Legislative Assembly of Alberta

The 28th Legislature
First Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Wednesday, April 17, 2013
3:30 p.m.

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Standing Committee on Families and Communities

Quest, Dave, Strathcona-Sherwood Park (PC), Chair
Forsyth, Heather, Calgary-Fish Creek (W), Deputy Chair

Brown, Dr. Neil, QC, Calgary-Mackay-Nose Hill (PC)
Cusanelli, Christine, Calgary-Currie (PC)
DeLong, Alana, Calgary-Bow (PC)
Fraser, Rick, Calgary-South East (PC)
Fritz, Yvonne, Calgary-Cross (PC)
Goudreau, Hector G., Dunvegan-Central Peace-Notley (PC)
Jablonski, Mary Anne, Red Deer-North (PC)
Jansen, Sandra, Calgary-North West (PC)
Jeneroux, Matt, Edmonton-South West (PC)
Leskiw, Genia, Bonnyville-Cold Lake (PC)
Mason, Brian, Edmonton-Highlands-Norwood (ND)*
Notley, Rachel, Edmonton-Strathcona (ND)
Pedersen, Blake, Medicine Hat (W)
Swann, Dr. David, Calgary-Mountain View (AL)
Towle, Kerry, Innisfail-Sylvan Lake (W)
Webber, Len, Calgary-Foothills (PC)**
Wilson, Jeff, Calgary-Shaw (W)
Young, Steve, Edmonton-Riverview (PC)

* substitution for Rachel Notley
** substitution for Matt Jeneroux

Also in Attendance

Strankman, Rick, Drumheller-Stettler (W)

Support Staff

W.J. David McNeil	Clerk
Robert H. Reynolds, QC	Law Clerk/Director of Interparliamentary Relations
Shannon Dean	Senior Parliamentary Counsel/ Director of House Services
Philip Massolin	Manager of Research Services
Stephanie LeBlanc	Legal Research Officer
Sarah Leonard	Legal Research Officer
Nancy Zhang	Legislative Research Officer
Nancy Robert	Research Officer
Corinne Dacyshyn	Committee Clerk
Jody Rempel	Committee Clerk
Karen Sawchuk	Committee Clerk
Christopher Tyrell	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications and Broadcast Services
Jeanette Dotimas	Communications Consultant
Tracey Sales	Communications Consultant
Liz Sim	Managing Editor of *Alberta Hansard*

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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

3:30 p.m. Wednesday, April 17, 2013

[Mr. Quest in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: All right. Good afternoon, everybody. We'll call the meeting to order. Welcome. The committee has under consideration the estimates for the Ministry of Health for the fiscal year ending March 31, 2014.

I'll remind members that microphones are operated by *Hansard*, and if you could keep the BlackBerrys away from the mikes as they can cause some interference.

I'm going to go around the table for introductions, starting with Mr. Strankman on my right, who is not sitting in the capacity of deputy chair today because we didn't have quite enough notice period. Mrs. Forsyth will not be with us this afternoon, so he's going to help me out with the speakers list and so on.

Go ahead.

Mr. Strankman: Rick Strankman, Drumheller-Stettler.

Mr. Webber: Len Webber, Calgary-Foothills, sitting in for MLA Matt Jeneroux.

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

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

Ms Jansen: Sandra Jansen, Calgary-North West.

Ms DeLong: Alana DeLong, Calgary-Bow.

Ms Cusanelli: Christine Cusanelli, Calgary-Currie.

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

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

The Chair: Thanks, Minister. Also, could I get you to introduce your staff, including the staff behind. If you could just stand up so that we can put a face to the name again. There are a few different faces than were here last night. Also, any of the staff that are going to be responding to questions, if you come up to the podium from the back there, if you could please identify yourself for the record.

Minister, go ahead.

Mr. Horne: Thank you, Mr. Chair. I'm here today with several executives from my department: my deputy minister, Marcia Nelson; the chief delivery officer, Glenn Monteith; the chief strategy officer, Susan Williams; David Breakwell, assistant deputy minister, financial and corporate services; Chi Loo, assistant deputy minister of seniors' services and continuing care; Christine Couture, assistant deputy minister, strategic services; Susan Anderson, acting assistant deputy minister of health information and technology systems; Lorraine McKay, acting assistant deputy minister of health benefits and compliance; Line Porfon, who is the acting assistant deputy minister of primary health care; and Kathy Ness, who is the acting assistant deputy minister of family and population health.

I also have a number of members of my staff here, Mr. Chair: my chief of staff, Dr. Carol Anderson; Matthew Hebert, who is director of operations with my office; and Bart Johnson, press secretary in my office. I believe also Mr. John Sproule, who is director of stakeholder relations with the office of the minister, may be here.

Thank you.

The Chair: Thank you, Minister.

Mr. Rodney: Associate Minister of Wellness Dave Rodney reporting for duty, also MLA for Calgary-Lougheed. With me today is the chief of staff, Robert Whittaker.

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

Mr. Wilson: Jeff Wilson, Calgary-Shaw.

Mr. Pedersen: Blake Pedersen, Medicine Hat.

Ms Notley: Rachel Notley, Edmonton-Strathcona.

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

Mrs. Fritz: Yvonne Fritz, Calgary-Cross.

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

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

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

For the record I'd like to note that the Standing Committee on Families and Communities has already completed three hours of debate on the main estimates for the Ministry of Health. As we enter our fourth hour of debate, I'll remind everyone that the speaking rotation for these meetings is provided for in Standing Order 59.01(6). We're now at the point in the rotation where any member may be recognized to speak, and speaking times are limited to a maximum of five minutes.

Members have the option of combining their speaking time with the minister for a maximum of 10 minutes, and just to clarify, both the member and the minister have to agree to the back and forth; otherwise, it will be the five and five. Please remember to advise the chair at the beginning of your speech if you wish to combine your time.

Six hours have been scheduled to consider the estimates of the Ministry of Health. With the concurrence of the committee I will 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, of course, address the committee.

As noted in the Speaker's memorandum of March 22, I'd like to remind all members that during the main estimates consideration members have seating priority at all times. Should members arrive at the meeting and there are no seats available at the table, any staff seated must relinquish their seat to the member.

If debate is exhausted prior to the six hours, the ministry's estimates are deemed to be have been considered for the time allotted in the schedule, and we will adjourn; otherwise, we will adjourn at 6:30 p.m.

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

Any written material that should be 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.

With that, again, we're at the five and five. We'll pick up where we were last night. The next speaker I have in the rotation is Mr. Goudreau. Did you have a preference for back and forth?

Mr. Goudreau: Sure. Thank you, Mr. Chair. I can go back and forth if that's the wish. Is that okay with the minister?

Mr. Horne: Fine. Very good. Whenever you're ready.

Mr. Goudreau: Well, thank you. Minister, I've got four hospitals in my constituency, and they're quite a few miles apart, but in every hospital I've got what we call bed blockers, you know, patients that are in acute-care beds waiting for a placement in continuing care facilities. Certainly, they're in a lot more expensive acute-care beds, and they're not necessarily receiving the appropriate level of care. In other locations across the province as well there are backups in emergency. There are backups in the surgical areas because they can't get patients into an acute-care bed. In spite of all of this, on page 118 of the estimates you didn't spend anything on supporting the affordable supportive living grant in 2012-2013. Are there explanations for this?

Mr. Horne: Certainly. I will ask the Associate Minister of Seniors, Mr. VanderBurg, to supplement on this as well.

We issued our request for grants in the past year later than we originally anticipated, so the $25 million that was originally budgeted for 2012-13 was not needed. We have been able to move that funding into the current year. You'll see an allocation of $50 million in 2013-14 for the affordable supportive living initiative.

Mr. Goudreau makes some important points around the numbers of Albertans, seniors who are waiting in alternate level of care beds in hospitals for placement in continuing care. Year over year since last March the overall number of people waiting for placement in continuing care has improved. Not only has the number of people waiting gone down; 75 per cent of people are now placed within 30 days of being assessed in hospital. That's an improvement of over 10 per cent.

When we look across the province, we see 81 per cent in the south zone of the province being placed within the 30-day time frame. In central Alberta a bit more of a challenge, just under 50 per cent being placed within that time frame, but certainly an improvement over the previous year.

We recently issued a request for proposals under the ASLI program. I'll ask Associate Minister VanderBurg to talk about that.

Mr. VanderBurg: Well, thank you. You were right. We did not spend the allocated funds in the last budget. We did call for the proposals that ended February 22, and those proposals were in the communities of Boyle, Slave Lake, Valleyview, Rocky Mountain House, Sundre, Red Deer, and Calgary. While that work was done in the past year's budget, the allocation will be in the next number of weeks. You know, according to the accounting process, we will be spending that money. It's not that we'll be turning that money back. We'll be spending it.

The other point you raised. How do we provide those opportunities in the smaller communities where there's not always that 120-unit opportunity? We're testing that out in this round. In Boyle we're looking for opportunities for spaces for 22 units; in Valleyview, 23 units. These are small communities, like we're all aware of here, that represent rural constituencies. We all have small communities that require supportive living opportunities, so this will be tested in this past round, and I think that we have opportunities further that we need to explore with possibly group homes as well.

3:40

Mr. Goudreau: Well, thank you for that. There's no doubt that my constituency probably has the highest per capita of seniors anywhere in the province of Alberta, yet they are scattered over probably 35 or 40 different communities. The smaller community concept has always been an issue with my constituents because they could never get to the numbers deemed sufficient to build the facility. I think what you're saying and I'd be curious about pursuing the options of joining seniors' facilities with people that have disabilities, for instance, and those kinds of things to make it worthwhile for that.

Last night you talked to MLA Jablonski, I believe, about your commitments to meet the thousand continuing spaces per year. Are you on track for that?

Mr. VanderBurg: Yes, we are. I had the opportunity to read out a number of the spaces that we are going to be building in the next year. These are all funded spaces, and we have the same for the following year. We will continue at the rate of at least a thousand units, and I need to remind the members around the table that it's not always building existing units. I think we have the opportunity for a retrofit in some communities.

We hear from a lot of our foundations that home care is working well, and the average entry age is well in their late 80s. So Albertans are coming into our facilities with more chronic issues, and I have to commend AHS in these last couple of rounds of ASLI grants. With all those opportunities for ASLI grants for per-door funding comes a health contract as well. We have to continue to work with AHS to provide care at our facilities, and I think that model will serve us well in rural Alberta.

But like I've commented on earlier, the PDD community has really paved the way for seniors in the opportunities in group homes in smaller settings. I had the opportunity to work down in Medicine Hat with a private operator that has a group home out at his farm, just an absolutely great model of what we need to do around the province.

Mr. Goudreau: Thank you.

Just going back, then, or following up on page 117, the funding for enhanced home care and rehabilitation is reduced by almost $4 million. In light of our discussions here and the shortage of continuing care beds and home care service, why would you cut funding in such a high-needs area?

Mr. Horne: Well, thank you for the question on this particular line. As you said, the enhanced home care and rehabilitation line has funded new and innovative projects in continuing care over the last few years. We had a surplus in that fund in the last year. We'll continue to support new pilot projects, but as you pointed out, Mr. Goudreau, we do need to do more to increase the availability of home care. The main home-care budget is provided through the Alberta Health Services operating budget. We're spending in excess of $500 million a year on home care today. The projection for the next fiscal year is that at least 3,000 new home-care clients will be added.

To go back to your earlier point, part of what we can do to help in a constituency such as yours as is much as we can through the use of home care to defer the need for placement in a continuing care facility. A big part of improving continuing care in rural Alberta is increasing the access to home care as well for as long as possible.

Mr. Goudreau: Good. Thank you.
No further questions.

The Chair: All right. We will go to Ms Notley, followed by Ms Jansen.
Ms Notley, back and forth? Five and five?

Ms Notley: I'd prefer to go back and forth.

The Chair: Okay, Minister?
Very good. Whenever you're ready.

Ms Notley: I'd like to spend a bit of time talking about the seniors' pharmacare program. I know you've said in the House and you also said at the beginning of the estimates debate yesterday that you've not been able to come up with either the deductibles or the income cut-offs. But I have some concerns about this, so I have a few questions on that.

Before I get to that, my first question is this. This is my calculation, and tell me if I'm right or wrong because I might be wrong. It does happen. Your budget document suggested that there was going to be a savings to the government not this year but next of $180 million as a result of the change in the seniors' pharmacare, but you also said that the addition of access to pharmacare for low-income people who are not seniors, or who are under 65, would cost about $50 million. So am I correct, then, that the amount of money in total that will have left the seniors' pharmacare line item a year and a half from now or into the next year is actually $230 million?

Mr. Horne: No. I don't believe you're correct, but we'll just take a minute and try to get a bit more of the financial detail. Just to go back, again, to the intent of the program, which I think you understand, we are looking to consolidate all the drug programs across government. There are 18 of them. So we are not creating a special seniors' pharmacare program; we're consolidating all the programs into one.

Ms Notley: I understand that. Yeah.

Mr. Horne: The estimates for the savings are based on experience in other provinces, in B.C. and Saskatchewan in particular. It's not a question of being unable to determine what the deductibles and copayments would be, but we are taking the time to study very carefully the cumulative impact of pharmacare in consideration, at the same time, of other programs and services that are provided to seniors and other low-income Albertans.

Ms Notley: So my concern is this. First of all, I have to get this on the record because in question period you inferred that the B.C. program was an NDP program, and in fact it is not an NDP program. The B.C. program as it currently exists was introduced in 2002 by the then-Liberal/conservative government. It was changed from an NDP program that looked a lot more like the one we have currently in Alberta.

Anyway, that being said, I've looked at what the income cut-offs are and what the deductibles are in B.C., and those are quite concerning to me. Now, while you may not have the final numbers, because we're having to vote on this budget, we need to have some sense of where you think we're going. Do you think, you know, you're plus or minus 10 per cent of the B.C. numbers in terms of what the deductibles will be and what the income cut-offs will be? I mean, there must be some information in your ministry. I can't imagine that you would have chosen to take $180 million out of your ministry without having some understanding of how it was going to impact which seniors and how much it was going to cost them.

Mr. Horne: Well, we certainly did look at the B.C. program, and we looked at the one in Saskatchewan as well. The B.C. pharmacare program has a very user-friendly website, which I'm sure you're familiar with, that allows people in different situations to calculate what their deductible and copayment would be. We have actually more flexibility, I believe, in Alberta in making these determinations for a couple of reasons. One is, of course, that we have a lot of other programs that other provinces don't have to support seniors, and that needs to be taken into consideration when we're considering the situation of a senior who is able to contribute financially to a pharmacare program. There will of course be many that cannot.

But the other thing that has to be considered as part of this is our ability to deliver on a commitment to lower drug prices for Albertans. So, again, part of the calculation involves projecting the additional savings to government for government-sponsored drug programs as a result of moving to 18 per cent for generic drugs. We also have plans in co-operation with other provinces to pursue joint procurement for a number of brand name drugs.

Ms Notley: That's all good. But for seniors . . .

Mr. Horne: If I could just finish my answer.

Ms Notley: Sorry. Fair enough.

Mr. Horne: You know, I certainly understand your question is with respect to seniors. The thing about pharmacare, I guess, what's important to understand is that their eligibility is not determined by their age or by their geography; it's determined by their income.

3:50

Ms Notley: That's why income is so important, and this is why I'm trying to get you to give me a plus or minus, a ballpark figure. Do you think it will be within 10 per cent of the income cut-offs and the deductibles in B.C. if the generic price strategy that you're pursuing fails, and if it's successful, we'll be able to go 30 per cent more generous than B.C.? I mean, you must have some sense of what this is going to mean for people. I just think that you can't ask Albertans to look at a budget that takes $180 million out of the seniors' universal pharmacare program without giving them some sense as to whether they're going to have to start paying. There are a lot of very worried critically and chronically ill seniors out there who are wondering because under the B.C. pharmacare program somebody that earns $35,000 a year may now be asked to pay about $1,400 a year. That matters to people.

Mr. Horne: I'm going to make sure I get an opportunity just to correct a couple of things that you've said. First of all, the projected savings of $181 million are not just as a result of changes to the existing seniors' drug program. This is a result of the consolidation of all the programs across government.

You've obviously studied the program in B.C., so you should be aware that the income threshold levels in B.C. have not changed since 2003. Obviously, we want to do some further analysis first. We're designing a program for 2013.

I actually don't think it would be responsible to guess at where we might land. It's a fairly sophisticated level of policy analysis. We're not looking to duplicate a program in any other province in Canada. We're looking for a solution that works for Albertans.

Ms Notley: But you're taking the money out and moving forward on a strategy that apparently you are guessing at right now because you don't have the answers.

Mr. Horne: Yeah. You're operating under the assumption that we're taking money directly out of an existing program that's dedicated to seniors, and that's not the case. We're consolidating programs across government. The savings that will be achieved will be determined by, first of all, the drug prices that we pay; it will be determined by the actual number of the 20 per cent of Albertans who become eligible for pharmacare, who currently have no drug coverage in the province; and it will be determined by our analysis, as I said, of the other programs that exist across the country.

Ms Notley: But then it goes back to the original question. If you can look at the consolidation and you can look at the number of people that are coming in and you can look at all these things and you can predict a savings of $180 million, why can you not then talk about the income cut-offs? It seems to me you have the information necessary to predict the savings, and in so doing, you should have the information necessary to give us some idea of what the income cut-offs are going to be and what the deductibles are going to be and what this is going to mean for the seniors. This is really their only opportunity through this mechanism here to determine whether this is a fair change that the government is proposing in this budget.

Mr. Horne: Again, to go back, the proposal of the government is not to design a new plan that's specific to seniors. The proposal is to extend . . .

Ms Notley: No, but they are going to pay more as a result of this. You know that.

Mr. Horne: Well, some people are going to pay more at different income levels, and that includes not only seniors; it includes everyone in Alberta. It also means that people who have no income or very little income will receive drug coverage free of charge, which is currently not the case in the province.

I guess inherent in our disagreement is the policy context in which you want to have the discussion. I appreciate that some people may want to discuss specifically the impact on seniors' programs. There are people who receive drug benefits under the Ministry of Human Services and other ministries that will have similar interests. That is the reason why it's important that we take the time necessary to do the policy analysis, to consult with stakeholder groups about what these thresholds are going to be.

Ms Notley: Well, then, I think that you should be consulting with stakeholder groups, talking about what the cost implications are for the average Albertan. Consult with them, and then introduce a budget with cuts, not the other way around.

Mr. Horne: Well, then perhaps we have a difference of opinion. Drug coverage is, of course, a very high cost. It's about $1.1 billion in Alberta today. It's growing. It's not only growing because of the aging of our population; it's growing as a result of the growth of our population, the disparity in income levels that we see. As someone who I know is very concerned about vulnerable Albertans, not just seniors but Albertans who are living on low incomes, who are suffering from mental health and addictions and other issues and who are not able to work, I would think you would applaud this initiative.

Ms Notley: We'll get to that stuff, too. Trust me.

Mr. Horne: I'm sure we will.
Thank you.

The Chair: All right. Very good.
I need to for the record welcome Mr. Young to the meeting.

Mr. Young: Thank you.

The Chair: All right. We will go to Ms Jansen, followed by Mrs. Towle.
Ms Jansen, back and forth?

Ms Jansen: Back and forth if that's acceptable.
I'd really like to talk about the primary health care/addictions and mental health section because that's of particular interest to me. I think the funding in this area is so important because what you spend here has ancillary effects in Human Services and a lot of different areas. I think if you have the ability to put a lot of resources into your addictions and mental health programs, it just benefits so many different areas.

[Dr. Brown in the chair]

You may have touched on this already, but I notice that under item 12.5 we can see that the funding was reduced by $5 million. You may have touched on that before. Can you give me a sense of why that happened?

Mr. Horne: Yeah. Thank you for the question. I think we talked about this a bit last night. The reduction is related to surplus funds in 2012-13. We've moved those into 2013-14. In addition, some of our funding last year was for one-time initiatives only. The initiatives that have been funded really run the gamut of social programs in communities across the province.

We have used the funding, for example, to support the Homeless Foundation in Calgary, $2 million there. We've provided an equivalent amount for Homeward Trust here in Edmonton, and a million in similar funds for the city of Lethbridge. This funding is particularly important, I think, because it supports our initiatives around affordable housing in that it funds the wraparound services in addictions and mental health that people need, people who are vulnerable, and gives us an opportunity to move from providing simply a housing placement to creating a sustainable home environment for that individual.

We've also directed some of the funds, as you may know, to students across the province, providing funding for mental health and addictions services in postsecondary institutions. There are many other examples across the province where we've invested not only in Department of Health programs but in programs in other ministries.

The other thing I'd just like to touch on is the importance of the primary health care initiative as it pertains to addictions and mental health. It's currently estimated in Alberta that 40 per cent of visits to family physicians are for an addictions or mental health related issue. We know that when someone ends up in an emergency department, for example, seeking mental health services or in another crisis program, we're able to provide some service, but we also know that in many cases the system's response is arriving too late for the individual concerned.

A big part of the mental health strategy that's actually not recognized on this line is funded through the primary health care strategy. We are making very good progress toward integrating addictions and mental health services with every primary care team across the province: primary care networks, family care

clinics, other types of models. In doing so, we're able to assist people at a time when they are perhaps most receptive to receiving help rather than going on the waiting list for an outpatient or in-patient program in another facility that could last for a much longer period of time.

We have the grant funding that you've referred to on this line of the budget. We also have funds within the Alberta Health Services budget for addictions and mental health. We have programs that we fund jointly with Alberta Education to provide mental health and addictions programs in schools through the mental health capacity-building initiative. In many ways, the whole budget of the Department of Health can be seen as a budget to support addictions and mental health.

Ms Jansen: Actually, that was my next question. I had looked at lines 12.2 and 12.3. Under Family Care Clinics the funding had gone from, I believe, $1 million to $50 million. I'm wondering if you can give me a sense of where that money went.

[Mr. Quest in the chair]

Mr. Horne: I'm sorry. Your page reference again?

4:00

Ms Jansen: Under item 12 you've got primary care networks at $185 million and family care clinics at $50 million. Family care clinics clearly have gotten a big boost in funding there, and it's good to see that the primary care networks funding remains stable when it comes to that. I was hoping you could give me a sense of, you know, what that extra funding for family care clinics means and what it involves.

Mr. Horne: Well, the change is actually due to some additional work that we've been involved in with health care providers across the province in planning a common set of guidelines that will provide standards in primary health care. As you may know, the notion here is to use multiple models to deliver primary health care but to have a common set of standards, a set of core services that Albertans can expect from their primary care team, a standardized approach to operating hours and also, you know, taking the opportunity to look at governance options, information management, and technology.

We have an opportunity to introduce a more standardized electronic medical record across the province that supports better collection of data to manage population health in the communities that are served by the teams, supports that would allow us to identify people who are most at risk for certain chronic diseases, like colorectal cancer, as an example, or diabetes, and offer them proactive screening.

We have delayed implementation of some of the additional family care clinics, and we're picking up that funding in the subsequent year. We have also increased funding for primary care networks. There was a per capita increase of $12 that occurred last year, and that's being sustained in this budget as well.

What we will see in the end as a result of all of this work – and it's work that's being done jointly with physicians and other providers – is a more standardized offering for primary health care in all parts of the province. Models will be chosen based on the needs of the local community. Where we have large numbers of physician clinics, the primary care network is an excellent model because it allows those clinics to work together and the funding the government provides enhances the support in hiring additional professionals and providing additional services. Family care clinics are a much more specialized model. They're designed to meet unique needs in the community. They're a stand-alone clinic, not a network. Again, this funding will support us in some very targeted communities in introducing additional family care clinics this year.

Ms Jansen: When you look at the ability to deliver services in some rural areas, one of the things I was hopeful for in that family care clinic model is the ability to take extended services into areas. For instance, if you go north of Lac La Biche, there are a lot of communities up there that have to travel, you know, quite a distance in order to get things like addictions and mental health aids and even well-baby care. I mean, there are so many restrictions for folks living in very rural areas. When you take a look at these numbers, how confident are you that you're going to be able to take that money when it comes to addictions and mental health and funnel it into some high-needs areas that have limited access right now?

Mr. Horne: Well, we're very confident, and we've been successful, I think, at doing that in co-operation with our partners in the three family care clinic pilots that we have today. The approach really varies by community. In a community like you're talking about, a family care clinic is an ideal model because it allows us to provide funding to support the hiring of staff that would not otherwise be present in the community. In other communities and particularly in the large urban centres a lot of those resources already exist, but they're not connected to the common platform of the PCN or the FCC, so the money can support hiring of additional staff. The money can also support contracting with additional resources that are already available in the community and providing funding that supports them to be co-located, so it's a one-stop approach for the patient and the family.

There's no doubt that in many areas of the province, including rural areas of the province, there is a high need for additional addictions and mental health services. One of the opportunities that I'm looking at with the Minister of Education is that with new schools or schools that will be renovated in Alberta, with funding under that ministry's budget, we have the opportunity to put more of this programming in the school, perhaps up to and including a family care clinic or an office of a primary care network.

As is so often the case with addictions and mental health, success depends on being able to respond to the need of the individual, whether it's a young person or someone my age, at the time they're ready to open up about their issue, at the moment that they are receptive to receiving support. As I said before, for far too long our system has relied on separate stand-alone services, each with their own administration and overhead, and this has resulted in extended waits for some people.

Ms Jansen: Thank you.

The Chair: Thank you.

We'll go to Mrs. Towle, followed by Dr. Brown. Back and forth?

Mrs. Towle: If possible, that would be great. Thank you.

The Chair: Very good. Please go ahead.

Mrs. Towle: I wanted to just start with talking about funding for continuing care beds and how that works. I agree with Mr. Goudreau when he was talking about the ASLI grants, and I appreciate some of the feedback you gave there. What I'm not quite sure of is – we saw the ASLI grants not having any more money. I understand the explanation that you're putting more money in this year and that the request for grants was put out a bit

late, but I thought you said something about the ASLI grant RFP being delayed. I'm just wondering why that was delayed. Was it a ministry issue, or what was that process?

Mr. Horne: You and I have talked about this in the Legislature before, about the issue of patients waiting in hospital for placement in continuing care. We did take some extra time this year to go through an analysis jointly with Alberta Health Services to determine those parts of the province where we had higher numbers of people waiting in hospital for extended periods of time for placement in continuing care. That became an important criterion in deciding where we would tender for projects this year.

The other thing that we wanted to make sure we were successful with when we designed the specifications was that every bed, every space that would be developed would be built to what's referred to as a B2 construction standard. For those who don't know, this is a standard that is required for what we would traditionally describe as a nursing home in Alberta. That supports the ability of the facility to adjust to the care needs of the resident or the couple, if that's the case, over time as opposed to the need to move the patient to a different facility.

Mrs. Towle: I think that you actually brought that up last night and walked us through that process. The analysis that you talked about, where would we find that? Is it a public document?

Mr. Horne: The analysis is in fact represented by the specifications in the request for proposal, so the communities that were identified were identified on the basis of need. As Minister VanderBurg also said, we were looking for opportunities to partner with existing facilities that have spaces that could be retrofitted in order to accommodate more residents. The RFP document is available on our website. It's a public document, and all the criteria are there.

Mrs. Towle: Great. Thank you.

I just want to go on even further. On page 70 of the capital plan the continuing care capital program has no funding this year. The ASLI grant has gone up, but the continuing care capital program has zero funding in it this year. Then I noticed that in 2014-2015 the ASLI program goes down again. It goes from $50 million to $25 million. Then the continuing care capital program goes up to $114 million in 2015-2016 in a similar way.

I guess I'm just wondering: are you using the ASLI program tied to the continuing care capital program? Did you increase the ASLI program but then pull back money from the continuing care capital program? If there's such a need for continuing care beds – I think everyone in this room agrees that there is a need for continuing care beds – why would we not be using both programs to get the best use of taxpayer dollars and make sure we're getting enough beds out there for all Albertans?

Mr. Horne: Thank you for the question. We are using both funds to fund continuing care, to answer your first question. I think we've covered the difference in the ASLI funding and indicated that we carried forward last year's $25 million to the current year, the $50 million. If you take a look at the capital plan that appears in the budget, you'll see the continuing care capital program. That represents a consolidation of four former continuing care projects that were in the budget.

The reason that there is no dollar amount showing in 2013-14 is simply a question of available cash flow, and of course that relates to the fact that we've delivered a budget that has $6 billion less revenue than the previous year. But when you look at the out-years – well, you'll see the three-year total, which would be next year and the year after – there's just under $230 million available in addition to what's provided for in the ASLI program. So continuing care is more of a priority than ever in our capital plan.

4:10

Mrs. Towle: Right. I think I acknowledged that. I did say that going into 2014-15, we see it go back up to $114 million, so that's why I wanted to clarify that.

I'm wondering: who is building the new continuing care spaces that you're talking about? I'd like to take that even further. Last night you talked about 2,300 new beds, I believe, but I'm wondering if you can break that down even further. How many of those beds were long-term care? How many of those beds were SL 1, 2, 3, 4, 4Ds? Can you provide a forecast for the next three years for the net gains and losses for continuing care – you might have to do that in writing, if possible, because I understand it's a lot of information – broken down by zoning, designated care level?

Mr. Horne: Well, we can certainly provide that. I don't want to miss the opportunity to give you an overview of what's in store. As of March 31, 2012, we had 41,013 continuing care spaces across the province. The final numbers aren't quite in for 2013 yet, but that is projected to increase by 1,128 continuing care spaces. We have the breakdowns available.

Mrs. Towle: But I think we might be confusing what I'm asking. I'm just asking about the new beds that you created, not the total beds. I think last night you mentioned that you created 2,300 new beds, I believe.

Mr. Horne: I'm not sure which response you'd be referring to, but we have the change between 2012 and 2013 as 1,128, and the projected change between 2013 and 2014 is just under 1,020. We do have some breakdowns on a zone basis that we could provide.

Mrs. Towle: That would be great.

If we talk about dementia, we know that as they age, there are huge care concerns for people suffering from dementia and Alzheimer's. I can tell you as somebody who took care of a person with Huntington's that they have an element of dementia, too, and it's very, very difficult care to provide.

I also noticed that on your own website you have age-standardized prevalence charts, which you actually provide to the public – I think it's great, just so you know – and this is what it looks like. In here it talks about these zones where dementia is the most prevalent, and the bottom part, which is pretty much all of southern Alberta, is supposed to be red. Your interactive health data application gives very clear guidance that southern Alberta, for whatever reason, is a huge, high-need centre for dementia care beds, yet it does seem a bit concerning when we had – and I understand that we can be at odds on why certain facilities closed, but Little Bow, Carmangay, was a dementia-Alzheimer's facility. It housed 20 patients there who specifically had that type of care need, yet we saw it close even after meeting all the specifications.

If we see that there's clearly a direction that Alzheimer's and dementia is prevalent in that area, I guess I'm just wondering: how does the Health ministry prioritize the closure of beds, and are you actually using this interactive health data application as one of the criteria when you're taking into consideration which facilities you're going to close? It just doesn't seem to square that we're closing dementia beds in an area that clearly has such a high need for dementia care.

One more question I'll add to that, and it's in your health action plan, the Alberta five-year health action plan. Your long-term goals: you talked about creating a 24/7 helpline to support those

with dementia and their families. I'm just wondering if you can give us some projections of when you're anticipating that might happen. I understand it's not for this year; it might be for next year. But I'm just wondering if we can have something to look forward to because I think that would be a fantastic initiative.

Mr. Horne: Well, thank you. It will take me a couple of minutes to answer the points that you raised. First of all, just in terms of health facilities and decisions around the use of health facilities and the decommissioning of health facilities, those decisions are the responsibility of Alberta Health Services. They are responsible for the delivery system. We have talked before about some of the criteria that they have indicated they use in making those decisions, and there's probably not a lot of point in the two of us going back over the ground of the facility you're referring to, but I appreciate your concern about it.

What I can tell you is that the number of supportive living level 4 dementia beds, the SL 4-D beds, is projected to increase by approximately 311 between 2012-2013, and in the south zone the increase should be around 30 beds.

Mrs. Towle: Thank you.

The Chair: All right. Thank you.

We'll go to Dr. Brown, followed by Dr. Swann.

Dr. Brown: Thank you, Mr. Chairman. I have some questions. First of all, I'd like to start by asking the minister about the overall spending increase. He's projecting a 3 per cent increase this year. In your opening remarks, Minister, you referred to the historical increases of some 9 per cent in funding. Given the fact that we have various drivers of this budget that we don't have a lot of control over, including the aging demographic of the population, considerable immigration to the province of Alberta, new procedures, new patent pharmaceuticals that are coming onto the market every year, and whatnot, I wonder if you could explain a little bit about how you expect to be able to achieve that very ambitious goal of limiting the expenditures to 3 per cent. I think if you can do it, you're going to be considered the guru of health ministers not only in Canada but in North America.

Mr. Horne: Well, thank you for the question. I mean, obviously, the final increases in all the ministry budgets, as you know, Dr. Brown, are determined by the Treasury Board. We are coming off about a decade of 9 per cent increases in Health. Interestingly, the 3 per cent growth is not a situation that would be unique to Alberta. It would not be unique to me as a minister in Canada to need to deal with a rate of growth that's restricted to 3 per cent. We have seen this already in central Canada and in other places. It's a reflection of economic circumstances and other factors, as you probably know. It is a considerable challenge in a province like Alberta, where we've been fortunate to have surpluses in the past, and a lot of those surplus monies have been invested in our health care system.

What I would say is that, you know, despite the reduction of about 6 per cent there are many opportunities within the health system to derive greater value from the money that's spent, not just from a cost containment perspective but from a quality and access perspective. We've outlined on our website an analysis of all the cost drivers in the health care system. The largest ones are related to workforce. About 75 per cent of the money is for salaries and wages. Hospital costs are a major driver, and drug costs are a major driver in health care. The strategies that we've outlined in the budget are intended to make better use of the resources that we already have in place.

One thing I would say – and I don't think it can be emphasized enough – is that many of our surpluses over the years have been invested in new hospitals, and we're really proud of that. Last fall alone, the fall of 2012, saw the opening of over $2 billion in new infrastructure in health across the province. Those are projects like the South Health Campus in Calgary, the Edmonton Clinic, and a number of hospitals in northern Alberta that received renovation and expansion.

We've always been very proud of our investment in hospitals and technology, and rightly so, but where we have not invested perhaps as much or exploited the opportunity as much as we could is in the area of community-based care. Primary health care reform is largely about not doing things in the hospital that can be done in the community, that can be done better, that can deliver better outcomes and a better patient care experience.

Obviously, administrative costs and streamlining programs like our 18 drug programs that will be combined into one are part of the efficiencies that we can achieve as well. Achieving good agreements with health care professionals, as we see in the memorandum of understanding with the Alberta Medical Association, that provides three years of zero per cent increase, is a major contribution to those savings.

I'm not suggesting for a minute that it will be easy for Alberta, for the department, or for Alberta Health Services, but I believe it's something that we can and we must achieve if we want our health system to be sustainable. Certainly, at rates of growth like 9 per cent or more for some of these cost drivers the rate of spending is not sustainable even in an economy like we've become accustomed to in Alberta.

4:20

Dr. Brown: Thank you.

I'd like to move on to another area, and that involves the health cards that we have for users in Alberta. I wondered if you could enlighten us on how many health cards are presently in circulation in Alberta. I know this has been an issue in the past. How many were issued in the past year?

Maybe I'll just go through a number of questions, and then you can respond sort of in a single go. What kind of personal identification and eligibility procedures are we using in order to issue new Alberta health care cards or replacement cards, and do you have any way to detect duplicate cards? What are we doing to beef up the scrutiny of cards and implement security features in our Alberta health care cards and make personal identification out of them?

Also, I wonder if you could tell us about how many noneligible residents, immigrants, foreign workers, or temporary visitors have received Alberta health care in the past year.

Finally, with respect to the Alberta health care cards I wondered if you could comment on how the integration of the Alberta health cards would work with the new electronic health records and how you intend to integrate those two things.

Mr. Horne: Thank you for the questions. There's a lot there. Thank you for mentioning this to me after question period today. I'll give you what I have, and we can provide the additional details that I don't have with me.

In December 2012 there were just under 4,018,000 Albertans covered on the Alberta health care insurance plan. Obviously, in there are a number of people who are not permanent residents of the province. Non-Albertans who receive services in Alberta do receive an Alberta health care card number for the purposes of recording the services that they do receive. As we talked about last night, there are reciprocity agreements between Alberta and other

provinces that provide for recovery of payment for services for nonresidents who receive health care services here in the province.

There are significant fraud controls in the system. One is something that I think a lot of us as MLAs are familiar with. Replacement cards are issued with a new number. When there is a situation, a change in family circumstances like a divorce or a separation, an individual receives a new Alberta health care card number. There are a number of fraud controls. We have a unit in the department, a special investigations unit. It's part of our monitoring and compliance branch.

I can tell you – I believe this is last year – that there were 96 fraud reviews under the Alberta health care insurance plan. We can get some more detail on this, but at a high level 60 per cent related to eligibility or termination of coverage, 20 per cent related to the use of prescription drugs, and 20 per cent related to other issues. Identity theft would be an example of that.

We've moved a long way in the province since Alberta Health Services was created. We developed a provincial registration, standards, and practices manual in 2012. There are a lot more reasons than fraud to want to have an efficient system when it comes to tracking the use of health care services. When we think about areas in the system where we want to do a better job of co-ordinating care – for example, someone moving from a primary health care team to receiving two or three different specialist services – we want to be able to do that efficiently, and a tracking process enables us to track the care, obviously, and help in navigation, but it enables us to collect data and do a better job of delivering the service to the next person that receives it.

We have now a final draft of the standards and practices manual. We're going to be rolling it out shortly. This is something that is only possible because we've gone to one health region for the entire province. Under the previous system with multiple regions we had different IT systems. We weren't able to track someone's progress through the system on a uniform basis. We weren't able to collect data in a common repository so that we could analyze the use of the health services that are delivered and plan, as I said, to improve service delivery the next time.

We're early in this. The first stage was the development of the standards and practices manual. That will also support the fraud review process. Of course, we have to obviously do some further work on the IM/IT system. As we move on in the years since AHS was created, we're making more and more progress in integrating the former IT systems into one.

Dr. Brown: Thank you.

The Chair: Great. Thank you.

I just want to welcome a couple of members that have come in the last little while here, Mr. Mason and Mr. Fraser.

All right. We will move on now to Dr. Swann, followed by Mr. Young.

Dr. Swann: Thank you, Mr. Chair.

The Chair: Back and forth: is that still good?

Dr. Swann: Back and forth.

The Chair: Okay.

Dr. Swann: We talked a bit about prevention last night, Mr. Minister. It's still a much-neglected area in our province, in our budget. You or the associate minister may want to respond to some of the questions. You've identified the unprecedented demands on our health care system, yet I see no plan for prevention. There's been little commitment to prevention over the past few decades, in fact, beyond what we've seen in the traditional public health system, a lack of planning for prevention in spite of the minister identifying that 5 to 10 per cent of our population is costing up to 50 per cent of the health care costs in the province. It's an important statistic.

I guess I'm wondering: where is the plan to address the high-risk individuals and the high-risk factors so that we can actually make a dent upstream in some of these important areas? How is the planning for prevention happening between primary care networks and public health services and between hospitals and seniors' facilities? If we are doing piecemeal prevention, we are not actually doing prevention in a very systematic or effective way. If we're not measuring it, then we don't really have a commitment to it. I'm talking about both injury prevention and disease prevention. Where is the plan, and how are we going to see results if we don't have a serious commitment to integrating it across the spectrum of acute care and community care and long-term care issues?

I guess the related question, then, is: what is your target for prevention? What is the kind of proportion of our investment that you would see in your vision for prevention? Do you have a figure in mind, a proportion of our budget of $17 billion, that would reflect a serious commitment besides 3 per cent, which we've been stuck at for decades?

Thank you.

Mr. Horne: Thank you, Dr. Swann. We covered some of this ground last night, so I will try to basically supplement the answers that I gave last night and perhaps ask Mr. Rodney to talk a bit about this as well. I think in our discussion last night I agreed with you that the traditional measure of the performance of a health system when it comes to prevention and wellness is a dollar measurement. We can look across the country, and we can see a very similar scenario, where programs that are specifically dedicated to wellness and prevention comprise a very small portion of the overall health care spending.

What we're trying to do in Alberta – we talked last night about the wellness strategy that Minister Rodney has been working on. I also talked to you about the role of primary health care as our primary wellness and prevention strategy and achieving that on the basis of formal attachment or enrolment of citizens with the primary care team that's serving their community.

One of the things that I think is really important about what we're doing, whether you're thinking of primary care networks or family care clinics, is increasing the representation of other professionals on the health care team. So we'll commonly talk about nurse practitioners and pharmacists, and they're there. Mental health workers are there. In the standards that we're developing for primary health care, that will apply to primary care networks and family care clinics, you will see a public health presence as part of that.

4:30

I talked earlier about the linkages with Education and Human Services in the areas of early childhood development and supporting people who are homeless, integrating strategies there as well to support wellness. We do still provide, you know, the traditional grant funding to agencies, and there have been many excellent new projects that have been launched in Alberta as a result of this. But I think you would agree with me that far too often those projects don't receive the sustainable funding that they need in order to keep operating. They don't necessarily get successfully integrated with the rest of the health system.

We also have an injury prevention strategy in Alberta that we've had, I believe, since 2003 if I'm correct. We're in the process of updating it now. We have an opportunity to do more in this area working with other ministries as well. Seniors is an area you mentioned where fall prevention, injury prevention generally is very important. I have a strong desire to see home care in the future based in the community as opposed to based out of the hospital. I think if we can achieve that through primary health care reform, we can succeed in identifying seniors in the community who are at risk of falls or injury, and we have an opportunity to proactively reach out to them. This doesn't have to be a function of a doctor or a specific health professional; this can be something that everyone does who is part of primary health care.

I will ask Minister Rodney to talk a bit about performance measures if he would.

Mr. Rodney: Absolutely. Thank you so much, Minister. Thank you, Dr. Swann, for the question. Certainly, we share your concern and passion to make sure that this is not piecemeal. I venture to say – and I trust that it's very true – that when it comes to immunization and infection prevention key initiatives, injury prevention, cancer prevention, and more that the word "piecemeal" would not apply.

I want to refer to a document that perhaps you've seen, Framework for a Healthy Alberta. That's going backwards, but I obviously prefer to go forwards. Minister Horne just mentioned the wellness strategy. In working with our partners in the past with the framework and to the future with the strategy, I do want to get on the record some performance measures that you may not be aware of. One of them is that in terms of physical activity we're not happy to stay static. We want to increase the proportion of Albertans 12 years and older who are moderately active or active from where we were at a couple of years ago, 56.3 per cent, up to 65 per cent in 2023, and there will be plans to make that happen. This is not arbitrary; this is evidence based. We are definitely tracking this past, present, and future.

When it comes to healthy eating, we plan to increase the proportion of Albertans age 12 years and older who eat at least five to 10 servings of fruit and vegetables daily from . . .

Dr. Swann: Thanks very much. I'm aware of that. I'd like to move on.

Mr. Rodney: Well, I'd like to actually tell you about . . .

Dr. Swann: I'm wondering if I can move on to some of the issues related to . . .

Mr. Rodney: Sir, I didn't interrupt. I will get it back to you, but I'll summarize to let you know that we . . .

Dr. Swann: It's my time, Mr. Minister.

Mr. Rodney: Right. Healthy weights, mental well-being, adequate sleep, decreased tobacco use, decreased alcohol misuse, injury prevention: there are statistics on each of those, and we have a plan to take care of those in a positive way with and for Albertans and our partners over time.

Dr. Swann: How are they going to be integrated across the various levels of the health system? Who's going to be accountable for those?

Mr. Rodney: Well, would you like to hear the rest of the numbers?

Dr. Swann: I'd like to know who's accountable for the results if the system is not integrated.

Mr. Rodney: Let's be fair. This is a shared responsibility between government, nongovernmental organizations, all of our partners, and every Albertan. That's not a line; that's the truth.

Dr. Swann: Okay. Well, you've said that 5 per cent of the population is consuming 50 per cent of the resources. How are we targeting the highest risk people to make a difference here?

Mr. Horne: I can answer that. It's actually that 5 per cent are consuming 60 per cent of the health resources, about 150,000 people in the province. We talked last night about some of the characteristics of that portion of the population: mental health and addictions issues, people who are living in poverty in the province, older Albertans who are suffering from multiple morbidity from different chronic diseases. There will be more detail about this that comes out when Alberta Health Services releases its health plan. I have it with me now. I have an obligation as the minister to approve that health plan.

I think what you'll see, Dr. Swann, is a very specific strategy around doing a better job of co-ordinating services for those individuals. For example, a group of those people today may end up only being noticed when they have an acute episode and they have to go to an emergency department for that care. Actually identifying those individuals and looking at their needs on a one-on-one basis and then developing an ongoing care plan that's more rooted in the community than it is in the hospital is a big part of that solution.

You know, you asked about integration. I don't think the importance of what you're saying there can be stressed enough. The days of being able to compartmentalize health care between institutions and the community and the days of having programs that are age specific or specific to a geographic area cannot continue in Alberta or in Canada. Care of the whole individual and providing as much care as possible in the community at the highest level of complexity is how we get from the six to the three and how we will still have a system here a decade from now.

Dr. Swann: Thanks very much.

Having come from the public health system, I see a real disconnect between the public health system; that is, between the medical officers, the public health nurses, and the rest of the system. That is a serious gap that needs to be addressed.

Thank you.

The Chair: Okay. I'd like to welcome Mrs. Jablonski to the meeting.

Mrs. Jablonski: Thank you.

The Chair: We'll go to Mr. Young, followed by Mr. Mason. Do you want to go back and forth?

Mr. Young: Minister, back and forth?

The Chair: Is that your preference?

Mr. Horne: That's fine.

The Chair: Very good. Go ahead.

Mr. Young: Okay. My first question is on structure. I know there's been a lot about how we have moved to one board, but within the bureaucracy there are about five regions. Has there been some savings in terms of the redundancy as you're moving

from those multiple boards to the regional approach, savings in terms of economies of scale, efficiencies, and those types of things? Sort of related to that is: how much is a regional approach versus a one-system approach like your board has?

Mr. Horne: Okay. Well, thank you for the question. In the area of administrative savings in Alberta Health Services the estimated savings as a result of consolidating things like payroll systems and other things that we might call a back office system is about $660 million. That's a significant amount of money, and those savings are in fact expected to increase over time as we look to consolidate IT systems on the clinical services side, as we look to consolidate IT systems that reside in my department and, you know, similar systems in Alberta Health Services. There are a lot of additional administrative savings I think to be had as the system evolves.

With respect to the structure there is a zone structure within Alberta Health Services that is specific to geography. There are five zones. One of the things I think that people do not always appreciate, an issue with the former structure that we had where the regions were governed separately, is that the regions very much determined on their own what services would be offered within their health region. Some of us as MLAs have encountered situations where, you know, for people living on opposite sides of the same road, a boundary road between two health regions, one would have a particular service available and the other wouldn't. Reducing those variations in access is one of the reasons that we went to one health system.

The reason for the zones. Well, there are a number of reasons. First of all, from a planning point of view, obviously, different geographical areas operate differently. We have different groupings of hospitals and continuing care facilities, and we have varying numbers of physicians in different parts of the province, so the resources are distributed. It becomes very important when you're planning for the future of the system to be able to look at things on a geographical basis and look at a minisystem, if you will, the collection of resources in that area, and make decisions as to where you need to supplement resources and make decisions as to how to better organize the resources that are already in place. So that's the reason for the zone structure.

The great thing about having one health region for the entire province is that we can provide a higher level – and we'll see more of this as time goes on – of consistency between regions in terms of the services that are offered, in terms of, hopefully in time, more consistency in terms of the access that's offered. When we're planning capital facilities, we have the opportunity to look at providing areas of specialization in Alberta for the, you know, tertiary and quaternary care.

4:40

Mr. Young: I understand that whenever you do big change like that, there's an evolution. Part of my question was about the disparity between it, and I think you answered that well.

The next question I have is on information management. Big IT systems are often referred to as a white elephant for good reason. There have been well-documented failures of massive IT systems. When I hear the word "integration" and the one-system approach, it kind of scares me. We have home care. We have pharmacists. We have PCNs. We have all the physician clinics. We have the FCCs. We have hospitals, EMS. We also have private diagnostics. Where does the integration end, and where does the inter-operability begin? Are we adopting the HL7 data standards to achieve that end? That's a big mouthful.

Mr. Horne: Well, that's a big question. On your first point, you know, on the degree of integration, we're proceeding. We started with sort of the back office systems that I talked about. One of the things that I think we have to pay more attention to in the future when it comes to IT is not how we are using IT to automate old ways of doing things, old ways of delivering care, but how we're using it to enable new models of care.

We are adopting the HL7 standards. We do have legacy systems, clinical information systems, which are systems that are used inside an institution to deliver care, that Alberta Health Services is working with us on to look at how we can standardize some of those systems to better support care delivery.

You know, a lot of this, I think, goes back to reminding ourselves of the basic principles around the use of information technology and health care delivery. The first principle is that the patient should have to tell their story only once. We see this regularly as MLAs when constituents come to us and they talk about either seeking specialized care and having difficulty knowing where to go or having received the specialized care – maybe it's surgery in a hospital; maybe it's another form of higher level treatment in the system – and having difficulty navigating the various support services that have been recommended to them. A lot of the function of that is that while their journey may be planned by the health professionals that are delivering the care, the journey hasn't been documented and isn't well supported by the IT system that's in place.

What I can say at this point is that we're looking to expand some of the things we've started. The personal health portal, a very important feature for the future, will allow people to access their own health information, will allow us to deliver to them information about a chronic condition, for example, that they might have been diagnosed with, deliver to them access to support groups and other services. As I said, we're working with Alberta Health Services. Now that we've got one platform for the province, we have an opportunity to integrate all of the clinical information systems into one.

With respect to primary health care we're working with the AMA. The physician office system program, which was a vendor-based program, is coming to an end in 2014. And we're working with the AMA and AHS to plan a new electronic medical record that could potentially be used across the gamut of primary health care.

Mr. Young: So is that a standards-based system?

Mr. Horne: That's the idea, to have a standard functionality.

Mr. Young: Yeah. I see your IT person nodding.

Mr. Horne: That's common. Yeah. It's a big goal, and it won't happen quickly, but it has to happen if we want to deliver the level of care that Albertans expect.

Mr. Young: The golden ring of this is when we can move from just the transactional kind of data, whether through a data warehouse or ETL, to get to where we can do actually analytical stuff and look at, at a policy level, what policies are working in the region and correlate that to different kinds of policies beyond even just health in terms of education and all this stuff. I suspect we're evolving to that point, but I'll get to my next question.

My next question is about accountability. How much of the budget is based on the honour-based billing that we have in place? We have an honour-based billing system, correct?

Mr. Horne: Are you talking about physician billing, physician reimbursement?

Mr. Young: Physicians, yeah. My question is that with any honour-based system there are a certain number of people that have less honour. It's a very small percentage, but when you have a big budget, it does add up. So I just wonder: what kind of resources or accountability do we have to track that? I mean, you mentioned it in relation to Dr. Brown's question about the consumer or, rather, the patient. For the service providers is there an audit or tracking of that honour-based system? I mean the outliers. What kind of resources do we have to track? I'm putting on my police hat. Because there are both ends of it. I appreciate Dr. Brown jumped ahead of me on that question.

Mr. Horne: If you don't mind, I just want to clarify that what we're talking about here is the fee-for-service billing by physicians across the province.

Mr. Young: Correct.

Mr. Horne: A little over 80 per cent of all physician billings are fee for service. Those payments are administered using a system that's housed in my department. Claims are submitted by physician offices, and they are reimbursed.

We have a monitoring and compliance unit, that I talked about earlier, that monitors the Alberta health care insurance plan enrolment of citizens. That unit also provides monitoring for fee for service, so there are random audits that are conducted. We do on occasion receive reports, not a lot, from the public about concerns with respect to physician billing. There's a methodical process to investigate each of those complaints.

Mr. Young: Thank you.

The Chair: All right. Thank you.

We'll go to Mr. Mason, followed by Mrs. Fritz.

Mr. Mason: Thanks very much, Mr. Chairman. I'd be happy to go back and forth with the minister if he's still prepared to. I promise not to ask any trick questions.

The Chair: Are you okay with back and forth, Minister?

Mr. Horne: I'm fine with that.

Mr. Mason: All right. I want to start with the largest item in your budget. There are 16 categories in your budget, and by far the largest one is Alberta Health Services, which is nearly $11 billion, so a huge amount of money. But there are only six budget lines here for the whole organization. I don't think the chair or the CEO of AHS are here to answer questions, are they? Is Mr. Lockwood here?

Mr. Horne: No.

Mr. Mason: Okay. The question I have is about accountability for AHS: how decisions are made, how the minister relates, and why, in fact, we need to have the organization structured in this way. It's hard, I think, for the Legislature to provide good oversight of the finances of the health system when a huge chunk of the expenditures and the operations is being conducted by a stand-alone board. I'm also concerned about unnecessary duplication in terms of staff by having two organizations instead of one.

I guess the other concern I have – and I'll just sort of lay them all out for the minister, and you can pick the ones to respond to.

Mr. Horne: Okay.

Mr. Mason: You know, the other concern that I have is: why do we put a group of unelected people who, in my recollection, are predominately from business backgrounds and don't particularly have a lot of expertise in a health system in charge of our health system? It really strikes me as a very corporate style of administration of the health care system. I'd just like the minister to make some comments with respect to those concerns.

Mr. Horne: Okay. I'm happy to do that. Mr. Mason is a knowledgeable, experienced member of our Assembly, so I won't take a lot of time just to go through the organization of the system. Just for the record, of course, the board of Alberta Health Services is appointed by the minister under the Regional Health Authorities Act, so with the creation of Alberta Health Services, nothing has changed in terms of the governance of the delivery system. It's just that it's a single provincial system, and I'm sure you understand that.

4:50

I think your comments with respect to the size of the budget are, obviously, understandable. What we see here in a single budget is what was previously represented by the collective budgets of seven health regions across the province. I don't think, however, it reduces the importance and the need for accountability for every dollar of that budget.

I want to assure you as the minister that I take the responsibility for the board and the operations of AHS very seriously. I do think it's important to acknowledge, however, that like most of the rest of the country the authority of the AHS board is a delegated authority. So when government makes the decision to appoint members to the board or to have a board in the first place, they are making a decision to delegate certain operational decisions, not public policy decisions but certain operational decisions, to the people that are on that board.

I'd certainly agree with your observation that there is a need to have a good, diverse representation of viewpoints for people on a board that is entrusted with so much public money and with such an important trust as the delivery of care. I have been perhaps – well, I'll put it this way. I have been measured, and I have taken extensive consideration in the people that I have appointed there. There are a number of additional vacancies on the board that have yet to be filled. I actually would agree with your observation that we need people who understand stewardship of large amounts of money, we need people that understand business processes and things like information technology, but we also need people who understand the front-line delivery of care.

I will continue to take the position that I've taken thus far in being very considered and deliberate in the appointment of individuals to that board. I intend to ensure that the representation that you're talking about is there. It does take a significant commitment on the part of someone to serve on this board. They are all volunteers, and they receive an honorarium for their services, but it is a huge undertaking as I am sure you can appreciate.

Mr. Mason: I'll just maybe reflect a little bit on my experience formerly with Edmonton city council. I was on council when we decided to establish stand-alone boards in separate organizations for our economic development department, first, our telephone company at the time and then Edmonton Power. It was my observation from that period of time that there was a real loss of accountability that took place.

The other thing that happened was that you almost immediately lost control of your compensation costs. Suddenly the salaries of the CEO and the senior executives were double and triple and more, and the expenses got out of hand. You've been having to pick up some of the problems related to that sort of thing. How do we control those costs? How do you provide adequate oversight? I mean, it's very remote for us here with the six lines, $11 billion, but you as the minister are a little closer.

It really seems to me that, on the one hand, you want to let them do what they're doing, but when you do step in – for example, the parking thing for veterans in Calgary – then, you know, you're accused of political interference. There's been sort of a history of that sort of back and forth with the minister. Forgive me for saying so, but it just doesn't really strike me as a particularly functional way to run our health system. I think it's fraught with a lot of problems, many of which end up at your doorstep.

Mr. Horne: Well, there have certainly been times where I have used – and I do not hesitate to use them – the directive powers under the Regional Health Authorities Act. My obligation is to act in the public interest and to be accountable to Albertans and to the Assembly as well for the operation of the health system. I guess we might have to sort of agree to disagree, you know, on the underlying philosophy behind governments appointing regional health authorities.

You raised the issue of line of sight, so to speak, between the minister and the health region, and I think that's a legitimate concern. There are a number of ways since I've been minister that we have tried to improve that line of sight. One, of course, is a close working relationship between the board chair and the minister. I've certainly enjoyed that opportunity with Mr. Lockwood, who's put a lot of time and effort into his role.

There are other checks and balances, of course, that apply to other public expenditures. The books of AHS are audited annually by the Auditor General, just as the books of the former health regions were. There are investigative powers that the minister has. There is still, obviously, the opportunity for the minister to order special reviews, and I have done that. We have undertaken a process to review governance in Alberta Health Services in conjunction with the board.

In terms of the operations – and you raised in your earlier questions the potential for duplication – we have an exercise under way now where we are reviewing the specific management functions of both AHS and my department to ensure that we are not duplicating one another.

The other reason, I guess, that I would support the need for regional health authorities is that there has to be an opportunity for government to fulfill its primary role in health care, and I consider that to be the role of assurance. So it's the development of policy, but it's also a very significant role in assuring that services that are provided are safe and are of high quality, that the system is adequately funded, that we have performance measures that are comparable to other jurisdictions so we can report on our performance. There's the regulation of health professions across the province. There is actually a very large volume of work above and beyond operating the delivery system that has to be done if we're going to have a high-performing system and if it's going to be sustainable.

I guess my response would be that I think we need both, but your point on line of sight is well taken. We have legal ways, of course, to deal with that, but I think it's very much a function of the attitude of both the board chair and the minister that delivers on that for people.

Mr. Mason: Thank you.

The Chair: Great. Thank you.

We'll go to Mrs. Fritz, and then we'll have a short break. Mrs. Fritz, back and forth?

Mrs. Fritz: Thank you, Mr. Minister. My questions are a bit varied.

The Chair: Sorry. Is that okay, Minister? Back and forth is good for you?

Mr. Horne: Yes, of course.

The Chair: Okay. Very good. Please go ahead.

Mrs. Fritz: Thank you. They are varied. About two weeks ago we had the Calgary Health Trust invite members of our community along with the executive team from the Peter Lougheed Centre to a meeting where they shared with us about the expansion at the Lougheed regarding the new cardiovascular area. It's absolutely, totally amazing. I mean, we were just thrilled. I want to thank you for your support of that being built. I know it's going to be leading edge. The cardiovascular surgeon explained the new technology that they're going to have in the ORs, why the two ORs are going to be so huge, and then also about the various techniques that are being used and how and why that will make a difference for people in the future in terms of their care.

The question I have, though, is that I know in the budget the capital – I mean, there's so much in the province that you're building, you know, and doing in different facilities. The Peter Lougheed Centre isn't a line item. So if you could please just reassure me that I can reassure our community and the hospitals in my area that that expansion will continue as it is, that it's going to go ahead, and if you have any timelines for when it would be finished.

Mr. Horne: Thank you for the question. The Peter Lougheed Centre does appear in the capital budget. You're talking about the vascular surgery program. It's in there as is the women's health program in Calgary. There's actually additional funding provided in Budget 2013 for this, a $37 million increase, for a total of $77.1 million, and that's for the space for vascular care, increased capacity to meet the demands in women's health services, and to meet current standards of delivery for maternal and newborn care, which requires additional space. So the additional money does appear in Budget 2013 in the capital plan.

5:00

Mrs. Fritz: Was it in this booklet here? Did I miss it? Dr. Brown and I have looked and looked through this booklet and couldn't find it.

Mr. Horne: It's a previously announced project, so you'll find it in the Infrastructure budget.

Mrs. Fritz: Okay. Thank you for that.

Mr. Horne: Only the new projects are noted in the Health budget.

Mrs. Fritz: Well, I appreciate that clarification. I'll get that out in my next newsletter to our communities.

My next question relates to one of my favourite areas of care. You know, it's a bit about prevention. It's a bit about the way that people use resources for acute care as one of their first steps. That's with Health Link. I did look in the budget to see where their dollars were. Health Link has been very successful.

The questions that I had were just related to how many calls you're receiving, whether that call load is increasing at 10 or 20 per cent a year, and what the stats show as well about the wait time for people on the phone. I have had some people say that they get through in two minutes; for some it may take half an hour. I guess it just depends on the nurse or whoever is speaking at the other end to the people in the community.

So questions about that and also if you've done any surveys recently, Mr. Minister, regarding Health Link on how many people are aware of it and if you have any plans to expand the awareness of Health Link even further in the province. It's an amazingly good program.

Mr. Horne: Well, thank you for the question. I'm not sure that I'm going to have the statistics on Health Link at hand. We can get those for you.

Mrs. Fritz: Thank you.

Mr. Horne: We do have the statistics. Very good.

Mrs. Fritz: I knew you had the best deputy minister.

Mr. Horne: Amazing.

These are the statistics for the third quarter. The 2013 target was 80 per cent for a call answer time within two minutes. The actual was 79.3 per cent. So pretty much right on the mark. In terms of the volume of calls we'll try to find that for you.

But I want to answer the last part of your question: how can we make Health Link work better? We have a huge opportunity with the work that we're doing in primary health care to help the call to Health Link for a nonemergent purpose result in something. It might result in an appointment the next day with a physician in a primary care network. It might result in a referral to a community program. It might result in someone connecting to home care.

When you think about the potential with 10 million calls to Health Link since 2000 and one million last year, there is a real opportunity there to provide better follow-up and co-ordination of care in real time with health professionals after the call to Health Link.

The average call to Health Link is 12 minutes. In the future there will be a tie-in to the personal health portal from Health Link, so Albertans who call will have the opportunity then to go online and access personalized information, perhaps a follow-up on a support program or perhaps in the future an opportunity to look at some of their own personal health information. It might be a history of their A1C indicators if they're at risk of developing type 2 diabetes. There is huge potential to support more personalized medicine and better self-management of chronic conditions through the use of Health Link when it's integrated with these other resources.

Mrs. Fritz: Absolutely.

Back to the budget, is there an increase in budget this year for Health Link, or does it remain status quo?

Mr. Horne: I can't answer that because it's part of the Alberta Health Services budget. When their budget is finalized, I'll be able to find that information.

Mrs. Fritz: Thank you.

I want to just now turn over to family care clinics. If you could please just let us know once again: when is the announcement going to be made regarding the application process for the next phase for family care clinics? The reason I'm asking is that I'm hoping that whoever is designing these – and I know that you have your Associate Minister of Seniors here – family care clinics could be co-located with seniors' centres. I know that some people, you know, have been discussing that. If you could just comment on that.

Mr. Horne: Sure. I don't mean to be cute about it, but the announcement that you're referring to will be very soon. I don't have an exact date for you today. The announcement will be a list of communities that we have been working with that have expressed interest in developing a family care clinic. Now, some of these do include an interest in co-ordinating with seniors' centres. Others are interested in working with other resources that exist in the community. Some of them are primary care networks, as a matter of fact.

The work that we've been involved in for the last several months has been to develop a set of standards for primary health care that will apply to FCCs as well as to PCNs. This will include a list of core services that all Albertans will be able to expect out of primary health care. It will address things like hours of operation. Obviously, we want to make sure that the PCNs and the FCCs are open and available to people at hours that are convenient to them.

The announcement of the communities is not the end of the process. It signals the beginning of a process where partners in those communities will work together on developing a plan for a unique FCC that meets their needs. So in remote areas of the province, for example, you might see a focus on services that those of us that live in the city take for granted and have easy access to. Some communities will have a higher interest in addictions and mental health services. Others may have opportunities to partner with nurse practitioners and others who are already operating in the community but are not co-located with other resources.

The first premise in the development of this model is that it is not, as was said in the House today, a cookie-cutter approach. It's very much a community-driven approach. The default position is looking at the resources that already exist in the community and working with the community to reorganize those so that they do a more co-ordinated job of serving the people who live there. Part of this discussion as well – and this is coming a bit further down the road – is how we can enrol Albertans in PCNs and FCCs so that they are formally attached to a care team in their community, looking at opportunities to integrate wellness and prevention and others as well.

Mrs. Fritz: Thank you.

Also, Mr. Minister, are you anticipating that you would have any family care clinics on-reserve, not just off-reserve? Gleichen comes to mind for me because it's just east of Calgary, east of my constituency, and they have a great health centre there.

Mr. Horne: There is certainly that possibility. We've had some discussions about that.

Mrs. Fritz: Thank you.

The Chair: Okay. Well, thank you, Minister and Mrs. Fritz.

We'll take a six-minute break. Everybody back in here for about 5:15, please. Thank you.

[The committee adjourned from 5:08 p.m. to 5:16 p.m.]

The Chair: Okay. I know those go fast, but we're going to call the meeting back to order. Folks, can we get everybody back to their chairs, please?

Minister, are you ready to go?

Mr. Horne: Ready.

The Chair: All right. Mrs. Towle, are you ready to go?

Mrs. Towle: I am so.

The Chair: All right. Preference for back and forth?

Mrs. Towle: Back and forth if you're okay with that.

Mr. Horne: Sure.

The Chair: All right. Whenever you're ready.

Mrs. Towle: Can you also let me know when I have about a minute and a half left? I just have an amendment I'd like to do at the same time.

The Chair: Yeah. Okay.

Mrs. Towle: Minister, I appreciate the opportunity to have a chat with you. As we go forward, I'd like to talk about the insulin pump promise that was made during the campaign and the program. We currently see under item 9.3 on page 117 that there is $5 million there in the 2013-14 estimates, but in January you said that $18 million was set aside in 2013 for the first free pumps, then $8.5 million to $9.4 million for each of the next three years, and then a total of $20.5 million in year 5. I'm just seeing, when I take a look at the estimates here, that what's in the program is $5 million, which is clearly nowhere near $18 million.

So I'm wondering a few things. I'll maybe list out the four or five questions that I have. Feel free to respond. Has the program scope changed? Are there income thresholds? Is there debt financing on insulin pump purchases? Are you rolling out slower than you first anticipated? How many people will be enrolled in year 1? I understand the need for cuts, but this one was a pretty big promise in the campaign and even in January 2013. The numbers still just don't jibe. We're told this program would save money long term. When would that be realized as well?

Mr. Horne: Well, first of all, the reason for the change in the numbers is simply that when we announced the program, we did not have all of the clinical criteria developed. Obviously, we wanted to work with physicians and others. As the criteria have firmed up, we've been able to provide a more accurate estimate of the cost. Nothing has changed in terms of the government commitment. The commitment is to fund both the pump and the supplies that are associated with it for eligible Albertans.

I can tell you that in terms of the current estimate we're showing over three years an estimate of $13.4 million: $3.4 million is the estimate for the first year, $4.4 million for the second, and $5.6 million for the third. In terms of the unit cost the pump cost is projected at approximately $7,000 per patient, and that's estimating that the patient would get a replacement pump every five years. Then the costs of the supplies associated are $3,000 per patient per year.

The number of Albertans that are expected to be enrolled annually: the initial estimate is 300 patients, and that's based on the clinical criteria that have been developed. The benefit administration will be through Alberta Blue Cross. There is no delay in the implementation. We're still planning to implement it this spring, so you can expect an announcement soon about, well, a lot of the information that I've just shared.

Of course, when we made the commitment, we knew that insulin pumps are not for everyone. We did work with clinicians to establish assessment criteria. Other assistive devices that are used also have clinical assessment criteria associated with them, including ones that are implanted directly in the body. We're almost to the point now where we're ready to launch the program, as I said, and release all of the criteria.

Your point about cost avoidance is really interesting because it's very hard to measure. We're trying to get some better data on that now. One consideration is, obviously, the age of the patient when they begin to use insulin pump therapy, so a child is going to have the benefit of the pump over a lifetime. If the pump is appropriate for them, there's going to be a higher cost avoidance. It's really impossible to estimate with any degree of accuracy.

The big thing with diabetes, of course, in terms of additional cost to the health system is the result of the complications of diabetes: renal failure, other circulatory problems, vision loss. You're probably familiar with what all of those are. You know, there's some empirical data out there that we can point to, but we have absolutely no compunction about launching this program for the clinical reasons that support the use of insulin pumps and also for the huge improvement in quality of life that results.

Mrs. Towle: I think I would agree with you that there's clearly a connection between getting people on insulin pumps sooner rather than later because of the cost to the health care system and quality of life and what happens with them. However, in this article you noted that right now "about 1,600 people with Type 1 diabetes are likely eligible," but then you just said it would only be 300. Is that a change? The article I'm looking at is from the *Calgary Herald* dated January 9, 2013, and I'm more than willing to give you a copy of it. Also in there it says: "The health minister said the government has set aside $18 million in 2013." Can you tell me in what line item that's identified? When I look at insulin pump therapy program, line 9.3, it says $5 million. It doesn't say $18 million.

Mr. Horne: The difference in the estimates is simply the fact that we've had a year to firm up the clinical criteria and therefore provide a better estimate of the cost. You know, we started with an overall commitment. We started on an estimate based on the number of insulin-dependent diabetics in the province. We were very clear at the time that the clinical criteria had yet to be developed.

Mrs. Towle: I can appreciate that it takes some time to do that. So you're saying that the actual cost of the program changed from $18 million to $5 million just because once you established the criteria, that changed the budget line item?

Mr. Horne: I have to confirm this for you, but I have a feeling that the $18 million was a projection over three years. Our projection over three years now is $13.4 million. It could be that I misspoke in the interview, or it could be that we're looking at two different time periods.

Mrs. Towle: Okay. Fair enough.

With that, you're saying that $5 million will be allotted for 2013 and that that will give eligibility to around 300 patients, which is an average cost of $16,666 per patient. The pump costs $7,000. Is the administration of the program $9,000 per patient? Is that what the difference is, or what would that be?

Mr. Horne: Well, we can get back to you on this. The difference is likely the fact that the pumps are what is in the line item that you referred to, the cost of the pumps. The cost of the supplies are in the Blue Cross plan because that's where the supplies are paid from.

5:25

Mrs. Towle: Okay. If you could confirm that to me in writing, that would be super.

One of the other things that it noted in this article is that it could cost up to $65 million in the first five years. So the first three years you were saying was around the $13 million plus the $5 million from this budget line?

Mr. Horne: I don't recall that estimate.

Mrs. Towle: Okay. We'll provide you with that just so you have it, so you know what I was getting at.

Mr. Horne: I assume that we're agreeing that insulin pumps are an excellent investment?

Mrs. Towle: I think we're agreeing that anything that saves the health care system money should certainly be looked at. Depending on cost appropriation, I think we could do that.

I want to move on to the Health Facilities Review Committee. In the budget we see that it's been eliminated. According to its 2011-2012 report, which I have here, the Health Facilities Review Committee reviewed 101 facilities, including continuing care, long-term care, acute care, and one other one. I apologize; I don't have it right in front of me. It spoke with almost 2,200 patients. It spoke with over 2,000 residents, 1,600 family members and visitors, and 3,300 staff members. That was just in the one fiscal year of 2011-2012.

Expenditures for this past year were $800,000. It's interesting, you know, the cost associated with that. I'm just wondering. One of the things that that committee does is that it includes unannounced routine reviews of hospitals and nursing homes. I don't know about you, but from my perspective, the unannounced part is very, very important. If we're going to get a true understanding of what's going on in our facilities, I don't think they should get a heads-up saying: I'm coming on Wednesday at 6 o'clock to review your facilities.

The other part of it is that they recognize two significant challenges in long-term care.

> The first challenge is providing care to the increasing numbers of residents whose acuity levels continue to rise while attempting to meet the expectations of family members and communities. The second is providing quality care and services more efficiently and effectively within the resources currently available.

They also noted that "some facilities are reporting that acuity levels have doubled over the past five years."

Given that this is sort of independent and it included many different types of people on the committee, I'm just wondering why you would choose to dismantle a committee that performed these hundreds of unannounced routine reviews of hospitals and nursing homes every year to save about a third of the money that AHS is actually spending in bonuses? [A timer sounded]

Mr. Horne: Perhaps someone will ask the same question later.

The Chair: I bet it will come up again.

Okay. We'll go with Ms Delong, followed by Dr. Swann.

Ms DeLong: Thank you very much. Actually, there was one more question I had on that insulin pump therapy program, and that is: is it that we are going to slowly bring it in over three years and the cost for the pumps is going to be sort of covered over three years, or is it that everybody who really should have one will get it that first year?

Mr. Horne: The program will be implemented fully this year, so we won't be phasing it in. The estimate of the number of people who are likely to be enrolled this year, the number of insulin-dependent diabetics, is 300, and I'm sure that that number will grow over time. But the full program will be implemented this year.

Ms DeLong: Okay. If someone for some reason chooses to get a pump even if they don't fit your criteria this year, will you cover their costs? Is that covered in here?

Mr. Horne: No. The answer to that question is no for the reason that, you know, the program requires that the patient be managed by a physician and a care team. It's actually a medical decision as to whether the patient is appropriate for the application of the insulin pump or not. This is different than some of the other basic assistive devices that we fund. It's a very complex process for a physician to make the determination about the suitability of the patient. I'm not even sure if an individual could independently choose to go on the insulin pump. I'm sure that's possible.

Certainly, some people are fortunate enough to have employer-sponsored health plans that will cover part of the cost. That's one of the criteria, that if you do go on the government program, that coverage applies and the government will pay the balance of the cost. But it will not cover people who do not meet the clinical criteria, and it will not cover people who have purchased an insulin pump or gone on an insulin pump prior to the commencement of the program.

Ms DeLong: Even if their criteria meet your criteria?

Mr. Horne: The cost of a new pump and supplies will apply to people who meet the clinical assessment criteria. People who have gone on the pump previously will not have an opportunity to recover those costs retroactively.

Ms DeLong: Okay. But continuing costs would be covered? It's, like, $3,000 a year in terms of the supplies, right?

Mr. Horne: The answer is yes on the supplies. If they have a pump already and they come into the program and meet the clinical assessment criteria, the cost of their supplies would be covered.

Ms DeLong: Okay. Thank you very much.

Going on to Alberta Innovates: Health Solutions, I was previously chair of that, but of course things have been changing over the years, and it has been, I believe, a couple of years since I was chair of that. I'm interested in why it was moved from Education over to your department.

Mr. Horne: Okay. Well, thank you. It's a good opportunity to acknowledge your leadership in Alberta Innovates: Health Solutions. I'm absolutely thrilled that health research and health services delivery are going to be integrated under the same ministry once again. There are a number of reasons for doing this. Obviously, health research needs a focal point of its own. Later this week I'll be travelling to Chicago for the BIO International Convention, and I'll be meeting with representatives of major biomedical companies across the world and talking about the opportunity that exists in Alberta for them to invest in research,

both pure, or what we would call biomedical research, and applied research.

In addition to giving it that focal point and making it part of Health again, one of the other reasons, of course, is the opportunity to support integrated applied research in health service delivery. You may be aware of some of the work that's been done in bone and joint health, for example, where we now have a situation where there is evidence and decisions have been made about the most appropriate drugs, devices, procedures, and clinical protocols that apply to orthopaedic surgery and other aspects of bone and joint health. This work was largely a result of the research done by the Alberta Bone and Joint Health Institute.

There is an opportunity to do similar research by partnering Alberta Innovates: Health Solutions, my department, and AHS. When we talk about appropriateness guidelines in health care and making best use of our resources, a lot of that depends on research that identifies what the standard should be for a patient with a particular condition. This doesn't get in the way, obviously, of the clinical judgment that needs to be exercised by a physician – and all patients are different – but it can provide us with some very appropriate guidelines that improve the quality of the care that's delivered, whether it's surgery or some other kind of procedure. It can improve the cost efficiency of the care that's delivered.

It can also improve throughput in our system. What we saw when we invested several years ago in additional support for bone and joint health research was that we saw more throughput created in our systems, so more patients could move through the system faster. Part of that research wasn't just getting more people through to surgery. Part of that research was designing a process that would enable us to divert people from the queue who don't actually require surgery or a consultation with an orthopaedic surgeon.

Just while I'm thinking of it, there is a primary care network in Edmonton here, for example, that has an orthopaedic screening program. By standardizing an assessment process in the primary care setting, they have managed to divert 75 per cent of patients who would have otherwise waited to see an orthopaedic surgeon to find out that they didn't need surgery. They have diverted them at an earlier stage in the process.

So this sort of research can be applied in all areas of the delivery system, and having Alberta Innovates: Health Solutions there will support us to do that.

5:35

Ms DeLong: Thank you very much. I came from the computer industry, and there are fantastic things out there available to us. But the hard part is getting them integrated into whatever environment they're actually needed in, and I think that we tend to underestimate that cost. I do believe that it is the same situation in health care, that we can show people, "Oh, there's this wonderful solution," but there is a lot of work in terms of getting it integrated into an organization.

I'd like to move on to family care centres, and the line item, I believe, is back here in terms of family care clinics. You have $50 million there. I really need a family care centre in my constituency, especially tied into support for young families. So what kinds of support will come out of here? Is this just the money for paying the actual employees of the family care centre, or what exactly – how can you help me out in Bowness? You know, with that money there, if we do manage to jump through all the proper hoops, what kinds of support will I be able to get out of there?

Mr. Horne: Recognizing your advocacy for your constituents, I will try to answer your question in the context of the line item in the budget. The funding for family care clinics and the funding for primary care networks can support a variety of services. The goal, as I said in the answer to an earlier question, is not – we do not have a standardized model for family care clinics. We have some standards that we have developed, that will also apply to primary care networks, that will govern what services need to be offered, but the funding will actually go to support a plan that's developed by the community to meet their unique needs.

If, for example, there are already physicians and there are already nurse practitioners but there are no mental health workers available in the primary care setting, there is an opportunity to use this funding to support adding that professional to the team. If there's a desire to develop some unique programming around chronic disease management – for example, perhaps there's a particularly high number of people with type 2 diabetes in an area or a large number of the people in that 5 per cent that we talked about earlier, the 150,000 people with very complex health needs – there's an opportunity to design programs to serve the unique needs of those people.

So what we're seeing here is a shift – right? – from a 1970s style of dedicated program funding, where it's one size fits all and the community or the patient has to meet all the criteria, to something that's based much more on the needs of the community. The funding is there to support the needs of the people that live in the community, whatever those may be.

Ms DeLong: Okay. Thank you very much.

The Chair: Thank you, Minister.

We'll go to Dr. Swann next, followed by Mrs. Leskiw.

Dr. Swann: I'll take my 10 minutes, thanks, just to read questions into the record.

The Chair: Well, five to read into the record.

Dr. Swann: Five minutes. I'll see if I can get through it in five minutes.

The Chair: Agreed, Minister?

Dr. Swann: I'll just read some of these into the minutes. You commented on the cancer legacy fund yesterday. It's impossible for me to track where the $25 million that went to Alberta health and wellness is invested in cancer prevention. Can you give me a breakdown of where that goes to cancer prevention services?

I've heard from some seniors. About 6,000 of them are concerned about the new harmonization with federal income calculations in relation to your pharmacare program because they will be ineligible if they receive disability or WCB benefits. This could be very serious for some of them, and their question really was: would you consider adjusting the income threshold so that these people are not left out in the cold? I assume the Blue Cross is going to take the lion's share of this new seniors' pharmacare program, but it's not clear to me at what cost and how it's going to be integrated with means testing. I'd appreciate some information on how this will actually unfold and what the extra cost is going to be in terms of means testing and monitoring.

Sections 11.2 and 13 and 15.4 in the budget all relate to home care or seniors' services. Can you clarify what's being spent on what in home-care funding? I'm also hearing from the field that there's a very variable quality and access to home-care services across the province. What efforts are being made to provide consistent qualifications and access to home care?

Next question. The Fanning day hospital in northeast Calgary, the seniors' day hospital, has been closed this past month. Ninety seniors are being forced to look elsewhere. These are the most complex seniors, who need care, assessment before care, and some monitoring. This was a special clinic, one of three in Calgary. They're now down to two in Calgary. What's the impact going to be?

With respect to PCNs I would reflect some insecurity among the staff in PCNs. There's been uncertainty about where the minister is going with PCNs and what kind of long-term funding they can expect. Can you dispel some of the climate of uncertainty and the concerns about the uncompetitive salaries they're able to provide if they don't see a cost-of-living increase associated with PCNs?

The private boutique clinics, as they're called, where individuals pay between $3,000 and $10,000 a year for services, some of which appear to be violating the Canada Health Act or potentially are double-billing for both medically necessary and medically unnecessary deemed services: this hasn't been discussed, in my view, well enough. They seem to be just picking up the slack from our troubled public health care system. When will you acknowledge that this is unfair and undermines the credibility of both your ministry and the health care system?

I'd be interested in hearing more about the south campus hospital in Calgary and what the in-patient capacity is at now, what the staffing numbers are, how that's progressing in relation to timelines, and, particularly, the psychiatric beds accessible because there is a significant shortage in Calgary.

Staffing, again, may be affected by the U.S. Obama-care going forward, where the new Obama-care program is going to draw thousands of our health professionals to the U.S., including nurses, which are a challenge for us to get here.

I want to just commend you for the human tissue and blood services increase and would ask about this $12 million and the good work that Mr. Webber is doing in developing this plan. What are the timelines, and when can we expect to see some concrete benefits from this enhanced program?

Those are all of my questions. Thanks.

The Chair: All right. Minister, you've got five minutes. Do you want to deal with some of those now?

Mr. Horne: I will. I'll give some of them a try, Dr. Swann, and we can get back to you on the other ones.

Your question about the cancer legacy fund: 12 and a half million dollars annually is provided to Alberta Health Services from that fund for innovative approaches to cancer prevention and screening, so it's both prevention and screening. The goal, obviously, is to reduce the incidence of cancer. The estimated cost avoidance of reducing cancer by 35 per cent by 2025 is $5.4 billion. It is with that in mind that these allocations are made by AHS with the 12 and a half million dollars we provide annually.

I can give you an example of a couple of the ones that were recently . . .

Dr. Swann: Sorry. I thought it was $25 million.

Mr. Horne: The legacy fund itself is $25 million in total. Each year that is split, half to Alberta Health Services for their prevention and screening and the other half to cancer research; that's Alberta Innovates: Health Solutions, which is now under our ministry.

I just want to highlight one for the record that I think is particularly important, and that's breast cancer screening. In 2011-12 there were 224,904 women screened, and that represents a participation rate of 53 per cent of Alberta women. As a result of these investments we're seeing higher rates as well in cervical cancer screening, colorectal cancer screening, and in other areas.

That's a little bit about the cancer legacy fund. There is information that's publicly available about the allocation of that fund, so I'll leave that with you.

5:45

I do want to talk about your second question because my concern is that you were talking about pharmacare, but I think the eligibility criteria you were referring to was for the Alberta seniors' benefit, which is the income supports program. There are two changes there this year, and they are both intended to harmonize the criteria for the ASB with the federal programs. One is with the exemptions for income, and there are the three areas that you mentioned. The other is a 10-year residency requirement, and again that's consistent with the federal programs. You know, we're going to monitor this carefully, obviously. It was a difficult decision to make, but we are confident that with the other programs that we have available for seniors, we're going to continue to be able to provide one of the highest levels of support in the country for seniors. But those exemptions relate to the Alberta seniors' benefit.

If you will permit me, the other thing I just want to talk about is the reference to seniors' pharmacare. We're introducing a pharma-care program for all Albertans, so it is not a seniors-specific program. It will consolidate 18 different drug coverage programs that are found across government today in, I believe, three different ministries into one program. The goal there is to extend drug coverage to about 20 per cent of Albertans who currently have none. I'm sure we'll be talking more about that later, in the time that's remaining.

Your questions about home care. I'm not exactly sure what the issues are that have been reported to you around quality and access. I made a comment earlier about a concern I have that a lot of home care is actually run out of the hospital instead of out of the community. One of the objectives of the primary care strategy is to put more of the home care into the community, the assessment process, the co-ordination process, and to have more consistency in the workers.

The other thing I think – and I readily admit it – we need to do is to look to the non health care supports that people need in order to live successfully on an independent basis and to live safely. That is a challenge. It's a challenge from a labour market point of view. It's a challenge from a cost point of view. But I can tell you as an MLA that people continue to emphasize with me that it's the non health supports in many cases, if they're relatively healthy, that they look to to help them maintain their independence.

I'll try to get through a few more of these. You asked for the progress on the South Health Campus. This is very high level, but there's information on the Alberta Health Services website. Of the total capacity of the facility, 30 per cent of it is operational today, and 50 per cent of it will be operational by May; 2,340 staff have been hired out of an expected 3,400 full-time equivalents that will be in the hospital. There have been some adjustments to the incremental funding increase for the South Health Campus, but it will still fully open as committed to.

The Chair: Okay. Thank you, Minister.

Mrs. Leskiw: I'll go five and five.

The Chair: You want to go five and five?

Mrs. Leskiw: Yeah. I only have two questions, so I'll just give my questions, then.

The Chair: Okay.

Mrs. Leskiw: Okay. I just have a few comments. As you know, I've been dealing with your office on a regular basis dealing with my seven independent pharmacies, so my questions for you are about pharmacists. Before I ask my two questions, I just wanted to sort of quote some of the things that my pharmacists are saying so that they know that I'm continuing to advocate on their behalf. These huge cuts are enormous and will have an enormous effect on my business: that is what one of my pharmacists says. Another one says: we're not against reducing the price of drugs for people, but the way the province has gone about it has gone too far; there has been nothing given for long-term sustainability, and all we want is long-term sustainability. On that note, with pharmacies still recovering from other generic drug pricing changes, is this going to put them out of business, as some of them say it might?

The next question is: how much is the government going to save by reducing all of these generic drug prices from 35 to 18 per cent? You hear all of these different numbers in savings and that it's going to cost us more, that it's going to save us more. What is it actually going to do? Those are my two questions for you.

Mr. Horne: Okay. On your first question, with respect to the impact of the price change on pharmacists, I mean, it's impossible for me to say. Pharmacies are businesses, and it's impossible for me to say as the Health minister of this province what the impact will be on every pharmacy. The circumstances vary. Some, of course, are part of very large chains across the country. Others are medium-sized pharmacies. Some of them are very small pharmacies. Some of the small pharmacies are part of larger buying groups, so despite their small size they have the opportunity to conduct their procurement as part of a pool. There are very, very many different conditions that govern the impact on pharmacies.

The other thing, of course – and I welcome the opportunity to say this for the record – is that traditionally in this country pharmacists have received much of their revenue from rebates and stocking fees that are provided by manufacturers and distributors. As a government we have no way of knowing what those arrangements are. They are private financial arrangements. I think most pharmacists I've talked to would agree that it's a system that they've been forced into. It's not an optimal system from their point of view.

Pharmacists have welcomed, I think, for the most part the opportunity to actually be paid for professional services that they are trained to provide. Alberta was very much a leader in this respect. We often think of things like renewing a prescription, but some of the services that pharmacists are paid to provide are much more complex than that. They involve working directly with the patient, but they also involve working behind the scenes with other professionals who deliver primary health care. I don't know of any pharmacist in the province who doesn't agree that this is the model that they want to pursue in the future.

In terms of the impact of price reduction, you know, it is important to note that Alberta actually lagged behind most other provinces in the beginning stage of reducing generic drug prices. A trend that we have observed as the prices have come down is that the actual number of pharmacies in the province has increased. Between April 2012 and April 2013 we went from 1,011 to 1,024 pharmacies in the province. When I've taken the opportunity to look at the impact in other jurisdictions, we've seen a similar pattern. We've seen that Ontario, for example, who led the initial price reductions in generic drugs, also has increased the number of pharmacies.

That's the change that we're talking about. What we're doing to support pharmacists in the change is also something that you will not find elsewhere in the country. It began with an investment of $80 million a few years ago in transition support for pharmacists. While, obviously, we're not going to guarantee to pharmacists that, you know, we're going to be able to balance out for them the difference in whatever their arrangements might be in drug purchasing with the new professional services, we did spread $80 million worth of support around roughly 1,011 pharmacies in the province.

In addition to that, for rural and remote areas we have a program that has provided over $15 million over three years. This is the second year of that program, and there are pharmacies in the province that have received up to a hundred thousand dollars in support through that program. That is very significant support.

We have recently added to that $40 million worth of additional support for pharmacists, not all funded by government. About half of it is funded by the savings that we're going to receive from generic drugs. These include things like – and I'm sure you're aware of many of them – an additional dollar per prescription allowance, something we had in place that we're going to extend for another year; the washout period that allows pharmacists during the month of May to sell drugs they bought at a higher price at that higher price; the remote access grant. The criteria has been changed there, and about 44 more pharmacies in Alberta will qualify for that grant because of the change we've made in the eligibility criteria. So more of them of them will be included. Many of them will receive up to $40,000 to assist them in hiring additional staff in their store so that they can go off and do the extra education that's required to take advantage of these new professional services that they can bill for. These are just some of the initiatives that we've put in place to support pharmacists.

I have been accused of not consulting with pharmacists on these changes, and I can tell you that my officials and I have worked very diligently with the Alberta Pharmacists Association. We have worked with you as MLAs to bring feedback to us, and we've done the best we possibly can to support all the pharmacists in a way that would be unparalleled elsewhere in the country.

5:55

The Chair: All right. Thank you, Minister.

We'll have Mr. Mason, followed by Dr. Brown, followed by Mrs. Towle. Mr. Mason, how would you like to use your time?

Mr. Mason: Ten and zero. Five and five, please.

The Chair: Very good.

Mr. Mason: Thanks. I want to talk about mental health because I think this is always the part of the health system that is neglected and shortchanged, and I think that it is being again. I think this budget is doing that as well. The SafeCom projects, including 36 focused on mental health and addictions, lost their funding. I'd like to know what the funding is for the children's mental health plan.

The 10-year plan to end homelessness, which is in a different department but is cited by your officials as key to meeting mental health challenges, is funded at about a third of the level required according to the government's A Plan for Alberta back in 2008.

Stakeholders involved with the FASD plan are saying that there's no growth in funding for four years and that it's not meeting demands, and now we see a 20 per cent cut to the budget line for addictions and mental health. That's a $5 million cut.

I have a number of questions. I'd like to know the total amount that Alberta Health Services will spend on mental health and addiction services in 2013-14, and I'd like the minister to please break it down so we can see how it compares with previous years.

Performance measures show that just 61 per cent of child patients in Edmonton receive mental health treatment within 30 days. The target is 92 per cent, and Edmonton is by far the lowest of any of the regions in the province. I want to know how adult mental health wait time performance measures will be established.

Last year $25 million was allocated to addictions and mental health, which was further allocated as $5 million to wraparound services, $9 million to Alberta Hospital Edmonton, $3 million to psychology and counselling services, and $8 million for children and youth services. Now we've got a $5 million cut to that, and I'd like to know how that is going to be distributed amongst the programs that I just identified.

I'd like to know how many mental health beds we have as of today, the occupancy rate of these beds. I'd also like to know how many people requiring mental health care are occupying acute- or subacute-care beds in the province as we speak.

AHS reports that there were 19,251 mental health hospital discharges in 2011-12 with an average stay of 20 days each, but if you divide those discharges by the 514 beds, we can see that this number in one year would actually require many more beds. I'd like to know the level of undercapacity in terms of mental health beds; in other words, how many more are needed if all 19,251 discharges were to be from designated mental health beds. How many new mental health beds will be added in 2013?

AHS is developing a provincial bed plan for children's mental health beds, including acute, residential, community-based, and group homes. Has the bed plan been completed? What's the timeline for completion? I'd like to ask you, Mr. Minister, if you'll commit today to make this plan publicly available to all MLAs and members of the public as soon as it's complete.

I'd also like to know the actual amount invested in each type of mental health bed, which Dr. Megran agreed to provide us on February 6, 2013, but which has not yet been received by members of this committee. I'd like to know if you'll commit to publicly release the gap analysis by Dr. Cam Wild as soon as it is completed.

I'll let the minister have what's left of my time to answer those questions, but I just want to say that this area doesn't get enough attention and doesn't get enough money. I just think it needs to be elevated in the priorities of the department and of the government of Alberta and in the province as a whole.

Thank you.

The Chair: All right. Minister, you've got five minutes to pick away at as much of that as you can.

Mr. Horne: Okay. Thank you. Well, I'll just start by, you know, expressing my agreement with Mr. Mason that mental health and addiction services have to be a top priority in Alberta and, I would say, across the country. We'll talk about some of the statistics that you've asked for, and I'll provide you the rest subsequently.

In my mind, the optimum in a health system that is serving the needs of citizens is where mental health and addiction services are regarded as part of mainstream health care, where they are no longer a sideline in a budget and are no longer simply measured in the number of beds and the number of grants that are handed out for specific new projects but where people can easily access those services. I talked a bit about the importance of primary health care in helping us realize that goal of making mental health part of the mainstream health care system. So I would agree with you on the importance of the priority.

I'll give you some numbers. You asked about psychiatric and addiction treatment beds and mental health community beds and spaces across the province. We had at March 31, 2012, a total of 1,515 psychiatric beds, 830 addiction treatment beds, and 514 community mental health beds across the province. I cannot speak specifically at the moment to the incremental increase that AHS is planning for next year. I'm not sure about the math of looking at the number of separations and how those would equate to what the appropriate number should be in the increase of the number of beds. We'll see if we can get you some information on that. That is the situation provincially with respect to the bed inventory.

I also am not sure about the number of patients that might be waiting in acute-care beds that are not part of a general hospital psychiatric unit – I assume you're talking about that – for admission there, and I'll try to get back to you on this. We'll see what we can get on that. Obviously, that is dependent upon, you know, the diagnosis at the time of the admission of the patient.

In general terms, I will tell you that last year I was very pleased to support for the first time in many years funding for 80 additional beds at Alberta Hospital Edmonton. This followed a period when I think a lot of people were wondering about the future of that hospital and what the commitment of the government and the health system generally was going to be. That $9 million that you asked about actually supported programs at Alberta Hospital Edmonton. There were four 20-bed in-patient units, for a total of 80 beds, that were provided. An additional $15 million came from the capital transition initiative to renovate the space to accommodate the beds, and that's in the old building 12 on the site. We're on track to open those. In 2012-13 40 of those beds were opened.

The units that I talked about include a young-adult evaluation, treatment, and reintegration services unit. This is for young people. This is for 17- to 24-year-olds who might be experiencing their first psychotic outbreak. Maybe they're newly diagnosed with schizophrenia. There is also a unit that's dedicated to alternate level of care transition from adult psychiatry units in the Edmonton zone. One of my concerns here was to support people who are constantly moving between the hospital and the community, so this unit can be used as a step-up unit for people who are moving from the community into hospital, perhaps for a short stay, and it can also support people who have been in hospital for an extended period of time and are going to give a go at living independently in the community and provide those supports.

6:05

I want to talk about some of the other programs that you asked about. You asked about AHS and what the money that they receive in their global budget is used for. I can tell you about 2012-13. Of the total of $596 million that AHS spent on mental health services and that was distributed here, some of the allocations were almost $251 million for community-based care and $216 million for nursing services alone in in-patient acute units.

The Chair: All right. Thank you, Minister.

We'll go Dr. Brown and then Mrs. Towle.

Back and forth? Five and five?

Dr. Brown: Well, I'll just state my questions up front, and then he can respond. I will try to be brief. I know there are other members who want to get on again.

The first part of my question is that I'd just like to give the minister the opportunity to follow up on a question I asked earlier about whether or not there's any plan to implement any further security features with the Alberta health care card, photo or biometric data or anything like that, to enhance the security and individual identification of the card and, secondly, whether or not there are any plans to integrate that with the electronic health records that are being moved into physicians' offices and providing services.

Then my final question. You mentioned in your earlier remarks, in your opening remarks, Minister, that 5 per cent of the population is costing approximately 60 per cent of the health care expenditures, and I wondered if you had any demographic data as to how many of those folks would be over 70 years, over 80 years, and so on; in other words, the elderly people of the population.

Those are my questions.

The Chair: Minister.

Mr. Horne: Thank you. Your further questions on the health card and the registration process and the audit process: we are looking at a new health care card for the province. One of the models that we're considering is the model in British Columbia, where they have one card which incorporates a driver's licence and a health card and a number of other features. The number on the card is actually also connected to the person's health care registration under the health care insurance plan.

I don't want to say too much about this because it's possible to talk about the opportunities for a long period of time. I want you to know that we're looking at fraud, obviously, as a consideration in going to a new card, but we're also looking at opportunities as to how to use that card to integrate it with a better electronic medical record across the system. You can go to some jurisdictions in the world, and people will actually swipe their health care card at their point of service, and that records the service that's delivered. Other systems incorporate personal health information as part of the card. We haven't made any final decisions with respect to this. I think the card should be a decision that's made based on the improvements we want to make in the electronic medical record across the province, but there are a lot of opportunities there.

I don't want to spend a lot more time on this issue because we talked about it before. I can't give you a detailed breakdown with me – I can get it to you – of the 5 per cent of the people. It's very interesting. It is not all seniors in our population. You know, a popular myth is that the aging of the population is directly attributable to the increase in health care costs. That's not the case. There are many healthy seniors in the population. A proportion of these people includes seniors with complex needs, includes the homeless – I talked about that earlier – people who have unmet addiction and mental health needs.

When Alberta Health Services releases its health plan, there will be a bit more discussion about, you know, the description of the demographic that we're talking about. But as it's been explained to me, a principal reason for the consumption of so much of the health care resources among such a small group of people goes back to the earlier discussion we had about prevention and wellness and focusing on opportunities for earlier intervention with someone.

We think, for example, of maybe a man my age, overweight, occupationally probably not living the healthiest lifestyle that one could hope for, who might be at risk for type 2 diabetes. I might be an individual who's not been diagnosed yet; I might be on the border. We collect the A1C statistics and all the blood tests in Alberta, so if our system is organized to reach out to someone like me when I'm identified and offer me, assuming I'm motivated, the support and the health care services I need to help me pull myself back from the brink of developing type 2 diabetes, I would call that a high-performing health system, and I would call that a dent in 5 per cent of people consuming 60 per cent of health care resources.

Sorry to sort of elaborate on your original question, but, you know, the makeup is important. This isn't a strategy about blaming individuals for their consumption of health care resources. It's actually a strategy about correcting our practices in the organization of services so we're reaching people before they have an acute episode that requires them to show up in an emergency department.

The Chair: All right. Thank you, Minister.

Mrs. Towle, we apologize because last time you'd asked for a heads-up when your time was running out, and we didn't do that. When would you like your heads-up this time?

Mrs. Towle: I'm just going to start off with it. If I can go with a straight five. I've got a list of questions, and if you can answer them, feel free. If you can answer them in writing, it's absolutely fine.

Mr. Horne: Okay.

Mrs. Towle: I do have an amendment. I did notice and appreciate all the efforts that you've made. You deal with a massive budget. I have to admit that I can't comprehend what $17 billion truly looks like, but I'm sure it's massive.

One of the things that I did notice that is in the ministry itself is that a lot of those costs went up, so I would like to make an amendment. A copy of the amendment is coming around. I'd like to move that

> the 2013-14 main estimates of the Ministry of Health be reduced as follows:
>
> (a) for the minister's office under reference 1.1 at page 116 by $27,000,
>
> (b) for the associate ministers' offices under reference 1.2 at page 116 by $548,000,
>
> (c) for the deputy minister's office under reference 1.3 at page 116 by $60,000,
>
> (d) for communications under reference 1.4 at page 116 by $1,001,000,
>
> (e) for strategic corporate support under reference 1.5 at page 116 by $6,547,000, and
>
> (f) for policy development and strategic support under reference 1.6 at page 116 by $1,733,000
>
> so that the amount to be voted at page 115 for operational is $17,010,573,000.

I'll put that into the record.

I'd then like to go on and just ask you a few questions, and if you can't answer them, I totally understand if they have to come in writing. The first one would be to the associate minister. I'm just wondering. On the $500 tax credit for seniors, the activity tax credit that was for seniors in the campaign by the Premier – I understand budget cuts, so I'm assuming that got cut from the Premier's promises because of the budget – I just wanted to know how many seniors would have qualified for that and what the estimated cost for that program would have been had it gone through.

The second one I wanted to just finish off because I never gave you the opportunity to respond on the Health Facilities Review Committee. The Health Facilities Review Committee made 267 new recommendations that year and 72 repeat recommendations.

What will happen to these recommendations now that the committee is being discontinued?

How much is spent annually by the Alberta health services facility audit committee? I'm assuming that probably one of the reasons that this has been discontinued is because the Alberta health services facility audit committee is maybe doing some overlap. However, the problem with that committee is that they actually announce their visits. They provide them with a letter and notice that they're coming, and that sort of defeats the purpose. So that's the question there.

The other question I have. You weren't in the Human Services estimates, but one of the things that is very concerning to me, as you well know, is the position of Michener Centre and the closure. I can tell you that I am against it – and you know that – and we can agree to disagree on why we're against it, but as a person who took care of someone with Huntington's, we know that those care needs that they're receiving there can be very unique.

6:15

One of the things that Mr. Oberle mentioned there was that he stated that every client in there that was a senior would be moved into a continuing care facility or a long-term care facility. We know that there are a number of people with disabilities that tend to get dementia faster than the average person. One of those examples is people with Down syndrome, people with Huntington's. They just have that go with them. But he stated that the people with developmental disabilities from Michener who enter into continuing care facilities or into the Alberta health system would "remain clients of the PDD program. They will be subject to our policies and our direction." He also went on to say that "the persons that are presently in care in the PDD program . . . will continue to be." I'm just curious how that's going to work. How is it going to work that PDD clients will get PDD services under Alberta Health Services?

He also went on, not in my questioning, but I think it was Ms Notley's questioning, to explain that any training that was required to take care of people with developmental disabilities would be provided to all Alberta Health Services staff, and it would be equivalent to the training provided to PDD staff. I'm not so sure he understands how it works when you enter into the Alberta Health Services. In the end it's not always the case. The reason I brought this up is because my brother had Huntington's. He went into Rosefield Centre in Innisfail, a long-term care facility, completely not the appropriate place for him to be, but it was the only place, and we understood that. He waited on a two-year waiting list for the Fanning centre, which is a fabulous facility.

Those are my concerns. Thank you.

The Chair: Minister, five minutes to deal with some of those.

Mr. Horne: Thank you very much for the questions. I'll try to answer some of them, and the others we'll get back to you on. First of all, on the question of the seniors' tax credit, it is still the intention of the government to proceed with this when funds permit. We are not as far along in the policy development as we would normally be simply because we have known for some time that we would not have the funds in order to deliver on that commitment this particular year. So we'll have more details for that as we move into a position, hopefully soon, where we're able to fund it.

You talked a bit about the Health Facilities Review Committee, and you referred to it in an earlier exchange, I think, as well. I do receive all of the recommendations of the Health Facilities Review Committee, and there is a process in my department to track the progress on those recommendations, so we'll be continuing to do that, obviously.

I wanted just to make a couple of comments about inspection and standards overall. You know, I would agree with you that over the years the committee did serve an important need. It was originally formed in 1978, as you may know, and many of its functions now overlap with other standards and audit processes that are in place that did not exist in 1978.

Two examples would be the continuing care health standards that we have today, which are provincial standards, and the continuing care accommodation standards. These standards apply across the board, whether the operator is a public or private or not-for-profit. There are monitoring of compliance processes both in my department and in Alberta Health Services to enforce those standards. There's also the Protection for Persons in Care Act, which I'm sure you're familiar with. There are standards that have to do with infection prevention and control in health facilities.

So there are a multitude of inspection processes that overlap. This particular decision is not a reflection on the good work of the committee. My understanding is that many of those other inspections that occur are also unannounced inspections. They are not always provided with notice. But we're trying to drive some efficiency here in the process. We're trying to reduce some overlap, and we're trying to focus on audit and compliance processes that are tied to actual standards of care. The direct feedback of residents and families is absolutely critical in an evaluation of the quality, and the Health Facilities Review Committee played a really important part in collecting that qualitative evidence and feedback from people. I think a lot of us as MLAs actually play that role. That's the answer to the question regarding the Health Facilities Review Committee.

I'll try to talk a bit about persons with developmental disabilities. I wasn't present at the estimates, so I can't speak directly, you know, to the comments that Minister Oberle made, but I can tell you that we made this decision as a government, and although the closure of the Michener Centre is proceeding and although a number of individuals with developmental disabilities will move into a continuing care setting, I'm sure, as Mr. Oberle would have explained in estimates as he did in the House as well, that all of this transition is going to be focused on the needs of the resident and the family.

Alberta Health Services will be working directly with Human Services in areas like training that you talked about. Minister Oberle's comments around – I'll leave it to him to explain what the program home will be for residents. I believe you said that he confirmed for you that they would continue to be part of the PDD program. But I think the most important thing about this in our commitment as a government is that no one will be moved to an alternate setting until everything is made right for that resident. I think, as the minister has freely admitted, that for some residents in the Michener Centre this could take an extended period of time. In my opinion as the Minister of Health, that is as it should be because this program is ultimately about the quality of life for these individuals.

I can't offer a lot more detail than that. Obviously, the PDD program is not in my purview, but the standards that apply to continuing care across Alberta are. We will enforce those, and we will ensure that PDD residents are looked after in those new settings.

The Chair: Great. All right. Thank you, Minister.

We've got about eight minutes left. Ms Jansen, back and forth?

Ms Jansen: Please, if that's okay.

Just so I have a better sense, I wanted to touch on the savings for Albertans through generic drug pricing. You know, we've heard some worst-case scenarios, but I've got to think that with 4,000 drugs on our list, there have got to be some good scenarios as well. I'm just wondering. I don't know if we can quantify the savings to an individual person because obviously that would depend on the type of drugs and the quantity of drugs they would be getting, but can you give me a sense of where we're going to realize or where Albertans are going to realize some of these savings?

Mr. Horne: There are three areas where savings will be realized, and the savings come on generic drugs. Just for background, there are 2,802 generic drugs on the drug benefit list in Alberta. Just for the information of the committee, the pan-Canadian price reduction to 18 per cent, which took place on April 1, involved the sixth highest volume of generic drugs in Canada.

I'm pleased to tell the committee that we received quotations from the manufacturers at 18 per cent for all of those drugs, and those prices are in effect now. We take that as a very strong sign of our ability to succeed in getting the prices for all of the other generic drugs down to 18 per cent over time, but as you can appreciate, we're dealing with multiple manufacturers. Obviously, in taking a leadership position like this, in the way Alberta has, we expect some push-back from the drug manufacturers. We're getting some of that, and we will deal with that.

In terms of the savings there are really three areas where savings accrue. Government-sponsored programs account for about $1.1 billion in expenditures for drugs. Obviously, government will save on those costs, and that will enable us to be more efficient in the delivery of services, but it will also enable us to provide more drug coverage to more Albertans. In a province where 100,000 people came to live last year, that's an important factor.

The second area – and I'm surprised that more people don't talk about the importance of these savings – is the savings for employers who provide drug coverage to their employees through their own health plans. We know that in Alberta after, you know, our major sectors in energy and agriculture and forestry, when we look beyond that, when we look to where the jobs come from for Albertans, most of those jobs come from small- and medium-sized businesses. Lowering generic drug prices contributes to the ability of those employers to provide jobs and to provide benefits that we want them to be able to provide to their employees. That's good for health care costs, that's good for the economy of the province, and that's good for employers. For the record, I want to say that I think that area of savings is overlooked.

6:25

The final area is for the Albertans who do pay out of pocket. There are Albertans who pay out of pocket for drug costs, so of course they will experience those savings as well. As those prices come down and as our utilization of generic drugs increases over time, we will see even further savings, and our ability to extend drug coverage to our growing population will grow commensurately with that.

There is one other point that I want to make with respect to the reduction in costs, and that is with respect to our policy on generics. Unlike many other jurisdictions in the country, Alberta has what's called mandatory substitution for generic drugs. At the point of dispensation of a prescription a pharmacist is required to consider and discuss with the patient the option of substituting a generic drug where the equivalent brand name drug has been prescribed. When people talk to us about this decision and they talk about simply increasing the use of generic drugs as part of the solution and making drug programs more affordable, they're right, but we're ahead of them because we have this policy in place that requires that lower cost alternative.

All of these things are really important for Albertans today. But when I look at the growing size of our population and our projected growth in the economy in the future, we're making decisions today, in my view, that are going to make it possible for future generations of Albertans to actually have drug coverage. That's a responsibility in any budget. It's certainly about next year and the needs next year and the programs that we all want to protect for our constituents, but it's also a responsibility to future generations. If we want to talk seriously about a commitment to universal health care, to universal access and public funding of health care, we have to be prepared to stand up and make those sorts of decisions.

Thank you.

Ms Jansen: One quick question about the 20 per cent of people you talk about who previously had no coverage and who are now going to have their prescriptions paid for. Do they pay some sort of a subsidy? Is there some amount that they pay?

Mr. Horne: There will be. What we're talking about in this instance is not the reduction in generic drug prices but the introduction of the pharmacare program. The way it will work – and I think we talked about this in House as well – is that there will be a deductible for each person who's enrolled in the program, so the first so many dollars are paid by the individual, and thereafter there will be a copayment for each prescription up to an annual maximum. Again, this is an income-based program. It is a change. There will be people who have concerns about what the impact will be for them.

That's why we're going to take the time to consider carefully not just the impact for what people who have drug program access pay today but what the cumulative impact will be when we look at all of the other support programs that people have access to in Alberta. You know, it's a very important decision. It's one that needs to be made carefully and with consultation. It's that process. It's that pharmacare model that will extend that drug coverage to 20 per cent of people that don't have it.

Ms Jansen: But everyone has a little skin in the game, then. You still have to pay, you know, some kind of a copayment.

Mr. Horne: Well, there will be a lot of people that pay nothing because of their income level. There will be other people who may be paying today, in one of the 18 programs that I talked about, that may be asked to pay a little bit more. That's what happens when you move from, you know, a model where eligibility is based on your age or where you live in the province or what ministry your drug program belongs to. When you move away from that to something that is universal, to something that is income based, you have that opportunity to provide coverage to more people and to provide a more equitable level of coverage to the population.

Ms Jansen: Are there other provinces that are doing this now? Where do we stand in the national picture?

Mr. Horne: I think we covered this in an answer to an earlier question. B.C. had the first pharmacare model in the country. Saskatchewan has adopted this model. I know that other provinces are considering the model as well. We all have the same issue. We all provide some level of drug coverage, but we provide it to a

very limited percentage of our population. What we do provide is based on criteria that vary widely, as I said: age, where you live, what ministry your benefit program belongs to. What we think we have an obligation to do is to try to extend that coverage to more Albertans and, as I said earlier, to try to work to make the access more equitable. It's based on your need, your health care need, and, of course, on your ability to contribute financially to the cost. Do we want to keep the costs affordable for Albertans? Absolutely, we do. We will do everything we can to keep it as affordable as possible, but we also have to consider the growing demand in this critical area.

Ms Jansen: Thank you.

The Chair: All right. Thank you, Minister.

I would advise the committee that the time allocated for this item of business has concluded.

Thank you so much, Minister, to you and all of your staff, for the last six hours.

Thank you to our committee members for helping everything run so smoothly over the past 27 hours. I can't believe it's gone that fast. However, we do have a couple of hours left on Monday, so I'd just like to remind you that we are scheduled to meet on April 22 to consider the estimates for the Ministry of Culture.

Thanks again, everybody. We are adjourned.

[The committee adjourned at 6:31 p.m.]

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