Legislative Assembly of Alberta

The 28th Legislature
First Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Tuesday, April 16, 2013
7 p.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

Ministry of Health
- Hon. Fred Horne, Minister
- Hon. Dave Rodney, Associate Minister of Wellness
- Hon. George VanderBurg, Associate Minister of Seniors

7 p.m. **Tuesday, April 16, 2013**

[Mr. Quest in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: Well, welcome, everybody. I'd like to call the meeting to order and note that the committee has under consideration the estimates for the Ministry of Health for the fiscal year ending March 31, 2014.

I'd like to remind everybody that the microphones are operated by *Hansard*, so if you could keep your BlackBerrys and so forth away from the mikes because they can cause some interference.

I'll go around the table for introductions. Ministers, if I could get you to introduce your staff, and then as you're introducing any staff that are behind the podium, if I could get them to just stand as they're being introduced so that we can actually put a face to the name. That would be great. I'll just remind staff that if you are responding to questions at the podium, if you could please identify yourself for the record.

We'll start on my right with the deputy chair.

Mrs. Forsyth: Hi. I'm Heather Forsyth, MLA for Calgary-Fish Creek. Thanks.

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

Mr. Fraser: Rick Fraser, Calgary-South East.

Mr. Young: Steve Young, Edmonton-Riverview.

Ms DeLong: Alana DeLong, Calgary-Bow.

Ms Jansen: Sandra Jansen, Calgary-North West.

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

Mrs. Jablonski: Good evening, everyone. Mary Anne Jablonski, Red Deer-North.

Mr. VanderBurg: George VanderBurg, Whitecourt-Ste. Anne, Associate Minister of Seniors.

Mr. Horne: Fred Horne, Minister of Health, MLA, Edmonton-Rutherford.

Mr. Rodney: Dave Rodney, MLA, Calgary-Lougheed and Associate Minister of Wellness.

The Chair: We'll get you folks to introduce your staff at this time, too, if you would, please.

Mr. Horne: Sure. Thank you very much, Mr. Chair. My two colleagues, associate ministers Rodney and VanderBurg are here, obviously. I'm very pleased to introduce my Deputy Minister, Marcia Nelson.

Other staff that are joining us this evening are chief delivery officer, Glenn Monteith; chief strategy officer for the ministry, Susan Williams; Mr. David Breakwell, seated to my left, ADM of financial and corporate services; Chi Loo, assistant deputy minister, seniors' services and continuing care; Christine Couture, assistant deputy minister of strategic services; Mark Brisson, assistant deputy minister, health workforce; Susan Anderson, acting assistant deputy and minister of health information and technology systems; Lorraine McKay, who is acting assistant deputy minister of health benefits and compliance; Joan Berezanski, acting assistant deputy minister of primary health care; and Neil McDonald, acting ADM of family and population health. We're also joined this evening by Carol Chawrun, director of communications; Bart Johnson, the press secretary for my office; and Matthew Hebert, who is director of operations in the minister's office.

Thank you.

Mr. Wilson: Jeff Wilson, Calgary-Shaw.

Mr. Pedersen: Blake Pedersen, Medicine Hat.

Dr. Swann: Good evening, everyone. Welcome. David Swann, Calgary-Mountain View.

Mr. Cao: Wayne Cao, MLA, Calgary-Fort, on behalf of the MLA for Calgary-Cross, Yvonne Fritz.

Ms Cusanelli: Good evening. Christine Cusanelli, Calgary-Currie.

Mrs. Leskiw: Good evening. Genia Leskiw, Bonnyville-Cold Lake.

Dr. Brown: Neil Brown, Calgary-Mackay-Nose Hill.

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

The Chair: I'm Dave Quest, MLA for Strathcona-Sherwood Park and chair of this committee.

Hon. members, as you know, the Assembly approved amendments to the standing orders that impact consideration of the main estimates. Before we proceed with consideration of the main estimates for the Ministry of Health, I would like to review briefly the standing orders governing speaking rotation.

As provided for in Standing Order 59.01(6), the rotation is as follows. The minister may bring opening comments not to exceed 10 minutes. For the hour that follows, members of the Official Opposition and the minister may speak. For the 20 minutes following that, the members of the third party and the minister may speak. For the 20 minutes following that, the member for the fourth party and the minister may speak. Then for the final 20-minute stretch private members of the government caucus and the minister may speak. Following that, any member may speak thereafter, and we will go in a government-opposition rotation.

Members may speak more than once; however, speaking times are limited to 10 minutes at any one time. A minister and a member may combine their time for a total of 20 minutes. Members are asked to advise the chair at the beginning of their speech if they plan to combine their time with the minister's time. I will also try to remember to ask members myself before we start.

Once the specified rotation between caucuses is complete and we move to the portion of the meeting where any member may speak, the speaking times are reduced to five minutes at any one time. Once again, a minister and a member may combine their speaking time for a maximum total of 10 minutes, and members are asked to advise the chair at the beginning of their speech if they wish to combine their time with the minister's time.

Six hours have been scheduled to consider the estimates of the Ministry of Health. With the concurrence of the committee I'll call a five-minute break near the midpoint of the meeting.

Committee members, ministers, and other members who are not committee members may participate. Members' staff and ministry officials may be present, and at the direction of the minister officials from the ministry may address the committee.

As noted in the Speaker's memorandum of March 22, I'd like to remind all members that during main estimates consideration,

members have priority at all times. Should members arrive at a meeting and there are no seats available at the table, any staff must relinquish their seat to the member.

If debate is exhausted prior to three hours, the ministry's estimates are deemed to have been considered for the time allotted in the schedule, and we will adjourn; otherwise, we adjourn at 10 p.m.

Points of order will be dealt with as they arise, and the clock will continue to run.

Any written material provided in response to questions raised during the main estimates should be tabled in the Assembly for the benefit of all members.

Vote on the estimates is deferred until consideration of all ministry estimates has concluded and will occur in Committee of Supply on April 22, 2013.

If there are any amendments, an amendment to the estimates cannot seek to increase the amount of the estimates being considered, change the destination of a grant, or change the destination or purpose of a subsidy. An amendment may be proposed to reduce an estimate, but the amendment cannot propose to reduce the estimate by its full amount.

Vote on amendments is deferred until Committee of Supply on April 22, 2013.

Written amendments must be reviewed by Parliamentary Counsel prior to the meeting at which they are to be moved. Twenty-five copies of amendments must be provided at the meeting for committee members and staff.

With that, Minister, whenever you're ready for opening comments.

Mr. Horne: Well, thank you very much, Mr. Chair, and good evening, colleagues. I am pleased, as I said, to be here with associate ministers Rodney and VanderBurg, who look after Wellness and Seniors respectively. I will be asking, I am sure, at different points this evening for them to supplement some of the answers and contribute to our discussion.

Mr. Chair, the Health budget for 2013-14 is $17.1 billion, an increase of almost $500 million, or 3 per cent. The increase reflects that health care is a top priority for Albertans and for our government. Although we're investing an additional half a billion dollars into health care while other areas are seeing reductions and frozen budgets, the increase is substantially lower than in previous years.

Health spending has grown at a rate of 9 per cent annually over the last 10 years, and this year it makes up 45 per cent of government's entire operational spending.

This budget reflects our intent to address health system sustainability by doing things differently. We want to find innovative ways to spend smarter, to achieve better health outcomes for Albertans, and to deliver better value to taxpayers.

This year Alberta Health Services will receive $10.5 billion in base operating funding for the delivery of health services across the province, a $307 million, or 3 per cent, increase over last year. This is lower than the previous 4.5 per cent funding commitment, but we believe Alberta Health Services can use its health care resources more effectively while improving Albertans' access to health services. AHS will also receive $393 million for operating costs for the Kaye Edmonton clinic and the Calgary South Health Campus.

The AHS Board approved its proposed budget and health plan last week, and it has been sent to me for review and approval. The AHS budget proposes increased spending in the coming year on continuing care, primary health care, mental health, emergency and other outpatient services, as well as hospital-based care. These are all consistent with government priorities.

Also consistent with what we have done in government, AHS is targeting savings in administrative spending. AHS has implemented a three-year compensation freeze for all management, out-of-scope employees, and physician leaders. It's eliminating pay at risk for all executives, and the organization is starting a review of executive compensation and has implemented a hiring freeze on all administrative positions that are not mission critical.

AHS expects to reduce its administration costs, which are already the lowest in Canada, by 10 per cent over three years. The majority of our remaining budget will be allocated as follows: $3.4 billion for physician compensation and development programs as well as programs that support the addition of more physicians to our system; $1.1 billion for drugs and supplemental health benefits, which includes prescription drug assistance, ambulance services, cancer therapy drugs, and specialized high-cost drugs; $927 million for other health services, including those provided by oral surgeons, optometrists, and podiatrists, as well as home care and rehabilitation, vaccination programs, tissue and blood services, and health services in correctional facilities.

7:10

This $927 million includes a new responsibility for my ministry this year, Alberta Innovates: Health Solutions, which has a budget of $86 million. Moving this research program into our ministry from Enterprise and Advanced Education will better integrate leading-edge health research with health service delivery. Also included in the $927 million is $162 million for community programs and activities related to healthy living. Focusing on wellness is an important part of addressing health system sustainability in the long term.

Mr. Chair, I'd like to take a few moments now to look at our Budget 2013 priorities of protecting primary health care, Albertans most in need, the very young, and our senior citizens. Let's look first at primary health care. We're investing $262 million into improving access to primary health care. This includes primarily $50 million to develop and establish family care clinics throughout the province, $185 million to operate primary care networks – and please note that physician remuneration is outside this envelope – $20 million for addictions and mental health programs, and $4 million for other primary health care supports such as reducing appointment wait times and improving patient care management.

I've asked the Primary Care Alliance, a committee of the Alberta Medical Association made up of physicians, to take the lead in developing recommendations for how primary care networks should evolve in the future. This is part of our work on primary health care reform that will provide Albertans improved access to front-line health services.

A number of initiatives in this budget will help to protect Albertans most in need. There are 20 per cent of Albertans who have no drug coverage of any kind. To ensure comprehensive drug and supplementary health benefits coverage for all Albertans, a pharmacare program will be implemented on January 1, 2014. Details are still being developed, but it will be an income-based program that is sensitive to those in greatest need and to the ability to pay. Lower income Albertans will not have to pay a deductible before becoming eligible for drug and supplementary health benefits coverage. Middle- and high-income Albertans will have to pay a deductible based on their income before becoming eligible. The pharmacare program will replace all government-sponsored drug and health benefits plans. Pharmacare will save government $180 million by 2014-15 due to a consistent and equitable approach to access and streamlined administration.

Mr. Chair, the health of young Albertans will be improved

through an early childhood development investment of $8 million. This will include implementing a new universal newborn hearing screening program, reducing rates of low birth weight infants, improving maternal mental health, and improving breastfeeding rates.

Another important priority, as I said, is to protect Alberta's seniors. In addition to prescription drug benefits, $405 million in direct services and supports will be provided by my department to eligible seniors in Alberta this year. The seniors' property tax deferral program will be implemented for all eligible seniors who own homes, including those most in need, so they can keep more money in their pockets by deferring taxes until they sell their homes. The voluntary program supports our aging-in-place policy by keeping seniors in their homes and active in their communities. Through this program seniors who own homes will be able to defer all or part of their property taxes on their primary residence through a low-interest home equity loan with the provincial government. The government will pay the property taxes, and the senior will repay the loan with interest when they sell their home or sooner if they choose. There is $3 million allocated for the loans in 2013-14.

Income testing for the current seniors' school property tax assistance program will take place in 2013 to ensure seniors most in need will continue receiving assistance before the program ends in 2014. With the establishment of the seniors' property tax deferral program the seniors' school property tax assistance program will be eliminated.

Now let's turn to the Alberta seniors' benefit program. We're spending $358 million in the program this year. Alberta seniors' benefit is the highest benefit of any province or territory in Canada, supporting about 152,000 low-income seniors. The program helps protect seniors most in need by supplementing federal programs for seniors with lower incomes. The program is increasing nearly $22 million, or 6.4 per cent, to a total of $358 million in 2013-14, a reflection of volume increases.

In order to harmonize the Alberta seniors' benefit with both provincial and federal income support programs, several changes are being made this year. Three income exemptions to the ASB program are being eliminated: workers' compensation benefits, alimony payments, and Canada pension plan disability payments. This aligns with the federal guaranteed income supplement program and the assured income for the severely handicapped program.

Also, seniors residing in Canada for fewer than 10 years will no longer be eligible for the Alberta seniors' benefit. This is consistent with the eligibility criteria for old age security.

We are reducing generic drug prices from 35 per cent to 18 per cent of brand name prices effective May 1. Drug prices are among the highest cost drivers in heath care, and we must do what we can to contain costs. The price reduction means Albertans will pay less on their out-of-pocket costs for generic drugs. Alberta's generic drug prices will be the lowest in Canada. Last week we announced more supports for pharmacies to help them expand their services and adjust to the lower generic drug prices.

The support programs have a total value of $40 million. The entire investment includes $5 million for a washout period as government continues to pay the original generic drug price for 30 days, which helps pharmacies dispense their inventory at the price they paid when they purchased the product; $24 million to extend a $1 per prescription allowance that was scheduled to end on March 31, 2013, of which about $12 million will come from government and the rest from employer and private insurance programs; $10.6 million to repurpose the remote pharmacy access grant over the next two years, changes that will make it easier for remote pharmacies to access the funding; and $500,000 for training and education to help more pharmacists provide front-line services.

On April 1 we introduced two new patient-focused services that pharmacies will be compensated for. These include providing patient assessments and trial prescriptions. This is in addition to seven other new services that pharmacies began providing in July 2012.

Government has provided over $80 million in transitional funding over the past few years to help pharmacies expand their services and adjust to lower generic drug pricing.

The Chair: All right. Well, thank you for your remarks, Minister.

I'd like to welcome Mr. Mason, who is subbing for Ms Notley, and Mr. Goudreau to the meeting.

We'll now go to the hour of discussion with the Official Opposition. Mrs. Forsyth, do you want to go first?

Mrs. Forsyth: Yes, please.

The Chair: All right. Whenever you're ready to go. Are you all set?

Mrs. Forsyth: Yes. Are you ready, Minister?

Mr. Horne: I am. Just to clarify, Mr. Chair, I would prefer to use the time in the 10-minute blocks that are allocated if that's acceptable to my colleague.

The Chair: Sure.

Mrs. Forsyth: Well, my preference, if I may, is to go back and forth. I think that way we can get an answer right away to the questions that we're asking. That would be my preference.

The Chair: It's your call, Minister.

Mr. Horne: Yeah. Well, I would prefer, as I said, to go in the 10-minute blocks. We'll certainly do our best to answer all the items that are raised.

The Chair: Very good. Ten-minute blocks it is.

Mr. Horne: Thank you.

Mrs. Forsyth: Well, that's a good start.

I'd like to start off with a quote if I may.

> Your government will also secure Alberta's economic future by demonstrating fiscal restraint and foresight, spending wisely, and saving intelligently. Starting with Budget 2012, our most critical public sectors – education, advanced education, health, and municipal services – are receiving stable funding in the form of three-year budgets. Institutions and municipalities know in advance what to expect so they can plan ahead, guaranteeing reliable service delivery for all Albertans.

That was a quote, Minister, by the hon. Premier during the throne speech in 2012.

In the past week we've seen you change, Minister, on several things. First of all, with physicians and then pharmacists. I want to acknowledge that we're pleased that you have secured a deal with the AMA. I want to acknowledge the 13 doctors that are here observing. Some are in this committee room, and some are in the other committee room listening. I also want to thank all of the health care professionals that have helped us put the questions together for the budget.

I want to emphasize, Minister, that the questions we'll be asking you tonight are from Albertans. They are from health care

professionals across this province. I think probably for us we're very fortunate that we've spent weeks on this budget and we've had the ability to get advice and questions from the wonderful health care professionals in this province.

7:20

Over a hundred million dollars has just been added to the budget as expenditures in the past week: a lump sum of $68 million to doctors, $40 million to extend transition funding for a year to pharmacists. I'd like to ask you where exactly that money is coming from if I may, please. I know we're preparing budgets, and I don't see any of that money in the budget, so I'd like to ask you about it.

The recent MOU that you have signed: the devil is always in the details. I'm looking forward to hearing more about the MOU that you have signed recently with the AMA. I'd like to ask, if I can, about some of the things that are in that particular MOU. One of them is about the fee schedules. Those are the calls that we're starting to get from docs right now. You talk about fees schedules in here.

The other thing I'd like to ask you about is where you're going on the engagement of physicians as you move forward in regard to changes within health care.

Minister, last year when you appeared before this committee for budget estimates, you said, "When I was appointed to this position by the Premier, I said that stability and predictability in the health system was our number one priority." That's on page 374 of *Hansard*, March 7, 2012. Well, Minister, funding obviously hasn't been predictable. It's been cut from a 4.5 per cent increase to 3 per cent for Alberta Health Services. What is being left out of the budget because of this reduced increase?

The business plan shows operating funds increasing 3 per cent in 2014-15 and 2 per cent in 2015-16. That's on page 40 of the business plan for 2013-16. Is this sufficient for a growing economy? When administration is increased by 22 per cent in this year's budget, how can we be assured that future funding increases won't be eaten up entirely by bureaucracy?

Line items 11.1 to 11.6 in the ministry's budget allocation to AHS versus the breakdown within Alberta Health Services' recently submitted budgets are completely different both in dollar figures and what funds are actually allocated towards. Why aren't they easily comparable? For a government that talks about transparency, it's very, very difficult to follow the money.

There is no administration line item in the ministry budget either. Wouldn't it promote accountability if the ministry designated a specific dollar amount for AHS administration?

Why is the operating spending on new facilities separate from overall operating grants?

I'll talk for a minute about primary health care. It's in the same program item as addictions and mental health. The creating connections strategy talks about the importance of primary care. The direction the Premier wants to take the province in as far as primary care goes is FCCs. When she talked about this about 18 months ago, she talked about 140; today we have three. What I'd like to know is: for the three family care clinics that you currently have going, what is the cost for administration, what is the cost for operation, and what is the cost for capital?

Last year $75 million was budgeted, and only $1 million was spent on budget item 12.2. This year $50 million is budgeted. Why was $74 million not spent? Why is the budget $50 million this year? This is interesting to me. Under your line item in your budget, why were the three clinics actually operating spending only $1 million? What is the projected cost of patients under the family care clinic model based on those three that are operating currently?

Funding for the primary care clinics is going up $21 million this year – that's line item 12.3 – from $164 million to $185 million. I think that's good use of public funding. Does this mean the government is recognizing the great value per dollar of PCNs versus FCCs? What is the cost to the government per patient under the PCN model? So we want a cost per patient under PCN versus a cost per patient under FCC.

What is the timeline for your other 137 FCCs to be completed? The cost of each FCC is about $5 million. This would mean another $685 million is needed to fund the program. Where is the money coming from? Will the funding be from inside spending envelopes, or will there be new spending? Will the government be buying out doctors' practices instead of creating new clinics? How many of these clinics are going to be government run versus doctor run?

I'm going to talk a bit about severance packages, expenses, and bonuses if I can, please. What is the total dollar amount of any outstanding pension and/or severance liabilities for former health executives for both the former health regions as well as any who are left?

According to the AHS financial statements – and that's on page 126 of the AHW annual report – the management employees pension plan is reported at a deficit of $517 million at the end of 2011. Who is responsible for the pension liability? The deficit grew by almost a quarter from 2010 to 2011. What is it now, and what is it projected to be over the next three years? How does the government plan on paying off almost half a billion dollars in the pension shortfall? What is the total liability for all pensions or retirement plans that the government is responsible for? Did Mr. Merali receive his 12-month severance package? Has he paid back any of the expenses?

Page 140 of the AHW annual report details AHS contingencies with respect to outstanding lawsuits. As of March 31, 2012, there were 137 claims totalling $234 million and another 21 with no specific amount. How many of these have been settled, lost, or won, and how many were paid out? If for whatever reason AHS lost each remaining lawsuit, how much money do you think the government would be on the hook for?

If I may, Mr. Chair. As I said, 10 minutes: that's a lot of questions for the minister to absorb.

I'd like to know, if I can, about the ongoing lawsuit on Mercan, which has to do with a thousand Filipino nurses that were supposedly to be seconded over here. I wonder how much money has been spent on that current lawsuit and if that lawsuit is finally settled and what has happened to the thousand Filipino nurses that were guaranteed jobs in this province.

I'd like to talk about the performance measures at AHS if I can, please, but I'm noticing that we're about 30 seconds short of my 10 minutes. So I'm going to wait for the AHS performance measures questions.

What I would like to know, Minister – the questions have been asked, and I know you're not going to be able to answer them all at this particular time – is if you will provide answers in writing to us, please. I would like to also tell you that we're still waiting for answers from last year on the budget.

The Chair: All right, Minister. You've got up to 10 minutes to respond to as much of that as you can.

Mr. Horne: Okay. Well, thank you very much, Mr. Chair, and thank you to my colleague for the questions. I'm sure we'll have

an opportunity to get through a lot of these items as the evening goes on. I'll do my best to address what was raised so far.

The hon. member began with a quotation from the Premier from the throne speech in 2012. Of course, I'm very pleased to say that the Premier has met her commitment in all areas but in particular with respect to health care and her commitment to focus on primary health care. The hon. member's questions referenced our progress in that area, and I'm happy to discuss it.

Questions were raised regarding additional expenditures with respect to physicians and pharmacists with respect to the memorandum of understanding recently signed with the Alberta Medical Association. The $68 million one-time payment is in fact being funded from last year's budget. It is an amount that was accrued from 2012-2013.

With respect to the additional support for pharmacists, as I said in my opening remarks, government is providing approximately $12 million to support the additional $1 per prescription over the next year. The funding for the rural pharmacy grant was already in the budget, so we have two years left to allocate. That was recognized in last year's budget. The additional funding with respect to support for education and professional development for pharmacists is coming from this year's budget. The other items that were referenced are coming from this year's budget.

Mr. Chair, this is consistent with our practice in previous years, where we have reduced generic drug prices and we have reinvested a portion of those savings to better support our pharmacists.

I apologize, Mr. Chair. I'm not sure if we're supposed to refer to ourselves by constituencies or by name here, in committee.

7:30

The Chair: By name.

Mr. Horne: Mrs. Forsyth also asked about the recent memorandum of understanding with the Alberta Medical Association. As I think she's aware, it is a public document. It was released with a news release yesterday. The two items that she referenced, the fee schedule and the MOU pending final ratification of the agreement, provides that the fee schedule would be managed by a physician compensation committee. This will include equal representation from both government and the Alberta Medical Association. The committee will be chaired by an independent chair that's appointed by the president and the minister.

Mr. Chair, we're very excited about this because for the first time it gives us a formal mechanism within the agreement to review fee codes, to review alternate relationship plans and other forms of compensation to physicians. This body will have the authority and the responsibility to review the codes and to make adjustments within the overall physician compensation envelope.

Mrs. Forsyth also asked about engagement of physicians, and the MOU speaks to ways to better engage physicians in decision-making in a number of respects. It talks specifically about primary health care and a greater role for the AMA. Most importantly, I think, the MOU will recognize the Alberta Medical Association as the representative body for physicians in Alberta, and that's the first time that that representation would be formally recognized in an agreement.

What we also talked about in addition to the MOU was an initiative whereby Alberta Heath Services and the Alberta Medical Association and my department will be working jointly to identify and realize system efficiencies. By this, Mr. Chair, we mean things like opportunities to expand primary health care, looking at different fee models that might be of interest, opportunities to identify guidelines for appropriateness with respect to diagnostic imaging and other areas in the health system where we don't currently have guidelines, and many other areas that are going to help deliver better quality and access to Albertans but also help reduce the rate of growth in health care costs, which is a concern for Alberta given our 9 per cent average rate of growth over the last decade.

Mrs. Forsyth also inquired about stability and predictability in the health care system. I think, Mr. Chair, it's fair to say that, as I described in my opening remarks, we are continuing to provide stable funding for health care in the province. The budget is growing at 3 per cent as opposed to many of my partner ministries, which have seen freezes or reductions.

A number of other costs with respect to primary health care were inquired about. First of all, I'll just reiterate for the hon. member that primary care networks, as I believe she knows, refer to networks of local physician offices in the province. There are 41 PCNs across the province. So the foundation of the PCNs is the local physician practice, and the funding of $62 per capita that's provided by government fund enhanced services to be offered by those groups of physician offices.

Some of those services, Mr. Chair, many of us are familiar with. They have funded nurse practitioners and pharmacists and other professionals to work as part of the health care team. They have funded some very successful programs, including chronic disease management programs. They have also funded shared services for local physician offices.

Family care clinics are, of course, stand-alone clinics. They have assisted us in providing specialized services in three areas of the province, in the case of the three pilots that we have now. Family care clinic operational costs were at $1 million this year. Operational costs for these three pilots were covered, as I think the hon. member knows, by Alberta Health Services in their budget, and those were running at approximately $5 million per family care clinic.

There is not a comparable per patient cost. As I said earlier, Mr. Chair, just as the $62 for the PCNs doesn't include physician remuneration, we do not have a standardized cost structure for family care clinics. The reason is simple. This is not a government-driven approach. It's a community-driven approach. The first place we look when we look to expand primary health care services in the province is the resources that exist in the community, and we look for opportunities to make better use of those resources. Sometimes, like the PCNs, they're our own local physician offices. In other parts of the province that are unserved or underserved with respect to primary health care, there are fewer resources to look to.

The plan going forward – and I'm happy to talk about this later in the discussion tonight – is to announce very shortly a group of communities that we intend to work with to develop FCCs. Again, they will each serve unique needs in their own community – they will not involve a cookie-cutter approach – and the timeline with respect to implementation will depend very much on the resources that already exist in the community versus what would have to be provided in addition. It'll depend on the plan that the community puts together, and that plan will be supported by teams working with my ministry. It will also depend on the linkages with other providers in the area.

I'm very pleased to tell the committee, Mr. Chair, that PCNs have been working with us in the assessment of what services need to be incorporated in family care clinics. They've been involved very much with us in discussions about how the two will work together. Of course, both models serve the objective of

expanding access to primary health care and providing every citizen with a home in the health care system in or near the home community.

There were some questions with respect to new facilities, specifically South Health Campus and the Edmonton Clinic. The question was: why are these monies not included as part of the normal operating grant? Mr. Chair, we set these up as what we call restricted grants to enable enhanced, focused reporting on the operations of these new facilities as they ramp up to full operation. So in the interests of transparency and good accounting for these new facilities the restricted grant allows us to isolate the funding for the incremental operating costs of new facilities, to track that, and to report on it to Albertans.

Mrs. Forsyth also asked about comparisons in budget numbers year over year. As I think she is aware – I'm sure she is aware – Alberta Health Services receives funding from other sources, which is why the revenue and expenses are different. The budgets are not consolidated, but the financial statements for the organization are. So it is quite possible and quite easy, in fact, Mr. Chair, to compare the numbers based on those financial statements on a year-over-year basis.

With respect to administration costs – and I think I've answered this question in the House as well – Alberta Health Services maintains its position as the health organization with the lowest administration costs in the country at 3.3 per cent. There were some changes in the budget preparation this year which incorporate other costs in administration that were not previously incorporated, and that accounts for part of the change.

The Chair: Very good. Thank you, Minister.

Mrs. Forsyth, for your next 10.

Mrs. Forsyth: If I may, Chair, the minister is a masterful orator, and I appreciate his oratorical skills. The problem that I'm having with this is the fact that we've just spent a huge amount of time and a huge amount of effort in regard to putting together many questions that have been asked from Albertans and from health care professionals. Of all the questions I asked you, you probably managed in your time allotment to answer four.

I would beg and ask, Minister, if I can, if we can go back and forth, one-on-one questions. I can ask you one or two questions, and then you could answer back on one or two questions. I have probably 15 pages of questions that have been brought forward to us by Albertans that are waiting for the answers, including the 13 doctors that we have in the House and many of the others that are listening to us online.

So if I may, you missed many, many of the questions that I've already asked. You spent exactly five minutes and seven seconds on questions that you're comfortable with in regard to family care and primary care. Can we at least start going back and forth?

Mr. Horne: Well, Mr. Chair, I'm quite aware of what the rules are here. I will continue as we have continued, in the 10-minute blocks. I will certainly do my best to provide a full and complete answer to as many of the questions that are raised as I can, but of course it has to be a number of questions that can be answered fully and completely in the time that's allotted. Certainly, I'll do my best to co-operate with Mrs. Forsyth in that regard.

7:40

The Chair: Up until now in all of our estimates it has been back and forth. However, that is an option, and if both the member and the minister do not agree, then we'll go with the 10 and 10.

Carry on.

Mrs. Forsyth: Well, if I may, I mean, it's disappointing. I debated the minister last year in regard to estimates, and as I indicated earlier – and it's in the record of *Hansard* – he indicated he would respond back in writing, and we're still waiting for questions from a year ago. I've put questions on the record that are important to Albertans.

I'm going to move on to AHS performance measures. I know these are questions that have been asked, and I'd like some answers. I'd like to talk about the performance measures of AHS. This year AHS will receive $10.5 billion from the Alberta government. Alberta, as you have indicated, has probably the best-performing health care professionals in this country. Our spending per person is second only to Newfoundland, yet we are consistently – consistently – falling below standards and falling below performance measures that AHS has indicated that they can meet. Now, how does the minister explain the continual underperformance of priorities that this government or your AHS has set forward?

Let me give you an example. A scheduled bypass can be performed in nine weeks in B.C. It's six weeks in Ontario. But in Alberta it's 26 weeks. That is according to your recent data on wait times. Can you elaborate on the reason why we're not meeting performance measures? Is it a shortage of staff? Is it a shortage of operating rooms? Is it a shortage of doctors? Is it bottlenecks that are contained in the system? I'd like to ask you at this particular time how you're going to start meeting those performance measures, whom you are consulting with on meeting those performance measures, whether it's surgeons and their frustrations on not being able to get operating space.

The ER wait times, yet another concern. I don't need to go on and on about ER times. I mean, Dr. Paul Parks brought out ER times – what? – three years ago. It's been a consistent problem in our health care system. I brought forward a motion last night on the floor, Motion 508, in regard to providing us with updates on all emergency rooms across this province. I elaborated in that speech about some of the wonderful hospitals that are having no problem meeting their performance measures. Can you please tell me why there has been no progress on this and what you're doing and whom you are consulting with in regard to meeting emergency wait times?

Let's just talk about pharmacies for a minute. I'd like to remind the minister of the exact words that you used at this same time last year at the forum at the U of A when you last messed with pharmacy funding. In response to the concerns raised by a pharmacist that his business would be out tens of thousands of dollars, meaning layoffs, reduced hours, and reduced services, you said, and I'll quote: I'm not an expert on how this is going to affect individual pharmacies. Minister, why did you not learn your lesson then and study the impacts these changes would have before changing them once again in this budget? Where are you going to find the just-announced $40 million in transitional funding?

Now, you briefly alluded to that, and I think it had something to do with the access. I want to know where exactly that money is coming from, if it's going to affect the remote access. You talked about the dollar prescription. How are you planning on getting the money? Are you prepared for the shortage of generic drugs as a result of your policy change? Is there any consideration that the costs may go up if only the brand-name drugs are available?

I'll talk about health and your seniors' advocate. Last year the Associate Minister of Seniors set aside $1 million for the seniors' advocate. He also said that the advocate would be up and running in months. This was also promised by the government during the 2012 election.

In 2010, Minister, you worked on the Alberta Health Act, which still has not been proclaimed. I have got all of the information from *Hansard*, all of your speaking notes on how passionate you were on that Alberta Health Act and what it was going to do. The Alberta advocate's office had a budget of $700,000 last year and again this year. Only $350,000 was spent on the health advocate last year. Help me, Mr. Minister, if you can. What is the status of the Alberta Health Act, the health advocate, the seniors' advocate? What was $350,000 spent on last year in the health advocate's office?

I want to talk about something that I know this is a passion of yours. You and I go back, Minister, a long time. I was on the Mental Health Board, and I remember all the passion that you brought to the table. Last year you said that one of the key strategic initiatives would be addictions and mental health, yet when I look at line 12.5, $5 million has been cut from the mental health and addictions budget. How is it strategic to cut funding to a priority area? What has happened to that $5 million? Last year you said that we had 817 addiction treatment beds. How many are there today? Last year you said there were 913 mental health beds, 617 for acute psychiatric care. How many are there today?

This year's initiative 3.3 is to implement the goals of the addiction and mental health strategy just like last year. Alberta has a mental health strategy called Creating Connections. I asked you this question last year. I'm going to ask you this question again this year. What psychiatrists did you consult with?

Out-of-province patients. Line 10.2 is the out-of-province health care services program. Can you tell me how many Albertans are treated out of province and which procedures are the most common? Mr. Minister, can you tell me about the contract with other provinces and territories? How are out-of-province patients prioritized for surgeries that are nonurgent? For instance, patients from northeast or southeast B.C. are often treated in Alberta. Is that being treated equally, and who's paying for that?

Recently one of the comments that we heard from one of your executives was that you were going to start doing cost recovery. Have you any idea what the cost recovery will be if other provinces start asking us for cost recovery?

Initiative 1.2 states: "Lead the health capital planning process and ensure capital priorities are aligned with the business plan, action plans and service plans." I understand that every health capital project cannot be funded. There are limited resources that our government has. Can the minister explain how a project is handled from conception to completion? Does AHS submit plans to Alberta Health and then to Finance? Does AHS submit directly to Finance? Do projects go through Infrastructure as well?

Let's talk a minute about e-health records. How much has the e-health record program cost to date? What is the estimated cost savings, if any, once it's rolled out, both immediate and long-term? What is the expected date of completion?

Let's talk a minute about your Associate Minister of Wellness.

The Chair: All right.

Minister, you have 10 minutes to respond to as much of that as you can.

Mr. Horne: Thank you, Mr. Chair. Thank you to Mrs. Forsyth for the questions. The first question was with respect to waiting times, and I'm pleased to note, Mr. Chair, some significant improvements in waiting times in several areas. For example, the wait time for knee replacement surgery is now at the lowest point it has been in two years in Alberta, with a year-to-date wait time of 41.3 weeks compared to 49.1 weeks one year ago. That's nearly a 16 per cent improvement.

We've also seen improvements in waiting times for cataract surgery, 28.7 weeks, down from 36.6 weeks a year ago, a 21 per cent improvement.

In cancer care, an area that's extremely important for all Albertans, waiting time from referral to first consultation with a radiation oncologist is at 4.9 weeks, down from 5.7 one year ago, a 14 per cent improvement, Mr. Chair.

There are also reductions in the number of people waiting in acute care for continuing care. That's down 10.8 per cent over the last year. The percentage of people placed into continuing care within 30 days of being assessed has increased from 62 per cent to 67 per cent. We can see, certainly, improvements in many areas, Mr. Chair.

7:50

We also continue to see challenges. I will certainly be forthcoming with the hon. member that we continue to see challenges in the area of emergency department wait times. I think it's important to note, Mr. Chair, that increases in visits to emergency departments have averaged almost 5 and a half per cent when you compare the third quarter of 2012-13 to the prior year. Our wait times, although not at target yet, have remained relatively stable.

This is a complex problem, as I know Mrs. Forsyth understands. It's certainly a function of the increase in volume, the number of people coming to Alberta. It's also a reflection of the need to do what we're doing in terms of expanding access to primary health care and keeping those primary care clinics available to people on an extended-hours basis and providing more services in those clinics. It is also a function of our ongoing demand for access to continuing care and home care for seniors. I'm sure we'll be talking a bit more about that later this evening.

The member also inquired about pharmacies. You know, I'm happy to reiterate, as I did earlier, that the $40 million in additional benefit to pharmacists includes only $20 million coming from the government of Alberta. The balance includes $10 million from the rural and remote program, which was already in the budget, and $10 million that was already allocated in this budget.

We continue to invest savings, as I said, when we reduce generic drug prices to help support pharmacists. Of course, the other aspect of this is the reduced prices that Albertans will pay. Government, as we've said, anticipates savings in the neighbourhood of $91 million, and that's at an 18 per cent equivalent in the brand name price. When we look, though, to other countries around the world like New Zealand and Australia, we can see that even below 18 per cent there are many more savings that are available. In fact, when we look across the world at the 60 to 70 countries that generic manufacturers sell to, we see them paying pennies on the dollar compared to what is paid by pharmacies in Canada for the same drugs. So we make absolutely no apologies for continuing our work to reduce generic drug prices.

We manage our pricing policy such that we do not delist a drug unless there is an equivalent drug that is available, and in the case of generic drugs most of the equivalent drugs that are available are, in fact, other generic drugs. In some cases it is necessary to substitute a brand drug for a limited period of time until the generic drug prices come back. If we do not take the actions that we have taken, the result, of course, will be higher prices for taxpayers, higher prices for employers who provide employee benefit plans to their employees, and, of course, higher prices for Albertans who pay out of pocket. As I said at the outset, Mr. Chair, drug prices are one of the fastest growing areas of cost in the health system.

The member asked about the Alberta Health Act. As I think she will remember from the debate in the House, the provision for the health advocate requires further consultation – we made that clear – as does the health charter that's provided for in the act. We do intend to follow through with that, but we also intend to meet our commitment to Albertans to consult with them on those regulations before that act is proclaimed.

There were also a number of questions about mental health. I'd be the first to acknowledge that as colleagues in this House we certainly do share a commitment to mental health, and I commend the member for that. With respect to the number of beds we have presently 1,515 psychiatric beds in the province, 830 addiction treatment beds in the province, and 514 mental health community beds available to Albertans. I think those resources are important, and being able to quantify them is obviously important, Mr. Chair.

What's also important is the work that we are doing to integrate mental health and addiction services in primary care across the province. One of the opportunities that's afforded when you have a policy to provide every Albertan a home in the health system, to be associated with a primary care team, including a physician, is the opportunity to provide services to people earlier and to identify people who may be at risk for mental health and addictions issues and to reach out to them.

I think we will certainly continue to add spaces for in-patient treatment in the future – and that's important – but we'll also do our utmost to reach out to people in the community, where they live. We will continue to provide investments like we have in association with the Ministry of Human Services to provide wraparound services for people who are living in affordable housing; to continue our work in the mental health capacity building in schools initiative, which now encompasses 119 schools across Alberta, where we have an opportunity to identify children and youth at risk and to provide education and training to teachers; and continue to do everything else that we can possibly do to address the unmet need for mental health and addictions services in our province.

We have a long list here, which I'm happy to make available to my colleague, of the different programs that we fund across the province through grants from the Ministry of Health. This includes everything from the Head Start program, that's run by the Child, Adolescent and Family Mental Health organization, through to programs for school boards, the Terra Centre for teen parents, the Edmonton and area child and family services authority. We have grants here, Mr. Chair, totalling a projected $3.8 million in 2013-14. We are also partnering with community organizations to reach out and provide additional mental health services.

There were also questions about the out-of-province health services program and reciprocal billing. This is an area of concern for us. My department is working with AHS to recover expenditures from other provinces. As I think most members are aware, it's standard across Canada that provinces have reciprocal billing agreements with one another. Most often the prices that are paid under those agreements are comparable in each jurisdiction. Sometimes they are not. So we need to continue to make efforts to recover all of those expenditures.

We're currently the lowest recovery province in Canada, and we are working to fix this. My colleague is right to raise it as an issue. It is, I think, a function of improving our administrative procedures, but this issue is also a function of our growth and the fact that we are a go-to province, Mr. Chair, for people from across the country because of our strong economic growth, because of the public services that we offer.

Out-of-country health care services in 2010-11, which is the most recent year for which we have statistics, were funded for 13,753 patients in the province. This is, of course, an area that is not administered directly by my ministry. The program is administered by the Out-of-Country Health Services Committee. It is a quasi-judicial body, and it includes many physicians on the committee. There is an appeal process, an appeal panel, which hears appeals for decisions that are denied. This is something, as I said, that is done independently of government, and rightly so, Mr. Chair.

Those are some of the areas that the hon. member talked about. I'm happy to address EHR costs and others next.

The Chair: All right. Very good.

Your next 10 minutes, Mrs. Forsyth.

Mrs. Forsyth: Minister, I've asked you about 45 questions, and you've answered approximately nine. I think that can emphasize the fact about how it's important to go back and forth. What's interesting in the questions and answers is the fact that you seem to pick the questions you want to answer and to not answer the questions that you don't want to answer.

Let's talk about out of the province again. How much money have we paid to other provinces for out-of-province patients, and how much money have we collected from other provinces in regard to patients that have arrived in Alberta?

8:00

I want to talk again about mental health. I would just like for you to reiterate the number of beds: how many addiction treatment beds you have, how many mental health beds you have, how many acute psychiatric beds you have. I know I don't need to tell you that under the five causes of death for Alberta residents according to the Alberta Health Services health plan and business plan, the fifth highest cause of death is mental health and behavioural disorders. I'm just again emphasizing your line item where you're $5 million less when we have recognized that one of the top five deaths is mental health.

I want to talk again about the health advocate and the Health Act and the charter. You talked about further consultation. How much consultation has been done, or when do you plan on starting this? Minister, you were key on that Health Act when you were a private member and very, very passionate. So as the Minister of Health I'm surprised and somewhat disappointed in the fact that as someone who was so passionate about the Health Act, you haven't moved this further as the minister of the Crown and made it one of your top priorities. So when is the consultation, or has the consultation been started? When are you planning on doing consultation?

This year your initiative 2.2 states: "Implement a long-term plan to promote wellness including Wellness Alberta – A Strategy for Action 2012-2022 and new mechanisms to support community based initiatives." Where is the funding for your associate minister to act on this initiative? Last year the goal was 2.4. The year before it was 2.3. The year before it was part of goal 4. What is the status of the wellness plan? What does the associate minister have to report on that status?

Explain the increase in funding for the associate minister's office. How many staff were in the office last year compared to this year? How much funding was allocated to the new press secretary role we see in the minister's office?

Let's talk a minute about Health Link. What is the cost per call to operate the Health Link service? Can you estimate cost savings as a result of Albertans receiving phone advice through Health Link as opposed to attending a clinic or ER?

One of the top priorities that you have under your priorities is immunization. This question comes directly from a nurse. I would

like to know: when a patient goes into a doctor's office or when a patient goes into emergency seeking medical advice or anything to do with the flu, how many of those patients are asked if they have had a flu shot?

I'd like to ask you about the Alberta health care insurance plan statistical supplement. Based on previous dates, Albertans should have seen a 2011-12 statistical supplement in December 2012. It's now April. Where is that report?

I want to ask again – I'm going to reiterate some of the questions we have asked. I'll go back to the severance packages and expenses that you haven't even touched on or even alluded to. I'm wondering if that's one of the questions that you can tell people around this table and all of those that are listening that you will provide a written response to or, if I may say, guarantee a written response. I want to again ask you: what is the total dollar amount of any outstanding pensions or severance liabilities for former health executives of both the former health regions as well as anybody left on AHS?

According to the AHS financial statements, page 126 of the AHW annual report, the management employees pension plan reported a deficit of $517 million at the end of 2011. Who is responsible for the pension liability? The deficit grew by almost a quarter from 2010 to 2011. What is it now, and what is it projected for the next three years? How does this government plan on paying off almost half a billion dollars in the pension shortfall? What is the total liability for all pensions or retirement plans that this government is responsible for?

Alberta spends much higher than any other province for hospital service, and we know that delivering health services within the hospitals is the most expensive place to do it. Why has the government not addressed that in this budget? How does the government manage overall waste in hospitals? Do you measure how much money is literally thrown away on supplies that are discarded because maybe they have been dropped or sterile packages opened and not used, equipment lost, et cetera? Do you have a dollar amount? This question comes directly from nurses. They feel that there is incredible waste going on and there's no oversight. Can you please elaborate if you've got something going on on that?

You know what, Mr. Chair? I know I've got time left, but I'm going to give that extra time to the minister so that he can answer maybe a few more of the questions, please.

The Chair: All right, Minister. It's back to you. Ten minutes to answer as much as you can get to.

Mr. Horne: Okay. Thank you, Mr. Chair. There are a number of questions there. First of all, just some of the ones that I can perhaps dispense with quickly. The 2011-12 statistical supplement will be published shortly. That information will be available, as it always has been, online.

With respect to Mrs. Forsyth's question around the health advocate and the health charter as provided for in the Alberta Health Act, we have not begun the consultation that we feel is required in order to finalize with Albertans their views on this matter. As I recall, you yourself voted against this particular piece of legislation and presented a number of concerns. We intend, as I said, to proceed with completing the consultation. We believe that both the charter and the advocate can play an important role in helping to guide decision-making about health care and incorporating, of course, very importantly, Albertans' views on that. We will be proceeding with that work, and at the appropriate time I will take forward to cabinet a request for proclamation of that act.

There were some additional questions raised around mental health, and I'm happy to further elaborate on that because it is a concern. The $5 million reduction in the budget this year is just a reflection of the fact that a number of the grants were one-time grants. Those grants have been completed. It does not indicate any less of a commitment to expanding services in this area on behalf of government. As I said, in addition to the dedicated funding for addiction and mental health, we are working with partners to incorporate addictions and mental health services in primary health care.

With respect to the out-of-country payments and then recoveries, I would be happy to provide that information in writing to my colleague. I don't have that with me.

Similarly, with respect to the issue around pension liabilities at Alberta Health Services, that is information that we can seek to get from Alberta Health Services.

You also asked about severance. These are financial statement questions that directly relate to Alberta Health Services as an employer. Of course, as I'm sure the member recognizes, although AHS is the employer, ultimately the government would be responsible for those payments. But specific questions about pension liabilities and severances for AHS should be addressed to AHS as the employer. I believe there is an opportunity to do that through the Public Accounts Committee.

You also asked, I thought, a really important question about waste. You said that the question was based on feedback that you've had from nurses that there are unrecognized opportunities to both monitor wastage in the system and then to take appropriate action. I'd agree with you very much that we need to do more in that area. One of the advantages of having one health region for the province is that when we have initiatives around waste in the system, whether it's with respect to supplies or other parts of operating the system, we have the ability to adopt a single policy to address the issue and to realize significant savings.

8:10

I know that the issue of the disposal of hazardous waste – and I'm not sure if my colleague was referring to this or not – was the subject of a recent Auditor General's report. There was a specific recommendation, which was accepted by Alberta Health Services. I certainly agree with her comments about needing to do more in that regard. Those are good and frequent topics of discussion between myself and the board chair.

With respect to the electronic health record as of March 31, 2012, the cost stood at $750 million. It is a very significant amount of money, Mr. Chair, in our budget. But I think it's also important to realize what is going to be available to Albertans when the electronic health record is complete. Most importantly, every Albertan will have one. We will have a one-patient, one-record system.

It will enhance the quality and safety of patient care, of course, by providing more up-to-date and more accurate core medical information about a patient, reducing the possibility of error; providing information at the point of care rather than through the exchange of paper, which reduces delays in treatment; streamlining the secure sharing of health information and building a common understanding of the patient's health condition, which is very important as we move to care delivery models that are focused on delivering team-based care; and preventing the duplication of tests, unnecessary treatments, and adverse events.

We are continuing to work with AHS to add more users every year to Alberta Netcare to add more data. And we have a project in place now to consolidate all the health data in a single

repository and to add important features like the patient health portal that is available at myhealth.alberta.ca.

In the remaining few minutes I would like to ask Associate Minister Rodney to address the status of the wellness plan.

Mr. Rodney: Thank you very much, Minister. Thank you, Chair. Thank you so much, Mrs. Forsyth, for your interest and your action over, if I may say, the years when it comes to wellness. It's a passion that we certainly both share.

I believe your first question with respect to Wellness had to do with expenses within the office. Of course, since the last election we've had one executive assistant and one administrative assistant in my office. I certainly appreciate the services of both of those individuals. They're invaluable. That has remained the same since the beginning. There's also a gentleman I certainly want to thank, our acting ADM for family and population health, Neil MacDonald, whose experience and expertise in the field over the decades, if I may say, has been absolutely inspirational.

Now, I believe the second topic that you were asking about is the status of the Alberta wellness strategy, and I can assure you that the formulation of that is very well under way. Just one of the bigger days that we had, that actually had months and months of work in it prior, was gathering in the neighbourhood of a hundred of Alberta's best professionals. You name a profession associated with wellness, they came together and gave us all sorts of ideas.

This isn't my wellness strategy. It's not a department or government strategy. It's the Alberta wellness strategy. Let's face it. If we want people to be happy, healthy, and out of the hospital, it's fine to have programs and policies, but unless individual Albertans take responsibility for healthy eating, active living, and more, it just won't go nearly as far as we need it to go. These programs are positive and proactive and preventative, and I'm really proud and honoured to be associated.

The event that I was referring to was known as the wellness forum. If we had them in the past, we'll have them in the future. We've also had a symposium, bringing together some of the world's brightest minds on wellness in conjunction with all sorts of Albertans, from everyday Albertans to professionals in the field. You know, it's not just from Health. It's industry and community and education. It's employers, all levels of government, and all sorts of folks who are interested in promoting wellness.

I know that many around the table are concerned with aboriginal wellness. There is a specific strategy for that. I'll just list for the sake of time. I know that the ministers both of Health and Seniors will have other things to add because it is really not just within this ministry but between ministries as well. I do want to mention the Why Act Now project at the U of A, the aboriginal step up challenge, which is really the Aboriginal Women's Professional Association. There are nutritional guidelines not only for adults but for children and for youth.

If you haven't had the chance to check out the Healthy U realm, I hope you do. There's a Healthy U food checker, and healthyalberta.com is an absolutely invaluable resource. I was able to refer to it during the Get Outdoors Weekend which we just had, which I wasn't even going to mention here. Going back to the summer, we launched the Alberta government's first-ever app, the Jr. Chef app. What we do is have fun activities for kids to get involved with in terms of having the right kind of food. If I'm interested in this and that, how do I put that together in order to have a good meal? The lovely thing that we're finding is that they're having a great time teaching their parents.

Speaking of their parents, at work we have the *Eat Smart Meet Smart* resource, which I'd recommend for meetings and conferences. Also in Healthy U is the information and education initiative, food and health innovation.

A story that I want to tell just very briefly is about the healthy school community wellness fund. There's $1.35 million dedicated to that. [A timer sounded] Oh. Well, I hope we can get back to that because it's very, very good.

The Chair: It's going to be even briefer than you thought.

Okay. Well, there are about three and half minutes left, so if you want to deal with a couple of questions back and forth in the next three minutes, go ahead please.

Mrs. Forsyth: Minister, I asked you about the capital planning. I understand that every health capital project cannot be funded, and I mentioned the limited resources. Can the minister explain how the project is handled from conception to completion? Does AHS submit plans to you and then to Finance? Does Alberta Health Services submit directly to Finance? Do projects go through Infrastructure? Your priority over and over again – I'm looking at your 2012-2015, line 1.2 – is to lead the health capital planning process. Can you explain that to me, please?

Mr. Horne: Sure. Happy to, Mr. Chair. Alberta Health Services is responsible for recommending new capital projects to my ministry, so each year they submit a prioritized list of the projects that they would like to see government fund. For projects that are under $5 million, Alberta Health Services does have the authority on their own to approve that funding and to initiate projects, but projects $5 million and over are dealt with by government upon the recommendation of Alberta Health Services.

The role of Alberta Health Services with respect to capital projects is to conduct what's called a needs assessment. This looks at, obviously, the demonstration of need in the local community. It involves consultation with the local community, looking at other resources that are available in the specific community and in surrounding communities to see how they can work together to arrive at a conclusion as to need. That needs assessment is forwarded to me for approval.

Recommendations around which capital projects should be funded: those are decisions that are made by government. My ministry makes the recommendation, and the role of Alberta Infrastructure, once a project has been approved, is to develop a business case for the project and, of course, to oversee the construction of the project.

There are multiple partners involved in the determination, Mr. Chair. I think it's important – and I think the hon. member has acknowledged this – that we are not always able to provide funding for all the capital projects that people would like to see in their own community.

In addition to needs for new facilities – and we've had a number of new facilities. In fact, almost $2 billion worth of new facilities were opened last fall, the fall of 2012. We also have significant need to refurbish aging facilities across the province, and we have to provide funding for those as well.

Part of the solution to this, we think, Mr. Chair, is to make sure that we are not doing things in hospitals that we can do in the community and where we can do a better job. That's one of the reasons that primary health care is so important.

The member also mentioned Health Link. Telehealth is another tool that's available to us. Sometimes simply funding specialized diagnostic imaging equipment like the CT scanner that we funded in the High Prairie project helps to reduce the need for people to travel back and forth to Edmonton for those sorts of diagnostic tests.

The availability of capital is important in a growing province such as ours but also wise decisions, Mr. Chair, and good needs assessments and business cases make for better decisions.

8:20

The Chair: All right. Thank you, Minister.

That concludes the first hour, so we'll go to the third party and then take a break. Again, just for clarity, if the member and minister disagree about the back and forth, it will be 10 and 10.

What's your preference, Dr. Swann?

Dr. Swann: Well, like our previous member, I'd prefer back and forth, but I'll leave it to the minister to decide.

Mr. Horne: Well, I'm certainly willing to give that a try, so why don't we proceed with a back and forth in this segment.

Mrs. Forsyth: We're going to call a point of order on that if we may, please.

Dr. Swann: I'll also express my thanks to the minister and his staff.

The Chair: Dr. Swann, sorry. We have to deal with a point of order.

And it is?

Mrs. Forsyth: Well, Mr. Chair, if I may, we had asked the same thing from the minister and thought it would be fair if we went back and forth. He said no; he wanted 10 and 10. Now he's prepared to try back and forth with the member of the opposition. I think that in fairness we had the opportunity to go back and forth. As I explained, in the 20 minutes previous to that we had asked 43 questions, and the minister had nine. We were quite willing to go back and forth, with me asking questions for two minutes and him possibly having an answer for two minutes. Now, all of a sudden, we're going to go back and forth.

It's no different than what we talked about in the Legislature this afternoon. I mean, we had an agreement as the chair and the deputy chair, and it's been going fairly well all the way through till just now.

I actually bragged and thanked the chair in the Legislature about how everything was running smoothly on budgets up until you came along, Minister. So I'm sorry that's happened.

The Chair: Well, let's be careful not to blame any one individual.

Maybe I was not clear at the beginning because we have gone back and forth through all of our questions through all of our estimates up to this point, but again it has nothing to do with member or minister. If the minister wants to go back and forth and the member wants to go 10 and 10, then the 10 and 10 will prevail. Both parties have to agree on how we're going to proceed, so there's no point of order.

Please carry on, Dr. Swann.

Dr. Swann: Thank you to the minister and his staff for coming tonight. It's important that we have these sometimes intense discussions and clarification of how the public dollar is being spent. Always challenging to sort through massive amounts of numbers without clear identification of the more specific impacts that these have. The minister has consistently said that we have the lowest administrative costs in Canada at around 3 per cent. Can he give us some comparative data? Is he comparing apples to apples?

Mr. Horne: Well, thank you for the question, Dr. Swann. These administrative costs are based on comparison figures from the Canadian Institute for Health Information. The 3.3 per cent is documented as the lowest administration costs in the country for a health delivery organization. I think that our decision to consolidate the former health regions into one gave us a number of significant opportunities in terms of back-office systems like payroll and other data systems that are not directly associated with patient care. It gave us an opportunity to consolidate those, and that process is continuing within Alberta Health Services.

One of the questions that was raised in the House earlier was that some of the preliminary budget information from Alberta Health Services indicated that they would be categorizing some of these expenses differently in order to continue to make them comparable with CIHI figures. I think we need to wait, obviously, for approval of the provincial budget before their budget is confirmed, but my understanding is that costs associated with the strategic clinical networks and other costs that are counted by CIHI as administrative costs are not currently counted in Alberta as administrative costs. So there will be some adjustments to their accounting around administrative costs, but it's solely for the purpose of making those costs comparable with other jurisdictions.

I can certainly tell you from the point of view of the minister that being able to make those comparisons and to answer some of the challenging questions that are asked, you know, I encourage that.

Dr. Swann: What are the comparisons in other provinces? What would an average rate be in another province? I would be interested in any individual comparison.

Mr. Horne: Well, we'll see here in the next few minutes if we can get those for you. I don't have them at hand, but certainly we'll provide them to you.

Dr. Swann: Your communications budget went up 44 per cent this year. With the massive amount of money we're spending on the Public Affairs Bureau, I'm surprised at that, and I'm wondering if you can explain what the increase in communications is about in your department.

Mr. Horne: Actually, Dr. Swann, the communications budget went down by $1 million, which represented about 30.7 per cent. That's the change from the budgeted amount to the forecast amount. We're actually simply forecasting to spend the original amount of money again next year, so you'll see that we've taken out – perhaps you won't; I'm not sure what document you're looking at – the $1 million, and we're adding it back in.

There was less spending in this area in the last year, and I believe the primary reason for that is staffing. We were not at full staff complement. We expect to be at full staff complement for the coming year.

Dr. Swann: I'm not clear. Is it increasing or decreasing? Is the $2.256 million forecast and the $3.257 million expected not the numbers we're working with?

Mr. Horne: The 2012-13 forecast – and I'm referring to element 1.4 – is $2.256 million, and then the 2013-14 estimate is $3.257 million. We underspent last year, budget compared to forecast. We're forecasting to spend about a million dollars less. We are expecting to spend that million dollars next year because we expect to be fully staffed.

Dr. Swann: I'd be interested to know how that communications budget compares across the country as well.

Population and public health is obviously a passion of mine. I spent 20 years involved in that area. I haven't seen the kind of investment, the kind of leadership, the kind of indicators that would show that we are committed to prevention and to a determinants-of-health approach.

Some of the proposals we've seen this past year are exciting. They reflect a commitment in the research community and the NGO community to increasing our outreach and involvement in the determinants of health. I'd appreciate hearing a little more about why we haven't seen more. Is that not one of the major contributors, then, to higher emergency room visits, higher doctor visits, higher costs in the health care system? When are we going to get prevention and population health higher than 3 per cent of our budget in this province?

Mr. Horne: Well, there are a few areas. I would agree with you that the traditional measure of a health system's performance on wellness and prevention has been, you know, the line item in the budget that has been devoted to that, and I would be the first to agree that in Alberta and, in fact, across the country we've seen typically, you know, in the neighbourhood of 2 per cent at most of health budgets devoted to that area.

I think what has changed is that rather than trying to deal with it as a sole line item where we provide grants to organizations to do one-time projects, we're putting a lot more focus on using primary health care, in particular, to advance the prevention agenda. That speaks to, for example, when we've talked about primary health care, PCNs and FCCs having a role in serving as a platform for other programs delivered by the government, like early childhood development, that can have a real impact on the social determinants of health.

In this budget we have funded at a relatively small cost compared to the size of the whole budget an early newborn hearing screening program, which will be phased in and will be available to all infants.

We have a social policy framework that was recently announced that speaks to some overarching principles. Really, you know, my main take-home from that as the Health minister is that it speaks to a determination by government to integrate services across the social policy sphere. So when we're talking about mental health, we're talking about what's going on in housing and children's services at the same time.

That really is the agenda, to build wellness and prevention into everything that we do in the health system.

8:30

You are absolutely right in terms of the demand from a budgetary point of view, not to mention a human point of view, about the lack of focus in this area across the country. I can tell you that currently 5 per cent of Albertans – 5 per cent of our population – account for 60 per cent of the expenditure of health care resources in the province, so that's about 150,000 people. Many of these people have mental health and addictions issues. Many of them have multiple chronic conditions that have to be managed and that are complex issues.

So the answer is to integrate wellness and prevention in all of the line items in the budget. We'll continue to give grants and support innovation, but we need a sustainable strategy in this area, and primary health care is the strategy.

Dr. Swann: We do. In that relation I'll go to the Wellness minister. He talks a lot about activities. He talks about forums. I don't hear about indicators or outcomes. When are we going to see some measurement and some change in the indicators and the outcomes of our population?

Mr. Rodney: How about right now, Dr. Swann? Would that work? I really do appreciate your asking the question because it's exactly where I was going to leave off with Mrs. Forsyth. Just one point of information. In 2008 schools that received the wellness fund grants had an overweight percentage of 17.6 per cent. That was actually slightly higher than the provincial average at the time, 17.1 per cent. Just four years later, so just going back to last year, that was measured again. Let's face it. You and I know that these things must be measured. The proof is in the pudding. We have to have the results. We can't just think that this is a good idea. Albertans deserve to have their tax dollars spent wisely. We can't just throw them into preventative, proactive, positive funds and have no results.

Get this. By 2012 wellness fund schools had 13.8 per cent overweight compared to the provincial average of 18.3 per cent, so we went from above to well below in only four years. In addition to that, the grade 5 overweight and obese percentage has dropped from 29 per cent in 2008 to 26 per cent in 2012. Some might say that those are baby steps, again, in four years to drop 3 per cent. At that rate, another eight terms of this, and we're going to be in a ridiculously healthy sort of situation. That's exactly what we want to work towards.

I'm like you. I don't want to just talk about programs and policies or awards. I could have mentioned the healthy school communities award or the Premier's award for healthy workplaces, Communities ChooseWell. Some might say this could be fluff. We're actually getting results. Please know that we have benchmarks. We're taking measurements. We have in the past. As you know, it just takes a little bit of time before we can actually have the results that will prove that, but we've started to get those, and I trust that as we continue on, we're going to see more and more good news.

Dr. Swann: You mentioned weight. What are the other indicators you're planning to measure over the next decade?

Mr. Rodney: In fact, it goes well beyond weight. Doctor, this may not be too much news to you, but it may be to other members or Albertans: influenza immunization, percentage of Albertans who've received the recommended annual influenza immunization, and that's broken down according to different age groups; sexually transmitted infections in terms of rate of newly reported infections in a number of different categories; childhood immunization rates for diphtheria, tetanus, pertussis, polio, MMR, and you're familiar with that; healthy Alberta risk trend index. Some know it as average number of health risk factors for people from 20 to 64. Those are a few. I can tell you that as we come forward with the wellness strategy, you will see even more.

Dr. Swann: Thank you.

I have some sense of what I can hold the Minister of Health accountable for. I don't have a sense of what I can hold you, Mr. Minister, accountable for. Can you outline how we should measure your performance at the end of three years?

Mr. Rodney: Well, I would trust that all the indicators that we just mentioned . . .

Dr. Swann: So you're going to take responsibility for immunization, then? That's a question the Health minister could also answer. How do we hold this minister accountable for his area and his budget and his activities?

Mr. Horne: Well, the person that you have to hold accountable, Dr. Swann, is the Minister of Health. The ministry is made up of

one budget and one set of programs, so I'm the individual that you have to hold accountable. I'm assisted, obviously, by my two associate ministers.

Dr. Swann: How will you measure his performance, then, shall I ask?

Mr. Horne: We will measure the performance of our health system as a whole, and immunization rates are a very important indicator. I would be the first to admit that immunization rates are lower than they need to be in Alberta. We did see pharmacies this year double the number of immunizations that they had over last year, but it is an uphill battle.

If I could, you asked an earlier question about administration costs. According to the Canadian Institute for Health Information in 2010 here is a sample of the rates. Ontario was at 6 per cent; Saskatchewan, 5 per cent; Manitoba, 5 per cent. B.C. was at 4 per cent, and Alberta was at 3.3 per cent.

Dr. Swann: But, again, you're not including some aspects that other provinces are, and you're going to reconcile those, I guess, in the next year.

Mr. Horne: These 2010 rates are directly comparable.

Dr. Swann: Oh, are they? What has changed, then?

Mr. Horne: What has changed is that CIHI is now including additional lines that we have previously not included in administration.

Dr. Swann: For every province?

Mr. Horne: Yes.

Dr. Swann: Thank you.

To the Associate Minister of Seniors. One of the long-standing concerns about seniors' care has been standards of care, staff ratios, inspections of those standards, and enforcement of those standards. The Auditor General several years ago said that one-third of seniors' care centres are not meeting those standards. I'm wondering if you could tell us what's happened since that Auditor General's report.

Mr. VanderBurg: Well, one thing that has changed since the Auditor General's report is the public reporting of each of our facilities, 765 licensed facilities in the province. At any time you can go on the website, and you can click on your favourite site and see the standard and the rating that each facility got. It's valuable information that the public uses when they're determining where a loved one may go.

The goal of the department is always to have an annual inspection. I have to say that I've been very, very impressed with the system since it's been transparent and available for the public to have access to, and I think it's a great measure to have as well.

Dr. Swann: What is the staffing ratio standard, and how is it being monitored?

Mr. VanderBurg: The staffing ratio standard? I don't know.

Mr. Horne: We'll get that for you, Dr. Swann.

Dr. Swann: Are inspections done at a regular time, or are they a surprise visit so that people are not prepared and covering up problems that may exist?

Mr. VanderBurg: I have to say that for the most part they're unannounced visits, but in the majority of the cases that I know, staff have an obligation to let the facility know to make sure that the administrator and proper people are there in place. But when driven by complaints or concerns, it's unannounced.

Dr. Swann: Thank you.

With respect to the academic alternate reimbursement plans for physicians one of the concerns I've heard expressed, particularly at the university centres, is that these academic plans that pay physicians for doing both research and patient service are not necessarily being monitored, so some physicians who may well be paid 50 per cent of their time for clinical services may or may not be doing 50 per cent clinical services. I'm wondering what kind of oversight and accountability physicians have for actually delivering on those patient service commitments?

Mr. Horne: Well, Dr. Swann, as you may know, both the University of Alberta and the University of Calgary have separate arrangements with respect to academic alternate relationship plans in their universities. The funding is provided by my ministry, AHS, and also by Enterprise and Advanced Education.

We are concerned about being in a position to attest to the value derived from the academic ARPs. I've actually instructed my officials next year to design and implement an audit process for all of the academic ARPs. I'm not suggesting for a minute that I have a concern that anything is untoward, but I think that the transparency and the accountability regarding these funds needs to be looked at.

8:40

Dr. Swann: Thank you.

I don't know how much you're able to say, Associate Minister of Seniors. What is happening to the increased funding that has been transferred from long-term care to assisted living? How is that going to deal with those individuals that clearly need fairly intensive, person-to-person care? What is it going to mean for those families and individuals that are actually transferring from 24/7 to some kind of alternate care?

Mr. VanderBurg: Well, we know that there are a number of different levels of care that are provided for families and Albertans in the system. I think what we always look for is that the appropriate care is given at each facility that the resident needs.

There is without a doubt a capacity issue in some parts of the province where patients have to move away from their communities to get the standard of care they need. The goal right now of the ministry is to continue to build capacity where needed. So how the process will work is that Alberta Health Services will identify the spots, and I'll go seek out the partners, whether they be private care or nonprofit or at the last resort government-built and -operated. We've been very, very successful over the years in getting those partners. Last year $66 million and 680 spaces were given grants to build over the next 18 to 24 months.

We're just going through that process right now, again, where the last requests for proposals were taken by the department. February 22 was the deadline. We'll have over the next 60 days the results of that.

Dr. Swann: Thank you.

The Chair: All right. Thank you, Minister.

Now, I said we would go to a break. Mr. Mason has requested we go to his 20 minutes right away. Are there any objections to

that? All right. In that case, we'll just carry on for the next 20 minutes.

Mr. Mason.

Mr. Mason: Thank you very much.

The Chair: For complete clarity, do you want to go back and forth, or do you want to go 10 and 10?

Mr. Mason: I want to go 10 and 10.

The Chair: You want to go 10 and 10? All right. There it is.

Mr. Mason: Is that okay?

Mr. Horne: Fine, Mr. Chair.

The Chair: All right.

Mr. Mason: Not that I would ask you any trick questions anyway.

First of all, in terms of long-term care we released an internal report about three years ago that indicated that the plan was to close long-term care beds or to shift the ratio of long-term care beds to other continuing care beds to reduce their percentage to about half of what it currently was. We've seen an ongoing process of the closure of long-term care beds, and at the same time new beds have been opened in continuing care. But there was a promise made in the election by your party to open a thousand new long-term care beds a year for five years. I'd like to know how that's going to be accommodated in this budget.

I'd also like to know – and maybe the minister wants to spend some time answering this question because this has puzzled me for a long time – how the continuing care strategy being followed by the government actually accommodates patients who require around-the-clock nursing care that would normally be medically assessed as requiring long-term care. That's something that I can't understand because it does seem to me that patients requiring long-term care cannot be accommodated without that level of care. I know the government talks about aging in place, and maybe that's something the minister can expand on.

I'd also like to know what the mix is of the beds that are being opened, whether they're operated in the public system by the health system or private.

I'd also like to ask the question about baths. I know this came up in the House in this last period of time, and the government announced that there was going to be a change in policy to allow more than one bath a week. I'd like to know if there's anything in this budget financially to support seniors' facilities to provide additional baths.

I'd like to also ask about the impacts of emergency room wait times, of a shortage of long-term care. We know that many doctors will place patients in acute-care beds if they require long-term care and can't get it. I'd like to know how many people are in acute-care beds in our hospitals because they can't get long-term care beds? I'd like to know the impact that that has on the ability to move patients out of ERs once they've been stabilized.

I recall that Chris Eagle, when he was appointed to replace Dr. Duckett in Alberta Health Services, talked about new targets for emergency room wait times. I'd like to know what the wait times are, if they're meeting the targets, and particularly in the major centres, Edmonton and Calgary, what the average wait time is as well as the mode and the range of wait times and how often wait times exceed the targets.

I'd also like to ask about what steps are being taken to allow ambulance attendants, paramedics and so on, who bring patients to emergency rooms to leave and get back on the road. I know that there are lots and lots of ambulance attendants that are tied up in emergency rooms because they have to wait until their patients are admitted before they can get back on the road and the impact that that has on wait times for ambulances. I'd also like the minister to talk about the situation with respect to ambulance response times in different parts of the province and what the government is doing to try and reduce those.

I'd also like to know how many people who require mental health care beds are occupying acute-care beds in our hospitals.

I'd like to know the figure for the hiring of additional nurses in the budget. I know that Stephen Lockwood in November of 2012 said that the government wanted to hire 750 registered nurses. He said, quote: there will be a nursing job for absolutely every qualified nurse who wants to work with Alberta Health Services; in short, we need everyone. I'd like to know what's in the budget to hire additional nurses and where we are with respect to making sure we have enough nurses in our system.

Now, a number of years ago – I believe it was when Iris Evans was the minister – the province worked with the health regions to experiment with new centralized waiting lists. I believe that it was for hip and knee surgery. It was dramatically successful in reducing wait times. I think it was reduced to about 1 per cent of what it had previously been. I'd like to know the status of centralized waiting lists in our system and whether or not that system has been extended to other surgeries and other wait times within the health system.

The Auditor General in July of 2012 indicated that no study of the effectiveness of primary care networks had been done up to that point even though they had been in existence for seven years at that time. I'd like to know what the government is doing to assess the effectiveness of primary care networks and whether or not the arrangement made or the memorandum of understanding that's been signed with the Alberta Medical Association addresses the question and whether or not the Alberta Medical Association has any authority under that deal to block an effective assessment of the effectiveness of primary care networks.

At the same time, your party promised in the election 140 family care clinics. I'd like to know how many of those are funded in this budget and whether the government intends within the current term of the government to fulfill the promise of 140 family care clinics. If that happens, I'd really like to know what happens to the investment that the government has made in primary care networks and whether or not the minister thinks that the two complement each other, overlap, or compete in the relationship between primary care networks and family care clinics.

8:50

I'd also like to ask a little bit about generic drugs. How will the government assess whether or not by lowering the generic drug price for specific drugs, they may simply be withdrawn by the drug companies? How will you monitor that? The suggestion was made to me the last time the generic drug prices were lowered that in some cases some generic drugs were being withdrawn from the market and that that would then require people to buy brand-name equivalents. How do you deal with that, and how do you monitor that to make sure that the impact of your program doesn't have unintended consequences or negative consequences? Certainly, we support the move towards lower drug pricing, but I'm worried about how that impacts both the pharmacists and the decisions of drug companies as a whole.

I want to ask about how many people, seniors, will no longer be receiving drug coverage as a result of the new drug plan that's been put forward. Have you made specific estimates of the

number of people who will no longer qualify for drug coverage? I know that the pharmacare plan that the government has brought into place . . . [Mr. Mason's speaking time expired] Okay. That's fine.

The Chair: The next 10 are yours for a response, Minister.

Mr. Horne: Okay. Thank you, Mr. Chair. Thank you, Mr. Mason, for the questions. I'll do my best to get through as many as I can here. He asked about shifting the ratio of long-term care beds to supportive living beds. I know we've talked about this whole issue in the House on several occasions. I know about Mr. Mason's concern that everyone who requires long-term care is able to receive long-term care.

In terms of the beds that have been added, in 2012 there were a net 4,427 new spaces in total that were added. That's comprised of 1,400 – I'm sorry; let me just go back here. The status at the end of 2012 was 14,614 long-term care beds across the province. We are estimating that to increase next year. We are expecting the numbers of supportive living beds to increase, the number of home care clients to increase. We are going to be adding across the system not beds but spaces that have been allocated that can serve a variety of needs for people to receive the care that they're assessed as requiring.

Now, I mentioned, I think in the House, the other day that of the current number of Albertans that are waiting for placement in continuing care, only 15 per cent are actually assessed as requiring long-term care, and we will certainly provide for all of their needs. The beds that we are building today in facilities that are funded through the affordable supportive living initiative and through other programs are all built to the B2 construction standard, which is the construction standard required for what we would traditionally call a nursing home.

When we commit to those sorts of standards, whether it's a public provider or a private provider or a not-for-profit provider, we provide the opportunity to do what Mr. Mason also asked about, and that's to allow the resident to age in place. As that individual's needs change over time, they don't have to move from the facility. The staffing mix in the facility does need to be adjusted to provide for the additional nursing component that is required for someone in long-term care, but that is the philosophy that is guiding our work in this area. It is much different from the traditional approach, which was to build blocks of beds in facilities that were dedicated to meeting only one level of care.

I want to take the opportunity to make a couple of other comments as well while we're talking about long-term care facilities. The public-private split at this point in Alberta is approximately 42 per cent public and 58 per cent private or not-for-profit providers, so there is close to a half-and-half split. Of course, as I think Mr. Mason is aware, the standards that apply to the provision of continuing care, both the accommodation standards and health care standards, are the same regardless of who the operator is and whether they're public, private, or not-for-profit. The inspection processes that Associate Minister VanderBurg was questioned about also equally apply regardless of who is operating the facility.

There are many levels of care in the system. I do believe that there is a need to take a look at these classifications of care to try to simplify the system so that Albertans and those of us that are trying to help parents or other loved ones make an informed choice have an easier road in terms of navigating that system. Being clear about the care that we're providing is absolutely critical to those decisions.

I want to go on here and talk about some of the other questions that were raised. The EMS response rates: I think response rates are on the Alberta Health Services website by community and by zone. One of the challenges, of course, in completing our work on making ground ambulance services a provincial service is finishing the consolidation of dispatches around the province for dispatches that are still municipally run or privately run. Once that process is complete, we will be able to not only have access to better data, but we will be better able to account for the response times because all of the data will be collected in one system and we'll be able to manage all of the ambulance fleet as one.

You also asked about emergency department wait times. I think I said in an answer to an earlier question that our performance on the indicators that we have has held relatively constant, but we have seen in the last year about a 5 per cent increase in the number of visits to emergency departments across the province. This has to do with a number of factors. It's not a simple answer. Part of it has to do with lack of access to primary care, family doctors and others. Part of it has to do, I think, with access to mental health and addiction services, and we talked about that.

You also asked about the number of people waiting in alternative level of care beds; in other words, waiting in an acute-care bed for placement to a continuing care facility. The number of people waiting at the end of the third quarter in 2012-13 was 436, and those are people waiting in acute or subacute care for a continuing care bed. I think that in some of the responses that I gave earlier, I noted as well that the percentage of people placed into continuing care within 30 days of being assessed has increased from 62 to 67 per cent. Admittedly, we still have a challenge, as you'll see across the country, with people waiting in hospital, but the time that people are waiting is decreasing. We're on track to meet our commitment of 5,300 additional spaces in five years. Continuing to meet that commitment will help to further bring that number down.

There are a number of other areas that were raised here as well that I want to try to speak to. You asked about the role of paramedics in the health system. I'm very interested in the opportunities to expand the role of paramedics. We do have procedures in place now in Alberta that allow EMS workers, including paramedics, to hand off the care of a patient in an emergency department waiting room to another crew that is there. I know that that opportunity is taken advantage of on a regular basis. I saw it myself on the ambulance ride-along that I did. I also think that there are roles that paramedics can play elsewhere in the health system that we need to take advantage of.

When I visit hospitals in the north, for example, I very often find busy emergency departments staffed in part by paramedics who are not needed on the road at a particular point in time. I think there are opportunities for paramedics to support primary care, to support continuing care and other areas. We're going to work with that profession to see what additional opportunities we can take advantage of.

9:00

You also asked about central booking for, in particular, high-demand elective procedures. You're correct. The move to central intake for hip and knee surgery did make a dent in the waiting times in Alberta. It was an important contributor. We are looking right now at similar approaches to cataracts and to other elective surgeries. What I find when I talk to my constituents – and I think this is true for most people – is that they are less concerned with who the specific surgeon is, obviously assuming that the individual is appropriately qualified and supervised. They are less concerned with the individual performing the surgery than they are their place in the line and the rationale for why they are at that place in the line.

We're working with physicians now to look at how we might further centralize that intake process. One opportunity that we're exploring is within primary health care, so PCNs and FCCs potentially having the opportunity to have dedicated blocks of specialist time available to the patients that they are serving. Those groups of patients are often referred to as panels. A team looks after a panel of patients in a given PCN. So there's an opportunity there to do some better linkages when people need specialized care right from the primary health care level. That's one of the things that we're working with the AMA and others on.

You asked about FCCs and the relationship with PCNs. I'm really happy to tell you that we've had some tremendous support from the Primary Care Alliance, which is a committee of the Alberta Medical Association, to help us plan the standards for all of primary health care. This also goes to your question about the Auditor General's report. I think one of the reasons that we have not provided the level of accountability that the Auditor General demanded is because until recently we have lacked the performance measures and we've lacked the tracking system to compare how a patient's experience is in the southern part of Alberta with the northern part of Alberta or any other part of Alberta. That is going to come with increased standardization in our approach to primary care.

This work that I referred to involves defining the core services that need to be offered in a primary care setting. It doesn't matter whether it's an FCC or a PCN.

The Chair: Thank you, Minister and Mr. Mason.

We will take a six-minute break. Try and be back in here by 9:10, please. Thank you.

[The committee adjourned from 9:03 p.m. to 9:11 p.m.]

The Chair: All right. We're going to call the meeting back to order.

For the next 20 minutes we're going to have private members of the government caucus and the minister speak. Mrs. Jablonski, your preference? Back and forth?

Mrs. Jablonski: My preference is to go the full 10 minutes, please.

The Chair: All right. Very good. Then we will go with the full 10.

Mrs. Jablonski: And I expect all my questions to be answered.

The Chair: Are you ready, Mr. Minister? All right.

Please proceed.

Mrs. Jablonski: Mr. Minister, as we all know, health is the number one priority for all Albertans, and Albertans expect the best health care available. One of our very important demographics in Alberta and indeed all of Canada is seniors, who are very concerned about their health and seniors' benefits. I know that it's a priority for our government to protect and promote the safety and well-being of Alberta's growing seniors population. Most of my questions will be based on seniors and a few on youth.

With a population of 447,000 seniors in Alberta now and a hundred more each day as each day a hundred people are turning age 65, we can expect that the number of Alberta seniors will double by 2029. We also know that by 2030 more than 1 out of every 6 Albertans will be a senior, and by 2033 there will be more than 1 million seniors in Alberta.

Minister, I want to know if we are prepared to protect and promote the safety and well-being of our seniors population and what you have placed in your budget to address these concerns. My questions will be primarily about seniors.

Home care, for example. I believe that our home-care needs are increasing daily as the population of seniors is increasing. On page 117 of the budget, under enhanced home care and rehabilitation, line 13, I see a decrease in the budget numbers for home care and rehabilitation from $34,400,000, to $29,540,000. I don't understand why we would be decreasing the budget for home care, so I'd like you to explain that, please.

Seniors' dental and optical assistance: I want to know if there are any changes in this program and, if there are, what those changes are. I see that you are going from $110 million up to 115 and a half million dollars, so that's good.

The aids to daily living program: I think that the majority of that program is used by seniors. On line 8.8 we are increasing from $126 million to $131 million, approximately. I want to know how you projected that and if that's sufficient. If you have changes to the aids to daily living program, are all Albertans eligible for aids to daily living, or will there be income testing or whatever for that program?

The changes to our property tax programs, which include the education property tax assistance program and the new seniors' property tax deferral program. In the education property tax assistance program we're going from $20 million to 7 and a half million dollars on page 118, line 15.5. I think I did hear you mention in your opening comments that we are moving out of that program, and that probably explains why there is a change. Tell me why there is a change. What have you done to change it from $20 million to about 7 and a half million dollars this year before you completely eliminate the program next year?

Then we have the new seniors' property tax deferral program, and you talked about a low interest rate. You've shown that it's going to cost $3 million for that program. I'd like to know what that interest rate is going to be because that should determine how much it's going to cost you to run the program. The interest rate will determine whether or not it can pay for itself and how much it's going to cost to run that program.

You mentioned in your opening comments that there is elimination of three exemptions: the WCB exemption, alimony, and CPP disability. I want to know: how much is that going to save, and how many seniors will this affect? I believe those are exemptions that we use for the seniors' benefit programs. I want to know how you determine who receives these programs.

The Alberta seniors' benefit program is an income supplement in addition to federal income sources, including old age security and the guaranteed income supplement. Assistance is based on income, and the program provides a monthly benefit to eligible seniors. I want to know how you determine who receives these benefits. What are the income levels where a single senior can qualify or a couple can qualify? Have you included enough of an increase to cover these types of benefits because of the growth in the seniors population? For couples who are involuntarily separated for health reasons – for example, one living in continuing care and one remaining in their home – we know that creates an additional accommodation cost. Under these difficult circumstances how do we calculate the benefit for seniors? Do we treat them or assess them as single seniors, or do we include them as a couple? Those benefits are different.

Can you tell me how the education property tax assistance program for seniors was calculated and is now going to be calculated in this year? In your opening comments you also mentioned that you plan to reduce and then eliminate that program.

I want to know also: are you implementing any changes to the special-needs assistance for seniors program? Does your budget recognize the increases in the population that we're facing?

How much is the new seniors' property tax deferral plan going to cost? I did ask you that, and that's why I wanted to know what the low interest rate was going to be.

Have you implemented income thresholds for the aids to daily living program and provided for the increasing numbers of seniors who require the supports of this program? How is that program assessed? Does every Albertan have access to the aids to daily living program? Have we changed how we qualify people?

On page 116, line 8.4, we show a reduction in the seniors' drug benefits from $532 million to $472 million. Right now seniors are required to pay I think it's 30 per cent of the cost of a prescription to a maximum of $25. How is this changing under the new pharmacare program, and what can a senior now expect to pay for a prescription? Does that make up the difference between $532 million from last year and this year's $472 million? I'm assuming it does.

Last but not least, I'd like to ask about the affordable supportive housing for seniors and people with disabilities. I know that since 2010 we've opened 2,600 affordable supportive living spaces. How many are presently funded and being built as we speak? How many will we fund this year? How much is in your budget for these new spaces?

I didn't see it – maybe I didn't look carefully enough – but it's in your goals that you will implement addressing elder abuse in Alberta. I want to know what we have in the budget for that program.

Also, there's a falls program. I'm not sure if we still do anything with the falls program. We know that 80 per cent of all seniors who have a fall begin the deterioration towards the last stages of living, so the falls program is an important program.

9:20

Last but not least, I'm wondering about the PCHAD program, which is the protection of children abusing drugs program. I wonder if you know how many youth have been through that program and how many youth have been through the program successfully. I think successful means that they have agreed to go into rehabilitation from that first-stage program. I want to know if you have increased or decreased the number of spaces in this program.

Minister, I don't know that I've used up all my 10 minutes, but those are pretty important questions for me and for the seniors that I serve, and I'd appreciate your answers.

The Chair: You used up about nine of them.

Minister, whenever you and your staff or associates are ready.

Mr. Horne: Thank you, Mr. Chair, and thank you, Mrs. Jablonski, for the questions. I'm going to answer three things here that you raised, and then I'm going to ask Associate Minister VanderBurg to speak to the other items.

First of all, in the line with respect to enhanced home care and rehabilitation there are no negative consequences expected as a result of the decline there. We have surplus funds from the previous year that will continue to support the program. I just want to make the distinction that these were enhanced initiatives for home care. In previous years this money was used to fund pilot projects for new initiatives, new approaches to delivering home care.

The primary funding for home care is contained within the Alberta Health Services budget. It was well over half a billion dollars last year in total, and it's very much a growing area of the Health budget. The projections that I have from AHS indicate that they expect to take on at least 3,000 additional home-care clients next year, so there's no question that home care is expanding.

You know, as you rightly point out – we'll see if we can get the information about the falls program for you – the role of home care in actually reaching out to seniors in the community who are at risk and preventing unnecessary visits to an emergency department or perhaps preventing an unnecessary admission to hospital or a continuing care facility is a really, really important function of the home-care program in addition to the health care that is provided. I see it as an area of the AHS budget that will continue to expand.

You also asked about the aids to daily living program. The increase there is 3.9 per cent, and that's the projected increase in utilization for aids to daily living over the next year. That's consistent with our previous experience. The AADL program is universal. In other words, it is not tied to income. The only change that's been made in that program this year is that the responsibility for administering the respiratory care that's provided under AADL is being transferred from my department to Alberta Health Services. We've done that in full consultation with respiratory technologists and seniors and other stakeholders.

The elder abuse strategy is captured in the seniors' services budget, and my colleague will speak more to that. We have made no changes.

We have no changes planned for the special-needs assistance program for seniors. As you know, the dental and the optical assistance that's provided under that program is very important as well.

I just wanted to talk a bit as well about the seniors' drug benefits. The reduction in cost that's projected in the budget is a function of the planned reduction in the generic prices that Alberta will pay for all of our programs. I didn't mention this earlier, but we, in fact, have 18 individual drug benefit programs across government, so the creation of pharmacare will involve the consolidation of 18 different programs. They all have different drug benefit lists, different eligibility requirements, so we will no longer have a situation in Alberta where your eligibility is determined by your age or by where you live geographically in the province. It will be determined on your medical need and your ability to contribute financially.

The intention of pharmacare is not to limit the access to drug programs for seniors or any other group. This was a question that Mr. Mason asked earlier. It's actually to make it possible for us to provide drug coverage to everyone. About 20 per cent of Albertans currently have no drug coverage, so the number of people who are served will increase. It will not decrease as a result of these changes. As I said, that reduction is a result of our policy decision to reduce the price we pay for generic drugs.

Similar savings are accruing across the government in other ministries. Human Services provides a number of drug programs as well. Of course, that makes it possible not only to provide lower prices to taxpayers and employers and people who pay out of pocket, but being a discerning purchaser when it comes to drugs is also what makes it possible for us to extend coverage to a greater number of Albertans who would otherwise not have that coverage.

I think I will stop there. You asked some questions with respect to the seniors' property tax deferral program, the seniors' education property tax benefit, and some other questions related to seniors' benefits, so I'll ask Associate Minister VanderBurg to address those, and we'll come back to PCHAD.

Mr. VanderBurg: Thank you, Minister. Mr. Chair, the questions on the Alberta seniors' benefit program are probably the ones that I get most. The impact of this budget will remove some existing seniors from the program by harmonizing our seniors' benefit

program with the federal program – the benefit program is there to supplement the federal program – workers' compensation benefits, alimony payments, and Canada pension disability payments. Seniors now need to reside in Canada for 10 years to be able to qualify for this program.

Approximately 6,000 seniors will be impacted by the three exemptions, and another 3,500 seniors will be impacted by the residency clause. On the three exemptions it averages to about a $75 cash payment a month that it makes a difference to the senior. In some cases that will create some hardship. But to supplement the federal program, we need to harmonize our rules. That was the intention of the change. Again, for the 3,500 seniors that will no longer qualify for the cash benefit that have not resided in Canada for the last 10 years, that will impact their budgets by about $95 on average per person. There are some seniors that will be impacted.

You asked about the seniors' benefit program and the qualifications. In general, a senior that's single with an annual income of $25,100 or less will qualify, and a senior couple with an annual income of $40,800 or less is eligible for the benefit.

Again, you mentioned the issue of involuntary separation. We in the province don't use the term "involuntary separation" as defined by the federal government. When a couple is separated because of an issue where one needs to move into a care facility and the other would like to stay at home, we add their incomes together and divide them in half so that they get the greatest maximum benefit given to them. It's worked well. All that's required is a simple phone call to the benefit line. We deal with this on a pretty regular basis. It happens. It's unfortunate that it happens. That's part of the reason and part of the answer that I have in my next set of questions, where you asked about the continuing care model and if we're meeting our targets.

In the province right now we have close to 22,000 spaces that are funded. Each year we're trying to meet a goal of a thousand new units per year, and we're meeting or exceeding that goal. In every one of our projects – and the minister talked about this – the B2 standard is required, but operators are also required in all of our new locations to find places and build accommodations for couples. That's so important because we've had too many of our senior couples that have been separated because of lack of space. We're making sure that while we build, we consider the opportunities for couples.

9:30

You asked about where these spaces are going to built. The goal over the next year to 24 months is to open 651 new spaces that we've provided funding for, and they include in the next year Bashaw, 63 units; Calgary Covenant care, 100 units; Calgary Golden Life, 110 units; Calgary Shalem Society, 43 units; Edmonton housing ventures, 42 units; Grimshaw, 68 units; High River, 108 units; Medicine Hat, 10 units; Medicine Hat Park Place, 80 units; Olds Vantage West, 60 units; Peace River, 42 units; Red Deer, 100 units; Stettler, 88 units; Strathmore 100 units; Sturgeon County, 12 units. That's a thousand spaces in the next year that we're going to not just turn the sod on, but we're going to open for seniors. When the minister talks about seniors waiting for spaces, they're being built.

The Chair: All right. Thank you.

Mrs. Jablonski, you've got about another minute if you've got another question.

Mrs. Jablonski: One more minute? Okay. Minister, you said you'd help me with PCHAD.

Mr. Horne: I'm sorry. I don't have the numbers here from last year for clients in protection of children abusing drugs, but we will get that information for you.

Mrs. Jablonski: Thank you very much.

Mr. VanderBurg: So does that mean I get to fill that extra minute?

You asked about the rate on the seniors' property tax deferral. It'll be set at prime.

Mrs. Jablonski: Minister, do you know if we've increased or decreased the beds in PCHAD, or do you have to find that out, too?

Mr. Horne: What we have done is that we've increased the number of days from five to 10 that a child or a youth can access the program. There are a total of 21 beds in Alberta under the program. The number of spaces is 21, but the number of days that someone can stay in one of those spaces has increased.

Mrs. Jablonski: Thank you very much.

The Chair: Okay. So now we're on to the portion where we're at 10 minutes for questions and answers, or it can be blocks of five and five.

First up would be Mrs. Towle. Back and forth or five and five?

Mrs. Towle: I would appreciate the opportunity for back and forth, but I'll go with what the minister would like.

Mr. Horne: That's fine.

The Chair: All right. We're agreed. Back and forth it is.

Mrs. Towle: Thank you very much, Minister. I appreciate the opportunity to engage in a conversation with you, and I appreciate having the opportunity to learn some of the things that we maybe don't have clarification on.

I'd like to go back to your discussion with regard to the seniors' advocate, the health charter, and the health act. I wasn't here before, but I heard from my colleague from Calgary-Fish Creek. She insinuated that your passion at the time in passing that act was really quite noticeable. I've had the benefit of going back and taking a look at some of the things that you had said at that time in promoting that act, and I can tell you that I share it with you. I think it would probably be something that would be very good to bring forward. You indicated that the Alberta Health Act had to be debated in the House for more consultation, but that was two and a half years ago. The hon. member asked you, you know: how long does it take?

One of the things that I note is that in a report called A Foundation for Alberta's Health System, dated 2010, you did a survey and provided a very comprehensive report on the act, in which you actually spoke with nurses, health care providers, health care administrators, physicians, and pharmacists for a total of just under 3,200 people. I'm just wondering exactly how much consultation comes into that.

I'm just wondering: what is the process now to move this forward? You've done this report, you're clearly passionate about it, and the consultation happened two and a half years ago. Is there something legislatively that you need to do, or is it a funding issue? What kind of consultation are you looking for?

Mr. Horne: I'm happy to answer that, and I appreciate your interest in the Alberta Health Act. The report that you referred to

was prepared before I became the minister. It was prepared by a committee called the Minister's Advisory Committee on Health, which I co-chaired.

The purpose of the Alberta Health Act was to set out principles-based legislation that would guide decision-making in the health care system. I'll talk about the two features that you've queried me about, but you'll see in the opening of the act that it sets out a series of guiding principles for the health system. It talks about a process involving consultation with the public that would apply to changes to existing regulations. There are about 30 statutes. Well, there would be more now with Seniors included, but at that time 30 statutes were in the Health portfolio and over a hundred different regulations.

A feature of the act, as you said, was the proposal for the establishment of a health advocate and a health charter for Alberta. The charter is not a rights-based charter. The charter is intended to set out expectations for Albertans from the health system, talk about roles and responsibilities of government and the health authority and providers and citizens, most importantly, in the health system. The health advocate is envisioned in the act as providing a navigational role for Albertans, assisting them with having their concerns addressed. It's not an adjudicative role; it's a navigation role, as I said earlier. The government at the time that the act was passed committed to – and that was also recommended by the report that you have in front of you – further consultation on the content of the charter and also the role of the health advocate.

That is where we stand today. It, of course, will be a decision of the cabinet as to when the act is proclaimed. But we would need a regulation both on the health advocate and the health charter, and that act commits to a process of consultation to do those two things.

Those are important issues in the province. They are not directly related to things like waiting times and direct patient care and other things that you and I debate in the House during question period. But I certainly do feel that it's still a very valid piece of legislation, that it has a role in the health system in terms of guiding decision-making in the future and making the most of the financial resources that we have in the system. So I'm sure that at the appropriate time as a government we'll make the decision to proceed with finalizing all of that.

Mrs. Towle: Thank you for that.

Along that line, I believe it was you who said – and if I'm wrong, please feel free to correct me – that you felt that there was good value and that for seniors and those who were navigating the health care system, you know, that would be sort of one of the things they could help with. I appreciate that as somebody that's been in the health care system as a worker and, unfortunately, on the other side of it. It is difficult to navigate.

I'm a little bit perplexed by one of the things that you said. Clearly, I understand what you're saying, that you needed to go back for consultation. This very clear document talks about the need for consultation. But one of the things I'm wondering, then, is about when the Associate Minister of Seniors in budget estimates last year, on February 21, 2012, clearly stated that he had set aside in his budget a half a million dollars for the implementation of a seniors' advocate. I quote from *Hansard*. He said, "It's going to take me some months to roll this out, knowing some of the work that I've done finding out where seniors need help and what kind of help they're looking for."

I would also draw your attention to that in the Premier's own campaign platform she said that she'll be collaborating with Health, and "we will establish a targeted seniors' advocacy component with the Office of the Health Advocate."

Then if you go page 116, it goes even further in that there's a line item budgeted of $350,000. So I'm wondering: if all this consultation is required and if everyone knew that legislation needed to be changed and regulations needed to be changed, why would the Premier or the associate minister or anyone, you know, tell Albertans they were going to enact it if clearly they couldn't do so since after two and half years there's a lot of consultation still needed?

9:40

I would also even go so far as to ask you: where did that $350,000 go? What was it spent on? The line item is dedicated to a health advocate office. The Premier made a promise for a health advocate office. In that health advocate office there's supposed to be a health advocate and a seniors' advocate. But if what you're conversing with me right now is accurate, it would seem that none of that could have happened regardless without this consultation and changes to the regulations. I'm just curious as to how these promises could have been made if they never were even possible.

Mr. Horne: Well, first of all, the funding commitment is still in the budget. The $350,000 for the advocate is still protected. Just to go back with a bit of history, the commitment to the seniors' advocate was actually not part of that document and was not part of the Alberta Health Act. It was a commitment that was made and that we will fulfill for a seniors' advocate subsequent to the passage of the Alberta Health Act.

One of the options would be to establish the seniors' advocate as part of the health advocate's office. One of the questions that we have to answer – and this is something that the Associate Minister of Seniors is working on – is whether that is going to be an effective tool from the perspective of seniors with respect to helping them navigate the system, the processing of complaints, and so on. They were never originally envisioned to be one and the same thing. The commitment to the seniors' advocate is still there. I think there are some legitimate questions and consultation to be had about exactly what form the seniors' advocate role needs to take in order to be effective, but the commitment on that score hasn't changed.

Mrs. Towle: Just to clarify, are you saying that $350,000 from this year's budget is actually protected and that that's what's making up the increase to $700,000, or is that $350,000 gone and spent and then you're adding $700,000 to the 2013-2014 estimates?

Mr. Horne: If I'm reading in the same place as you . . .

Mrs. Towle: I'm on page 116, item 1.9, under operational expense.

Mr. Horne: The budget for 2012-13 was $700,000. We didn't spend all of that money, obviously. The forecast for 2012-13 is $350,000. You'll see in the estimate for 2013-14, over to the right, that that's back up to $700,000. As I said, the funding is still there, and it's protected.

Mrs. Towle: Right. But you spent $350,000. So that's what I'm wondering. The original budget was $700,000. The forecast was $350,000. It's back up to $700,000. Where did that difference go?

Mr. Horne: The forecast is less than the budgeted amount, as you'll see. The forecast of what we're going to spend at the end of the fiscal year that just ended is forecasted to be half of the original budget. Obviously, we have not yet implemented either the health advocate or the seniors' advocate. But you'll see in the

estimate for the upcoming fiscal year that it's back up to $700,000. So the funding is still there, and it's protected.

Mrs. Towle: Thank you.

The Chair: All right. Thank you, Minister.

We'll go to Mr. Fraser, followed by Dr. Swann. That will do it for tonight. Mr. Fraser, back and forth or five and five?

Mr. Fraser: Back and forth. Whatever the minister is comfortable with, I guess.

Mr. Horne: Sure.

The Chair: Very good. Whenever you're ready.

Mr. Fraser: Thank you, Minister. I have a couple of questions about emergency medical services in the province. I know that, you know, the transition and merging of that service to make, I guess, one complete service throughout the province has come with challenges, but it has also come with some new costs.

I'm just wondering. I'll ask a few questions here. Merging some of the technology, I know that just recently some of the technology between some of the IV pumps, moving from the old Baxter to the new ones – and forgive me, Minister, I forget the names. Clearly, having taken that training will enhance patient safety. What's the initiative around emergency medical services to enhance that type of technology throughout the province, which not only addresses, obviously, better practices on the ambulance in terms of transferring patients, you know, into new facilities? I know that the South Health Campus has all of that new technology, but are we looking to do that throughout the entire province with EMS equipment as a whole?

Mr. Horne: Well, I'll answer the question as best I can. We might need to get you some additional information, or it might be more appropriate to ask AHS, you know, on the technical side. The objective is always, you know, to provide the best possible equipment that we can for the provision of emergency medical services. This is one of the things we'll be looking at in the implementation plan that AHS has developed. The intention is that we make those investments in order to get the best value from them, to make sure that they're used appropriately in complex situations dealing with patients. I'm sorry; I can't answer your question about IV pumps. I'm not exactly sure what you're talking about there.

Obviously, we do have gradations of the level of training of EMS professionals. We have our most highly trained advanced care paramedics, and we have other emergency medical services workers. We need to continue to make investment in new technology that allows people to practise at the level of training that they've received in order to meet the particular needs of patients in any given emergency situation.

This matching of resources and technology with service delivery is really what we are looking to AHS to provide in their implementation plan coming out of the Health Quality Council of Alberta report. I think the report recognized that one of the advantages of having a provincial EMS system was the opportunity to move those resources around and deploy them strategically where they're needed at different points in time and in different geographical areas of the province. We can only do that when we truly operate EMS as a single system. I think the question that you're asking will in fact be answered by the implementation of the Health Quality Council's recommendations.

On the technical part, again, I'm sorry. We'd have to get that information for you.

Mr. Fraser: Thank you. In part that answers my question. There is an investment, I guess, in more efficient equipment.

Pertaining to my constituents in Calgary-South East as the community and as the province continues to grow and as we expect a hundred thousand people kind of on a yearly average – and we've had that conversation – in this budget is your ministry looking at more resources particularly around emergency medical services to be deployed throughout the province? Is that part of this budget?

Mr. Horne: Alberta Health Services' budget will provide for emergency medical service needs in the province. That would be funded as part of the grants that we provide to Alberta Health Services.

I think you make a valid point. We grew by 100,000 people last year. Obviously, the need is going to increase, and we have added capacity to the system both in terms of units and personnel. Again, one of the things we'll be looking for in the AHS implementation plan is: what is the growth plan to meet the capacity that's required across the province?

One of the issues that I asked AHS to look at in addition to how they're going to implement their recommendations is the issue of interfacility transfer for nonemergent patients. We all know from statistics that we see and quote as MLAs that there is a very high percentage of EMS services that are delivered simply for the purpose of moving a patient for an X-ray or for a test, sometimes from a continuing care facility and sometimes from home.

Again, to go back to your original point, we need to make sure that we're matching the use of our most highly trained personnel and our most technologically advanced equipment with appropriate uses for that level of service. I've asked them as part of their implementation plan to look at other options within the system using other resources for those interfacility transfers.

Mr. Fraser: Thank you, Minister.

That kind of segues well into my last question. I have to commend you and certainly AHS around the usage of advanced care paramedics, particularly in the South Health Campus, and certainly the community care paramedics that are being deployed to work specifically with geriatric patients to try to get the treatment they need on site. Can you kind of give me an idea? Are we gauging any kind of cost savings for Alberta taxpayers around some of those initiatives? Are we going to be leaning to more of that type of thing in the future to try to save money and make a more efficient system?

9:50

Mr. Horne: Well, I think, you know, there may be some cost savings involved, and I don't think we've really quantified what those are yet. That would be one benefit of making better use of our emergency medical services personnel generally throughout the health system, but of course the other opportunity is to provide more access to services and to provide a higher quality of care.

We've begun to work with paramedics in particular to look at scope of practice for that area. You know, in some of the other debates we've had in question period one of the things that at least I've talked about is not just looking to enable health professionals to practise to their full scope of training and expertise but to allow them to practise at the top of their scope; in other words, to use the most advanced skills that they learned in their training in the delivery of patient services. I think there's a lot more room to do that with paramedics.

I know that there's interest in the profession across the province and moving into the areas that you mentioned, community care,

and there are other opportunities as well. We want to work with paramedics as a profession to develop that in the same way that we worked with pharmacists to develop the new services that they're offering and with nurses and other professions as well.

Mr. Fraser: Thank you. That's all.

The Chair: All right. Very good.

We'll move on to Dr. Swann. Did you want to go five and five or back and forth?

Dr. Swann: Back and forth if the minister is comfortable.

To the minister of Wellness, again, since you are the Associate Minister of Wellness and prevention, do you think it'd be reasonable to evaluate your contribution to progress in your stint as associate minister in moving resources towards prevention? We have a pathetic 3 per cent of a $17 billion budget going to prevention. You are the prevention associate minister. Is it fair to evaluate you on the basis of how much we've moved those resources into prevention?

Mr. Rodney: Well, let's face it. We want to evaluate the program, the effectiveness for all Albertans. Some of the benchmarks that we use were mentioned in a couple of previous answers. In addition to what I've said in two previous answers, we also measure things like BMI, fruit and vegetable intake, alcohol use, activity level, perceived level of stress, and that's through the Canadian community health survey.

I hope that folks are aware that we're really leading the country. This Premier had the vision to put a special focus on wellness, and that just does not happen in other jurisdictions. It's health and wellness, it's not health with a special focus on wellness. Of course, we work together.

In conjunction with all the other ministries there are incredible gains. Name a ministry, and they're doing amazing things. I didn't mention earlier – perhaps it's the best time to mention it right now – that they are an integral part in the Alberta wellness strategy. Again, it's professionals from all over the province but also within ministries as well but not government-led.

When it comes to child and youth nutritional guidelines, as an example, we've got the most stringent in the country. That's one way to measure it. It's being adopted by jurisdictions across the country for best practices when they're developing their school food guidelines. So we're not only championing those for the country but evidence-based, healthy weight initiatives. Perhaps you've heard of MEND: Mind, Exercise, Nutrition, Do it.

Dr. Swann: Thanks very much, Mr. Minister. I'd like to go on to the cancer prevention legacy fund.

Mr. Rodney: But there's more good news, Doctor. Thanks for your interest. Go ahead.

Dr. Swann: I know there is.

The cancer prevention legacy fund is one that's somewhat related, $132 million transferred in former Premier Klein's name to Health. There's been a significant proposal related to chronic disease prevention, and it relates to what I was saying earlier. There's an opportunity to invest more, to show we really are committed to prevention by investing some of that money. Where is that money going, that $132 million that's transferred to Alberta Health?

Mr. Horne: I'd just ask for some assistance here from the officials in terms of the list of projects that have been funded. The money is provided in the form of grants to organizations to support cancer research and prevention. There's a $25 million a year allocation that's provided for that purpose. I'll stop here in a second so you can go on.

You know, I think one of the opportunities that we don't always acknowledge is the things that are done to support cancer prevention and wellness that are not on that particular line in our budget. I have to go back to what I said before. I think primary health care is going to be absolutely critical to the wellness agenda because it capitalizes on the contact between patients and families and communities and the team of health providers. That will perhaps not necessarily be as easy to measure in money, but it will be measurable in terms of health outcomes for the population.

Dr. Swann: Thank you very much.

Line item 11.4 talks about diagnostic and therapeutic services. It's certainly increasing. It raises the question about queue-jumping and MRIs. Are we ever going to address that question? People get into queues because they have a diagnosis. They get a diagnosis because they have an early test, an appropriately timed test. What's happening today is that people who have money get MRIs faster than people that don't and as a result get into the queue faster. Perhaps one of the most significant examples of queue-jumping in our society is people with money getting their MRIs ahead of those who don't and therefore getting into the surgical line or the treatment line. How are we going to create some equity there within the context of our principles of medicare?

Mr. Horne: Well, I'm really glad that you asked the question. I mean, the proliferation of private diagnostic imaging services across Canada is very significant over the last decade. As the minister I acknowledge the concern that you're raising. I think the issue actually has more to do with the lack of guidelines for the appropriate use of diagnostic imaging. As you would know as a physician, we have some of the highest rates of DI utilization in the country. Sometimes that occurs because we don't have a process whereby we make it easy for patients to receive the screening that's necessary prior to seeing the specialist and receiving the diagnosis.

We talked earlier with Mr. Mason about the central intake process for orthopaedic surgery in the province, and that was the result of the establishment of three central assessment units in Alberta where that entire process, using the best available evidence, was designed and was the same for all patients. We saw huge diversion rates out of that work for people who would normally have waited months or perhaps longer to see an orthopaedic surgeon who were taken out of the queue because the resources were organized so that they were identified as not needing that consultation.

I actually think that that principle needs to apply to other areas where we have high demand for elective procedures, and I actually think it's a question of using the resources we have more appropriately. The AMA in the MOU that they signed with the government has committed to work with us on that issue among others.

Dr. Swann: Thank you.

Over a number of years we've expended a tremendous number of dollars on electronic health records. When are we going to see province-wide electronic health records that are usable by all the caregivers, and how much are we going to pay for this?

Mr. Horne: Well, you're certainly correct in that we've invested a very significant amount – we quoted that in an earlier answer today, and we'll get that for you – in the development of electronic health records, as of March 31, 2012, $750 million. We

know that we're seeing increased users of Netcare outside of the hospital, and it's making it possible for them to view lab results and imaging and so on. I think where we have to work – and again, we addressed with this with the AMA in our MOU – is that we need a common electronic medical record across the province, particularly in community settings.

The AMA has committed to work with us toward that objective. In the past we've had a program called the physician office service program. It's still in effect. It made it possible for physicians to bring EMRs into their community setting. But there does need to be a higher level of standardization. Part of the challenge, I think, is that we've got a good provincial EHR, but the standardization around the information that we're collecting and how we make it easier for professionals working on a team to share that information is still very much an issue that needs to be addressed. It goes to quality and safety, as you would know. It also goes to our ability to do a better job of co-ordinating the care.

People talk about difficulty in navigating the system and finding their way and being left to find support services that they need on their own after an interaction with the health system. A more standardized, co-ordinated EMR can change that. With AHS involved, we have the opportunity now with a single health region to make that happen. We don't have to have seven different systems or 17 different systems anymore. We can have one. We're very much engaged in that work with AHS right now. We know we've got just under 3,300 physicians using an EMR in Alberta. We know physicians have provided the leadership. The uptake is there. Now we have to think hard about how we want to use this to improve patient care and the patient care experience.

10:00

Dr. Swann: The 3,300 physicians is just over a third of the physicians in the province. We've got a long way to go. What proportion of institutions are linked?

Mr. Horne: I'll just read you some statistics if I could, Dr. Swann. Just under 3,300 physicians are using EMRs. The adoption rate is 74 per cent. It is one of the highest rates in Canada. I'd agree with you that there's a ways to go. That includes just under 2,300 general practitioners and 996 specialists.

We're talking here about an electronic medical record that's used in the practice setting. Over and above that we have Netcare, the provincial electronic health record that allows for viewing of lab and DI images and so on.

Dr. Swann: Is that all of the public institutions that are connected to Netcare?

Mr. Horne: Yes. There are a total of 42,000 users today for Netcare across Alberta, so obviously many more professionals than just physicians are using the tool.

Dr. Swann: Very good. Thank you.

Items 11.2, 13, 15.3, and 15.4 all relate to home care or seniors' care. How do we separate home care from all of those different categories?

Thank you.

The Chair: I apologize for the interruption, but that does conclude our business for this evening.

I'd like to remind everybody that we're back here tomorrow, Wednesday, April 17, to continue consideration of the estimates of the Ministry of Health. Thank you.

The meeting is adjourned.

[The committee adjourned at 10:02 p.m.]

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