Legislative Assembly of Alberta

The 28th Legislature
Second Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Wednesday, March 19, 2014
3:30 p.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

Ministry of Health
Hon. Fred Horne, Minister
Hon. Dave Quest, Associate Minister – Seniors

3:30 p.m. Wednesday, March 19, 2014

[Ms Olesen in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: Well, good afternoon, everyone. I would like to call this meeting to order and welcome everyone. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2015.

I'd ask that we go around the table and introduce ourselves for the record, and, Mr. Minister, when we get to you, if you could please introduce your staff. My name is Cathy Olesen. I'm the MLA for Sherwood Park. I'll go to my right.

Mrs. Forsyth: Hi. I'm Heather Forsyth, MLA, Calgary-Fish Creek, and Health critic for the Wildrose.

Mrs. Towle: Kerry Towle, MLA for Innisfail-Sylvan Lake and Seniors critic for the Wildrose.

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

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

Mr. Pedersen: Good afternoon. Blake Pedersen, MLA, Medicine Hat.

Mr. McAllister: Good afternoon. Bruce McAllister, MLA, Chestermere-Rocky View.

Mr. Horne: Thank you. Good afternoon. Fred Horne, MLA for Edmonton-Rutherford and Minister of Health. I have a number of officials here with me this afternoon. On my left is the Deputy Minister of Health, Janet Davidson. To her left is chief delivery officer Glenn Monteith. Also in attendance is Mr. David Breakwell, chief financial officer and assistant deputy minister of corporate services. As well, we have joining us Christine Couture, assistant deputy minister of strategic planning; Linda Mattern, assistant deputy minister of health system accountability and performance; Susan Anderson, assistant deputy minister of health information technology and systems; Dr. Alan Casson, the acting assistant deputy minister of health services; Dr. James Talbot, the chief medical officer of health for Alberta; Frank Bosscha, corporate counsel; Dr. Michael Trew, the chief mental health and addictions officer for Alberta; Cameron Traynor, director of communications; and Bernard Anderson and Michele Evans, representing professional services and health benefits program areas of my ministry. In addition, I have a number of members of my own staff: my chief of staff, Ashley Warnock; and my press secretary, Matthew Grant.

Mr. Quest: Dave Quest, Strathcona-Sherwood Park, and Associate Minister of Seniors.

Mr. Eggen: Good afternoon. I'm David Eggen, the MLA for Edmonton-Calder and the Health critic for the Alberta New Democrats.

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

Mr. Sandhu: Good afternoon. Peter Sandhu, MLA, Edmonton-Manning.

Mr. VanderBurg: George VanderBurg, Whitecourt-Ste. Anne.

Ms Fenske: Hello. Jacquie Fenske, MLA, Fort Saskatchewan-Vegreville.

Ms DeLong: Alana DeLong, MLA for Calgary-Bow.

Mrs. Fritz: Hi. It's Yvonne Fritz, Calgary-Cross.

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

The Chair: Thank you. At this point I'd like to confirm for the record that pursuant to standing orders 56(2.1) to 56(2.3) Mr. Eggen is substituting for Ms Notley this afternoon.

Please note that the microphones are operated by *Hansard*, and we'd ask that BlackBerrys and iPhones be turned off or set to a silent vibrate and not placed on the table, like this, as they may interfere with the audiofeed.

Anyway, the speaking order times. Hon. members, as you know, the Assembly approved amendments to the standing orders that impact consideration of the main estimates. Before we proceed with consideration of the main estimates for the Ministry of Health, I would like to review briefly the standing orders governing the speaking rotation. As provided for in SO 59.01(6), the rotation is as follows. The minister may make opening comments not to exceed 10 minutes. For the hour that follows, members of the Official Opposition, Wildrose, and the minister may speak. For the next 20 minutes the members of the third party, Alberta Liberals, if any, and ministers may speak. For the next 20 minutes the members of the fourth party, the New Democrats, if any, and the ministers may speak. For the next 20 minutes the members of any other party represented in the Assembly or any independent members and the minister may speak. For the next 20 minutes private members of the government caucus and the minister may speak, and for the time remaining, we will follow the same rotation to the extent possible; however, the speaking times are reduced to five minutes.

Members may speak more than once; however, speaking times are limited to 10 minutes at any one time. A minister and a member may combine their time for a total of 20 minutes. For the final rotation, with speaking times of five minutes, once again a minister and a member may combine their speaking time for a maximum of 10 minutes. Members are asked to advise the chair at the beginning of their speech if they wish to combine their time with the minister's time.

The chair acknowledges that this is a new procedure, and if members have any questions regarding speaking times or the rotation, please feel free to send a note or speak directly with either the chair or committee clerk about the process.

Three 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 mid-point of the meeting.

Committee members, ministers, and other members who are not committee members may participate. Ministry officials may be present, and at the direction of the minister officials from the ministry may address the committee. Members' staff may be present and, space permitting, may sit at the table or behind their members along the committee room wall. Members have priority for seating at the table at all times.

If debate is exhausted prior to three hours, the ministry's estimates are deemed to have been considered for the full time allotted in the schedule and we will adjourn. Otherwise, we will adjourn at 6:30.

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

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

Vote on the estimates is deferred until consideration of all ministry estimates has concluded and will occur in Committee of Supply on April 16, 2014.

An amendment to the estimates cannot seek to increase the amount of the estimates being considered, change the destination of a grant, or change the destination or purpose of a subsidy. An amendment may be proposed to reduce an estimate, but the amendment cannot propose to reduce the total estimate to be voted on by its full amount. Vote on amendments is deferred until Committee of Supply on April 16, 2014. Amendments must be in writing and approved by Parliamentary Counsel prior to the meeting at which they are to be moved. Twenty copies of amendments must be provided at the meeting for committee members and staff.

Now I would now like to invite the Minister of Health to begin his opening remarks.

Mr. Horne: Thank you very much, Madam Chair. Good afternoon, colleagues. I'd just like to begin by bringing regrets on behalf of our colleague, hon. Dave Rodney, who is the Associate Minister of Wellness. Unfortunately, he was taken ill this afternoon, and he unexpectedly did have to leave, so we bring regrets from the associate minister.

Colleagues, the Health budget for 2014-15 is $18.3 billion, an increase of $628 million, or 3.6 per cent, excluding flood recovery initiatives. The $18.3 billion breaks down as follows: $10.7 billion for Alberta Health Services, $4 billion for physician compensation and development, $1.5 billion toward drugs and supplemental health benefits, $805 million for community programs and other health services, $395 million for the Alberta seniors' benefit and other seniors' services, $393 million to Alberta Health Services for operating costs of new facilities, $326 million for primary health care and addictions and mental health services, $111 million for endowments related to research and cancer prevention initiatives, and $78 million to ministry support services.

The 2014 budget is an investment in families, communities, and seniors and reflects the priority that government places on giving Albertans access to the care they need when and where they need it. It enables us to continue looking after the most vulnerable in the health care system. It also includes strategic investments in areas like primary health care and community-based health services to help keep Albertans healthy and out of the acute-care system.

Next year the government of Canada is providing Alberta with $3.7 billion in health transfer funding, which will cover about 20 per cent of this year's health budget. This is a $1 billion increase from last year. We are investing in total $14.6 billion over and above what the federal government is providing us in 2014-15.

I'd like to take a look now at some of the major areas of health investment proposed in Budget 2014. The base operating funding for Alberta Health Services will increase by $210 million, or 2 per cent, to $10.7 billion. These funds will be used to deliver health services and operate health facilities throughout Alberta. The Alberta Health Services operating allocation represents 59 per cent of the health budget in 2014-15. Over and above this funding AHS will receive an additional $393 million for the operating costs of three health facilities, including the Strathcona community hospital. This breaks down to $341 million for the South Health Campus in Calgary, $30 million for the Kaye Edmonton clinic, and $22 million, as I said, for the Strathcona community hospital.

3:40

With respect to physician services there is a $4 billion budget in 2014-15 for physician compensation and development programs, a $275 million increase, or 7.5 per cent. Physician compensation and development represents 22 per cent of the health budget next year. This includes payments for Alberta's 9,200 physicians and 1,500 medical residents, programs to add more physicians to the health system, and programs for training and support. The budget reflects the costs of the new seven-year agreement with the Alberta Medical Association, which provides 2 and a half per cent increases to fee rates in both 2014-15 and 2015-16 and a cost-of-living adjustment in 2016-17 and 2017-18.

As you will also note, there is a $1.5 billion budget allocated to drugs and supplemental health benefits, representing 8 per cent of our total budget in 2014-15. This money, as we all know, assists Albertans with cancer therapy drugs, specialized high-cost drugs, prescription drugs, ambulance services, the Alberta aids to daily living program, and other benefits such as ground ambulance, prosthetics, and orthotics. This includes $159 million for outpatient cancer therapy drugs, $90 million for outpatient specialized high-cost drugs, $387 million for prescription drug benefits for seniors, $127 million for dental, optical, and supplementary health benefits for seniors, and $138 million for Albertans who don't have a group drug plan or supplemental health benefits through a group plan.

New for 2014-15 are health benefit programs for the assured income for the severely handicapped, or AISH, and the health benefit programs for income-support clients, formerly of the Ministry of Human Services. There is $805 million budgeted in 2014-15 for community programs and other health services. This includes $198 million for community-based health and wellness programs, $173 million for spending on blood and blood products, and $40 million for enhanced home care and rehabilitation. Through the $12 million increase for enhanced home care and rehabilitation $2 million will be used to help up to 1,000 more people go home from hospital with enhanced home-care support, and $10 million will be invested in other continuing care initiatives designed to make further improvements to quality and patient safety.

Turning to investments and seniors, there's $353 million budgeted for the Alberta seniors' benefit, an increase of 6.2 per cent. As we know, Alberta has one of the most comprehensive packages of seniors' benefits in the country, supporting approximately 150,000 low-income seniors. The increase in the seniors' benefit represents an expected increase in demand. In addition, there's a $31 million allocation for special-needs assistance to low-income seniors, an increase of $6 million, or 23 per cent. These funds will be used for things like home repairs and medical expenses. This will help ensure that this unique program continues to be available to our most vulnerable seniors who face unexpected costs.

Over $20 million in loans are anticipated under the seniors' property tax deferral program in 2014-15. Through this program seniors in need are able to keep more money in their pockets by deferring property taxes until their home is sold.

The 2014-15 budget allocates $326 million for primary health care and addictions and mental health. Improving Albertans' access to primary health care is a top priority for our government. There is a $271 million allocation to support primary care networks and family care clinics and $48 million going toward addictions and mental health. Strategic investments in primary health care will help Albertans receive co-ordinated, team-based care that is responsive to their needs, provided closer to home, and prevents

or reduces the need for acute care. Addictions and mental health funding will go toward new and continuing programs, including those for children and youth, as well as enhanced community supports and treatment for people coping with severe mental illness.

An additional $25 million will be used to support the long-term social and psychological recovery for Albertans who were impacted by last year's floods. This funding will also help to promote resiliency in the general population, especially among children and youth, and develop provincial capacity to respond to mental health needs that may present themselves in future disasters.

Another key feature of the budget is $111 million in endowments for research and cancer prevention activities. Transfers from the Alberta Heritage Foundation for Medical Research endowment fund provide $86 million annually for Alberta Innovates: Health Solutions. Transfers from the Alberta cancer prevention legacy fund provide $25 million annually for cancer research and prevention initiatives.

The final part of our $18.3 billion budget is $78 million allocated for ministry support services used to operate the ministry, including policy development.

Let me conclude, Madam Chair, by saying that the 2014-15 budget will allow us to continue spending smarter, achieving better health outcomes for Albertans, and delivering better value for taxpayers. We will spend $50 million every day, or $2.1 million every hour, for the 4 million Albertans that depend on our health care system in the coming year. With the help of front-line health care workers we'll continue to build a healthy Alberta by making health care and wellness programs more accessible and providing them closer to home.

Thank you very much. I look forward to the questions from my colleagues around the table.

The Chair: Thank you, Mr. Minister.

We've had another MLA that has joined the table. If she could please state her name.

Ms Cusanelli: Christine Cusanelli, Calgary-Currie.

The Chair: Thank you.

At this point we will move on to the rotation. It is the Wildrose's opportunity to have 60 minutes. Will you be speaking, Mrs. Forsyth?

Mrs. Forsyth: Yes.

The Chair: Did you want to go back and forth? How did you want to work that?

Mrs. Forsyth: Back and forth.

The Chair: Is that okay with you, Minister? Okay. Thank you.

Mrs. Forsyth: Thanks.

Thank you, Minister, and thank you to all your staff for attending. For my first question I'm going to start on the $10.7 billion for AHS. Can you please tell me who is representing AHS here?

Mr. Horne: AHS is not represented here. AHS is an agency of the government, as you know. We provide them with an allocation, which is the subject we're discussing in these estimates, and then AHS prepares a budget based on that allocation.

Mrs. Forsyth: Okay. Can I just follow up on that? It's an agency of the government, I understand, but we're talking about $10.7 billion. Are you going to be answering questions on their behalf, then?

Mr. Horne: I will answer any questions about any Health expenditure. As I think you know, AHS does appear before the Public Accounts Committee, and there is an opportunity there, obviously, to ask detailed questions of them, but we're quite prepared to answer any questions you might have today or get the answers for you if we don't have them.

Mrs. Forsyth: All right. I'm going to start with page 100 of the estimates, line 1.1, and that's the minister's office budget, $854,000 for the current year, the coming year. Can you give us a breakdown on that budget, please?

Mr. Horne: Sure. We're happy to do that. I'll start off by saying that my office employs several staff. There is a chief of staff and a press secretary. There is a director of operations in my office as well. There is a deputy press secretary, which has been added. There are three administrative assistants, and occasionally there are additional staff that are brought in to support as required.

What specifically would you like to know?

Mrs. Forsyth: Well, I was just wondering about the expenses of $854,000 for your office. Is that mostly for salaries in your office?

Mr. Horne: Yes. The elements in the minister's office line for my department are the same as the minister's office line in any other government department. Obviously, staff functions are the largest part of it. As you know, my travel expenses and other expenses that I incur in my role as minister are part of this category and are publicly reported.

Mrs. Forsyth: Can you tell me how much you spent on travel last year? I know it's posted. How much did you spend specifically on travel?

Mr. Horne: I don't believe we have that information with us, but we'll get it to you.

Mrs. Forsyth: Thank you.

Can you also break down the associate ministers' budget, line 1.2?

Mr. Horne: The associate ministers each have within their allocation for their office an executive assistant. Again, as is the case with expenses I incur as minister, travel and so on, I believe their expenses are allocated to that line.

Mrs. Forsyth: When we're talking about the associate ministers' offices, line 1.2, you have three associate ministers right now. Am I correct?

Mr. Horne: I have two associate ministers that are directly assigned to the Ministry of Health. The Associate Minister for Recovery and Reconstruction for High River was recently also appointed to cover the Public Safety portfolio. So he is linked to my department, and I have involved him in some aspects of emergency medical services. This line item, I believe, does not include an allocation for that associate minister. We're speaking of Associate Minister Fraser. You would have to inquire with him as to which department his office expenses are covered under.

3:50

Mrs. Forsyth: So the associate ministers that we're referring to are Associate Minister Rodney and Associate Minister Quest?

Mr. Horne: That's right.

Mrs. Forsyth: Is there a breakdown on those associate ministers' offices? Is it just split in half?

Mr. Horne: No. We can provide you with a detailed breakdown. There's a global allocation. There is an increase that's noted in the budget for this year, which I understand has to do with the cost for CPP and income adjustments for nonmanagement positions. There's a $12,000 increase. So those are allocated to those mandatory costs.

Mrs. Forsyth: But you don't know where Minister Fraser's expenses are allocated, to what department he'd be allocated?

Mr. Horne: Well, again, I don't want to speak out of turn. Unless anyone at the table knows, we can inquire, and we can let you know about that.

Mrs. Forsyth: Great. Thank you.

On page 100 of the estimates, line 1.3 of the budget is the deputy minister's office, and the budget has increased by $428,000, 47 per cent. Can you explain this expansion in the office, please?

Mr. Horne: The major part of the increase is due to the salary for the deputy minister, which I think you're aware of. That was posted at the time the deputy minister was contracted for a period of two years. Just for some additional information, the benefits for the Deputy Minister of Health are the same as for all other deputy ministers in the government. There is no pension that forms part of that contract. As I said, it's two years in duration and provides for an eight-week notice period.

Mrs. Forsyth: So that line item included the deputy minister prior, and the $428,000 increase is a $428,000 increase in the deputy minister's salary?

Mr. Horne: No. The deputy minister's salary is one element of that. The contract, as I said, is publicly available.

Other components that would be included in that line: the deputy minister component is $0.4 million; there is an increase of $2.2 million to provide additional support for strategic corporate support and policy development. It reflects a realignment of staffing to better administer the work required in the department. As you know, a couple of years ago the former Ministry of Seniors was combined with the Ministry of Health. So there are some additional costs associated with that.

If you look at the line breakdown, you will see a decrease in funding to the program support areas under Community Programs and Healthy Living, Support Programs, and Seniors Services. Treasury Board also provided an additional $1 million to address a potential salary settlement with the Alberta Union of Provincial Employees, which is a contract currently under negotiation.

While it's not specifically a part of this line, one thing that I would like to point out in my budget this year is that the increase in the number of FTEs in the Ministry of Health is significantly less than we have seen in recent years. The total this year is, I believe, six additional FTEs. I believe that last year we saw 30 FTEs. A recent reorganization of the ministry by the deputy minister saw a reduction in the number of assistant deputy ministers and a realignment of many of the senior management positions. So as a department I think that we certainly have much to say about our own efforts to find efficiencies within the department and to do more with less.

Mrs. Forsyth: Thank you, Minister.

Carrying on with efficiencies and increases in staff, then, would you like to tell me the increase of staff in Alberta Health Services? We've been recently given a FOIP. So what is your take on that?

Mr. Horne: You're referring to the question that you asked of me in question period earlier today. I haven't seen the information that you're referring to. I mean, Alberta Health Services is a very large organization, as I've pointed out, getting close to a hundred thousand employees now. We would expect staffing levels in Alberta Health Services to grow at least commensurate with the population growth in this province, which was, I believe, 140,000 people last year. As I think you're also aware from your experience over the years with us, about 75 per cent of total costs in health care are for salaries and wages, and that is true, really, anywhere you look in the country. So I would certainly expect the number of positions in AHS to increase.

There are also three new facilities that came on stream last year. These are not small projects: the South Health Campus, very important to you in Calgary, the single largest hospital construction project in recent years in the country; the Kaye Edmonton Clinic, which opened last year; and, of course, the Strathmore community hospital, which is opening as well.

We can try to provide a greater breakdown, but we're talking about, obviously, a large organization. I would certainly share the view that, as much as possible, we want the additional staff that are coming into Alberta Health Services to be focused on either delivering patient care or directly supervising and supporting those that are delivering patient care.

I think the road map to achieve that is already well under way through the work that Deputy Minister Davidson did during her tenure as official administrator with an organizational review that saw a reduction of vice-presidents from 80 to 10, the removal of two levels of senior management within the organization, and a realignment of all the other management positions to ensure that they directly support those that are delivering care.

So that's an overview of what the priorities are in staffing in Alberta Health Services.

Mrs. Forsyth: Okay. Then my next question, which you brought forward, is that the deputy minister reduced the staffing of vice-presidents from 80 to 10. The 70, we have been told, have new titles and work in the Alberta health care system at the same salary.

Mr. Horne: Well, we're not here to talk about individual people's salaries, and I'm certainly hoping that you're not expecting me to do that. What I can tell you is that the official administrator – and I'm speaking of Dr. Cowell – more recently completed a salary review for Alberta Health Services. We now have a series of salary grids for the senior leadership team. There is only one level of vice-presidents in the organization.

There's a review process that's under way under the direction of the co-CEOs at Alberta Health Services and Dr. Cowell to review all of the other positions that were formerly in that group. There are a number of people that will be reassigned to other duties. In other words, their duties will change so that they achieve the goal of being aligned with direct support of those who deliver patient care. The other key elements of his review, in addition to the

salary grids, were the complete elimination of bonuses, pay at risk, or any other incentive that is non salary based. Alberta Health Services also fully complies with the government of Alberta's guidelines with respect to travel, accommodation, and other expenses. They follow the government of Alberta rules in that regard.

Very shortly Alberta Health Services will be disclosing the salaries of all employees with a salary in excess of $100,000. On the day that the government adopted this policy, I sent a letter to all of the agencies, boards, and commissions within my ministry indicating that I expect them to follow those same guidelines, and that will be forthcoming shortly.

Mrs. Forsyth: Minister, what are the cost savings of the salary review?

Mr. Horne: The annualized cost savings, as Dr. Cowell reported it to me, are estimated to be in the neighbourhood of $4 million a year.

Mrs. Forsyth: On page 100 of the estimates, lines 1.5 and 1.6 under Ministry Support Services are for strategic corporate support and policy development and strategic support. Together they receive about $5 million more this year than last. Why the large increase for strategic support?

Mr. Horne: Well, I'm glad you're asking that question. One of the issues that we've faced in our health care system, in my view – and I think you and I might have actually talked about this last year – is what I saw until very recently as some blurring or some confusion around the respective roles of the Ministry of Health and Alberta Health Services.

4:00

My ministry, under Ms Davidson's leadership, is taking on significant new roles with respect to not only public policy development but quality assurance and monitoring within the health care system. Those functions, very shortly, will be overseen by the Ministry of Health. Alberta Health Services will play a role, but the ministry itself will be responsible for quality assurance and measurement and reporting.

In addition – and we'll perhaps get an opportunity to talk about this later – we are making some changes with respect to how Alberta Health Services is funded. Beginning this year we will be moving out of global funding for Alberta Health Services, which was the subject of your first question, to an envelope-funding approach, where dollars that are dedicated for a specific purpose are funded within a single envelope. I'm happy to talk about that later on today as well.

So what this means is that the Ministry of Health is returning to its appropriate and its rightful role as overseeing policy development; quality assurance within the health care system; funding, not just the allocation of funding but the monitoring to ensure that funding is used for its intended purpose; performance management and reporting; and many of those other functions that are critical to my ability to answer the question about whether our health system is performing as intended and whether we're meeting those goals.

Those things require additional resources, and in your earlier question you asked and I believe I answered that there's an increase of $2.2 million for strategic corporate support and $1.6 million for policy development and strategic support. These things go to ensure that we have a proper alignment between ministry functions and AHS functions.

Mrs. Forsyth: Thank you.

Page 101 of the estimates, line 12.5, shows an increase of $28 million for addictions and mental health. I know we have Dr. Trew here, who is your chief medical officer on addictions and mental health. I'd like to ask: how is the money being deployed? That's my first question. How does this budget reflect the findings of Dr. Wild, who performed the gap analysis on mental health services in Alberta? I'd like to ask you about how the report was released. Why was it done on February 14 at 4:30, actually dumped on your website with no press release or anything, no comments from Dr. Wild? Where, specifically, will the increase go? What kind of services and where? What are you going to do with the psych beds that are all full of preteens right now?

Mr. Horne: There are a number of questions within that area, so I'll take a few minutes to address all of them. I'll speak first to the estimates that are in front of you. The total increase for addiction and mental health services is proposed from $20 million to $48 million in 2014-15. We will be obviously coming forward in the future with more details on the specific allocation, but the focus for the $28 million will be community treatment orders, child and youth mental health – and I'm happy to talk about that – mental health capacity building, and youth residential treatment.

In previous years we have provided grants to not-for-profit agencies to deliver a lot of these services. We will be continuing to do that in the future, but we will not be automatically renewing grants for the sake of renewing them. We intend to take a very critical look at the grant allocation process that we have. We have many good not-for-profit agencies that are delivering care, but we do not have the mechanisms that we need to ensure that they're actually delivering the outcomes that Albertans are looking for.

We will continue to work with AHS to transform the addiction and mental health system in the province. In answer to your last question about the move to envelope funding, one of the first areas that will be enveloped will be addiction and mental health services. So AHS will receive a separate budget specifically for that purpose. There will be accountability measures that are tied to the budget, and AHS will report back.

I think that probably a lot of people around the table would agree with me that, well, in any health system budget but particularly in one as large as AHS we seem to find, no matter where we look across the country, time and time again concerns about insufficient funding for addictions and mental health services. But we also find – and we have observed this in Alberta; this isn't a reflection on providers; it's a reflection on oversight – time and time again that we are unable to account for all of the dollars that were budgeted for addiction and mental health services. A lot of times, as in any large health system, that money gets swallowed up by acute care. So we will be taking some very deliberate steps, as I said, to envelope the money for addictions and mental health.

The other part of your question dealt with Dr. Wild's report. Dr. Wild, actually, if I can correct you, did speak publicly about his report. He came and met with me before the report was released and discussed the findings of it.

Dr. Wild's report is what's called a gap analysis. It is intended to be a resource to support the implementation of the provincial addictions and mental health strategy. What he did – and I think it's one of the most important parts of the work – is that he actually mapped where addictions and mental health services are provided in this province. That is a tool that we have not had in the past. We haven't had that kind of comprehensive inventory. It has been developed as a database that's available to us to use going forward. He made a number of other observations, including

the issue that I just referred to, which is the difficulty tracking the allocation of monies that are provided for addiction in mental health.

I think we've made very good use of Dr. Wild's report. As you know, he did not make recommendations specific to program delivery. He provided data that can be used to serve as a resource to implement the addictions and mental health plan. That's exactly what he was asked to do. That's exactly what he has delivered. As with other types of analysis like this that we receive, we do make them available to the public, and we were quite pleased to post it on our website.

Mrs. Forsyth: Page 101 of the estimates line 12.2 is for family care clinics. It's also a primary initiative, 3.2 on page 50 of the business plan. Eleven million dollars is forecast to be spent in 2013-14 fiscal year, far below the budgeted $50 million. Yet for the 2014-15 fiscal year the budget is up to $63 million. How many FCCs will be open this year? Next year? How close are you to the 140 FCCs that were promised? And my last question: what is the cost of each FCC, and where is the outcome from the three that you have going right now based on your results-based budgeting?

Mr. Horne: Well, I'll start with the last part of your question. We will be releasing some analysis very soon on the three FCC pilots that were established in Slave Lake, in east Edmonton, and in east Calgary. I'm very happy to use this opportunity to give you a bit of a preview of the results. As one example, we have seen in patients that are attached to a family care clinic a 50 per cent reduction in admission to hospital. For those patients that are admitted to hospital, we are seeing a 50 per cent reduction in the average length of stay for those patients in an acute-care setting. Those are just, you know, two of many statistics that have been shared with me that we'll be sharing publicly very soon.

You know, the success of family care clinics is already extremely well demonstrated. I think, if you would agree with me, that the major issue perhaps we're facing in health care today is the appropriate management of chronic diseases like diabetes and hypertension. This type of community-based care that's close to home, that's open when people are available to access it, and that's made available to them on a regular basis is working. We know that about 5 per cent of the population of Alberta accounts for about 65 per cent of the use of health care resources in our province. A large portion of this cohort of people are people that have what they call multiple morbidity, so two or more chronic diseases.

With respect to the FCCs we did announce last fall 23 communities that we had identified for wave 2 of FCC development, wave 1 being the three pilot projects. We are very close to being able to make a positive announcement about projects that are ready to move ahead in all of those 23 communities. I would use this example for two reasons in answer to your question.

4:10

First of all, this was a community engagement process that involved staff from my ministry and other stakeholders working with local community groups, some of them primary care networks as a matter of fact. Many PCNs have expressed an interest in developing FCCs. So we will see very shortly an announcement around those 23 proposals going forward.

That experience, that discussion, that basic community groundwork taught us a great deal about Albertans' preferences for what they wanted to see in primary health care in the local community. We will be making the announcement on those 23 communities. From there we will be announcing further FCCs that, because of this experience, will not require as much time in order to develop a proposal and have it funded. We should be in a position to roll out many more – exactly how many more I can't say – in the balance of the year.

The last part of your question, and then I'll stop. We had, I think, this discussion last year. You asked me a question about a unit cost for a family care clinic. As I explained last year in answer to that question, we don't have a unit cost for FCCs. They are asked to provide certain core services, but they are all uniquely different. What we found in the proposals that we received from the 23 communities is exactly what we asked for. People are looking, first, at what's available in their own community, and then they're looking for what they need in order to enhance what is already available.

On some of the proposals – and we'll share this when we make the announcement later – we see some that focus on after-hours care for patients. There might be a PCN in the community that isn't able to provide care in the evening hours, so they have developed an FCC proposal around supplementing that need. Others want additional professionals, in addition to doctors in their communities, that they think can help with chronic disease management in other areas.

So we do not have a unit cost for FCCs. We will not have a unit cost for FCCs going forward. We are funding enhancements to services that already exist. This is different – and then I will stop – than, of course, PCNs, which are funded on a per capita basis. PCNs, of course, are not clinics. They are networks of independent physician offices, where we provide funding for them to enhance some of their shared services.

Mrs. Forsyth: Do you have a unit cost for the three FCCs that you've already got up and running – Slave Lake, Calgary, Edmonton – a total cost? If you get the cost – you have one cost here, and then you've got some of the other costs under AHS. So the total cost, everything in, for the FCCs in Slave Lake, Calgary, and Edmonton.

Mr. Horne: Okay. I don't think we have those specific figures with us. We will get them for you. Just for the record, the three FCC pilot projects are directly run by AHS, so they receive their funding from Alberta Health Services.

Mrs. Forsyth: Page 101 of the estimates, line 11.1, is acute-care services at AHS. There is a cut here of $27 million. My understanding of acute care is that the occupancy rates are quite high. What is being cut there? Will rural hospitals be affected by these costs? Were the cuts done in consultation with AHS?

Mr. Horne: I'm happy to talk about acute-care services in Alberta. First of all, just for the record, we in Alberta have the highest per capita number of acute-care beds anywhere in Canada. That's been our position for many years now. Just for the sake of illustration, Alberta has 99 approved hospitals for a population of 4 million people. The province of Ontario has 170 or thereabouts acute-care hospitals for their population of well over 30 million people. So when it comes to the availability of acute-care beds, we're very well positioned here in Alberta.

To go to the specific vote for AHS for acute-care services, 11.1, the change is due to a reallocation of funding supported by AHS that better reflects their budgetary requirements and operational needs. As you may know, AHS posted a small surplus last year. The overall annual-based funding takes into account population growth, aging, and inflation, and that was reduced from 3 per cent to 2 per cent to reflect other ministry priorities.

We're talking here as well, I think, about a part of our health care system that is in transition. Through FCCs and PCNs we are delivering more care in the community than we have in the past. We are very successfully avoiding unnecessary hospitalizations – I'll go back to that 5 per cent of the population that I talked about earlier – and we're providing care to people earlier. That is today and will be very significant in the future in avoiding some of the complications of chronic disease, people losing limbs and their sight and so on and so forth.

AHS manages the acute-care bed inventory, but I'd say to you, with the greatest of respect, that a measure of a health care system – well, in 1970 the measure of a health care system might have been: how many hospital beds do you have in operation? The measure of a health care system in 2014 has much more to do with: how well are you doing at preventing illness and injury in the first place? How well are you doing at providing services in the community that don't need to be provided in a hospital? When you do provide services in the hospital, how well are you doing at making efficient use of those resources?

We talked last week. I'm not sure if we talked in the House or not, but I know I was out talking about the latest results in hip and knee surgery in Alberta Health Services, where not only had the length of stay in hospital for a hip replacement or a knee replacement been reduced because of more efficient use of resources and better community care but where that created well over 150,000 additional patient care days. In other words, 150,000 units of time, measured in days, were available for other patients who need to be in the hospital to get those services. That's the direction that we're trying to head in.

Mrs. Forsyth: Minister, with all due respect in regard to the acute-care question that I asked you and the answer, someone who entered the health care system in January spent eight days in an acute-care ward with patients jammed to the rafters, including the patient lounge. How can you say that we don't need more acute-care beds?

Mr. Horne: Well, in order to be able to come to that conclusion, you would have to be able to argue, I guess, that we're making the best use of the acute-care beds that we already have. You know, we can debate this, and I certainly respect that there are other views on the matter, but when you look at the acute-care bed inventory in this province, we do have hospitals in some parts of the province, certainly not the large urban areas but in other parts of the province, where we have empty acute-care beds on a regular basis. So I don't think you can make an argument that provincially we don't have enough acute-care beds. Whether they're all allocated exactly where they should be, I think, is a question we have to answer. Whether they're all being used as efficiently as possible is another question that we need to answer.

We looked at, as well – and I think we talked about this last year – how people actually get into some acute-care beds. Your experience was different, but I think we would all agree that, you know, the role of home care in preventing unnecessary admissions to hospital is actually very significant.

I often use the example of a senior living alone, trying to live independently in the community, perhaps without a spouse, that has a fall in the bathtub that leads to a visit to the emergency department, potentially an admission to an ALC bed and possibly even admission to a continuing care facility that the individual doesn't need.

So through things like the additional $40 million last year and again this year for home care, through things like the destination home program which allow people who are appropriate to return from hospital sooner, and through a greater focus on acute care, we can prevent unnecessary admissions to hospitals in the first instance as opposed to dealing with overcrowded hospitals.

I will acknowledge that, you know, our seven major hospitals in the province do experience periods where they are over occupancy. This has been a concern to me. I provided a directive to Alberta Health Services a little over a year ago to implement measures to reduce the occupancy rates. They have had success in some of the hospitals, not all of them.

There are some functions internal to the management of the health system that I know are being looked at now in the hospital system: discharge protocols, making sure that patients, on the day of discharge, are discharged in a timely manner so that acute-care bed can be made available to another patient. There are lots of areas in terms of efficient management of acute-care inventory that are a priority right now, and Ms Kaminski, who is coming in in June as the CEO, has some very special expertise in this area and some very specific ideas about how to reduce those numbers.

Mrs. Forsyth: I'm just going to make one more comment on acute care, and then I'm going to go on to another question. I have to tell you, Minister, that there isn't an acute-care bed in this province that isn't being used efficiently at this time other than the seniors'. We've been telling you, and the Seniors critic is going to ask those questions about moving these seniors out of the bottlenecks – and Dr. Paul Parks will talk to you about that – and getting them into long-term care.

4:20

We're still waiting for the Health Quality Council review of continuing and home care services, which you mentioned. We understand there's a preliminary report that was delivered to you at the end of February, and we're wondering if you were able to consider budget decisions out of the findings from that.

Mr. Horne: Well, I haven't read the report yet. We are taking a look at it now. I have been told that it doesn't contain specific findings or recommendations. It talks about the process that was used to develop the report, so I want to be really clear about what I asked for there. I asked the HQCA to look at what quality assurance processes exist for both home care and facility-based care in the province, what recommendations they might have with respect to strengthening that process, specifically in regard to the oversight of providers of those services. As you know, those providers include public, private, and not-for-profit providers. That is a very important report, and it certainly will be shared as soon as it's available.

Mrs. Forsyth: When we talk about page 48, goal 1 is strengthening the health system leadership, accountability, and performance. But the AHS performance report was delayed six months last year, and then a radically smaller one was delivered to the public. How does the smaller performance report, with less information, fit under your ministry's number one priority? How can health system leadership be held accountable if the vast majority of performance measures are now reported only internally?

Mr. Horne: Well, we continue to publicly report on the performance of the health system. Alberta Health Services did recommend changes in performance measures to me. We discussed this in the House. I can tell you as the minister in this department that the things that I'm interested in are, first of all, that the performance measures we use are relevant to the experience of Albertans in the health system. If you look at that

list, you will see things like patient satisfaction, but you will also see things like the rate of hospital-acquired infection, which is a major indicator that people look at across the country, so that was certainly a priority in the selection.

The second was – and I would think you would have an interest in this in your role as the Health critic – making sure that the performance measures that are chosen are directly comparable to other provinces and territories in the country. As you know, the Canadian Institute for Health Information is the national body to which, I think, all provinces and territories except Quebec submit data for performance reporting nationally. I don't know about you, but I really don't think it's reasonable for Albertans not to be able to compare the performance of their health system to that of Ontario or British Columbia.

Of course, the third thing was to make sure that wherever possible we were including quality and patient satisfaction, so those are reflected in those 16 as well.

So I think what Alberta Health Services has done is that they've come back with a product that's relevant to the experience of Albertans in their own health system, that allows them to better compare the performance here in Alberta to other provinces, and that where we have high-pressure areas in the system, we're reporting on those and we have the ability to delve deeper.

Those were the bases for the selections. For those people that might want to accuse me of cherry-picking, you know, there are a number here where we are performing better than the national average, and waiting times for hip and knee surgery would be an example of that. There are some others in here where we have some room for significant improvement. If we look at radiation therapy wait times as one example, we do not compare as favourably to other provinces and territories.

So we'll be continuing to report publicly, but I can tell you that it was certainly my view from the day I was appointed the Minister of Health in Alberta that, you know, 50 performance measures, most of which weren't comparable to other parts in the country and none of which we could have any hope to see meaningful improvement on a quarterly basis, were not doing Albertans a service in terms of reporting on that performance. So that is the answer on the performance measures question.

Mrs. Forsyth: Turning to the capital plan, page 72, we see there's $70 million allocated for the 2014-15 fiscal year towards health facilities' capital maintenance and renewal. I asked some questions about facility maintenance in the House this week, pointing out that we have dozens of facilities listed in poor condition. As minister you also mentioned that there was $19 million earmarked for the Misericordia. Can you please provide a breakdown on that $70 million?

Mr. Horne: I'll give you what I know off the top of my head. IMP is the name of the line that you're referring to, I think. IMP stands for the infrastructure and maintenance program. That money currently is flowed directly to Alberta Health Services, and they have the ability within that envelope to determine where they allocate those dollars for infrastructure maintenance projects.

I don't mind admitting that, you know, the costs of deferred maintenance are a real concern in the province, particularly given the high number of hospitals that we have compared to other provinces in the country. We have many hospitals that were built in the 1970s, and I think the oldest hospital in Alberta was constructed in 1954, if I'm correct. I think that's in Beaverlodge. So we have a number of aging facilities that certainly need attention.

You know, we're going to continue to work with AHS to make sure that we're striking the right balance between building new capital projects and appropriate maintenance for the ones that we have in operation. Certainly, I'm not opposed in any way to members on any side of the House pointing out to me in the way that they have individual facilities where they think there are urgent issues. As was the case with the Misericordia, my ministry is not hesitant to demand answers from AHS on specific facilities and what is being done to address those needs.

Mrs. Forsyth: What's the total price tag for deferred maintenance of health care facilities?

Mr. Horne: We estimate it at about $800 million provincially.

Mrs. Forsyth: I just want to go back to the capital plan, which is on page 72. There's a line item that talks about health facilities' capital maintenance and renewal, and you've allocated $70 million. I'd like a breakdown of what you've allocated that $70 million for. That's my first question.

The second one that was interesting is that you mentioned that you're working with AHS on capital and maintenance, yet we're in receipt of FOIPs, Minister, and in fact we're in receipt of 2010, '11, '12, and '13 on capital from AHS and their 10 projects, which they submit to you. We're having a tough time trying to rationalize what they have as number one and then what the government comes out with as number one. Maybe you could elaborate on that also.

Mr. Horne: Well, I'm happy to. I'm sure you would be very familiar, having been a government member in the past, that the budget for capital projects actually belongs to the Ministry of Infrastructure. I've tried to give, you know, a general answer on the $70 million you asked about, but if you want to sort of delve into how infrastructure administers those funds, I'd direct you to the Minister of Infrastructure to go through the capital projects list, that belongs to his ministry.

With respect to the AHS capital plan, as with the former health regions AHS makes recommendations to government around its priorities. Obviously, AHS doesn't set the budget for the province, and they do not have the ability to generate the funds from within their own budget. Obviously, their funds are for operations. Then, as you know, I think, through the Treasury Board process the Treasury Board makes the decisions about which projects will be funded. We certainly consider the advice of Alberta Health Services, and I do in making any recommendations that I do to Treasury Board. But those decisions are Treasury Board decisions.

Mrs. Forsyth: Of the 14 health facilities that are considered to be in poor condition, including a couple that I brought up yesterday, could you give us the status of these?

Mr. Horne: We would have to get back to you on that in writing.

4:30

Mrs. Forsyth: Okay. Thank you.

Page 101 of the estimates, line 10.6, is other support programs. This budget has been cut by $16 million. Can you tell me what is being cut? Grants, programs? How many will be affected by the cuts to the programs?

Mr. Horne: I'm sorry. That line again?

Mrs. Forsyth: Page 101, 10.6, other support programs.

Mr. Horne: Thank you. So on that line the change from the 2013-14 forecast to the 2014-15 estimate is, first of all, elimination of the reserve for demand-driven programs for reallocation to other priority initiatives, $9.6 million; realigning the pharmaceutical health services program to pharmaceutical innovation and management, which is a major function within my ministry, $4 million; and an increase of $333,000 for the hepatitis C dedicated revenue initiative due to increased demand for that program. The answer is that they are changes with respect to grants and department operations.

Mrs. Forsyth: Thank you.

In the business plan, page 48, priority initiative 1.1 is about the e-health records and allowing more sharing of information. Last year, as I know you're well aware, over half a million Albertans had their health information stolen on a laptop. How are you going to ensure that the private health information is protected with an increase in sharing of that information? How much has been spent on the e-health project to date?

I want to refer you to the December 2013 Health Quality Council study. You and I had a discussion in question period about the tragic death of Greg Price. The Continuity of Patient Care study recommends the implementation of the e-referral system attached to the e-health system. This was a priority in 2010, the five-year action plan, and it was to be implemented and in place by March 2015. What is the progress on this so far? Will it be in place by next year, when you said it would be? How much has been spent, specifically, creating the e-referral system?

Mr. Horne: Okay. Thank you. This will be a longer answer. There's a lot there. First of all, we'll talk about the Health Information Act and mandatory breach reporting. As we know, the Information and Privacy Commissioner is conducting an investigation, that I requested, into that incident, so we'll have to obviously wait for the results of that information. I guess what I would say in general terms is that the steps that need to be taken in order to ensure the security of personal health information are extremely well known. They are basic practices that include the appropriate storage of data, the appropriate encryption of data, and a number of other measures, that some of us might refer to as plain common sense, that come into play when you're charged with the important responsibility of being a custodian of health information. I'm very much looking forward to seeing that report and seeing what value it might add in that regard.

I have said that I am now actively considering and looking at options for amendments to the Health Information Act that would provide for mandatory breach reporting. This is something that I know has been discussed and called for in the past. These provisions, should they be brought forward, would address issues or questions such as: should a custodian of health information who understands there to be a breach of information in their custody be required to report that to the people whose health information was affected?

In the case of the medicentres incident we know that the laptop contained personal information of 620,000 Albertans. One of my concerns as minister was whether or not the company had actually notified those individuals. It is true that the Health Information Act today doesn't provide for that sort of mandatory reporting. I believe that it should. As I said earlier, you know, the law is here to protect people, but we also depend on custodians of information to exercise appropriate due diligence when they're storing the information in the first place. The law can back that up. I'm looking at amendments that would provide for that now.

As well, with respect to the HIA in this particular case I needed to ask the Information and Privacy Commissioner to conduct an investigation, and thankfully she did agree and is conducting the investigation now. We will be looking at mechanisms that might perhaps require investigations in the future. I think anything we can learn from any incident like this is very useful. There will be a number of other amendments, as I said, that I have currently under consideration.

The second thing that you had asked about was the budget for . . .

Mrs. Forsyth: How much have you spent to date on the e-health project?

Mr. Horne: Yeah. The answer to that is that $791 million has been spent to date. That's the total expenditure for development of the electronic health record, known as Netcare, in Alberta. That's an investment that goes back to 1999.

Since we're on that, just quickly, a few statistics about Netcare. We anticipate an expenditure next year, the coming year, of $37.1 million; $12 million of that is a capital expenditure, and $19.7 million is an operating expenditure. Commitments to Alberta Health from Canada Health Infoway to support various EHR, electronic health records, projects to date total $126 million. So that has been the federal contribution to the development of Netcare in the province. Today we see approximately – I need the glasses for this one – 43,183 care providers out of 60,000 who have access to Netcare, so that's about 72 per cent of the potential health professionals who could have access to Netcare that actually have it. About 22 per cent of those are physicians and residents, 30 per cent are nurses, 10 per cent are pharmacists, 10 per cent are allied health professionals, and 24 per cent are administrative.

So we are seeing, you know, the uptake on the electronic health record increase each year. I'll come to your question on e-referral in a minute. I'm very excited this year that we will see the introduction of personal health information into the Alberta health portal, which is part of Netcare. This will allow Albertans to see things like lab results, prescription records, other information that might assist them, where they have the ability to do so, to be active participants in managing their own health. That will be a remarkable achievement when you put that alongside Netcare, which incorporates all of the information that health providers need to assist patients in making decisions about their care. Of course, that includes imaging, lab results, clinical records from hospitals, and many other elements.

I'd love to talk about the continuity of care report that the Health Quality Council produced. We are proceeding with the e-referral project. It will be a component of Alberta Health Services' path to care program. You'll recall that the fundamental finding of the report – it certainly cited e-referral as a potential tool. But the fundamental finding of the report was that physicians that were involved in the care of this young gentleman failed to exercise the appropriate degree of accountability for their care of that patient and for the transfer of information and other records to other physicians either known to be involved in that patient's care or anticipated to be involved in that patient's care.

The core issue that comes out of the continuity of care report is physician accountability. I have written to both the College of Physicians & Surgeons and Alberta Health Services, and I've asked them to provide me – and I'm going to be happy to share this information when I have it – with what their plan is to implement the recommendations that were directed to their respective organizations. The e-referral is one of these. We've

allocated $5 million in the access to care grant to AHS for development of the e-referral system. This isn't going to be another computer application that's off on its own as a stand-alone program. This is going to be a tool that's fully integrated with Alberta Netcare so that when health care providers sign on to the Netcare Portal, they'll have the benefit of that information.

Mrs. Forsyth: Thanks, Minister.

Time is short. We've got what?

The Chair: You've got seven minutes.

Mrs. Forsyth: I'm going to talk about something that's dear to my heart and to one of your former colleagues, and that's priority initiative 1.6, that relates to increasing organ and tissue donation. I can't help but notice that on page 100 of the estimates, line 7, human tissue and blood services is forecast to be underbudget by $15 million for the 2013-14 fiscal year. The amount is lower than 2012-13, but the budget for this year and next year is about $172 million.

I've got four questions, so I'd like to get them on the record, please, and if you could respond back if we run out of time. Why was the actual spending below budget for 2013-14? How can you increase organ and tissue donations by spending less on the system? What is being done to increase donations? When will the organ donation registry be up and running? Are there any capital dollars allocated for this fiscal year?

4:40

Mr. Horne: Okay. I'm happy to answer those. The change from the 2013-14 budget to the 2013-14 forecast is that we experienced a surplus due to a one-time prior year surplus that reduced the current requirements. In other words, more money was budgeted than was required in order to operate what we have today as the organ and tissue donation program. My understanding, then, is that the budget for next year was adjusted accordingly. The actual organ and tissue donation budget is located on line 9.4, community-based health services. It is not in the human tissues and blood services budget on line 7. If you refer to line 9.4 – and I'll get a page number for you.

Mrs. Forsyth: I've got it, Minister.

Mr. Horne: So you'll see that there's an increase in the budget for the organ and tissue donation program of $1,895,000. This is specifically to fund the initiatives that were in the legislation that was passed earlier this year. Great question.

Mrs. Forsyth: Sorry, Minister. I need just a clarification. Are you saying that line item 9.4, community-based health services, where we're going from $39 million to $68 million, is incorporating the organ and tissue donation question that I asked you?

Mr. Horne: That's correct. The increase is $1,895,000.

Mrs. Forsyth: Sorry, Minister. We may be a little slow here. Honestly . . .

Mr. Horne: We'll include it in the written answers, and we'll give you the specific reference.

Mrs. Forsyth: Please.

Mr. Horne: So why are organ and tissue donations not going up in Alberta? We've provided more money. Do I think it's simply a function of money? No, I don't. I think it's primarily what we've debated in the House, that it has not been easy for Albertans who wish to register their intent to donate to do so.

That leads, then, to the answer to your third and fourth questions: how do we address that? We will have the online organ and tissue donation registry operational in April of 2014. I have seen a demonstration of this. I'm extremely impressed. It will allow Albertans to electronically register their intent to donate. It includes choices around which organs and tissues an individual might wish to exclude. The data from the system is fed into an organ and registry database, which is maintained by my ministry, the security of which is maintained by my ministry and is integrated with Alberta Health Services' information systems.

We will be in a position not only to make it easier for people to donate, which, I think, will increase donations significantly; we will also be in a position to take advantage of people who have said: "Yes. I want to donate organs and tissues." Should that unfortunate time come for that individual, their intention will be registered electronically. The information will be readily available to health care providers and, where it's appropriate, pending the results of a discussion with family, there is the potential for many, many organs and tissues to be harvested at the time that they are needed.

Mrs. Forsyth: Thank you.

I want to get this on the record because I understand we only have about two minutes. It's on page 49 of the business plan, your priority initiative 2.6, which is that you're increasing immunization rates and decreasing the incidence of vaccine preventable diseases. We all know what happened this year. I know that you've announced an increase of vaccine that would be purchased for the next flu season. How was that number determined? Have any alternate purchasing methods been considered to allow flexibility based on vaccine uptake?

Mr. Horne: Yes. Well, I'll explain what I can, and then we can provide some more detail. The vaccine budget, including the number of doses that are ordered, is determined by the chief medical officer of health, Dr. Talbot, who is here. He makes a recommendation to the deputy minister and myself as to what our orders should be. As I understand it, the vaccine budget, which is an increase from $8.3 million to twelve and a half million dollars, I think, buys us enough vaccine for approximately 45 per cent of the population.

There is a direct correlation between the percentage of the population immunized, the number of deaths we can expect from flu in a particular season, and the number of hospitalizations that we would expect to see. If I recall, as one example, the projected number of deaths at 30 per cent immunization is well over 60. That number goes down to as low as four in a scenario where 45 per cent of the population is vaccinated. If I've quoted the specific number incorrectly, we'll correct that in the written answer.

Finally, hospital use. You had an earlier question about overcrowding in hospitals. The major driver of this is people who are suffering symptoms of flu that have not been vaccinated, and that was indeed the case of the vast majority of people who were hospitalized this year for the flu. So I would really hope that you as a colleague in the Legislature will support the government, in particular in this part of the budget, not only in increasing the budget for vaccine but encouraging more Albertans to come out next year.

Thank you.

The Chair: Thank you.

At this point we'll move on to the Alberta Liberals. Dr. Swann.

Dr. Swann: Thank you very much, Madam Chair. Thank you to the minister.

The Chair: For 20 minutes. Would you like to go back and forth, or how would you like to proceed?

Dr. Swann: Yeah. I think so, for the time being. I may change my mind, but I'll let you know. Thank you.

First of all, congratulations, Mr. Minister, on recognizing the tremendous need in mental health and addictions. I think that was critically needed and is going to be much appreciated, depending on where the money actually goes. Alberta has lagged behind other jurisdictions in the provision of mental health and addictions services, yet the resources poured into middle management positions in these areas have been substantial. There is still a need, I think, to look at where the money is going. Given the government's stated interest in investing in families and communities and the importance of mental health to healthy families and communities, what are your specific priorities within addictions and mental health? Do you believe that in 2014 the budget adequately addresses these priorities?

Mr. Horne: Okay. Well, thank you for the question. Actually, thank you for the support of members on all sides of the House around the need to do more in addictions and mental health services. I think that the increase we're seeing this year, which is approximately $20 million, is a significant increase. I think it can be put to very good use.

There have been two problems, in my view – and I'm talking about my own perspective here prior to becoming the minister – with mental health. The one I referred to in answer to the earlier question. It's very hard in a system that is so dominated by acute care to be sure that the money for addictions and mental health actually goes there. So it's one thing in a budget of, you know, $1 billion or $2 billion for a large health authority. That problem is greatly compounded when you get to a budget in excess of $10 billion in AHS. Specifically, the way we will ensure that the money goes where it's intended is, as I said before, that we will be enveloping the funding for this in a separate budget. So AHS will not get this money as part of their global budget; they will get a set amount. There will be specific terms and conditions that are associated with how that money is allocated.

The priorities that I see coming. Again, we have some details to work out on this, but I believe – and I actually think a lot of you believe – that some of the most important investment we can make in this area is with children and youth. I think we have issues at times with responding to kids that are in trouble when they're identified. I think that's improved a lot in the last few years. But, you know, it wasn't that long ago where for a child that was identified with a potential mental health issue in school, for example, the best that could be done would be to refer that child to a three-month waiting list for the former AADAC service.

Today we have many, many programs in schools across the province. Maybe somebody will pass me the number of mental health capacity-building projects that we have in place. We have dedicated resource officers in place in the school. They're not only providing early identification and treatment; they are training teachers in things like mental health first aid, how to identify kids at risk early, how to work with families. I know there are some schools that are running peer support programs where kids in a senior high school go out to their feeder junior high school and start preparing the next generation of students.

That will be a priority for these funds. Increasing the number of in-patient beds for youth will be a priority as well. We know that we have needs across the province, but I know that we have some very specific needs in Calgary.

4:50

Dr. Swann: Thanks, Mr. Minister. I'll move on if you don't mind.

Mr. Horne: Okay. All right.

Dr. Swann: There are more than 2,000 patients in Alberta living with opioid addiction. With wait times that extend from six to 50 weeks, Edmonton is particularly struggling with addictions services and especially those with comorbidities, with a huge societal cost well beyond the health care costs. Do you have a specific plan to get these patients into treatment, many of whom are not, and get them on the road to becoming safe, healthy, employed citizens?

Mr. Horne: Just to clarify, by opioid dependency are you referring to prescription drug abuse specifically?

Dr. Swann: No. I'm talking about methadone and heroin, sort of the heavier addictions.

Mr. Horne: Well, we have . . .

Dr. Swann: Two thousand.

Mr. Horne: Yeah. This is a growing issue, and as our population grows, unfortunately, we seem to see a higher and higher incidence of it. I don't have a lot of detail, I don't think, to offer specifically on methadone and those types of addictions. What I can tell you is what I said in my answer to the earlier question. We have to identify these children and youth in school, and we have to reach out to them through the school using the school as a hub for those services. I also spoke about the need, I think, for additional in-patient services for some of these patients.

I think the other thing we have to recognize is that it's estimated that about 70 to 75 per cent of people with a substance abuse issue also have a concurrent mental health disorder. As you know, it wasn't that long ago that we integrated addiction and mental health services, and now we're delivering those through the same programs.

I'll just finish with this. We have a challenge in Alberta. We come from a history where these services were segregated, but the clients are the same people. So we are working with a number of the provider groups to provide some additional training so that they're able to deal with a patient within a context of a co-existing addiction and mental health problem and not as two separate silos. I think that's part of the answer as well.

Dr. Swann: Good. I guess my understanding is that a team approach is missing for these people who are addicted. We have people not getting sustained, co-ordinated, multidisciplinary care, and many of them are remaining on the street, many of them are causing huge societal problems because we don't yet have a comprehensive approach to those people with addictions. I'll just leave you with that.

Mr. Horne: Okay.

Dr. Swann: Jumping to the IT system, because I only have 20 minutes, it's nice to see an increase in funding, but we have had 15 years of an evolving Netcare system and electronic medical records, and still you reported that only 22 per cent of physicians are accessing one of the largest data sets in Canada. It's not being capitalized; instead, we see duplication of testing, communications

gaps, increased costs, increased frustration, and patients that are harmed in a system that doesn't communicate with each other. Community systems don't communicate with hospital systems. Even hospital systems in some cases can't communicate with each other. Calgary can't necessarily communicate with Edmonton. Who is responsible for 15 years of failed efforts to electronically connect health professionals and institutions in Alberta? Surely it's not the lack of money.

Mr. Horne: I guess I would disagree with part of your question. I just read some statistics earlier about the access to Netcare by health professionals in the province. It's about 72 per cent of all health professionals today that have access to Netcare, so I think the access is there. I think the challenge is in thinking about these information systems as ways to enable new models of care, new ways of delivering care, things like family care clinics and primary care networks, as opposed to just automating the old ways of doing things.

I think the personal health portal – we budgeted $2 million this year to expand the personal health portal. Rather than, you know, simply accessing information about a particular disease or service, people will be able to see their own clinical information, including information from Netcare. Lab results, prescription records, blood sugar tests would be a good example.

We have some work going on now, as you know, in the new agreement that we have with the Alberta Medical Association. We have discontinued the old physician office service program, which funded hardware and software costs and was very successful in helping physicians move out of paper but didn't really enable them to deliver the new models of care that we're seeing today. We are working on a common electronic medical record system for all primary health care in the province. We are working with the AMA on that. These will be systems that do talk to each other.

Also, with the one health delivery platform at AHS we do have the opportunity to have a fully integrated clinical information system. You would know what that is, but for others that's the information system that is present in hospitals when people receive acute care. Those systems don't talk to each other today the way that they need to.

So this is the value that I'm looking for out of the investment in this area. I think the investment has bought us a lot to date, but as I said, I think it's about looking at it as how we enable better models of care delivery and making sure that – you know, we talk about health professionals working as a team. Enabling them to do that means having them get access to the same information and use it to develop a team approach.

Dr. Swann: Thank you.

Jumping to prevention, we spend about 3 to 5 per cent of our huge Health budget on primary prevention health promotion. What is your target? How do you see shifting investments away from the insatiable acute-care appetite? What new dollars have you targeted for key health risk reductions in childhood obesity, prevention in mental illness and addiction, nutrition policies, et cetera?

Mr. Horne: Well, thank you for the question. I guess I will read about a number of the programs that we have in the area of wellness. It's unfortunate that Associate Minister Rodney can't be here. You know, certainly, wellness programs and prevention programs have to have adequate resources, but the problem has been – and I think you raised this issue last year – that they've been a sidebar to the rest of the health care system.

What I'm looking for for my ministry is, certainly, you know, continuing to build on and expand things like Communities ChooseWell; the healthy school communities wellness fund; the workplace wellness programs that we support in Alberta; things like Uwalk which encourage health-related walking and physical activity; the Get Outdoors Weekend, which Minister Rodney will be talking about, that's coming up in April; our support for prevention through grants to things like the Alberta Centre for Injury Control & Research and a number of other organizations.

I think the problem is that we have not necessarily tied these things together in a way that delivers a result that we can all observe. So we'll continue to support these programs. I don't believe that simply throwing more money at them will actually buy us a better result. I think these are important. I think child and youth health is extremely important, including their mental health. But I also think that primary health care is a big part of the answer.

The primary health budget is separate from the wellness budget. I mentioned about the 5 per cent of Albertans and the 65 per cent of resources. You know, pretty much every admission to hospital for someone with a chronic disease is an avoidable admission to hospital. It means that we've let someone's diabetes get out of control, and they're going to lose a leg.

Dr. Swann: Absolutely.

I don't see a connection between our community care system – that is, primary care – and our public health primary prevention system. I raised this last year at this time. I don't know what's happened to try to integrate better the public health primary prevention system and the physician acute-care system so that we can see some kind of planning for prevention in this province. I can see individual activities in different parts of our society, but I don't see an overarching plan for prevention, and that troubles me.

Mr. Horne: You know, I would agree. This perception of a disconnect: you see this across the country. One of the main reasons is that primary health care is mostly physicians; physicians operate independent of the main health care system, and to get the two working together is a bit of a challenge.

Dr. Swann: Is anybody working on it?

Mr. Horne: Yes, they are.

Dr. Swann: Who? Who is working on it?

Mr. Horne: My ministry and AHS are working on this, and the AMA is working on this, and we've done some very specific things. In a number of the family care clinics and PCNs we have links to other social agencies that focus on the social determinants of health, things like housing and income support. Certainly, the way we see in the future is to use those models to also deliver those sorts of services.

5:00

We're introducing newborn screening, as you know, newborn hearing screening, and there will be other screening programs to come. Those will be delivered through the primary health care domain. People won't have to rely on getting on a wait-list to get into a hospital to access those services. It's really, you know, a case of continuing the effort to make primary health care, in the broadest sense, available to people close to home and at hours that are convenient to them and having the patient's experience be indifferent to which budget the particular program belongs to.

Whether it's my ministry or Human Services shouldn't matter. Those things are coming.

The last thing I'd say – and I know you're short of time – is that AHS is working with us actively in primary health care. We have lots of primary health care type resources that AHS operates. Public health clinics are an example. We traditionally associate them with maternal and newborn health, or we associate them with things like immunization. We are looking at opportunities for those clinics to play a greater role in primary health care so that, you know, we avoid this perceived siloing between primary health care provided by doctors and the rest of the system.

Dr. Swann: Good. Well, just to leave this topic, the wellness strategy is a rehash of the '80s and '90s health promotion framework. I'd like to see a work plan associated with prevention in this province that would show us that we really have a direction, priorities, deliverables, and people involved at those various levels to move us in that direction. Otherwise, the continued insatiable acute-care system and doctors and high-tech medicine will dominate our budget. I don't see any hope for turning that around without a clear working plan.

Mr. Horne: Well, we do have a very comprehensive provincial wellness strategy, which – if Associate Minister Rodney was here, I'm sure he'd be happy to talk at length about the different measures in there. You know, can we go beyond that? We can. I will tell you that – I just wanted to see what Janet had to say about this – we do have the opportunity to put public health and prevention dollars in one of those separate funding envelopes that I talked about earlier.

Dr. Swann: We used to have it, of course.

Mr. Horne: Did we?

Dr. Swann: Community and occupational health, it was called.

Mr. Horne: We're going to bring that back, and that'll be one of the ways we make sure those dollars don't get lost.

Dr. Swann: Terrific. In relation to research I fear that health research in Alberta has been transitioned to knowledge management. What are the delivery implications of not increasing the body of basic knowledge, especially around population health and its social determinants?

Second, how is this funding really affecting health delivery in the areas outside Edmonton and Calgary? How does knowledge translation get outside the urban areas? And if knowledge management is the focus now, we should be seeing differences in the rural practices as well.

Why is it assumed that government should define the goals of research and have such influence on the directions of research? Government departments need research capabilities in a context we have today, with health and health system challenges connecting to economic, environmental, and social elements. I'm deeply concerned we've lost capacity for research across the man-made boundaries due to disruption in organization and leadership and some confusion over direction in research and the lack of expert oversight.

What policy provides direction in balancing this work with the role of supporting clinical and biomedical research? Where's the balance there, and who's setting that balance? I fear that it's government, not experts. Where in these strategic priorities, then, does biomedical and clinical research fit with some of the other cross-disciplinary research? As Alberta Health moves forward towards supporting knowledge management and translation, as suggested by their health research and innovation strategy, how will the funding be divided, then, between biomedical, clinical, and health services research?

Mr. Horne: There's a lot there, so I'll do my best to touch on some of those points, and perhaps we'll . . .

The Chair: Just for the record there are two minutes left.

Mr. Horne: Okay. So there's not much time at all. On this area, actually, I would disagree with the premise that the research agenda is being managed by government. I can tell you that since we brought Alberta Innovates: Health Solutions into the Ministry of Health last year, we've got the single biggest delivery platform in Alberta married up with over $83 million in research funding. A lot of that work has brought us things like the improvements in wait times and the quality of hip and knee surgery. It has brought us reductions in the waiting time for lung cancer treatment and access to specialists. There is a lot going on in the area of applied research, that is being done in partnership with industry, that's being done in partnership with other governments.

You know, I had the opportunity a few months ago to meet with a number of global CEOs who are interested not just in bringing new drugs to market in our province but in actually making a contribution to improving systems and processes that drive a higher quality of care. There is concern out there – and I'm glad you raised it – about: what is the role of basic research, and are we preserving our reputation as a global leader? I believe that we are. I think that we still look to the universities to drive the agenda when it comes to basic science, and Alberta Innovates: Health Solutions certainly supports that work. That is our tradition in Alberta through the Heritage Foundation for Medical Research. We're doing both. We're seeing very significant grants from the Canadian Institutes of Health Research for things like the spore grant that we just received and supporting patient-oriented research and many others.

Dr. Swann: Could I just get one quick pitch in regarding the private lab that's being bid on in Edmonton today? I think it's critical that that lab be located adjacent or coterminous with the University of Alberta. Otherwise, all the training, all the residents, all the medical students will be travelling hither and yon to get some of the important lab stuff that's being done. I don't know if that's possible to include in the terms of reference of your bidding, but I would hate to have the company decide where it was going.

The Chair: Thank you. The time has concluded, and now would be a perfect time for a five-minute break. If we could be back promptly, and then we'll move on to the New Democrat rotation.

[The committee adjourned from 5:07 p.m. to 5:12 p.m.]

The Chair: Okay. If I could have everyone, please, take their seats – it's been five minutes – and we'll get back to work. We have a quorum.

The leader of the New Democrat – oh, I'm sorry. I gave you a promotion there. MLA Eggen, did you want to go back and forth, or how did you want to do it? And don't break this news to Brian.

Mr. Eggen: I'm not even the leader of my own family.

Well, actually, I wouldn't mind trying something, hon. Minister. I wouldn't mind trying the 10-10 thing for something different, right? [interjection] Yes. That's not the Wildrose 10-10, Lord knows.

Mr. Horne: Not that 10-10.

Mr. Eggen: Yeah. Then we can move to something else after if that's okay with you.

The Chair: Yeah. That's fine.

Mr. Eggen: Thank you so much for the opportunity to speak to you here this afternoon and for all of your staff to be here as well. I know that it's a lot of information. How you can react to the intensity of questions is impressive. I'm just trying the 10-10 version here just to give it a try. Quite frankly, I've never done it, plus I'm trying to do a bit of a cleanup from the other critics asking questions.

My first question is global in nature. In regard to the budget from last year to this year I'm just wondering what percentage increase it actually is. And if your comments can perhaps reflect on the fact that we use an agreed-upon combination of the per cent of population increase in the province plus inflation – I think that was agreed upon in this budget at about 5 per cent – I'm just wondering how your global health budget stacks up against that issue. Of course, if there is a discrepancy, then, really, if we are looking at an increase sort of from last year but less than the 5 per cent that we see with population and inflation, that means we have to look for some cuts in various areas around this budget.

My second question is quite specific. I'm looking in this new budget here for any new funding in regard to in vitro fertilization. It's a procedure that has been considered elective here in Alberta, but I know that there's been a lot of pressure across the country and specific to Alberta to include it as part of our public health system in some form. In vitro fertilization can have the benefit of controlling this procedure quite a lot more and has shown a demonstrable reduction in the requirement of using neonatal units and extra care and other health benefits, that ultimately results in economic benefits, too. I was watching to see, because just before the budget there was some talk about this, and I just haven't seen where there might be even a pilot project to start to include in vitro fertilization as part of our public health system. I would appreciate that one.

The next question I have is in regard to mental health and the GAP-MAP. I appreciate the increase that we're seeing in this year's mental health budget, but I just wanted to know if the ministry is accepting the conclusions that we found in this GAP-MAP exercise, that we just went through, and about the systems level. You had the information from that GAP-MAP before this budget was submitted. I'm just wondering: what areas can I look for that directly reflect your response to that GAP-MAP to address some of the problems that were brought forward in that very extensive and very useful report, that was brought forward by Dr. Wild here fairly recently?

My next question is in regard to seniors' health benefits. We've been scratching our heads for a week or more now in regard to how this budget demonstrates anticipated savings in regard to seniors' nongroup benefit plan changes. We'd really like to get a fuller account of that because we would like to see, certainly, some savings there. We just can't quite understand the logic around how those anticipated savings might be realized here in this budget. In regard to the seniors' drug benefit just in general, I'm glad to see that your ministry has moved back from the plan or the intention to change the benefit payout and how that might be going. I just wanted to express my gratitude on how this ministry has backed off on that plan.

My next question is, I guess, in conjunction with the seniors' drug benefit plan. I just want to know if this ministry has looked into reducing the premiums for nongroup plan holders. I'm just finding that people find that quite expensive. You know, even with some temporarily subsidized rates or even the possibility of beginning to reduce or eliminate seniors' drug fees in this year's budget, I just know that we have an opportunity here to maybe start to build the road map for a more comprehensive universal pharmacare plan, that other provinces have been talking about. I just wanted to see if maybe there were some reflected tracks in this budget that would demonstrate that we're looking to reduce premiums, maybe eliminate some drug fees for some groups, and build the beginning of a framework for a universal drug plan that could perhaps be tied into a national plan.

My next area – I know this is a lot of information quickly, but you certainly don't have to answer it all here; you can send me the information later – is in regard to the Misericordia hospital and the infrastructure problems that we see in association with the Misericordia. I know that a few days ago we talked in the House about some money that was put forward towards the infrastructure in the Misericordia – it must be from last year's budget – but I'm just wondering if there's a more comprehensive . . .

5:20

The Chair: For your record there are three minutes, 23 seconds left. Sorry; I missed the five.

Mr. Eggen: Okay. Well, maybe I'm just going to stop, then, for a moment. I do have this amendment that I want to pass through, so I want to use my time to do that. If I can just give the amendment to have it passed around. Because we're not voting on the budget here, I'm just going to read this amendment in. The Alberta New Democrats are doing this for each ministry that does have associate ministers. This is part of a larger thing that we've put forward for this year's budget. I'll just read the amendment into the record. Everybody has got a copy of it here, but we won't be voting on it today, so that's fine.

The amendment reads as follows:

> Mr. Eggen to move that the estimates for the associate ministers' offices under reference 1.2 at page 100 of the 2014-15 main estimates for the Ministry of Health be reduced by $561,000 so that the amount to be voted at page 99 for operational is $18,246,948,000.

This is as part of our initiative to eliminate the associate ministers from cabinet in general.

I'm probably getting short on time now?

The Chair: One minute and 44 seconds.

Mr. Eggen: Okay. Great.

The last little bit, then. I know that the Misericordia themselves have talked about a requirement for at least $36 million for some infrastructure. You know, also, just to bring up the larger issue, it feels like you're putting good money after bad if you're renovating something but don't have that larger plan to build a new facility. I just wanted to know if there's any small plan or any budget provisions in this budget to start the process to actually build a new structure for the Misericordia hospital.

Thank you very much.

The Chair: Thank you. You still have 59 seconds left if you want.

Mr. Eggen: No. It's okay. That's fine. Thanks. There was obviously lots of information there, so if there's anything that you've got to look up after or what have you, please feel free to pass it forward to us later on.

Thanks again to everyone for doing this today.

Mr. Horne: Okay. Thank you, Mr. Eggen. I'll attempt to cover off most of the areas that you've mentioned here.

First of all, in terms of the global increase for Health the percentage increase is 3.7 per cent this year over last. The estimated population and inflation growth, as I understand it from Treasury Board, is approximately 4.9 per cent. I stand to be corrected on that, but that was approximately the estimate. Your question leaves out, of course, the possibility that we might need to do more to get better value from the dollars in Health that we're already spending.

We talked earlier and answered some questions about higher than average rates of hospitalization in Alberta and avoidable hospitalization in Alberta because of not enough access to primary and community-based care. Those sorts of things all play a major role. In looking at the global increase that I received, if I compare us to other provinces, we are certainly in the range of increases that we see in other provinces.

Historically, of course, the Health budget in Alberta has increased by about 8 to 10 per cent per year, so we've been far above other provinces. I know, as an example, that last year Ontario only had a 2 per cent increase.

So that's the factual answer to your question. I think that for me as the minister in this department the question is: what is the value that we are getting from those dollars, that $18 billion? Do we have the systems and processes in place to know that we're getting the maximum value? I believe we're getting much closer to being able to answer that question.

I'm very pleased that you raised in vitro fertilization. It is true that it's currently not a publicly funded service in Alberta. Some provinces have included limited access to IVF. We're quite actively looking at it now. I have a great deal of empathy for prospective parents in Alberta, couples who have challenges around conception and access to reproductive technology. IVF specifically is going through our health technologies assessment process now. I'm quite serious about looking to see what the options are so that we could provide some access.

You mentioned also, you know, multiple births. Some of the considerations will be in the technology review. If we look at Quebec, as an example, they have a restriction on the number of embryos that can be implanted and the number of trials that are funded. Those are some of the considerations that come into a decision. It's not simply a question of whether to fund it. It's for whom and under what circumstances. But we certainly are looking at that right now.

In mental health you talked about the GAP-MAP report, that Dr. Wild did, and I think I answered your question earlier on a couple of fronts. You know, one of his major findings was: you don't seem to have a system in place to make sure that the money is going where it's intended to go. I indicated that we're moving to envelope funding for addictions and mental health this year as well as some other areas, including public health, for the record. You know, his conclusion was essentially: you need an inventory. He's provided us with that, so we know where all the services are now. Those are adult mental health services.

I did talk with him about the need to do something similar for children and youth and also to have some assessment of the need, which we have not yet been able to quantify, for individuals who are in kind of the margins of our population, so for people who are homeless, for example. Technically that's a bigger challenge, but we are certainly committed to developing a better understanding of what those needs are.

In conclusion, the role of that report, then, will be to support the implementation of the provincial addictions and mental health strategy. I'm glad you're supportive of the increase in the funding of $20 million. From some of your comments I take it you'd be also supportive of making children and youth a priority for the allocation of that funding, and that's exactly what we intend to do.

Now, I'm very happy to talk about seniors' benefits, and I go back to some of my earlier comments. You know, the position of seniors in Alberta and the support that's available for them to live independently are actually, I think, unsurpassed anywhere else in the country. In some of the areas that Minister Quest is overseeing like the seniors' drug benefit – and I'll come back to that and talk about it specifically – there's $127 million here for dental and optical programs for seniors and a 6.2 per cent increase in the Alberta seniors' benefit. The property tax deferral program: those are loans that are made available to seniors so that they can take money they would otherwise have to spend on their property taxes, and they can devote that to other services, including drugs and other supports that help them live independently. That's about a $21 million item in the budget. The aids to daily living program, which is the most comprehensive that I know of in Canada, is $135 million, with an additional $40 million for enhanced home care and rehabilitation. Those are just some of the examples of the services we're providing for seniors.

Let's talk about those drug benefits because we know they are very important to all of our constituents. We are projecting a decrease in spending in drugs and supplementary benefits overall of 5.9 per cent this year and the decrease that you mentioned of $128 million in Seniors. Really, it's a proportional decrease. The seniors' drug program is, I think, about a third of the total, probably higher than a third of the total, closer to half of what we spend in that category, so it stands to reason we're going to see the decrease there.

5:30

So what are the issues? The issues are not related to the seniors themselves, obviously. People need access, and they have access in Alberta to some of the most comprehensive drug coverage in the country. The issues come down to – well, you referred to one of these things yourself – the lack of a national approach to catastrophic drug coverage for Canadians. I'm the minister in a province of 4 million people. There isn't a whole lot I can do on my own, acting independently, to make the prices that we pay more comparable to the prices that other countries like New Zealand pay for drugs.

Part of the strategy to work within this budget is to use our positions with the Council of the Federation, a health care innovation working group which we colead, and to use my position as the co-chair of the federal, provincial, and territorial ministers of Health to quite frankly push the federal government quite hard to recognize this. Until we begin to pool our population health risk, our need for drugs, and our financial resources, I don't know what the future will hold for Canadians. In Alberta, as the highest per capita spender on health not just in Canada – actually, we spend more per capita than some developed countries in the world – if we're having difficulty in this area, you can imagine what other, smaller provinces are coping with. So that's a big part of it.

As the second part of this strategy we will be continuing to try to reduce the drug prices that we do pay. We saved about $80 million last year in total through reductions in generic drug prices if I'm correct. I invested about 50 per cent of those savings in enhanced services that pharmacists now provide, which includes, actually, supporting seniors in complex medication management.

Those are just two of the strategies.

The Chair: There's about one minute left.

Mr. Horne: Okay. We'll get back to you with written answers on some of the others.

The last point I'll make. We will continue to provide seniors with access to the drugs they need. We can't forget the fact that 20 per cent of the citizens of this province have no access to any drug coverage whatsoever. So part of our goal has to be to manage all of these 18 programs, that we're combining into one, in such a way that we make some room for those 20 per cent of people that we are all so concerned about.

Mr. Eggen: Thank you so much.

The Chair: Great. Thank you very much.

At this time we will move on to the PC rotation, and up first we have Mr. Sandhu.

Mr. Sandhu: Thank you, Madam Chair, for giving me a few minutes to ask questions.

Mr. Minister, I'm a little bit confused on the organ donor budget. The hon. Member for Calgary-Fish Creek asked you a question. You already answered. If you look at the item, I think it's about a million dollars and a little bit of money in the other ones, page 101, line item 9.4. Could you explain to us how much it's increased in the human organ donor registries and awareness?

Mr. Horne: The budget for organ and tissue donation is actually not in that line. It is in line 9.4.

Mr. Sandhu: Yeah. There's $20 million there.

Mr. Horne: There's a $1.8 million increase for organ and tissue donation there. So we're actually spending more on this area, not less.

Mr. Sandhu: Remember that I had an organ donor bill pass through the Assembly, Bill 201. I've got a copy. Why is it taking so long to proclaim this bill? It was only about awareness for the organ donors, nothing else. There's no money involved. Nothing. Are you saying that we cannot get people to donate an organ? What are you doing on that? Why did you hold onto it for three years?

Mr. Horne: Well, I would argue that we haven't held on to it. I would argue that your bill actually raised the necessary awareness to get where we are now, where we're not only spending more on organ and tissue donation, but we've actually got some concrete plans in place to make it easier for people to donate organs and tissues. You know, my argument would be that it was your bill that actually initially raised the awareness around the issue. We put it together with some of the ideas in the other private member's bill that was passed in the Legislature. What we've got as a result of your leadership and that other hon. member's is a better product. We can talk about this now or later as you wish.

In Alberta we do not have the legal authority, I'm advised, to compel people to sign the back of their organ donor card, but what we can do and I think what your bill helped us realize is that we can use things like the electronic registry to make it easier for people to donate. You know, the next stage of that is coming up – this is actually more in tune with your bill – later in the spring. When people go to renew their driver's licence or their personal identification card, they're going to be asked on the spot if they want to register their intent to donate. That information will be able to be put in the database and potentially encoded right in their driver's licence or their personal identification card. So I think we've come, you know, a long way as a result of the leadership that you provided, and we're going to see those donation rates go up very, very substantially.

Mr. Sandhu: Just for your knowledge, you know, the Sikh community in Toronto is almost a million people, and they've kept talking to me the last couple of years. They have a TV show, and they talk about organ donors. It is simple. My bill was just: yes, no, undecided on the organs you want to donate or you don't want to donate. It's simple awareness, and that takes so — like in the community in the Toronto area, you know, it gets up into everybody's head that we have to donate organs. As your ministry we need to do more. We have only 16 per cent of Canadians donating their organs. We could do more. We could save a lot of people's lives. In health care: we could even save money on that side. We need to do more. Just, you know, any bill possible, we need to take action on that, not sit on the shelf for the next minister to come and proclaim.

Mr. Horne: Yeah. Well, I agree, and I think that's what we're doing, and as I said earlier, we'll being opening up the electronic registry in April, early in April, and the driver's licence and personal identification card will follow shortly after. The thing we're going to do after that, of course – and I think you and I talked about this – is that we need a better home, a designated home for the organ and tissue donation function within the government. We don't want it to get lost in, you know, the myriad of other health programs and services and mixed up with hospitals. We want it to be obvious. We want to focus on it. So we will be watching later this year the organ and tissue donation agency for Alberta, that will oversee, you know, the recruitment of donors, the harvesting and transplantation activities, working with other people across the country. Also, it's not just about donating, as you say. It's actually about the transplantation itself.

Another one of the areas where we'll be moving to envelope funding with AHS is in organ and tissue donation. So it will no longer be just part of the global budget. It will be separated off along with mental health and addictions, along with public health, along with some other areas, and we'll be able to follow where the resources go that we put into this.

Mr. Sandhu: Thank you.

The Chair: Thank you.

MLA Fenske.

Ms Fenske: Thank you very much, and thanks for being here. Yesterday, I think, the Minister of Service Alberta mentioned over and over again the health portal. So he was here. He broke the ice, I guess, more so than he had to.

A few questions. First of all, physicians, and it would have to do more with remuneration. I know that at one point in time you spoke about trying to get the physicians we need or the specialists we need. Sometimes we may have enough bodies that fill the requirement of physicians, but they're not the right physicians for the needs, particularly in rural Alberta. In this budget is there a look-see if you can encourage certain specialties?

Mr. Horne: Yeah. Thank you for raising this issue. This is something that's very difficult for provinces to do. The assignment of residency positions is done through a national process, and it results in real disconnects between the areas where we really need doctors and actually where we get doctors. As an example, last year we saw right across the country a very large number – I don't have the exact number in front of me – of orthopaedic surgery residents who graduated who couldn't find

work. That was true in Alberta as well. Yet in the whole of Canada we only have about 200 geriatricians, and we only have about 20 in Alberta. We need geriatricians, we need family doctors, and we need psychiatrists.

5:40

We're looking at what strategies we might be able to employ within Alberta to try to steer in this direction. We've never really had a physician workforce plan in the past, so we've never had a long-term view of: in which specialties do we need doctors, and where in the province do we need them to locate? We're working on that now. There are some other provinces that are doing the same thing, so that will be a base of knowledge to work from. I think, certainly, through your efforts and other members' we know where we need to attract family doctors.

In terms of the support for rural physicians, the rural physician action plan is a $10 million program. The bill for locums in Alberta, which are typically 89 days, where a physician from another part of the province – each locum is worth on average about $126,000. We have within our agreement with the AMA things like the business cost program, $66 million; the rural, remote, and northern program, in which a physician can earn up to $60,000 in addition to their regular billings per year. That's about $38 million. So I would say to you that the lever isn't the money. I think the lever is the planning around where we need them and getting the co-operation of the universities.

The other thing I'm talking about with the Minister of Innovation and Advanced Education is how we manage our enrolment in our medical schools. At the moment we don't really have any parameters around the number of seats. We're doing some good pilot work around distributed medical education. This year, for example, we have a number of medical students from the University of Calgary that are studying in Lethbridge.

So it's a very complex issue. I think the bottom line is that we have to provide not only the right incentives but have the right planning to make sure we get the specialists we need where we need them.

Ms Fenske: Thank you.

I know you're aware of the issue with respect to physician assessment, that when they come to our province and they have to go through their assessment period, there is sometimes a backlog there finding, I guess, the appropriate physician mentor. Hopefully, we'll find some tools to be able to encourage those needed services.

Mr. Horne: Just on that point, there are really two things. There are international medical graduates, and as MLAs we all know about some of the lengthy procedures and requirements that they face when they come to practise not just in Alberta but in any other province in the country. We're working with the college on it. The system today is very much focused on looking, obviously, at the country where the physician is coming from, but it's very much focused on observed practice of the individual physician in the care setting. I'm sure that's very important, and we leave it to the college to regulate the practice of medicine.

We also know that there are countries that have very similar medical school curricula to what we find here in Canada. The experience of practice as a family physician in countries like the U.K. and Australia and others is very similar to what we see in this country, both in their education and in the model of practice. It's a case of trying to find the right balance.

What we are doing – and I want to particularly acknowledge Premier Redford for her leadership on this – is that we are working to develop more dual licensing arrangements with neighbouring provinces. We have them in place now with B.C., and we have one in place with Saskatchewan as well. If you're an MLA in a border town, you know some of the problems that that has caused in the past, so we've got that addressed.

Ms Fenske: Super. Thank you.

My people in Vegreville would be very disappointed if I didn't ask about the maintenance dollars or the new capital dollars, eventually, for St. Joseph's hospital. I appreciate that you've added $20 million to a budget that's been typically about $50 million over and over. I've heard from Covenant Health and Alberta Health Services that those just aren't enough dollars. I know you addressed that earlier today, but do we have dollars to fix the boiler and do some of those things?

Mr. Horne: We do. I explained in the earlier answer that AHS receives a budget through the capital plan, which is $70 million in each of the next three years for the infrastructure maintenance program. So AHS actually makes the decisions. You know, as the minister I have asked some questions about where the priorities are and will continue to do that going into the future.

But I'll say for the record that your advocacy for the Vegreville hospital is probably unparalleled. I know it. I've visited it. I understand that we have to attend to the aging infrastructure. Absolutely.

Ms Fenske: Okay. I only have one more quick question, and that would be with respect to mental health. I know you said that we're now doing envelope funding and you're looking for the outcomes. I think you mentioned partnerships with schools at some point in time. I know the successful model program in Elk Island public schools. People rave about it. Will there be any kinds of controls in that envelope funding to be able to encourage programs that are working now, or do they start from point zero?

Mr. Horne: Yes. That's one of the benefits when you move to an envelope approach. If you're talking about – I'm going to talk about it because it's near and dear to my heart – the mental health capacity building project, the latest numbers, there are 37 projects in 55 communities in 153 schools in Alberta. Will these programs continue to be funded? Yes, they will.

One of the things I'm talking about with the ministers of Education and Human Services is: how can we expand that? I'm not in a position to make, you know, a specific commitment with detailed funding to it today, but I can tell you that the three of us have talked about a vision where every child in every school would have access to mental health and addiction services where and when they need them. If there's any place that this can be done in Canada, it's here.

I know some of the programs may be listening for some reassurance on this. I would want them to be reassured that their funding is going to continue and that we're looking at how we can expand this to every school in the province.

Ms Fenske: Thank you, Mr. Minister. And they called it model because they thought mental health capacity building just didn't hit it for the elementary and junior high school age.

Mr. Horne: Yeah. Excellent point.

The Chair: Thank you.

MLA Fritz.

Mrs. Fritz: Thank you, Madam Chair. Mr. Minister, I'd like to begin by thanking you personally for all of your assistance to my constituency and the province of Alberta. It's been absolutely amazing, the work that you and your staff have done. I'd like to thank your staff as well. You've just got such knowledge that you've put out there. You know, no matter what we've brought, you've developed solutions along with your staff, and I just really, really appreciate it.

The one area that I wanted to especially thank you for, though – and I had been at the announcement – is the cancer care centre in Calgary. I know it's capital and that we're in operations mainly with this budget, but it's very exciting news. What I wanted to ask about that is – I think it was the functional plan that you had mentioned was in place right now – when you would expect to have results from that functional plan and whether you're considering having a P3 with that cancer care centre.

Mr. Horne: Sure. Well, first of all, thank you for the compliment. I know both associate ministers, Quest and Rodney, would want to join me in thanking all of our staff. They work extremely hard, so I appreciate your acknowledgement of that. We join you in acknowledging them.

The Calgary cancer centre is moving along. I expect to see the functional plan within the next six weeks or so. It's nearing completion now. The project certainly could be a candidate for a P3, for a private-public partnership. I will certainly have some input into that decision, but that's ultimately a decision for the Minister of Infrastructure in consultation with the Treasury Board in terms of how it's financed. But there's absolutely no question that this project is going ahead.

You know, the cost is anticipated to be in excess of a billion dollars. We have in the capital plan now, you'll see, about $160 million that's been allocated so far to support the planning and design and the initial phases of construction. It is very exciting. It will be a leading facility in the country, and I think Albertans will be very proud of the final project. We will move ahead without any delay on this. You are from Calgary; you'll know about some of the capacity challenges that we already have at the Tom Baker centre.

5:50

Mrs. Fritz: Thank you.

A second question I have. I hear it often said that you received a billion dollars from the federal government and that that billion dollars is sitting in your budget. I was listening carefully, and in your opening comments you said that the Health budget was going to be increased by $628 million. So would you please explain about that billion-dollar transfer payment from the feds?

Mr. Horne: Certainly. I'm happy to. Alberta's funding under the Canada health transfer increased this year, and the reason that it increased is that the federal government, after many years of advocating by Alberta, finally recognized that as a principle of fairness they should be funding that transfer on a per capita basis. Up until this year there had been a cost-sharing formula that had determined the amount of the Canada health transfer, and our position was that we received a disproportionate amount compared to other provinces. Of course, we're the fastest growing province, so we're very pleased to see that.

It's the move to the per capita that results in the increase in the Canada health transfer. Does that money go directly to the Health budget? No, it doesn't go directly to the Health budget; it goes to general revenue. Like any other minister, I have to stand up and argue for my budget in front of Treasury Board. As I said in my earlier comments, I think we're very well funded in Canada, in Alberta with our health system. We're the highest on an age-adjusted basis in the country. So we don't have a money problem.

For people who have raised questions about the $1 billion, I think what they should know is that the federal government share of our health expenditure in Alberta has gone from 15 per cent to 20 per cent, so the federal government is paying more of its share. It's certainly significantly more than we've seen in the past. In fairness to my colleague ministers, you know, there were provinces that received less under the Canada health transfer as a result of this change, so there are other people that are having a much more difficult time. But we are well funded, and it's nice to see the federal government step up and contribute 20 per cent.

Mrs. Fritz: Thank you.

I think that's almost the end of our time here, so I'm hoping to get back on the list. Before I do go, I'd like to thank you as well for the neonatal intensive care beds that were opened in Calgary. They were so needed, and it's just good work.

Thank you.

The Chair: Thank you.

We still have a rotation. We can go back to Wildrose, Alberta Liberals, NDs, PCs. There are 10 minutes each.

I'm getting pressure and requests from people who want to adjourn, but we still have more work to do, and I think that we have to keep taking care of business. I think that if people need to leave, then they leave, and we will continue with the business.

At this point, Wildrose, you have 10 minutes. Will we do five and five back and forth?

Mrs. Towle: Yeah. Five and five – it's not very long – if that's okay with the minister.

Mr. Horne: Yes. That's fine.

Mrs. Towle: Okay. Thank you so much. I'd like to start out on page 102 of the estimates. Over the last number of weeks we've heard a shocking number of stories emerge about the substandard care in our facilities and, in some cases, the abuse. I know that you have a review under way, and I can appreciate that, but what I see under line item 15.3 is that the funding for licensing and monitoring of supportive living accommodations is actually being cut. We saw last year the complete removal of the Health Facilities Review Committee, which could go into every single facility unannounced and provide inspections. So it's concerning that we're seeing that one taken down a little bit. I'm just wondering what specifically will be affected by this cut. Will the number of monitoring visits be affected, the quality of the inspections, the number of inspectors? Exactly what does that cut entail?

Also, on page 101, line item 10.5 – this is an issue that's very near and dear to my heart as somebody who took care of a person in a long-term care facility – we also see that the budget for protection for persons in care is being cut. That is hugely concerning, especially when we saw the situation with Revera and saw three deaths at Revera, including the story of Violet MacDonald, where, due to sepsis and wounds that should have been able to have been taken care of very, very easily, she unfortunately ended up passing away from her injuries. During the protection for persons in care inspection process, that seven-month process, which is an excessive amount of time as it is, there was another death for the exact same reason.

One, if it's taking investigators seven months to complete an investigation, it seems to me that this would be the area that

requires substantial investment rather than taking money away from them. One has to ask if that means that there will be fewer investigations or fewer people available, fewer resources to ensure that our seniors in care are properly taken care of.

Also, in light of the number of protection for persons in care reports that we recently saw, after a nine-month delay in the reporting in July, that just got released quietly again on the website on February 28, the number of protection for persons in care reports is rising, and the number of sexual abuses and physical abuses is also on the rise. This has a direct relation to those in care. It seems to me that the profile of the legislation is certainly higher than it's ever been. It's very important legislation, and I appreciate the minister's commitment to protection for persons in care, but it certainly does seem like this would be an area that you would absolutely not be cutting.

It would also seem that when we see increases in the budget like, say, in the deputy minister's office, which saw an increase large enough to at least cover the cuts in both protection for persons in care and supportive living monitoring, it would seem that it would be more appropriate to cut the bureaucracy versus cutting the actual areas of the government that are meant to protect those who are in care. So those are my first two.

I'd also like to indicate: would this cut to the protection for persons in care line item have a direct impact on that agency's ability to report in a timely fashion, when the report is due to Albertans, the public report? Or is this going to result in more delays in releasing the protection for persons in care report? The next report is due in July of 2014. Will we see another nine-month delay in the reporting on abuse of people in care? Will the cuts to that area have a direct impact on that? That's very concerning to me.

The other thing I'd like to address is that we are still seeing the hundred-kilometre rule for seniors in care around the continuing care placement list. The first available bed policy is still rampant in the Edmonton region and central region. We have Alberta Health Services telling people right now that they have to take the first available bed. We have letters – and I'm happy to provide them to the minister – from people who actually have the documentation. I'm wondering where in the budget you are accounting for all of the people who are sitting in acute-care beds with long-term care needs, not continuing care needs, and where we see the increase in the budget to move those 500 people. We know from your own reporting that the number of people waiting in acute care for long-term care placement has risen although we're not going to see that quarterly anymore because you've chosen not to report that.

Thank you.

The Chair: Thank you.

Mr. Minister.

Mr. Horne: Thank you. I'm sorry, Madam Chair. Just to clarify, are we on five and five?

The Chair: Five and five. Yeah.

Mr. Horne: Okay. Thank you. A number of things raised by the hon. member. First of all, very specifically, on your question about the reduction in line 10.5, protection for persons in care. That decrease of $133,000 is reduced administrative costs. The reduction does not impact in any way the inspections that occur or the number of visits that will occur.

You referenced the former Health Facilities Review Committee. I think we talked about this last year. We have moved from a qualitative feedback model, which was an important function but a function primarily fulfilled by that committee, to a function of enforcement of provincial standards.

As I mentioned in answer to an earlier question this evening, one of the reasons that the ministry budget is increasing is that we are bringing into the ministry a much greater role in overseeing inspection and enforcement of provincial standards. That will be a change. We will not be relying solely on Alberta Health Services to investigate those facilities and simply pass the information on to us. Obviously, they'll have a role in the inspection. One of the core roles of government is quality and safety in the health care system. That's one of the reasons that you see the increase on the health system side.

6:00

You know, you made a number of comments with respect to the Protection for Persons in Care Act and, first of all, the results that come out of the annual statistical reports, which also concern me. Also, you've raised – well, not here, but you've certainly raised it in the House – the issue of whether the recommendations that come out of those reports are followed up on.

I am going to talk about the changes that I've asked for, the review that I've asked for. There are really two issues for me, and I think you probably share the same concerns. The first is: what is the analysis around the implementation of recommendations that have been made in each of those reports? I have the department looking at that now. I think, quite frankly, that we should be able to answer those questions, you know, on a timely basis, on a basis that provides Albertans with the assurance that they would like to have that the recommendations are actually implemented. So all I can tell you on that is that, again, using the ministry as the lead in this, we're beefing up the process on that, and we'll be able to report on it.

The other thing I would say, though – and of course this is prefaced by, you know, the idea, that we all share, that even one instance of abuse is one too many. I would say, in fairness, that by design – and the hon. Member for Whitecourt-Ste. Anne will know this because he was very much involved, as I understand it, in developing this act – this act has a very broad definition of the term "abuse." It's designed, as I understand it, in order that we encourage people, first of all, to report and, secondly, that we use the opportunity of the reports to learn from things that can help us improve the system going forward. Obviously, some of the cases that we heard of this year were extremely disturbing, and I'd be the first to acknowledge that, but I'd just balance that off with a reminder that we've got a very, very broad definition of the term "abuse" in that act.

I'll move on here quickly to some of the other points you raised: persons waiting for acute and subacute care, persons waiting in acute and subacute care for continuing care. As of December 31, 2013, 285 people were waiting for long-term care, 20 people waiting for supportive living 3, and 230 waiting for supportive living 4 or 4-D, and that's a total of 535. That number is down 66 since the last quarter. You know, is that number higher than I would like to see? Absolutely it is. But what I can also tell you is that the ones who do need admission to facility-based care are waiting a shorter period of time than they have before. I believe we're down to an average wait of less than 30 days now, if I'm correct, for people who are in that position.

I don't know how much time I have left.

The Chair: Seventeen seconds.

Mr. Horne: So maybe I'll get another question where I can talk about the model for continuing care going forward. We've put a

lot of thought into that in developing this budget and business plan.

The Chair: Great. Thank you.
Now we'll have Dr. Swann.

Dr. Swann: Thank you very much, Madam Chair.

The Chair: Is it back and forth or five and five?

Dr. Swann: Back and forth.
It's now been six years since the wholesale renovation of health care in Alberta, and I'm not sure myself whether the nine regions have finally been incorporated into the payroll system, this single payroll system.

Mr. Horne: Yeah, they have. There were seven payroll systems, and they're now one.

Dr. Swann: Congratulations.
Can you tell us more about the new strategy for continuing care to improve quality?

Mr. Horne: Yes. Thank you for asking. About eight months ago now we put together a group of leaders in the area – obviously, Alberta Health and Alberta Health Services, a number of the major operators, and we'll be expanding this to include residents and families as the next stage – to really look at the model of continuing care that we have in the province to date. A lot of us as MLAs who have concerns about how much care someone may be being provided will say: you know, we need more long-term care beds. The reason most people point to that is because the legislation that we have on the books today guarantees a minimum number of skilled nursing hours per day per resident under that nursing homes operation regulation.

I believe and I think everyone who's been involved in this discussion so far believes that there are, quite simply, too many levels of care in the system today. I think that if you count all of them, including independent living and home care, there are something like seven. But what we are seeing instead is that the profile is not that fine a distinction. The profile of a resident in SL 4 or SL 4-D is in many cases – and this is my opinion, based on my own observations and my own constituents – pretty much the same profile as someone that's in long-term care.

What we are looking at is changes in a number of avenues. First of all, we will be enveloping all of the funding for continuing care as part of the same process that I talked to you about earlier. Part of the review is going to look at the levels of care and what we might be able to do to simplify those. I think it's pretty tough for some people to support a mum or a dad in making an informed decision when you have all of these different levels of care. The distinctions are apparent to people that work in government, you know, that sort of thing, but they're pretty much incomprehensible in some cases to the average person. So we're changing that, and we're going to need support for the changes that we want to bring forward.

The third thing is the funding model. I know that last year a lot of people here asked me questions about patient care based funding. AHS did do a review of that model, and there were a number of recommendations that were made. We are prepared to take a step back as part of the work that we're doing now and look at the whole funding model for continuing care. People are concerned, you know, that there might not be enough resources that are allocated to things like mental health and dementia and palliative care as compared to other services.

So we are looking at it both from the point of view of "What are the services we want to fund?" and then "How do we provide some flexibility to front-line staff?" I'm not talking about the operator here. I'm talking about the nurse who's in charge of a floor where she or he might have a disproportionate number of dementia patients and what flexibility they have in order to make decisions about adjustments on a month-to-month basis.

I don't want to get too far ahead of myself – we're involving a lot of people in the work – but we do realize that there is a need to rethink the structure that we have and, quite frankly, some of the underlying assumptions that we have around continuing care.

Dr. Swann: Thank you.
Emergency medical services has changed little since the major investigation by the Health Quality Council: frequent red alerts, patients waiting hours and hours in hallways, and a recognized inability to respond to a disaster in the two big cities – a plane crash, a multiple-car crash – requiring dozens of ambulances and professionals and then waiting hours and hours in emergency rooms with all of these disaster patients, let alone emergency surgical suites.

The interim director of EMS is still in place after a year, leaving several interims beneath him. Is there a problem that we're not seeing in renovating this system and providing the resources and the leadership and the management that's needed?

Mr. Horne: Thank you. I'll try to be brief here, but there are a few points that I would want to make in respect to this.

First of all, I would disagree. I think we've made a lot of progress in EMS in the last year. As you know, this issue of EMS becoming part of the health care system goes back to 2007, when some of the initial changes were proposed by a former minister of health and wellness, and I think we have succeeded in making EMS part of front-line health care delivery. We recognize the role that municipalities have played in providing the service traditionally, but I think that even municipalities themselves realize that these aren't municipal services. These are health care services, and they need to be part of the health care system.

We have completed most of the recommendations that were outlined in the Health Quality Council of Alberta report. I was very happy with the support of colleagues, some colleagues from different parts of the province, to complete the collaborative dispatch model for the province. I anticipate we'll be sitting here next year, or someone will be, at Budget 2015 talking about the fact that the entire province is on the same computer-assisted dispatch technology, that we've got two provincial centres and three satellite dispatch centres that can see the whole province, that can provide backup and co-ordination.

6:10

I have ensured that there's some stability around air ambulance services while we look at that part of the system, so operators are having their contracts renewed for three years. I know that's really important to some of our rural colleagues.

You raise an important question about focus. EMS is so important to our system, so we are studying the possibility now of whether we need a separate agency that brings all of the EMS resources together – ground ambulance and air ambulance – in the way that some other provinces have done, in order to allow us to manage it and get it that focus and the co-ordination that it needs. Certainly, there's some room for improvement.

I've asked my department to present me with some options to do that. One of the benefits of that arrangement, one of many benefits, would be, you know, an ability to deal with this issue of

interfacility transfer, which now comprises about 30 per cent of all ground ambulance calls in the province. You can imagine the possibility if we organize things so that all of those transfers are in a separate stream and if you and I were MLAs in a system where we had a 30 per cent increase in the amount of emergency resources that could be used for emergencies. So that's where we're headed.

On the record I want to thank the staff in my ministry and AHS. I think they provided excellent leadership in this area. Meetings like I had today with the Alberta Association of Municipal Districts and Counties and the Alberta Urban Municipalities Association are reinforcing that, so we will continue that. There's certainly more to do.

Dr. Swann: Thank you for that response. I guess I would ask you to look at some of the longer term internal work environments that many, especially the big-city EMS workers, tell me has not changed, has not improved, and is continuing to be a tremendous barrier to the kind of quality and outcomes that we all want.

Mr. Horne: I would agree. One point of interest is that in the last two years we did an awful lot with expanding the scope of pharmacists and actually paying them to do some of the things that they're trained to do.

I believe the same opportunity exists with paramedics. We're working really hard right now to bring paramedics under the Health Professions Act. People have talked to me about opportunities for paramedics in community settings like family care clinics and primary care networks. We have areas in the province – and other provinces do this as well – where they're used in long-term care and continuing care settings, and they avoid a lot of unnecessary trips to the hospital for a resident that's in distress.

We actually think part of the answer to the issue will be looking at the role of paramedics beyond just transporting someone from A to B. There are still some issues in Edmonton, and I don't mind saying for the record that I'm aware of what those are, and I'm following up very directly with AHS.

Dr. Swann: In Calgary as well.

Mr. Horne: Okay.

Dr. Swann: Thank you.

The Chair: There are 19 seconds left. We're good to go? All right. Thank you.

From here we'll go on to MLA Eggen.

Mr. Eggen: Thank you so much, Chair.

The Chair: Back and forth or five and five?

Mr. Eggen: Well, if that's okay, back and forth?

Mr. Horne: Sure.

Mr. Eggen: Yeah? Okay.

In the first round I had some questions in regard to the Misericordia hospital, and I guess the last thing that I was talking about was the idea that you put renovations into a building but that at some point it's sort of good money going after bad, right? So the resolution to that would be to begin some process in this budget that would start the new hospital in motion. I'm just wondering if there's any small provision here, either in planning or otherwise, that would maybe start that ball rolling to build a new hospital at the Misericordia.

Mr. Horne: There's nothing specific in the capital plan for new hospital development in Edmonton this year. Obviously, we're just bringing the Edmonton clinic on stream, and we have the new facility in Strathcona county that will be opening shortly.

We do need to look at a new facility for Edmonton. I would say to you, you know, that I think a lot of the $19.2 million that we've provided to the Misericordia has already been spent. It's gone to good use. I have asked Covenant Health to provide me with an estimate over the next five years of what additional funding on top of that they might require. But you're right. That's about holding the status quo.

It's not just the Misericordia. The bigger issue is: what additional hospital capacity is required in Edmonton and the capital region, and where should that be positioned? We have tremendous growth in all parts of the region at the moment, so it's a question of looking beyond just the capacity that exists in the Misericordia. The first step in this is actually not the money; the first step in this is having a reliable needs assessment, which I've asked Alberta Health and AHS to get to me as quickly as possible. You know, the time horizon we need to plan here is the same as the time horizon they used in the '70s, 20 and 30 years out. So that's where we stand.

Mr. Eggen: Yeah. Sure. That's good, I mean, but in the interim, I guess, we need to make moves to fix some parts of the hospital, certainly the Misericordia, so I hope that we can push forward there. Are there additional funds available to do that bridging renovation at the Misericordia over this next financial year? I know that documents that I got suggested that they were looking for, like, $36 million, maybe over three years, and then you came back with the $19 million. I just need to clarify it somehow, right? So you haven't received that information from Covenant, how much they need to do that ongoing maintenance.

Mr. Horne: No. But you'll see in the capital plan that there's $70 million there each year that's allocated for infrastructure and maintenance. I mean, there is additional funding available. My understanding is that they spent about $6 million of the $19.2 million so far, maybe 6 and a half million dollars.

Mr. Eggen: Yeah. Mostly on the flood.

Mr. Horne: Yeah. Obviously, we always have the ability to look elsewhere in the capital plan to see if we can realign cash flows to support the Misericordia. We don't always end up building things as quickly as we planned for, so there are opportunities within the capital plan to adjust those cash flows. That's something that I have to apply to Treasury Board to do, but I'm quite confident that the Misericordia is going to have what it needs to maintain its current operations for the next five years.

Mr. Eggen: Good. That's what I'm trying to do, too, so we're pushing in the same direction, I think, right?

In regard to the lab services the RFP was moved over to April 1 now, I guess. Are there provisions in this year's budget to start that process? I know the RFP was meant to close a couple of weeks ago, but certainly during this financial year there must be provisions to start to make that transition to the winning bidder, and so forth, in this budget, right?

Mr. Horne: Yeah. I appreciate the question, and I know it's of concern to you. I want to be cautious because it's a competitive process.

Mr. Eggen: Yeah. I understand.

Mr. Horne: Responses to the RFP close on April 1, so I'll leave it there. If you're familiar with the terms of the RFP, I'll . . .

Mr. Eggen: I am, yes. I just want to . . .

Mr. Horne: So it's private sector or not-for-profit sector – it's a nongovernment design and build – so we wouldn't make provision for the capital for that in this budget because that's what's being tendered. It's design, build, and operate.

Mr. Eggen: Oh, I see. Okay. All right. Well, thank you for that clarification. That's kind of why I couldn't see it, I guess.

I think I'm going to leave it there, considering that we're all thinking out of two minds here right now. Thank you.

The Chair: Okay. Thank you.

MLA VanderBurg, back and forth, or five and five?

Mr. VanderBurg: Back and forth.

The Chair: Thank you.

Mr. VanderBurg: Minister, thank you and your team for the work that you do. One thing that's of a big interest for me – and I haven't been able to publicly ask the questions for a number of years now, and now I can get on *Hansard* and ask the question.

Mr. Horne: I can't imagine what the topic is.

Mr. VanderBurg: In the $2.6 billion capital projects budget I know there are a couple of dozen projects that are needed across the province. You know, in my constituency, in Whitecourt-Ste. Anne, we have a need for a capital project. Can you expand on if there is an opportunity in that $2.6 billion budget over the next couple of years, if there's anything in there for Whitecourt-Ste. Anne?

6:20

Mr. Horne: Yes, there is. The $2.6 billion represents 24 capital projects that are included in the infrastructure capital plan. There is a budget there for the replacement of the Whitecourt hospital. There's $10 million that's presently allocated in the budget, and that will support the planning and design and certainly some of the initial construction.

Mr. VanderBurg: Thank you for that. That way I have something to send home, finally. I also want to thank you for coming out to the constituency and talking to our folks about that and looking at some of the great programs that we have.

The family care clinic opportunities in the future abound throughout the province. When will we have the opportunity for future applications for family care clinics?

Mr. Horne: Well, very soon.

If I could just supplement my last answer, I wasn't suggesting that, you know, all of the money was in the capital plan now. I explained that there's $10 million there. Obviously, we won't know what the full cost of the facility is going to be until the planning process is complete, and then it's obviously in the purview of Treasury Board in terms of the funding. Just in case I wasn't clear in my answer, I hope that clarifies it.

We have about 23 communities now that we've been working with to develop family care clinics, and I kind of call these green-space family care clinics because these are community groups, grassroots community groups, that have come together to put together a proposal for what they believe they need to have a family care clinic in their community. I'd said in answer to an earlier question that we've learned an awful lot from that process, from the work that we'd done shoulder to shoulder with those communities. What you will see here within the next month, probably a little over a month, is an announcement regarding those projects moving forward and some additional projects that we've identified where we may not require such a lengthy application process and analysis process.

Part of our problem was, you know, just a lack of experience in the development of the new model. We've pretty much figured out now what the core services need to be in a family care clinic and some of the strategies that deliver on the commitment to extended hours of service. Those sorts of things have been worked out largely in the proposals that we've already received, so what I anticipate is that we can go beyond the 23 very, very quickly. We can work with existing communities where we might have facilities that are already available or we have PCNs or other groups of professionals that are ready to move ahead already, and they can start from, you know, a further place down the road than our pioneers, our three in the 23.

This has been tremendously successful. You can see in the budget estimate that we've allocated $63 million a year for the next three years to support this work, so obviously we're expecting a lot of promise. I think I'll leave it at that.

Mr. VanderBurg: One of the successes our primary care network has had over the last number of months is a very good buy-in with our local physicians. The physicians on their own have created an opportunity for youth clinics off-hours, where the youth of our community can go and talk to a physician or other professional about a number of things. It might be a teen pregnancy, it might be contraceptives, it might be other health issues. I want to know from you: in the upcoming budget do we have confirmation that that type of funding will be available for those types of programs? In small-town rural Alberta, Minister, this is working. I'm seeing the results, and I think that if other communities aren't embracing this, it's something they can learn from. But, again, it all comes down to funding. Can we keep funding programs like this?

Mr. Horne: Yes, we can. I had the opportunity to visit that primary care network with you when I was in Whitecourt recently, and it was truly amazing, not just that type of access but many other innovations within that PCN. This comes back to, you know, having some flexibility in the funding arrangements that we provide. As you can see, the biggest single increase in this budget on a program basis is primary health care. We've got the dollars. I think it behooves us to be more flexible and allow communities to do what makes sense for them to do.

In the case of the youth clinic that you talked about, you know, that opens up an opportunity for someone to disclose a mental health issue or a family violence issue. It's an opportunity for education around sexuality and many other things that are really important to young people. It can identify situations in bullying. I know from talking to the health professionals that offer that program at the PCN in Whitecourt that they work with schools, they work with teachers in schools, and they work with other leaders in the community who are also in touch with those same youth. That gets us from a siloed approach, about what in the past would have been today's cough or cold or other physical health

issue, to a place where the professionals are really working as part of a team. It's a much more holistic approach, where they're looking at all the needs of that young person, thinking about their quality of life, thinking about their future.

I think that's the kind of health system that this Premier and this province stand for. I'm certainly committed to delivering more of that. It's not just about the dollars. It's about the outcomes that we're trying to invest in.

Mr. VanderBurg: Well, those are the outcomes that we're all looking for. It's a great example, and I'm glad you had the opportunity to see it.

Now I want to switch gears over to the other side of my constituency, Onoway. It's a small town of a thousand folks. We bus a thousand students a day into our community in Onoway. The need for physicians and lab services and other services is important, but we also understand that in small communities we can't have everything that larger communities have. Do you think we'll be able to at least keep our lab services going in communities like the size of Onoway? Specifically to Onoway, is Alberta Health Services willing to make those commitments? Otherwise, we can't keep our physicians.

Mr. Horne: Well, you know, I want to be encouraging in my answer on lab services. We have some very good lab services all over the province, including in rural Alberta. I think many of those services will remain exactly as they are today. I'm not in a position to say which ones. One of the reasons for building the new facility that we're going to see in Edmonton is to actually eliminate the need for us to send a lot of tests out of province, that we're having to do now because we lack the equipment and the technical capacity and staff to do very, very specialized things. Certainly, for basic routine lab tests that support in-patient care in hospitals, there's a lot of wisdom in preserving those on-site as much as possible.

I want to be careful here because we're thinking about the future in this as well. The rate of growth in lab services in Alberta is about 6 per cent a year right now. It's not just the volume of tests; it's the number of tests that we can do and how specialized they are that is also increasing. With the new facility they'll continue to have very strong linkages with local hospital-based lab services. Obviously, we want to maintain those, but we need to maintain quality at the same time. We're committed to doing both.

Mr. VanderBurg: Thank you.

The Chair: Thank you.

MLA Towle.

Mrs. Towle: I imagine I only have probably two minutes.

The Chair: Well, 1:55.

Mrs. Towle: Perfect. That's actually probably okay. If it's okay, I'll just get the question on there, and I'm happy to receive it in writing if at all possible.

The question that I have has to do with the insulin pump promise. On page 101 of the estimates line 9.3 is for insulin pump therapy. I appreciate this promise, and I absolutely encourage the government to keep the promise that they made. The budget is increasing from $5 million to 7 and a half million dollars. I'm just wondering: how many people were in the program last year, how many are you expecting to come into the program this year, and what is the cost per client? I know that last year there weren't as many as we had hoped would be in the program. So I'm just wondering, now that you're able to show some more efficiencies, if those costs can be more broadened and we can get more people into the program. Obviously, getting them onto the insulin pump saves us health care dollars on the other side: trips to emergency, acute care, all of that. If you have time to respond, that's great; if you don't, if you want to send it in writing, I'd really appreciate that.

6:30

Mr. Horne: I'm happy to respond very quickly. This increase is based on an estimate of 300 more people coming onto the insulin pump program next year. The increase also supports the purchase of their supplies, which is something that we added once the program was instituted. You know, I'm not sure where you get the idea that demand is less than expected. If anything, it's probably more than expected. It's been very successful, and it's making a big difference in the quality of life for many people across the province.

Mrs. Towle: I think that I might not have conveyed it the way I meant to convey. I actually agree with you totally. I think the demand should be more than we expected.

Mr. Horne: Yeah. There have been 1,014 patients come under that program to date. Next year: 1,314.

The Chair: That's it? Four seconds left. We're good? Okay.

Well, thank you so much. Excellent job. Did you want to make any comments? It was an excellent presentation. You guys did a great job. Thank you so much.

Mr. Horne: No. Thank you, Madam Chair. Thank you to the committee, and thank you for the quality of the questions from all parties that were at the table. They certainly spoke to the priorities that I think we're all working on. So thank you.

The Chair: Thank you.

Pursuant to Standing Order 59.01(8) the estimates of the Ministry of Health are deemed to have been considered for the time allotted in the schedule.

I would like to remind committee members that we are scheduled to meet next on April 8, 2014, to consider the estimates of the Ministry of Education.

Thank you, everyone, for being here. This meeting is adjourned.

[The committee adjourned at 6:32 p.m.]

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