinces were putting 8 and 9 percent per year over a decade into their physicians.

You had this sort of compounding piece where…. Alberta in particular started that. Saskatchewan needed to keep up with them. Manitoba needed to keep up with Saskatchewan. Ontario, Manitoba, Saskatchewan and Alberta all tend to compare to each other. Ontario, of course, put a lot of money into their primary care networks. Then you have the Maritimes, who all sort of see themselves as a block, for comparison too. They all put a lot of money in, whereas B.C. really did control its advances.

Our figure is slightly below the Canadian average now. Where we used to be able to say, "Yes, we're number one," we're now just slightly below the average. I think a lot of it is because other provinces have just put so much money into their physician services and their health care as well. We put in more than GDP growth on average, but we still have been, in comparison to our other provincial colleagues…. They've just dedicated a lot more money to that.

M. Dalton: I don't see that as a negative. I see it as a positive, providing we're able to retain. I'm wondering specifically about the specialists, how that's playing out in British Columbia.

Then looking at the following page of the chart, the wide spectrum there is of how much is paid to the different specialists, ranging all the way to almost $3 million per year for a medical microbiologist to a lot lower. I'm just wondering what determines some of these fees. Is it because of the schooling, the number of practitioners, specialists? What goes into such a discrepancy in these?

J. Higgs: Let me come back to your first question on specialists. May I come back to you with additional information on the growth in specialists over time? I don't have that particular piece with me, so if I may take that as something that I can report back to you on.

B. Ralston (Chair): Or just give your report to the Clerk, and it will be circulated to all members of the committee. Thank you. That's good.

J. Higgs: Okay, I will do that.

With regard to what you're seeing in exhibit 6, what

you'll see at the very top with those first three — medical microbiology, laboratory medicine and nuclear medicine — is that those tend to be payments to facilities. They're not payments to physicians. We don't have medical microbiologists who are earning $2.9 million a year. They actually tend to be….

[1440]

They are very much in line, actually, with the grid rates that we've established for alternative payments, which is about $340,000 or $350,000 per full-time-equivalent. The same thing for laboratory. Most laboratory physicians are on contract or salary arrangement, and nuclear medicine is much the same way.

Really, in the fee-for-service world what ends up happening is that the billing number gets used on the claims for services. But the actual payee, where the money goes…. It goes to a facility like a hospital or a private provider. Let me just deal with those top three. So that explains that.

When you're getting down into some of these other ones down here like ophthalmology, cardiology, hematology…. I can say for hematology that it's mostly lab billings for that.

Ophthalmology, as mentioned, has had vast, vast improvements in productivity due largely to technological improvements. Their increases…. The fact that they are where they are is driven a lot by their ability to do more procedures per unit of time now. It's not just cataracts. It's what they do for macular degeneration and various other pieces. They have, if I may, sort of hit the sweet spot for having good surgical levels of compensation but also technology improvements, so they're up there because of that.

Other ones that are like that too…. Cardiology has also benefited from increases in technology, and it's also a highly technical specialty.

Going down to some of these ones down more at the bottom, you've got a lot of things down here — neurology, internal medicine, infectious diseases, rheumatology, pediatrics — where the patients there tend to be fairly complex and the skill sets are largely cognitive specialities.

These are not proceduralists. These are not people for whom productivity is something they can improve constantly, like you might be able to do with surgical or diagnostic procedures. So they also can tend to have — and this is one for internal medicine, in particular — very, very complicated patients, people with numerous co-morbidities.

These are the people that manage the co-morbidities, so their time is not just taken up with a single piece — "How's your heart feeling today?" or "Let's change your prescription." It's managing the heart. It's managing the blood pressure. It's managing the kidney disease. It's managing the diabetes. It's managing all of those things. Down at this end they tend to be…. Like I say, these are more cognitive specialties.

At the very bottom…. It's worth pointing out, though, that things like emergency medicine don't really rely on fee-for-service anymore. Emergency medicine is largely in the world of alternative payments now, and this is a fee-for-service-only chart. The same thing for geriatric medicine. Of course, general practice has been enhanced greatly by the General Practice Services Committee. Psychiatry has a fair amount of alternative payments in addition. Pediatrics also has a fair amount of alternative payments.

What you'll find, actually, if you start pulling all of these things together….

Something we've been doing an awful lot more of in the last eight years is synthesizing all of these expenditure streams. You can see for specialists that they're doing fee-for-service, but they're also doing an awful lot more of alternative payments as well. They're working in a number of venues. They'll work in a clinic and do some fee-for-service. They'll come to another clinic. It'll be under a sessional or a contract arrangement. That's changed quite a bit.

I think the other thing that it points to is that you also have a lot of differences in the fee schedules themselves and that the relative value….

M. Dalton: If I could just interrupt you here for a second. You're saying that these figures here don't capture it all, that they capture just one stream of funds.

J. Higgs: Yes, and it affects some in particular. Proceduralists like the surgeons…. Surgeons tend to rely more on fee-for-service. They like fee-for-service. Fee-for-service really works well for proceduralists.

It's the cognitive specialties, and we tend to see a lot more of the cognitive specialties in things like alternative payments because the amount of complexity per unit of time is a fair bit higher.

[1445]

D. Eby: There are a couple of key bright lights in terms of the potential to reduce costs that I'm aware of. One is interprofessional teams, which is a stated priority for the ministry, and the other is public health — that is, encouraging people to undertake preventative means to reduce their risk of lifestyle diseases.

In this report, when I was looking through it, it seemed like there were two issues that came up with that. One was — the ministry representative addressed that briefly in terms of the chart of billing — that public health is right near the bottom in terms of billing totals. I would guess that some of that has moved from fee-for-service to contract, but I'd certainly be interested in knowing why that number was so low and if that is in fact the case.

The other issue that's raised in the report is on page 6, in which there's a discussion about how the current bill-

ing structure means that physicians can only charge for services that they perform themselves, which restricts the formation of interdisciplinary teams outside of, for example, a health authority clinic.

We know that in Vancouver, health authority clinics are closing, so we're actually moving away from interdisciplinary teams within the health authority in Vancouver, in my opinion. It doesn't look like, according to this report, interdisciplinary clinics are being encouraged out in the wild, as it were, among the community physicians.

I'm wondering if the Auditor General can expand a little bit on that issue of interdisciplinary teams and if the ministry can help me reconcile that priority of interprofessional teams with the reality that physicians can only bill for themselves and the restriction that that places on these types of teams.

R. Jones: I'll let Jessie talk to you about that.

J. Giles: Our analysis around interdisciplinary teams came from many discussions as well as our literature review. What we found…. It's really because of the way the fee-for-service model is designed. Because physicians can only bill for the services that they've provided, they're unable to…. It makes it challenging to create a team, because they obviously want to get paid for the work that they're doing.

As far as my knowledge, based on the work here, there is no code for a physician to manage a team, so they're unable to do this. We also heard one of our subject matter experts, who was a retired physician, and he said that that's something he really wished he would have had that opportunity for, especially as he aged. He would have really enjoyed not only coaching a younger physician as they moved forward with their career but also working with a team, with many different types of health professionals. It was something that he highlighted as well as an issue and something that he certainly wanted.

D. Eby: Just so I have a clear understanding of this, my understanding of an interprofessional team would be that I'm a doctor, and I might hire a nurse practitioner or a nurse or some other type of health care professional and then supervise their work. They could do the initial intakes and sort of work to their full scope of practice at a lower rate, as opposed to mentoring a younger physician.

J. Giles: Yes, absolutely, but I was speaking just in terms of his vision for as he aged and also speaking to our discussion around the change in the generation. There's a shift.

T. Patterson: If I may, you're right. It is one of the priorities. I think this ties into my comment earlier. There's no perfect compensation model per se, but in my experience…. I'm also responsible for nurse practitioners, as you mentioned. We had a workshop about a year ago with physicians and nurse practitioners, and precisely those sorts of comments came up.

We really need to take the next step in terms of a payment model or a business model to encourage and incent interdisciplinary teams. That may be fee-for-service in some situations, but it may be a contractual arrangement as well. I would agree that we have some work to do to land on a model that works for physicians and nurse practitioners and other professionals — physiotherapists.

There's some exciting work happening in various places in the province where these sorts of clinics are happening, and the physicians and other professionals like PTs and OTs and nurse practitioners find a way to make it work, but I think we have some work to do to maybe enable them and make it a little bit easier for them.

D. Eby: Is that work happening, or is it on the schedule for work, given that this is a stated priority of the ministry?

T. Patterson: Yes, it is.

D. Eby: What form is that taking?

T. Patterson: My division, and there's another division in the ministry called the health services policy and quality assurance division, work closely on a program called the NP4BC program, where we've funded health authorities to hire nurse practitioners in certain targeted areas. [1450]

The feedback that I referred to from the workshop of physicians and nurse practitioners was part of that program. We've taken that feedback in. We're, again, in the policy stage, so over the next year we'll be doing a lot of work to move that forward.

K. Corrigan: One of the components of the cost of physician services when you're using a fee-for-service model is the actual fee for each service, but the other component is the number of times that those fees are collected — in other words, the volume.

I noticed in the report under appendix C that it says Canada, compared with 13 other jurisdictions, ranked close to the bottom for access to care. I guess if you're talking about fee for service that's one way to limit the amount of money that you spend. But you also want to be sure, if you are in any way controlling the volume of services performed, that it's appropriate and that it's linked to some kind of analysis that says this is appropriate to have X number or something.

I recall that several years ago we used to get a little statement from the Ministry of Health asking you whether or not you'd actually received this service. I don't know if that happens anymore.

I guess my question, then, is: what are we doing about ensuring, one, that services that are claimed are taking place? I'm sure they are the vast majority of the time. Then two, what are we doing about ensuring that there is not unnecessary service — people who are just repeatedly going to the doctor at times when they don't need to go to the doctor — and, on the other hand, ensuring that people that do need doctors have the ability to access those doctors?

It's a pretty big question, but it talks about access, and it talks about volume.

T. Patterson: I will jump in and let Jeremy jump in as well.

I think a lot of our cost control with physician services has been, I would say, on the price side rather than volume. One of our challenges, in fact, has been trying to work with the Doctors of B.C. and physicians on volume to make sure that…. There's a lot of work nationally and even internationally on appropriateness of care, for example. I would say that as a starting point.

In terms of ensuring that people are receiving the right care, we do have an audit and inspection committee through the Medical Services Commission and a billing integrity program at the Ministry of Health that does audits of physician billing patterns.

I would say that also, through the Medical Services Commission, there is a Patterns of Practice Committee that looks at how a physician is practising and whether there are a number of, I guess, standard deviations from the norm of one's peers in terms of a certain practice. It sends information to physicians about, literally, their patterns of practice.

Those are a few things that we're doing.

J. Higgs: I believe service verification letters still go out. They don't come from our area, but there are still some service verification letters. I was speaking to someone on the phone the other day who said: "I got this letter that said, 'Did you get this service from the doctor?'" I said: "Yeah, we still do that."

Ensuring that people can go to the doctor is something that's really important. One of the great questions is on making sure they go to the right kind of doctor, because one of the things we've seen over the last 30 years is the promulgation and the proliferation of walk-in clinics. People can generally go to walk-in clinics. There's been this huge effort by the government and by the medical profession over the last ten years or so to try and approve or reinvigorate full-service family practice.

[1455]

Ensuring that people can go to the doctor — it's there. I mean, people can go. Walk-in clinics are everywhere. But what we really want to be able to do is make sure they're going to the right kind of doctor and getting that primary care.

The regional exams that are most commonly billed, the office visits, as you can see in your report — they are the most commonly billed services in there. When it comes to appropriateness, it's really, really difficult to police that. There's a great challenge in being able to deal with patients in that way. Patients feel that they may need to go to the doctor, so off they go.

What we do have on the physician side and the payment schedule, for general practice in particular, is high-volume billing limits so that for a physician whose bill gets up to 51 services on the day, that 51st service is cut to 50 percent of the fee, and then beyond 65 — so the 66th visit — they don't get paid for anything.

That's a good thing, because, as I've said before, I don't know that I'd want to be the 70th patient in the day, but at the same time, I get a lot of letters from people saying: "Why is the walk-in clinic closed?" They put up signs that say that government has limited how much they can be open, and that's not what we've done at all. The government and the medical association decided almost 20 years ago that it's very good practice to not just have unfettered volumes per prac every day.

One of the things we're doing on appropriateness is we've long had the guidelines and protocols advisory committee in addition to Patterns of Practice. There's lots of stuff on the web, on the Ministry of Health website. The government and the physicians — I would say this is one of the best examples of where we've worked together for a long time. I think it's as old or older than the rural committee. They really get down to saying: "This is the best thing to do for a sprained ankle." "This is the best thing to do for diabetes." "This is what you should be doing for treating people for osteoarthritis," and such.

I think that's done a fair bit. We've done some measurement of the impacts of that, but they take a long time. Once you've come up with a guideline or a protocol, it takes a long time to actually see it. You've got to have diffusion out into the medical community. You've got to have diffusion into the patient population.

Patients like to go sometimes and ask for tests and say: "I really want to get a vitamin D test" or "I really need to have my vitamin B checked." The doctors might say, "Well, no, you don't need that. I'm not going to give you a requisition," or they might say: "Well, okay, fine, go. You can have that requisition."

The other thing I just want to point out is a little example of something we've done well in the last year or so. We did a piece, went through the Patterns of Practice Committee. It started with our laboratory office, and it went through to our billing integrity program and then the Patterns of Practice.

What we did was we identified 50 general practitioners who had lab referral patterns that were very, very far from the norm — three standard deviations away from the norm in terms of ordering, so thousands upon thousands of lab referrals that they were ordering. We wrote

them letters. The Patterns of Practice wrote them letters, so they were getting a letter from a physician to say: "Please explain yourself. This is how far you're out." There was a long list of all the tests that they'd ordered that were really far out. "Please write back to us and let us know the rationale for this."

It actually had an impact right away. We saved a couple of million bucks right away by having doctors write back and say: "Oh, I didn't know that. I didn't know I was so far out, and I will undertake to change this." That's just an example of where we're trying to work on appropriateness.

It takes a lot of work to that, though, right? We got the first 50. There are 5,000 GPs in the province, and there are a whole bunch that are above the average. It just takes a fair amount of effort to really cover everybody.

K. Corrigan: I have another question. A comment made on page 11, and one that I've actually heard the minister make a few times as well, is the combination of what's already been talked about. B.C. is one of the lowest in per-capita spending, yet it has one of the longest life expectancies. I know there was discussion about low infant mortality and so on as well.

[1500]

The first part of the sentence…. How long have we had a longer life expectancy in British Columbia? And do we have links with the performance or with portions of the health care system? Has that analysis been done?

I'm trying to figure out whether we know why that is, what the reasons are. Is it linked to the health care system, and are we aware of what it is in the health care system, if it is the health care system?

J. Higgs: I don't have that information. I can commit to get back to you.

T. Patterson: I think it would be more advisable for us to actually get you a solid answer on that to report back to the committee.

K. Corrigan: Thank you. I would appreciate that.

B. Ralston (Chair): That is a huge question, no doubt.

L. Throness: Just a comment and a question.

My comment is with respect to the cataract surgery example. The trouble with cutting back fees when you get better at something is it doesn't drive further innovation. People can always find ways to do things slower. So it's just a caution. I think we have to watch the incentives that we give.

My question is for the Auditor General. Looking over the summary of recommendations here, there are six recommendations. But really, when you count the sub-recommendations, there are 19, and it's full of things — defining and setting measures, evaluating, reporting, requiring all physicians to participate, action plans, and so on.

When the Auditor General makes her recommendations, does the office consider the cost burden in terms of money and in time and in effort of actually implementing those? If I put brighter and brighter headlights on my car, eventually I'll be able to see for miles, but I won't be able to move. There is a cost burden. Is that cost considered on a regular basis in your recommendations?

R. Jones: Thank you, Member, for that question.

Yes, we do take that into account when we're making recommendations. We make recommendations because we think they are of value to the taxpayers of the province as well as to the legislators and to the organizations that we're auditing.

V. Huntington: I'm sitting here having trouble trying to put together what I'm feeling and want to say about what I've heard here. Selina just said to me: "My gosh, they should blow it up and start all over again." That was what I was trying to say.

Let me say that I understand the importance of the Health Ministry, the complexity of what you're dealing with, the culture in which you're dealing with it, the various interests. But I have to say that my first question…. I have a couple and a comment.

My first question, then. When was the last time even your section, let alone the ministry, took themselves apart and started all over again with a specific goal in mind? When is the last time you defined a goal and looked completely through your processes to design a new, more efficient way of approaching the problems?

T. Patterson: Last year, I can say, to be honest. Shortly after the election, I was called to the ministry, and my role…. The deputy minister — and the minister as well — has a keen interest in the development of a health human resources strategy. Through history there have been various attempts, but I think it's something the ministry has struggled with — to do a good, robust health human resources management strategy. So my division was created out of a number of divisions that existed prior to my existence. That's for sure. Over a decade, in some cases.

My division was created as a result of pulling apart a number of pieces in the ministry in order to try and drive a health human resources approach in the ministry.

What I will say is that, in terms of the second part of your question, reviewing the processes and setting goals and all of those things, I keep referring back to…. We're in the early stages of that, so we're doing that now. But I think the creation of my division itself is an example of that, to be honest with you.

[1505]

V. Huntington: Let me perhaps go over a few of the things that I have heard here today. Perhaps they could be of some meaning to you as you look at this process.

Firstly, you've already, in replying to the emerging concept…. Well, it's past emerging. We now know that interdisciplinary teams provide better outcomes, whether it's for seniors aging or mental health or youth in trouble. These interdisciplinary teams are now recognized as a component of modern medicine for better outcomes. Yet you haven't got the flexibility to deal with the fee structure physicians on one hand and the nurse practitioners, which seem to reside in a different section of your ministry, on the other. Your ministry hasn't looked at yet, or hasn't completed a core review of, how it can more flexibly respond to changes in culture and changes in medical demand.

I guess I'm hearing: "Yes, we've got work to do. Yes, it's complex. Yes, we have to work with these different cultures." I understand that. But what I'm seeing is just silo after silo after silo and no shared goal. And numbers: algorithms versus defining real outcomes — which you could do with surveys, perhaps. I just feel that there are no defined goals, or if there are, they haven't been prioritized in a manner in which you're capable of coming to grips with them. Not you, but the….

I don't believe what I've heard indicates a flexibility that's able to capture changes in medicine quickly or changes in official thinking at your level. There must be many changes and modifications throughout Canada, if not throughout North America and Europe, on how they're handling these issues.

In other words, I'm beginning to think there's a bureaucratic complexity that has to be dealt with in a core review of its own if you're to even get to the point where you have to share goals among these other silos. Maybe what it will take is government issuing some demands among the different parties in the system to define the goals and priorities that are needed here if we're going to put patient-centred care first. And we haven't talked about patient-centred care here today.

It's like somebody, following the review of Fraser Health, for instance, saying to an individual just the other day: "Thank god. We're now looking at patients, not parking." Maybe that's what the core review has to start examining. What are the goals, and how can we share them, in order to come out with an affordable patient-oriented system?

I guess those are my comments.

B. Ralston (Chair): Thank you for that. Does any member of staff want to respond?

T. Patterson: I certainly appreciate the comments. I will say, just very quickly, a couple things. Within my division I'm responsible for all human resources — all professions. It is specifically my responsibility to deal with Health human resources planning and management for both physicians, nurses and nurse practitioners — the compensation arrangements, the regulatory arrangements and the analytics. I'm personally responsible.

I will get in trouble if I go back to the office and don't say that my minister and my deputy are clear with me about the need to take action and to think differently, think outside the box, about these issues. I've been given that clear instruction, no doubt about it.

The silos you mentioned — those come up in the report. They exist in many places between organizations, and we have to work on those. There's no doubt about it. I appreciate your comments.

B. Ralston (Chair): I'm going to suggest we take five minutes now. It's been a long afternoon. We still have some way to go. If we can maybe recess for five minutes, and we'll come back.

The committee recessed from 3:10 p.m. to 3:20 p.m.

[B. Ralston in the chair.]

B. Ralston (Chair): We're continuing our discussion of the report on *Oversight of Physician Services*. I had myself on the list next.

I wanted to ask a question I think arising out of the previous answer that Mr. Higgs gave. I'm looking at page 32 of the report. I'd quoted the general conclusion on alternate payment programs, talking about the observation of the Auditor General that over half of the contracts are outside the boundaries of the contract as negotiated. But I did note, and I didn't get to it last time, at the bottom of page 32 they say that negotiations…. There's a topic box on page 32 that says that alternate payment program negotiations are at a standstill between the British Columbia Medical Association and the Ministry of Health.

I'm wondering if there could be a little bit of an explanation. Is that still the case, or is there progress on that?

T. Patterson: I can address that. That box refers…. I think this would have been sometime last year.

B. Ralston (Chair): The report is dated February 2014.

T. Patterson: Right. At the time that the report was written or was being prepared, there were a number of negotiated agreements that involved increases for alternative payment physicians. Those were to be allocated by an alternative payments committee that was established under the agreement to do certain things. The work of that committee….

It was challenging to decide how to distribute the money. There were some, I guess, challenging negotiations, we'll say. But we landed in a good place, so the al-

locations for those amounts have been resolved. We're now in the process of securing the data that we need to actually pay that money out to physicians, so that, from our perspective, has been resolved.

B. Ralston (Chair): The last sentence says that we "referred the interpretation issue" — I gather there was a difference in interpretation as to what basis it should be paid — "to the upcoming PMA" — and I'm not sure what PMA stands for — "negotiations for resolution." Can you explain that?

T. Patterson: I guess the issue at stake — one of the issues, anyhow — was that the ministry has a policy that we recognize practice categories or specialties that are officially recognized by the Royal College of Physicians and Surgeons of Canada. Those are the specialties we recognize, and those are the practice categories that have been negotiated into the agreement.

I guess I won't speak for the Doctors of B.C., but they would argue that we should acknowledge other categories and skills and credentials and compensate those in different ways. We couldn't come to an agreement on that.

However, I referred earlier to the idea that we need to undertake a policy review of the alternative payments program, and that's one of the things that we will be looking at during that review — that issue. It was challenging for the Doctors of B.C. and challenging for us as well, but that was really about recognition of specialties and subspecialities.

B. Ralston (Chair): So the issue is still unresolved, then. Is that…?

T. Patterson: That issue we don't have agreement on.

B. Ralston (Chair): Thank you.

I think David next, then Selina, and that was the end of the list.

[1525]

D. Eby: I just had a request for further information. The chart of interprovincial expenditure per capita on physicians, at appendix A, was very interesting to me. I assume the Auditor General included this based on information provided to them by the ministry. I wonder whether the ministry could provide the source material for this chart. I'm very intrigued about the differences between the various provinces and wonder whether there is anything that goes behind this bar graph that I could have a look at and that you might be able to make available to the committee through the ministry.

B. Ralston (Chair): Just for clarity, that's the chart on page 39 of the report.

D. Eby: That's correct. It's the bar graph showing per-capita expenses.

J. Higgs: The answer to that is absolutely yes. The source material for this is from the Canadian Institute for Health Information. It's from a data set, the database that they have, called the national health expenditure database. What they have in there…. For all the provinces they have information going back to the 1974-75 fiscal year or the '75 calendar year.

In this case what they do is they divide up…. This is a series that's divided up between total health and then hospital care and then physicians and pharmaceuticals, administration, etc. In this particular table, we just pull out the series, and it's there. So by all means, yes, we can get you this information.

S. Robinson: I just had a couple of questions about the GP for Me initiative. I know that there's been, certainly, some conversation about just how long this culture of fee-for-service was and the fact that there hasn't been a history of performance indicators in this group and the challenge in shifting the culture and getting people to think differently, getting the stakeholders to think differently about their role.

Here we have sort of a brand-new program announced by the minister in 2010. I'm assuming that there has been some thinking for a while that we need to do a better job in terms of accountability and in terms of measurement — that that's not new. Here we are in 2014 anticipating getting some measurement in 2015 — because that was the commitment — and we're still not doing what would be adequate performance measures, performance indicators.

I just want to know when we actually start thinking and start implementing some of these things, given that there are all these new projects that are coming up, the new commitments. At some point you have to step out and start doing the measurements in terms of what we expect. Here's an example where it hasn't happened. The Auditor General pointed that out. I just want to know where we're at in terms of at least stepping in that direction.

I know that when the report comes out, it will be a weak report because we won't have data. Regardless of what the report says, it'll be challenged. I'd like to know what the ministry's thinking is about how to get clarity around just that program.

T. Patterson: I'll speak to reporting generally, maybe, rather than the program. Jeremy is more familiar with the algorithm. He explained that. I can't necessarily explain what happened before. I would say, as I said earlier, there's a lot of measurement going on. There's a lot of quality improvement activity. There is a lot of this going on.

I think the challenge that we have is bringing it all

together, taking a more systemic approach to how we do this and aggregating some of this information, as a number of you have said we need to do. We agree. That is our challenge. I would just say that it's not as though we're not measuring or not monitoring. It's that we need to bring it together in terms of a more cohesive and comprehensive framework. That's our goal.

J. Higgs: Would you like anything in addition?

S. Robinson: If you have anything, I'd appreciate it.

J. Higgs: I think even from the outset this has always been something that…. It will be very difficult to know that B.C. has hit an equilibrium where everybody who wants a physician has one. I think one of the challenges with that is that we not only have this little bit of an algorithm, we also have fee items under the General Practice Services Committee. They actually are an indicator that an unattached patient has now got a physician.

[1530]

Part of the issue is, of course: how many people were we starting with in the first place? We've always had to rely on the Canadian community health survey to give us an idea of how many people in the province are looking for a physician. That number has long been around 100,000-plus in terms of those who are actually looking — age 15 and above, I should say.

We have that challenge. Then we have this attachment fee. It's meant to match the pairing. Then we have the algorithm. I can't be anything but honest and say it's going to be really difficult to know that you can cross off that and say that you know for sure that you've hit everybody, because there are always people that are in transition. There are always people that are going to move to a new town and have a hard time finding a physician.

Part of the thing that we're trying to set up here in the province, having established the divisions of family practice — there are now dozens of them in the province — is giving them the mandate and the tools to really help in that pairing up of people. It's certainly something that I think some of them have made a lot of progress with. For some divisions, getting in contact with the division and saying, "I'm new in town" or "I've lost my physician" — that can happen fairly quickly. In other ones, they have challenges with it because the physicians are either all full up or they just don't have as many in the area as to accommodate all the people.

S. Robinson: Or they don't have one at all, like in Logan Lake. They don't have a physician — 2,200 people.

J. Higgs: Or they don't have a physician at all. Yeah. Really, it's always been very difficult to be able to finally say. But I think that at least now we can measure some progress. We can know the difference between where we were and where we're going to be, and we can know that for particular patient populations, we may well be able to measure a solid difference between where they were and where they are now.

G. Kyllo: I want to thank all of you for your answers. It's been actually very informative. I've really enjoyed this.

One of the challenges I think that we have in British Columbia is with our aging population. With our cost per capita — if I could read this small print — at $803, we must be the envy of other provinces across the country on how we've been able to take off that spending curve.

One of the items I know that the minister has mentioned in the past is the fact that the federal transfer payments don't take into consideration the demographics of our population. I was just wondering if you had anything you could share as far as any negotiations you've had with the federal government on taking the age of our demographic into consideration with the federal transfer payments.

T. Patterson: That would be something I'm not responsible for. I can't honestly comment, but I can follow up and bring information here for you.

B. Ralston (Chair): I think it is an important question, but I think it is outside the scope of the report. But certainly, the federal government has decided on a formula that they've implemented, and the long-term implications are adverse to the B.C. budget, I think it's fair to say. But I'm sure someone can get a summary of that.

G. Kyllo: If I may, the chart that's presented on page 38, where it actually shows the total expenditure per physician, does that take into consideration hours worked at all?

J. Higgs: Well, it does, sort of. One of the unfortunate things about measuring full-time-equivalents in the physician world is that the time element isn't really part of the calculation. What you have here is an average annual payment that should be by fee-for-service full-time-equivalent. I will rely on my colleagues from the Auditor General to correct me if I'm wrong on this.

[1535]

They've sourced the national physician database from which that calculation comes and that I rely upon. This is from the Canadian Institute for Health Information.

What they do is, again, you have an algorithm that takes into account the relative effort of physicians. So you have a physician from the lowest biller to the highest biller, and what you do is at the 40th percentile you put a cut point, and you say anybody below that is part-time. Between the 40th percentile and the 60th percentile on their billings, they are equivalent to one FTE. Beyond that, there's a natural logarithm for calculating

their FTE value.

There's no time part of that, unfortunately. It's hard to get in the hours. And a big part of it for fee-for-service is we don't actually collect any information on their hours. They can really vary. One consult can be five minutes; another can be 55. It really varies from time to time.

G. Kyllo: One other question, a point of clarification. For the MSP payments, my understanding is that those are exclusively for physicians and that nurse practitioners would not be paid out of MSP premiums at all.

T. Patterson: Right now nurse practitioners are paid on salaried arrangements, typically with health authorities. Right now it's salary. But it's one of the things…. One of the members was asking about ways that we might enable interprofessional practice and teams. So it's something that we'll consider — the payment model for nurse practitioners as well. But they're on salaried arrangements typically.

B. Ralston (Chair): I think there are no further questions. Do the Auditor General or the ministry want to sum up or make any closing comments?

R. Jones: No. A good discussion, and we're just happy that everybody had some questions on our reports.

B. Ralston (Chair): I don't think you'd go through a session where there weren't any questions.

R. Jones: No. I know. Very good questions.

B. Ralston (Chair): Did you have any comment?

T. Patterson: No, just thank you for the opportunity to be here today.

Work of the Subcommittee on Agenda and Procedure

B. Ralston (Chair): Okay, well, thank you very much for the presentations.

Before members rush away, do we have any other business? I want to deal with the issue that Vicki raised earlier.

You wanted to talk about the agenda subcommittee.

V. Huntington: Well, yes, Mr. Chair. Do you wish to have this discussion just among committee members, or no?

B. Ralston (Chair): I mean, there are a number of ways. Sam may want to…. He may have something to say about it.

V. Huntington: I have a few things I want to say.

B. Ralston (Chair): These two days are a couple of days before prorogation. The committee will be formally dissolved and then reconstituted in a couple of weeks. In the cycle of things, it might be better to address those issues — I think they're important issues — at the beginning of a new session. But you expressed the wish to raise it here, so go ahead.

V. Huntington: Well, I guess firstly, I find it unfortunate that we're having this difficulty as a committee, and I'd like to kind of just say to our Chair and Deputy Chair that if this becomes an ongoing problem, which it seems to be, perhaps the committee needs to discuss it and come to a resolution on its own and perhaps give some direction to the Chair.

I will say, from my perspective as a member of this committee — and I have said this before, as I mentioned — that this committee ought to be as non-partisan as possible. We are here for the benefit of ensuring good governance and nothing more — and that the expenditures of the public purse are done in a manner that reflects good governance.

I have felt for some time that we are having not difficulty but…. As a member, when we do not have a regularly scheduled series of meetings on a fixed basis, if at all possible, we are sometimes looking at reports in large numbers.

[1540]

It makes it difficult to get on top of them. It makes it difficult to read them all and feel secure in being able to participate and reflect and ask good questions. And I feel that on a regularly scheduled basis, we would be able to see reports in a more timely manner.

I mean — good heavens — we're dealing with reports sometimes at this committee that are over a year old or up to a year old. I don't think that is providing good benefit to the public at large or to the Legislature. We are a committee reporting to the Legislature not on the business of government but on how the ministries and the various agencies are functioning in the performance of their mandates.

I guess as one member of this committee, I would like to urge the Chairman and the agenda committee to try and come up with some sort of fixed schedule of meetings. You can always cancel a meeting if we don't have the reports in hand or if there is some other necessity to cancel. But at least in the coming month I would say that we could easily look at having meetings every four to five weeks on a regular basis — six, if you prefer, but that means you're having basically one meeting in a session. I think that doesn't benefit the work that we're intended to do and charged to do.

From my perspective, I would like to see the Chair and the agenda committee come up with some sort of schedule that reflects the importance of the work done at the Auditor General's office and the importance of the

Legislative Assembly having a handle on what that work is. I guess I would just like to see this issue cleared up as much as possible.

B. Ralston (Chair): Sam, did you want to say anything?

S. Sullivan (Deputy Chair): Yeah. A few things that I would like to address. First of all, I have heard some of the members of the committee say that they would rather not have short meetings, many different short meetings. It's not very efficient, especially when people have to come from long distances, so it has been my effort to try to get a block of days together that we can meet. There is a certain advantage. There are certain economies of scale where you have the ability to just focus for short amounts of time.

If I could just go to some previous conversations. I know the Chair had made a comment that I had taken up to four months to get a meeting together. I was quite shocked by that, so I went back in my records.

For example, for these particular meetings for these two days I received the e-mail from the Chair on August 22 proposing a number of dates: three days, two of three days and then four of six Wednesdays during the legislative session. I was able to get agreement by my caucus on August 28, and I responded. So six days after I was given the dates I was able to give confirmation. I was trying to avoid the….

Well, the days that were given to me were Wednesday mornings. These are particularly difficult. I have in the past suggested that we try to meet during the legislative session, when many of us can take a few hours here and there to meet. That was not favoured by the Chair.

The particular dates that I was given were Wednesday mornings, and those don't work with some of our members. We have members who are on cabinet committees, and that is difficult. So I was trying to get the dates that I was offered.

[1545]

Because I've changed my computer system I can't really be sure, but I know that on September 20 of 2013, or September 22, I agreed to the November 18 to 21 dates. As far as I know, I was proposed those on September 4. That's a three-week period, and it is difficult to get a lot of my people organized as to what time that was. Three weeks may be a long time. I apologize if that is true. It's certainly not four months.

I very much hope that I am not looking at obstructing, not having meetings happen, as I gave you some statistics. This committee has had more meetings in a shorter time than any committee in history, as far as my records that I can look into. I don't believe I need to apologize for anything of that. I do regret the comments of the Chair, and I hope that he can maybe look through his notes and review if indeed I have made it difficult to get meetings.

The point that you have brought up about having regular meetings. I have generally tried to favour a block of meetings so that we could get more efficiency, so we don't have people travelling long distances just for short meetings. There are some advantages being able to see different reports in one block. I believe we've had a conversation where there is at least some advantage to being able to compare different ministries and how they respond to different reports.

It is open for discussion as to whether we should just try to schedule regular meetings. If we want to do it during the legislative session, I would be very interested in doing it when we're actually sitting, because we all take turns sitting in the House, and we do have certain blocks of free time. I know it's a little bit more complicated to organize. The Wednesday mornings are a problem, but I'm certainly open to maybe regular blocks of meetings when we can do that during the session.

B. Ralston (Chair): Okay. I'll respond a bit later then. I think it's more important that we hear from members.

K. Corrigan: I find two — I believe we've even had three days; is that correct? — days…

B. Ralston (Chair): Four days.

K. Corrigan: …or four days of meetings onerous. I agree with the comments made by MLA Huntington that when you try to go through a great volume of reports in one set of meetings, it's difficult to do justice to it. I think we all are very hard workers as MLAs. We certainly know how to read, because we have to in order to survive in this job. But I find it onerous. I would prefer to have a smaller number of reports dealt with at any given time. A full day is fine. Therefore, I would like to see more regularly scheduled meetings.

It may be impossible. I certainly recognize, MLA Sullivan, that it can be difficult, but I would prefer to have shorter meetings so that we can be properly prepared. That's my feeling.

G. Kyllo: With the amount of travel that I have to do, I certainly appreciate them being in smaller blocks, two or three days where we can get a lot of work done in a very short amount of time. With the amount of travel, I don't spend near enough time in my riding as I'd like to, so anything we can do to try and reduce the amount of travel, I definitely would be in support of.

V. Huntington: Perhaps I could add that my desire to see more scheduled meetings doesn't preclude when we're not in session to have a block of two days, three days, as we have had. I haven't found….

[1550]

The only difficulty with those is sometimes the sheer volume of the material you have to prepare for. Maybe

we're just more conscious of it because we're the ones asking the bulk of the questions, perhaps. I haven't got a problem with that, nor do I think it's healthy to ignore the reports that have been done over the period of the spring and summer.

I have no problem, in order to assist anybody travelling, with congregating the meetings in that off-period, but that doesn't mean that we shouldn't be scheduling them fairly regularly when we are sitting, too, so that we can avoid this huge number of reports that we sometimes end up having in front of us.

When there are two reports a day, like this, I think we've covered them properly and well. Some aren't nearly as complex and don't need that kind of time.

Just so that Sam understands, these aren't comments pointed at either the Chair or the Deputy Chair. It's just that we've obviously run into a problem here, and I think it needs to be resolved. Perhaps hearing the will of the committee will be helpful.

L. Throness: What kinds of reports are left unconsidered? What does our workload look like in the next, say, six months, or do we have any idea? Are we right up to speed?

R. Jones: No, we're not. I think we have a number of…. I wish they were only a year old. I think there are a couple that are a couple of years old, actually — a couple of the follow-up reports and summary ones, which are fairly easy to go through. They're not too bad. I'd say there are probably about seven or eight reports still left.

We've got one that will be coming out probably in about three weeks that is a report on last year's public accounts, which I think you'll find fairly interesting. I would like to see some good discussion, because we've put in a section about how to understand what's in the public accounts — some of the numbers and how to read them and whatnot and what story is being told. I'm putting a plug in for that one.

But there are probably seven or eight — something like that. Not too, too many, and I think some of them will be very quick to go through.

There was one other report that I had asked, hopefully, that we could get some discussion around, which was the information piece on B.C. Transit, just because I think it has some very good questions in there. But it's not one that you have to review with us. I think you might find it interesting to take a look at it and ask some questions.

M. Dalton: Last year at about this time were we not at about 18? I thought there was quite a stack of reports. It seems that we've reduced that, plus the ones that you've brought down. It seems like we've been making good progress.

R. Jones: Yes, I don't disagree. You've made very good progress, and I'm happy to see that.

I forgot to remind you that we wanted to have a discussion around the follow-up process, as well, at one of the meetings. I think that's fairly important.

S. Robinson: When I'm thinking about the work that we're sort of asking our government bureaucrats to do around accountability…. I think that we have to hold ourselves to the same sort of standards — making sure that we're being accountable, also, to the Auditor General's office. They're producing these reports, and to allow them to languish for a year or two doesn't serve that office well, and it certainly doesn't serve the public well.

I think it is in the best interests of the public that we actually have regularly scheduled…. Whether it's two days every third month that we're going to dedicate or whatever it is, that we know ahead of time — ideally, preferably a year ahead of time, I think — when it's going to come up for review…. I think that's us being accountable to our citizens, to our taxpayers but also that we recognize that there are limits to our human capacity.

I do get concerned when we're doing more than two days in a row. My capacity for reading reports is pretty good, but keeping them all straight and making sure that my questions are clear and concise when I have to read eight different reports to get ready for three days of meetings doesn't bring out the best in me and my ability to do the job. I would suspect it's the same with everybody else.

I think that there needs to be a balance between our capacity, our travel needs, as well as our accountability to the citizens of this province. Because I think that's what we've been charged to do.

[1555]

What we owe them, at a minimum — and we certainly owe the Office of the Auditor General — is that we can get our shit together and figure out how to do this. Sorry, a bad word to *Hansard*. I apologize. But we should be able to make this happen.

B. Ralston (Chair): Okay, anyone else? Well, thank you for the discussion. I think it's important that the committee meet regularly. With the previous chair, Doug Horne, that was a fairly easy thing to arrange. It seems to have become more difficult.

I notice that Sam has not referred to the discussion that took place between December 2013 and March 2014 to arrange two two-hour sessions while the House was sitting and two days at the end of June. That did take an inordinate amount of time, and it was very frustrating to me. But I don't want to prolong the acrimony in that sense. I think it's important that the committee work together. I will renew my efforts to set a more long-term agenda. I think it's important that the committee meet regularly.

I am told by others on the government side that it is possible to schedule meetings on Wednesday, because

not all members meet every Wednesday, on the government side, in cabinet committee meetings. That's the information I received from other sources. So I think it is possible to put together a schedule. I think it's important that we put together a schedule, and I will endeavour to do that, with the assistance of the vice-Chair, in the future.

If there's no further comment, I guess we'll reconvene here tomorrow at nine o'clock.

S. Sullivan (Deputy Chair): Maybe I can just ask one question of members. Would they be interested in trying to find a few hours, not during a Wednesday morning but during the times, the weeks, when we are meeting in session? If people would be flexible to do that, I'd be very open to that. That's for sure. It would make my life much easier.

B. Ralston (Chair): That's something that would have to be taken up with the Whips. Usually, they're pretty keen on House duty being followed, and it may be too late, given that their schedules are already set now. But certainly, that's something that we can look at.

V. Huntington: I guess it's not a fair question, because it would be difficult even for me, but we do have Fridays. No? Everybody says no.

S. Sullivan (Deputy Chair): You can talk to your Whip about that.

B. Ralston (Chair): Thanks very much. We're adjourned. We'll meet tomorrow at nine.

The committee adjourned at 3:57 p.m.

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