Legislative Assembly of Alberta

The 29th Legislature
First Session

Standing Committee
on
Families and Communities

Ministry of Health
Consideration of Main Estimates

Monday, November 16, 2015
7 p.m.

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Standing Committee on Families and Communities

Sweet, Heather, Edmonton-Manning (ND), Chair
Smith, Mark W., Drayton Valley-Devon (W), Deputy Chair

Hinkley, Bruce, Wetaskiwin-Camrose (ND)
Jansen, Sandra, Calgary-North West (PC)
Littlewood, Jessica, Fort Saskatchewan-Vegreville (ND)
Luff, Robyn, Calgary-East (ND)
McPherson, Karen M., Calgary-Mackay-Nose Hill (ND)
Orr, Ronald, Lacombe-Ponoka (W)
Payne, Brandy, Calgary-Acadia (ND)
Pitt, Angela D., Airdrie (W)
Rodney, Dave, Calgary-Lougheed (PC)
Shepherd, David, Edmonton-Centre (ND)
Starke, Dr. Richard, Vermilion-Lloydminster (PC)*
Swann, Dr. David, Calgary-Mountain View (AL)
Turner, Dr. A. Robert, Edmonton-Whitemud (ND)**
Westhead, Cameron, Banff-Cochrane (ND)
Yao, Tany, Fort McMurray-Wood Buffalo (W)

* substitution for Sandra Jansen
** substitution for Bruce Hinkley

Also in Attendance

Barnes, Drew, Cypress-Medicine Hat (W)
Clark, Greg, Calgary-Elbow (AP)

Support Staff

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

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Standing Committee on Families and Communities

Participants

Ministry of Health
Hon. Sarah Hoffman, Minister
Carl Amrhein, Deputy Minister
Martin Chamberlain, Assistant Deputy Minister, Financial and Corporate Services

7 p.m. **Monday, November 16, 2015**

[Ms Sweet in the chair]

Consideration of Main Estimates
Ministry of Health

The Chair: Good evening, everybody. I'm Heather Sweet, MLA for Edmonton-Manning, and I'm the chair of the Families and Communities Committee. I'd like to call the meeting to order and welcome everyone. The committee has under consideration the estimates for the Ministry of Health for the fiscal year ending March 31, 2016.

I'd ask that we go around the table and introduce ourselves for the record. Madam Minister, please introduce your staff. For the record, Dr. Turner is substituting for Mr. Hinkley, and Dr. Starke is substituting for Ms Jansen.

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

If we could please start introducing ourselves. Mr. Rodney.

Mr. Rodney: Yes. Dave Rodney, Calgary-Lougheed.

Dr. Starke: Good evening. Richard Starke, Vermilion-Lloydminster.

Mr. Yao: Tany Yao, Fort McMurray-Wood Buffalo.

Mr. Orr: Ron Orr, Lacombe-Ponoka.

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

Mrs. Pitt: Angela Pitt, Airdrie.

Ms Hoffman: I'm Sarah Hoffman, honoured to be the Minister of Health here tonight. Joining me are Deputy Minister Dr. Carl Amrhein; assistant deputy minister of finance and corporate services, Martin Chamberlain; as well as Charlene Wong, executive director of financial planning. I thank them for being here tonight and their many hours of preparation as well.

Dr. Swann: Hi. David Swann, Calgary-Mountain View.

Ms McPherson: Good evening. Karen McPherson, Calgary-Mackay-Nose Hill.

Mr. Shepherd: David Shepherd, Edmonton-Centre.

Ms Luff: Robyn Luff, Calgary-East.

Dr. Turner: Bob Turner, Edmonton-Whitemud.

Mr. Westhead: Good evening, everybody. Cameron Westhead, Banff-Cochrane.

Mrs. Littlewood: Jessica Littlewood, MLA, Fort Saskatchewan-Vegreville.

Ms Payne: Good evening. Brandy Payne, Calgary-Acadia.

The Chair: Thank you.

Hon. members, the standing orders set out the process for 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 Standing Order 59.01(6), the rotation is as follows. The minister or the member of the Executive Council acting on the minister's behalf may make opening comments not to exceed 10 minutes. For the hour that follows, members of the Official Opposition, the Wildrose, and the minister may speak. For the next 20 minutes the members of the third party, the Progressive Conservatives, if any, and the minister 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, the New Democrats, and the minister may speak. For the time remaining we will follow the same rotation just outlined to the extent possible; however, the speaking times are reduced to five minutes as set out in Standing Order 59.02(1)(c).

Members may speak more than once; however, speaking times for the first rotation 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 total of 10 minutes. The speaking rotation is set out in the standing orders, and the members wishing to participate must be present during the appropriate portion of the meeting. 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.

If members have any questions regarding speaking times or the rotation, please feel free to send a note or speak directly to either the chair or the 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 midpoint of the meeting. The clock will continue to run through the break, usually after the third party's slot. Are members in agreement with this process? Are there any objections?

Committee members, ministers, and other members who are not committee members may participate.

Dr. Starke: Chair, I have no issue with taking a break, but the clock should be stopped while the break is on.

The Chair: Thank you, Member. After the consultation with the House leader the decision has been made that the clock will continue to run, so we can choose to have a break with the clock stopped or not have a break at all.

Dr. Starke: Sorry?

The Chair: We can take a break with the clock stopped, or we won't take a break.

An Hon. Member: It's stopped time, you said?

The Chair: Or not stopped. Sorry.

Dr. Starke: That's interesting. I've been in one session where it did stop and one session where it did not stop.

The Chair: I understand that, and since then the House leaders have discussed it, and the decision was made . . .

Dr. Starke: No. Not this House leader.

The Chair: Well, we were told that the House leaders had had the conversation.

Dr. Starke: Not with our caucus.

The Chair: Okay. Well, we could not have a break.

Dr. Starke: Well, if it means losing the time of the break, then, Chair, with respect, we should go for three hours.

The Chair: Okay. Is that in consensus with the rest of the members?

Ms Hoffman: Madam Chair, just given that I'll be responding to all the questions, might I reserve the right, if my bladder cannot make it three hours, to request that we take a brief break and the clock be stopped for that two or three minutes and then resume? I will hope that I can make it three hours; I just don't want to make any promises that my body can't keep.

The Chair: The standing orders at this point say that the clock can't be stopped.

An Hon. Member: You're the chair. You can do anything you want.

The Chair: The standing orders say that the clock cannot be stopped.

Ms Hoffman: Okay. So I'll hold it. Okay. Thank you.

An Hon. Member: As long as we can grill your team, that's all right.

Ms Hoffman: I'll be just fine.

The Chair: Sorry, Minister.

Ms Hoffman: No. Thank you.

The Chair: 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 time allotted in the schedule and we will adjourn. Otherwise, we will adjourn at 10 p.m.

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

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

The vote on the estimates is deferred until consideration of all ministry estimates has concluded and will occur in Committee of Supply on November 23, 2015.

If there are amendments, an amendment to the estimates cannot seek to increase the amount of the estimates being considered, change the destination of a grant, or change the destination or purpose of a subsidy. An amendment may be proposed to reduce an estimate, but the amendment cannot propose to reduce the estimate by its full amount. The vote on the amendment is deferred until Committee of Supply convenes on November 23, 2015. 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, and the originals must be provided to the committee clerk

I would like to invite the Minister of Health to begin her opening remarks. You now have 10 minutes.

Ms Hoffman: Thank you very much, Madam Chair. Good evening, everyone. I'm very pleased to be here today to present the Health estimates for 2015-16. With me today are a number of officials, whom I'd like to introduce before we get started. You've been introduced to my deputy minister, Dr. Carl Amrhein; assistant deputy minister of finance and corporate services, who's also acting ADM for health services, Martin Chamberlain; as well as Charlene Wong, executive director of financial planning. Also, other department officials in the room include Denise Perret, ADM of strategic planning and policy development – I'll ask them to give a little wave – Linda Mattern, ADM for health systems accountability and performance; Kim Wieringa, acting ADM of health information technology and systems; Miin Alikhan, ADM for professional services and health benefits; Wayne Campbell, executive director, health facilities planning; Tom Rothwell, corporate counsel; Corinne Schalm, executive director for continuing care; as well as Cameron Traynor, who is the communications director.

The 2015 Health budget speaks to one of the government's most important commitments, and that is, of course, to support the health and well-being of every individual Albertan and their family. We know there is no more difficult time than when you or a loved one is sick or injured, and that's why one of our core values of government is to protect Albertans by protecting front-line health services. This budget emphasizes stability while taking meaningful steps to improve service delivery and sustainable spending through efficiency-based decisions. It's also focused on delivering the right services to Albertans. Those are the right services at the right time in the right place by the right health care professional and team.

The 2015 Health budget accomplishes exactly what Albertans have asked for. They've asked us to protect front-line patient care, and they've asked us to address some of the most pressing needs of Albertans, including long-term care for our seniors and our aging population and protection of those who are in care, and we've listened. The 2015 Health budget creates opportunities for stability in the health care system, better health service experiences, responsive care, better quality of care, care that is safe and effective, better value for our health dollars, and better health outcomes for us all.

The consolidated Health budget for the 2015-16 fiscal year is a whopping $19.7 billion. This is over $800 million more than the previous government would have spent in the budget that they were proposing back in the spring. This increased spending reverses some of the cuts made by the previous government and also addresses a volume increase that we're seeing here in Alberta. Quality health services are protected while bringing our spending more in line with our national average.

7:10

I want to make two points about this increased spending. First, we're putting more resources into key areas of priority. This includes mental health, community care, and continuing care. These are clear areas of priority that we want to improve. There are also certain obligations that require additional funding such as volume increases, physician compensation, and drug funding.

The second point I want to make is that we've taken steps within this budget to bend the cost curve on health spending. Health care spending in Alberta has gone up an average of 5.8 per cent per year for the last 20 years. Instead, this budget goes up by 4.4 per cent compared to what the last government proposed, or a 2 per cent increase to the actuals from last year.

In the coming three years we are going to continue driving down costs, and we are going to do it carefully, without causing chaos in the system. We are looking at areas like physician compensation in

partnership with the Alberta Medical Association and areas like drug programming to ensure that our costs are effective; for example, the RAPID announcement that we made a few months ago. I believe it's crucial that we continue to maintain services for Albertans while also looking at ways to make the health system more sustainable, and this budget is doing just that.

Another crucial area of investment is infrastructure. The capital plan invests $2.2 billion over the next five years to build and renew health infrastructure, addressing the needs of patients and staff such as operating rooms and clinical spaces, upgrades to building systems, improving safety, and beds for acute-care, continuing care, and mental health patients. These projects will help protect and improve health care services for Albertans, providing the right services in the right place.

The capital plan includes $830 million to begin work on the new Calgary cancer centre, to be located at the Foothills site in Calgary, as well as $841 million to continue health facility projects in Edson, Grande Prairie, High Level, Lethbridge, Medicine Hat, and Red Deer and also $20 million in planning funds for the much-needed and overdue work on the Misericordia and Royal Alexandra hospitals here in Edmonton. Continuing to invest in these projects is crucial not just for the future of our health system but also for our jobs and our economy today.

In conclusion, our government is strongly committed to protecting health services that Albertans and their families rely on each and every day, and this budget does that. At the same time we are taking tangible steps to bring costs down but doing it carefully, thoughtfully, ensuring that patients and front-line health professionals are always our focus. For too long Alberta's health care system has suffered from on-again, off-again funding, privatization experiments, and schemes that weren't based on evidence. The 2015 Health budget stabilizes this important public service and better manages our public finances and supports each Albertan in being as healthy as we can be.

We are strengthening health care because in these tough times taking care of each other is what Albertans do. It's the Alberta way. Addressing the well-being of every Albertan is taking care of our greatest strength and greatest responsibility: each other. Keeping us all strong and healthy keeps Alberta strong and healthy. We are committed to securing this front-line service, taking care and responsibility for our quality of life today and into the future.

I look forward to us having a very thoughtful conversation tonight through our discussion, increasing our understanding of what's in the estimates as well as the business plan and the capital plan. I'd be happy to answer your questions for the next three hours.

Thank you, Madam Chair.

The Chair: Thank you, Minister.

We'll now move into 60 minutes for the Official Opposition. Mr. Barnes, I believe you will be asking the first questions.

Mr. Barnes: Yes.

The Chair: Would you like to go back and forth, or would you like to go 10 minutes?

Mr. Barnes: I'd like to go back and forth, please, if that's okay with the minister.

Ms Hoffman: It is, yeah.

The Chair: Please go ahead.

Mr. Barnes: Okay. Thank you. First of all, Minister Hoffman and all of the Alberta Health employees that are here tonight, on behalf of Cypress-Medicine Hat and on behalf of the Wildrose Official Opposition and Albertans I want to start by thanking you all very, very much for your hard work on behalf of all of us. I'd like to start by asking you about the largest single line item in this department. I'm absolutely sure it's the largest single line item in the entire budget estimates. That, of course, is line 2, Alberta Health Services. For many years several of your colleagues spoke quite critically of the structure of Alberta Health Services and particularly the lack of accountability and the lack of oversight offered to this Assembly when we vote on massive allocations of funds with shockingly little detail. My first question: who is representing Alberta Health Services here tonight at this committee meeting?

Ms Hoffman: Thank you very much for the question. I've had quite a bit of time working with my department and with the Alberta Health Services executives over the last several months to talk about their proposed budget allocations. You'll note that we have increased the number of line items. I'm sure you would like many more line items, but we have definitely made strides to increase the number of line items to demonstrate a commitment to that increased transparency.

Of course, in terms of the Alberta Health Services budget what they're working on now is a proposal that they'll be bringing forward to their board of directors, assuming that the budget is ratified by the provincial government. In the room tonight I don't think we asked a specific employee from Alberta Health Services to come, just like we wouldn't ask a specific administrator from a school board to come, but we certainly have had very thorough conversations. My officials, I am confident, will be happy to get into a little detail if you have some specific questions that you want to ask that either myself or one of my officials here at the table will be happy to help flesh out for you.

Mr. Barnes: Okay. Thank you, Minister.

Considering all the functions that Alberta Health Services covers from ambulance services to long-term care to public health initiatives to labour, one of the largest employers in the entire nation, the broad categories we see listed from 2.1 to 2.5 are, unfortunately, nowhere near the level of detail that we'd like to see and what we would need to cover all these in proper detail for Albertans. The lines, though, are provided down to the thousand dollar mark, and that makes me wonder about the process, how you arrived at these precise dollar figures. Do you come up with a bottom-line number for Alberta Health Services and then tell them to budget within those parameters, or instead are you presented with a budget from Alberta Health Services that you put into these estimates? Do you provide the number, or do they?

Ms Hoffman: Thank you very much for the question. There is certainly a dialogue that happens between Alberta Health Services and myself as well as the entire department to look at the specific obligations that they have, including prenegotiated staff salary increases as well as new buildings that will be coming online, to make sure that commitments that have been made will be able to be achieved within the budget line items.

At the end of the day with the entire financial budget of the province we have targets that we work on with Treasury Board. Those targets are given to the different ministries, and the ministries themselves assign their targets to the different service providers just as it would be with another ministry. For example, in Municipal Affairs the municipalities find out how much they're going to get through MSI, and then they meet their obligations within that line item. It's not dissimilar here with Alberta Health Services.

We certainly in the back and forth look at ways that we can push for efficiencies and make realistic tightenings wherever feasible, but at the end of the day we pass them the budget. They have to hit both our budget targets as well as our policy objectives. So we assign the budget.

Mr. Barnes: Okay. Thank you.

So essentially you're suggesting that you make the largest allocation of funds in the entire budget without a detailed breakdown of what Alberta Health Services needs as an agency?

Ms Hoffman: No, that's not what I'm trying to say. I'm saying that we do a significant back and forth. Just like Treasury Board does a back and forth with each of the departments around what the departmental needs will be, we do the same type of process with Alberta Health Services. Alberta Health Services will be bringing more detail to their budget when they do finalize their budget based on the final decision of the entire Assembly.

I'd be happy to give some additional details around the aggregates from the estimates through my deputy minister if you'd like slightly more detail around Alberta Health Services.

7:20

Mr. Barnes: Okay. Thank you.

If they're in the back and forth, it sounds like there may be a lot of numbers provided. I'm wondering if, in the spirit of transparency, you would be able to table the Alberta Health Services numbers and budgets in the House so that we can, going forward, have a greater understanding.

Ms Hoffman: The problem with doing that is that right now they're drafts. What they do is just like any of us who have sat on any type of a board before. We find out what our allocation would be as a board, and then the administration will work with their board to achieve their outcomes.

Those budgets will certainly be public – and I'm confident that the new board has every intent around ensuring transparency – but they can't finalize their budget until we finalize this budget. That process happens after the Legislature, all of us together, gets an opportunity to vote on the provincial estimates. So a very much more thorough budget will be available, and it will be online, but it will not be until after this process is complete.

Mr. Barnes: Okay. Thank you, Minister Hoffman.

Ms Hoffman: My pleasure.

Mr. Barnes: I'd like to draw your attention next to line 1, ministry support services. It has increased by a total of about $10.8 million over last year's spending. Percentagewise this is the largest increase in the entire Health department. I'm wondering if you think it's an appropriate use of tax dollars to increase spending in your ministry, the upper levels of bureaucracy, by nearly 15 per cent? Do you think that's right?

Ms Hoffman: Thank you, Madam Chair. The increase that we have is due to needing to fill critical vacancies within the department that are impacting our ability to be able to be efficient and effective stewards of the resources so that front-line service delivery and individuals can focus on doing their jobs best. There were certain critical department staff vacancies that needed to be filled.

The other piece, though, that is important to be aware of is that there was a wage increase negotiated by the last government for department staff, and those negotiated salary increases have been committed to. The government needs to honour our salary agreements, that we inherited. So part of it, of course, is for that.

The other piece, that I think is even more important, is that when we looked at what was tabled in the spring budget, there would have been a greater increase. We're looking at an $84 million line item, and it was actually an $89 million line item that was tabled in the spring budget. So I'm proud of the fact that we're seeing a $5 million cut to what was being proposed by the last government.

Mr. Barnes: Okay. Thank you for that.

Again, just when I compare it to private industry now, which is undergoing, you know, several serious reductions, and with my three and a half years sitting in the Legislature, I really wonder about the health of human resources in Alberta Health Services, where I continually hear that everybody uses the number five: five layers of bureaucracy to get an answer. That concerns me about more money to increase that bureaucracy.

Let's go into a little more. . .

Ms Hoffman: If I could just clarify, this is the department, though. This isn't AHS.

Mr. Barnes: Yeah, I understand.

Ms Hoffman: Thank you.

Mr. Barnes: Just to go a little more into detail about the ministerial expenses, I want to talk about line 1.4 next. Your communications department received a 15.7 per cent increase in spending. That's a 15.7 per cent increase in spending for communications. Do you expect to see patient care improve in any meaningful way with a 15.7 per cent increase in spending, or is this just promotion for government announcements?

Ms Hoffman: Thank you for the question, Madam Chair. While there is a 15 per cent increase, it's a result of realignment. The Public Affairs office used to be much larger than we're proposing it be moving forward. So there were two individuals who were members of Public Affairs that are now actually department staff, and we feel that that's the appropriate place for them to be working, that they are public servants. So those salaries – while the Public Affairs office budget has shrunk, this is where some of those line items have been transferred over to. It's not just our department. Other departments have realigned some of those resources.

It also, again, includes the impact of those negotiated salary increases. That's something that was negotiated by the past government, that we're honouring now.

Mr. Barnes: Okay. Thank you for the answer.

It's certainly no secret that many people, again, including your colleagues when we shared opposition in the past, believe that the governance structure between Alberta Health Services and Alberta Health has been deeply flawed. Now your ministry has made an attempt to re-create a superboard structure that has come under considerable fire in the past. I'd draw your attention to line 1.5, strategic corporate support, and 1.6, policy development and strategic support. There is a combined increase of close to $6 million. Is this large increase in relation to the new superboard in any way?

Ms Hoffman: The fast answer is no. I can explain what the increase is, though, because I think that's important to know. The strategic corporate support includes funding for financing corporate services division, which includes human resources, legal and legislative services, information systems, staff development, and accommodation budgets. It also supports a variety of boards and committees such as the Public Health Appeal Board and the Expert

Committee on Drug Evaluation and Therapeutics as well as the Hospital Privileges Appeal Board. The increase was largely due, again, to the negotiated salary costs and increased costs for postage, printing, information technology services, and communicating with those who are accessing those services.

Then line item 1.6, policy development and strategic support. The increase is to fund increased policy work as we move to a more community-based model of health care. Expectations of filling critical staff vacancies in the area of policy are important to us because I think we all agree that we want to make sure that it's a patient-centred or an Alberta citizen-centred system as opposed to just continuing on with the system that we've inherited. That will require a few additional staff in those critical positions to help transform the model of health care that we currently have.

Mr. Barnes: Thank you, Minister.

Ms Hoffman: Thank you.

Mr. Barnes: Do you not feel that your ministry could provide strategic and corporate direction on a combined $73 million budget rather than the $84 million increase? Seventy-three million dollars is a lot of money.

Ms Hoffman: It is a lot of money, and this budget overall for Health is a lot of money. The reason why it is is because it is such a fundamental service for each and every individual who elected us. They really do count on us to make sure that when they are in a time of tremendous stress and anxiety, they have – I've visited a number of different facilities, some with yourself, hon. member. When you're in a health care facility, most of the family members who are there and patients who are there just want to know that they're going to get better. We owe it to them to make sure that we're doing the work as a ministry to run those systems as efficiently as possible, because I'm not convinced that we have been.

Increases approaching 6 per cent per year for the last 20 years say to me that the growth has been unsustainable moving forward. So to be able to bend that cost curve, we need to have some of the experts, in my opinion, in places like policy development so that we can look at what they're doing in other jurisdictions to bend that cost curve. The intent of investing in some systems alignment in this fiscal budget is to be able to see those efficiencies in the out-years.

Mr. Barnes: Okay. Thank you.

Those rather drastic increases or those investments you just mentioned to support the governance of the health system and bring it under your ministry's direction: will these rather drastic increases be matched by a decrease in executive and upper-level management expenses at Alberta Health Services? In other words, does having your ministry take on a vastly greater expense here allow us to find efficiency for the taxpayer at Alberta Health Services?

Ms Hoffman: Thanks very much for the question. I should have addressed something that you said in an earlier question that was talking about the reorganization or lack of reorganization. Alberta Health Services is the fifth-largest employer in Canada right now.

Albertans and I believe the health care system has been in disarray for far too long with having the realignment, organization, disorganization, reorganization. Our priority is, of course, to ensure that we have that strong, stable public health care system for Albertans today but also for Albertans 10 or 15 years from now. To make that possible, I believe we need to make some of the investments now around realigning the system.

If I were a minister 10 years ago, would I have said, "Yeah, let's go and have one board instead of having 15 or nine or five"? I don't know if I would have. But I'm the minister today, and I feel like my job is to make sure that I provide some assurances to the public as well as assurances to the staff that we have working there. I'm confident that the board that we are putting in place is going to be, on the Alberta Health Services side, looking at efficiencies because I asked them about it in the interviews. It was one of the areas.

There are certain cost drivers in my budget, and you'll all see them. The big ones are physician compensation, hospitals, and pharmaceuticals. The hospitals piece is almost entirely under Alberta Health Services' direction. They know that with it being one of those big cost drivers that's led to that 6 per cent increase, it isn't sustainable, and they themselves are really invested in wanting to make sure we find those efficiencies. Alberta Health Services will continue its cost-saving initiatives into fiscal '15-16, and they have committed to maintaining quality of services and patient care while keeping administrative costs low.

7:30

Alberta Health Services is engaging right now in a best practices comparison and service delivery process to ensure that the organizations it has within its operation are operating efficiently, and they've identified opportunities for improvement when compared with similar health organizations across the country.

We're looking, for example, at the Stollery and the Children's hospital being compared with Sick Kids in Toronto. The hospital administrators are working in tandem to make sure they're optimizing those efficiencies, so there are a number of different systems alignments in play right now as well as implementing cost controls on administrative and overhead spending, including spending on travel, education, consulting services. You may have seen in the paper this weekend that they're moving to one cellphone provider, which is going to save us up to $5 million, just by having one cellphone provider as opposed to multiple contracts out there.

There are a number of areas where they're already showing leadership, and I'm excited that there will continue to be more of those in the years to come. Everyone who enters this line of work – and I know the member that I'm engaging with right now feels the same way – is in this because we want to make sure that the health outcomes for Albertans are as good as they possibly can be, that they're done efficiently, and that we get effective service at the end of the day.

Those are a couple of the things that I wanted to highlight.

Mr. Barnes: Okay. Thank you for that.

Moving on to line 2.4, diagnostic and therapeutic services. This line is an increase in cost of about $198 million, or an incredible 10.2 per cent. How much of this line item is related to the increasing costs of lab services administered under Alberta Health Services?

Ms Hoffman: Before I add to that, I just want to say one other thing for the last response, and that's that going forward, we certainly expect Alberta Health Services to live within the budget allocations that it receives. Part of that includes, of course, bargaining in good faith with the staff that they have working under their authority.

In terms of the 10 per cent I appreciate your flagging that because it was one that I went through with great detail. Alberta Health Services' base operating funding is increasing by $117 million from the '14-15 fiscal amount. Further details will be available when AHS announces its budget in the coming months, but lab services are, of course, under review. We announced that back in the summer around the review of the Edmonton and north zone lab. Lab costs are going up, and we all know that.

What do diagnostic and therapeutic services include? Electrodiagnostics, pharmacy, clinical, numeration, rehabilitative services as well as community rehabilitative services, and contracted amounts to operate the provincial laboratories. For example, rehabilitative services like audiology, occupational therapy, physical therapy are investments in us, ensuring that people don't need to end up in a higher level of care, that we help them get back into the community.

Mr. Barnes: Okay. Thank you for that.

On top of diagnostic and lab services earlier this year you cancelled the agreement with Sonic Healthcare to provide lab services in Edmonton and the north zones. Regardless of the rationale for doing this, we are now facing a situation where the current provider cannot provide lab services past the spring of 2017 due to an expiring lease. It seems to me that we are nearing crunch time because, essentially, we now have just the one construction season left to build the central hub lab facility that was part of the cancelled deal. Has this decision on the future of lab services been factored into these budget estimates? Is there a contingency for higher costs?

Ms Hoffman: In terms of this year's lab services we were able to have a contract that is inclusive of the fiscal year that we're debating here tonight. Of course, Albertans deserve access to high-quality lab service. Any change in lab service delivery I believe and I'm sure we all believe needs to be in the best interests of patients as well as the provincial treasury, so our government is going to do our due diligence to ensure that Albertans get the best value for services with their health care dollars.

Our government is really focused on making transparent and evidence-based decisions. That's one of the reasons why I didn't feel comfortable just proceeding along the path. I didn't see the evidence that the last decision was going to be in our best interests, that it was going to increase access and that it was going to provide financial benefits to Albertans. I didn't see evidence that all options had been considered.

In terms of the space that they are renting, what the hon. member has to know is that that space is owned by AIMCo. Of course, the situation is a little different right now than it was a year and a half ago around vacancy rates and our ability to extend leases. The lease provider has been open to having a dialogue around whether or not we need to extend the time of that lease if necessary. Part of it is because there is more commercial space on the market right now than there was a year and a half ago. That's about the only upside to this situation that we're facing right now in our economy.

Mr. Barnes: Okay. So we'll stay tuned to see the final outcome, I guess?

Ms Hoffman: Yes.

Mr. Barnes: You mentioned the $117 million increase to Alberta Health Services. If we move down to line 3, where we have physician compensation and development, can you please explain how you arrived at a budgeted $340 million increase for physician compensation and development?

Ms Hoffman: Thank you very much for the question. One of the things that I've learned over the last six months – well, it was faster than that; it was very up front – is that it's different from when you're operating a business, where you set what your budget is going to be and then you work to meet the targets you can within that budget amount. When it comes to accessing physicians, that line item is really driven by patient demand. This has been one of the areas that's been growing the fastest in the budget because right now we don't have a lot of controls over when billing stops. If there's a bad flu season and a lot of people end up in the emergency room, there are going to more physicians seeing more patients, and that cost is going to go up.

At this point, based on past years' analyses, this is where we're at in terms of where we anticipate that line item going. Remuneration for primary care physicians has increased $127 million, or 10 per cent, to $1.4 billion as a result of the rate increase of 2.5 per cent and fee-for-service volume growth of 7 per cent. So the actual rate increase is actually a small percentage of what the budget is, and it's because it's been demand driven.

We have some work to do in collaboration with the AMA. They know it. I know it. We all know it. We need to make sure that we have some more oversight and controls over how we are allocating these funds. I don't hold anybody responsible for the situation we're in, but the situation we're in does not leave a lot of management control over the physician compensation line item.

Mr. Barnes: Okay. Thank you.

I'd like to draw your attention next, then, to your business plan, page 60, where you have your three-year targets for physician compensation and development. Over the next two budget cycles you have the cost of physician compensation and development increasing just $243 million, again, an amount less than this year's increase. Your overall budget, that your party presented two or three weeks ago, predicts steadily increasing oil prices. If that's true and with what you just said about the drastically increasing patient demand and when you factor in the increased economic activity, the increased cost of living, increased population, on what basis do you see that that three-year declining target is accurate?

Ms Hoffman: Doctors certainly do play a critical role in the health of all Albertans, and they're leaders in not just the health care system but in their communities. The AMA is working with our government to ensure that we find the best ways to deliver that quality care for Alberta families. We are looking at a number of different proposals. The AMA has some ideas. We have some ideas. In the end, we need to bend the cost curve. That's all there is to it. We need to work collaboratively to ensure that those resources are there when Albertans need them. I want to make sure that we understand the full range of implications of some of the policy proposals that the AMA is bringing forward and that they understand some of the implications of the ones that the government's side is going to be bringing forward. But this is something that we certainly need to work on collaboratively. Some other jurisdictions in Canada have been able to do that, and I know Alberta can, too.

7:40

Mr. Barnes: Okay. Thank you.

While we're on page 60 of the business plan, I'd like to look at administration and support services. Now, this is the consolidated expense given here, and under the comparable 2014-15 actual you have for this line about $2.43 billion. In the annual report from June the consolidated administration and support expense was over 2 and a half billion dollars, a significant difference. My question is this. In the past few months since the release of the annual report has your ministry changed the way administration costs are measured in an attempt to minimize this expense and the reporting of this expense going forward?

Ms Hoffman: Just to make sure we're on the same page, because we have a few different pages here, can you walk me through exactly which page in the business plan?

Mr. Barnes: In the business plan on page 60 in the middle of your expenses you have administration and support services. See it?

Ms Hoffman: Right. Okay; $2.37 billion. Great.

In terms of administrative and support services every system needs to have some structure to be able to ensure that it can support the services that are going on within that ministry, including building operations, security, communications, administration, discharge, admission, information technology, research, and education. In terms of that back and forth that I was saying that we've had with AHS in preparation for this, AHS is looking for efficiencies, including on the administration side. They're already among the lower level of administrative jurisdictions in Canada. When you look at the CIHI data, it's investing 3.2 per cent of their total expenses, but we certainly need to have additional – and part of that includes the piece that we mentioned around the cellphone efficiencies that was identified earlier.

As well, administration and support services includes the Health Quality Council of Alberta, which has expenses of $6.7 million for administration; Alberta Innovates: Health Solutions, $8.3 million; AHS administrative expenses are $450 million; AHS support services are at $1.9 billion, which includes that building operations, maintenance, and security piece that I was going on about as well as housekeeping, laundry, food services, patient registration, and so on.

Mr. Barnes: Do you know specifically, Minister, why it dropped from $2.5 billion to $2.4 billion? Do you know specifically why administration and support services went down?

Ms Hoffman: Part of that has to do with the system alignment, around looking at other institutions and ways that they can be more efficient in aligning it, and other parts are asking some of these different pieces to invest their surpluses. I might ask my officials to touch on this. For example, the Health Quality Council of Alberta had surpluses this year that they were able to access in terms of efficiency. With your concurrence I'll ask my deputy to comment on that a little bit.

Mr. Barnes: Sure.

Dr. Amrhein: Government looked at all of the agencies, boards, and commissions within the Ministry of Health and across government and identified those that had accumulated surpluses, and we adjusted through Treasury Board the allowable expenditures in the current year so that they consumed some of the surpluses to ease the burden on government. This was the case with the quality council, and it was the case with Alberta Innovates: Health Solutions.

Mr. Barnes: Thank you for that.

While we're on this statement of operations on page 60, you have $916 million under capital investment. Does the $892 million figure under health facilities and equipment include this year's health projects as listed in your capital plan?

Ms Hoffman: Certainly, ongoing investment in the important infrastructure to meet Albertans' needs is fundamental, and we're really proud of a number of the different pieces that we're committed to in the out years, including the building of the Calgary cancer centre, completing Grande Prairie, and so on. My assistant deputy minister is just looking for the specific details around that line item, so I can go on about some of the other projects that we have or we can come back to that question in a moment if you like.

Mr. Barnes: Let's come back.

Let's talk about the other part. The remaining $24.7 million under information systems: is that capital expenditure on electronic health records?

Ms Hoffman: Which line item is that, again, please, hon. member?

Mr. Barnes: It would be on page 60, right at the bottom of the three subheadings: capital investment, information systems.

Ms Hoffman: The information systems piece is essentially ongoing maintenance at this point. You would not be surprised, I'm sure, to know that just like buildings have been neglected for many a year, our IT systems have been neglected for many a year. When you're looking at areas for deferred maintenance, not only is it the physical, tangible infrastructure that we have but also the IT pieces. Some of this is around essential backups to make sure that we're in line for protecting Albertans as well as ensuring portability of information between health providers. This is not a significant CIS investment, as some would like to see, of course, in this budget. That is really not probably feasible in the next year or so. In terms of the '15-16 budget it was reduced by approximately $1 million from the previous year's budget. The $1.4 million, or 21 per cent, increase from '14-15 actuals is due to the needed maintenance for resource allocations in anticipation of workload requirements as well as provision of negotiated salary settlements yet again.

In terms of the previous question, we're ready for that one now.

Mr. Barnes: Okay. We have an answer?

Ms Hoffman: Yeah. It does include this year's capital flow to Alberta Health Services plus their own spending on parkades. That's one of the things that they do for cost recovery.

Mr. Barnes: Okay. Let's talk about electronic health records if you don't mind. In the short time I've been shadow minister for Health, I've been told that Alberta Health has spent almost $1 billion on electronic health records. Across our province we don't have a consistent, accessible portal for all health care professionals, particularly one that involves patient participation, where patients can be involved in monitoring and watching the steps of their own health. You know, an electronic health record system that from the perspective of health professionals could streamline their time and their efficiencies and that the patients could be more actively engaged in monitoring their health: I think it's a lifesaver. I want to know what you think about that: if it has been a $1 billion spent over the last few years, where we are at with it, why we don't have it when places like the Canadian military do, where some hospitals in America have it just for their own database, and if this is on your horizon at all.

Ms Hoffman: To date so far with Netcare, which is the same as that, we've invested as a province $852 million, so you're not far off with your estimate, hon. member.

In terms of the personal health record piece, which I think you're speaking to, there is so much potential around the personal health record that I'm really excited about. With a personal health record Albertans will be able to keep a record of family medical history, procedures, and immunizations. I don't know about you, but I can't remember when I had my tetanus shot. Was it three years ago or five years ago? Those types of things will be much easier for us to access. Records to track your blood pressure, your blood glucose, to manage your complex conditions like diabetes, asthma, heart conditions: all of this is going to be available with a personal health record. Individuals will have the ability to log on as well as to keep

a journal and track certain things, conditions that are changing in their own lives, which they themselves can share with their health professionals down the road if they so choose.

We have a bit of a pilot that we're working through right now, and in the spring it's going to be moving forward. I'm really excited about some of the potential. It's not unlike what happened previously around that you'd get a bill sent to you in the mail, an estimate of what services you'd received and what those had cost. This will be focused on the outcomes of the work that you did, so uploading and tracking information from personal devices like your own Fitbit, for example, or blood pressure monitors, that will be able to interface with this data. Then, of course, individual patients will be able to use it in collaboration with their health professionals. I'm really excited about the potential that we have for increasing the expertise with which individuals can monitor and track their own health but also the way that they'll be able to share data with their health professionals down the road.

This really is a time – when I think back even 10 years ago, but definitely 20 years ago, to how much technology has evolved, I don't think we're using it as much to the benefit of patients, on patient ownership of their own individual health and well-being. This is one of the areas where that should be able to have increased outcomes and, hopefully, also economic ones in terms of our ability to ensure efficiency of the systems that we're using.

7:50

Mr. Barnes: Okay. Thank you. We'll watch for that.

Let's move to the performance and accountability measurement for your department as listed in your business plan. First, I'd like to know why none of the measures given are the most recent and accurate figures. Every measure we see has the last actual from 2013-14. In fact, we have far more accurate information from the most recent performance data from the 2014-15 annual report. I'm wondering why these older ones were presented.

Ms Hoffman: Sorry. This is in the business plan, with the targets?

Mr. Barnes: Your business plan, yeah. Page 59. Again, there are some, actually, on 58 as well and 57.

Ms Hoffman: Right. Thank you very much.

Mr. Barnes: Why don't we have the '14-15 information?

Ms Hoffman: The '14-15 actuals. While my colleagues here at the table pull that up, I'm going to mention a few that are brand new targets this year, that we've never had and that I think speak to some of the values that we share as elected officials in serving the needs of Albertans, and that's to segregate the data between the provincial average and the First Nations average. You can see that some of those targets – if you're First Nations, your life expectancy at birth is 10 years less than the provincial average, or the infant mortality rate is nearly double that of the provincial average. When we were talking about these targets that we were going to set and how we were going to hold ourselves accountable to a number of commitments, including the declaration on the rights of indigenous peoples, I think the first thing we need to do is to segregate the data and own it, and that's scary.

In terms of being able to pull up the actuals from the other years, that's a very valid question. I'm not sure when the data is tabulated and if it's specifically around the time in which it's submitted. But I'd be very happy to get back to you, hon. member, in writing, about why that's been an impediment in this document and when we might be able to have those actuals.

Mr. Barnes: Thank you. I'd appreciate that.

On measure 4(a), page 59, your department gives the target for satisfaction with the health system as 68 per cent for 2015-16, and the last actual from 2013-14 was 66 per cent. However, the annual report from June of this year tells us that the 2014-15 overall satisfaction was 68 per cent. I'm wondering why your current goal is no better than your current performance. Do you really think it's acceptable, first of all, to set a patient satisfaction target of just 68 per cent? Secondly, do you not have the confidence in your department to make any improvements over last year despite, you know, talking about restoring so many of these cuts? Shouldn't you have a higher target?

Ms Hoffman: I have a lot of confidence in my department. Thank you for letting me get that on the official *Hansard* record.

Change is hard. I think we all know that. While we have restored a number of the cuts, we are committed to bending that curve. Moving from a 6 per cent increase to next year's 4 per cent increase to 3 per cent and then flatlining at 2 per cent after that is going to require a lot of alignment of resources, especially given that there are certain cost drivers out there that we don't have a lot of control over today, including the pressures that we're seeing around pharmaceuticals, that are being added to the list of treatments federally but are not receiving the transfers from the federal government to cover that cost increase.

We have certain pressures that are not in our control to bend right now, which means that we're going to have to bend in some of the other areas. As I said, change is hard, so we're going to be working with people in the communities. I hope that the target is lower than what we achieve. My own personal target, of course, is a hundred per cent. I don't think it's realistic for us, when we're talking about system evolution, to be aiming for the moon. I think we need to acknowledge that there is potential for growth.

I appreciate your feedback on how you'd like to see some growth in the target, and perhaps that'll be incorporated into future years. My initial response is that change is hard. For example, when a family is going through a change in their own personal lives, for the kids to maintain a B plus average might be a good objective, right? There's my little analogy for the night.

Mr. Barnes: I look forward to discussing this with you in the future. Just so that you know, your 70 per cent patient satisfaction is exactly the same as what the two previous Health ministers set. That surprised me. I wonder if the bar is set low so it can be jumped, if that's not what it's all about.

One of the most glaring omissions in the accountability measures is that the 2014-15 actual results are not included for emergency room wait times. The percentage of patients treated and admitted within eight hours was a dismal 48 per cent last year, even worse than the 54 per cent shown here as the last actual in the business plan. Unlike under previous governments, this business plan contains no targets for this measure among others. In the interests of providing accountability for dollars spent, why does your department not hold itself to targets on emergency room wait times, patient safety, or per capita spending? Emergency room wait times, patient safety, and per capita spending.

Ms Hoffman: Can you point me to the 48 per cent line item that you were mentioning?

Mr. Barnes: Annual report.

Ms Hoffman: Oh, annual report, not the business plan. I'm happy to talk about those targets. I didn't bring my copy of the annual report with me today.

Mr. Barnes: Okay. Page 13 in your annual report.

Ms Hoffman: Of the annual report. In terms of the targets on ER wait times a big piece of it is making sure that people are going to the ER when they need to go to the ER, so I think increasing access to a variety of other ways to receive care, including the expansion of – I want to say telehealth – 811, as I call it now. You can dial 811 anywhere in the province and be connected with a front-line RN to ensure that you end up in the right place for the right care. More than half the time when people call 811, it does not require any further medical advice around that one specific incident or even a visit to any type of physician. Of the remaining 50 per cent, about half of those are fine to see a regular family physician the following day. A big part of making sure that ER wait times are appropriate is to make sure that people are going to the ER when they need to and that others are not.

In terms of the transparency piece around ER wait times I know in the Edmonton zone, as a citizen who lives here and occasionally needs to rely on those services, that I feel great when I can go to the website and see in real time how long the wait is in each of the ERs. I think that rather than having a benchmark that's reported on three months or six months or a year after, having that real-time feedback so that patients can use it to inform their own decisions around how they're going to access a health care professional is where I'd like to see us move in terms of accountability measures.

ER is certainly one of those areas that we're doing in some parts of the province that I think has merit to expand to other areas. It also not only helps the patient, but it also helps the ERs that are being flooded if people who have a means of transportation to get to an ER slightly further away are able to make the decision that if the wait time is less there, they can inform that.

There is a pilot project that I'm going to ask my deputy minister to touch on very briefly, if you're willing to do that, around EMS wait times.

Mr. Barnes: Yeah. I'd like to hear it.

Dr. Amrhein: One of the issues in ER wait times is the rate at which ambulances show up at the doors of the emergency rooms. There is a pilot project under way in the Edmonton zone that will allow the EMS attendants to redirect the patients to different destinations more aligned with their care status and care provisions. Now, this is a small pilot project. It's under way, and it's showing very good signs. If it all works out, then I imagine it will be expanded to other AHS emergency rooms.

Mr. Barnes: Thank you.

I want to talk about primary care networks next and, on line 4.3 of the estimates, the $41 million cut. A couple of questions grouped together here. I'm wondering how you're going to achieve these cuts to PCNs. Will there be a reduction in the per patient amount that they receive from the current $62? Especially in rural communities quite often PCNs are the primary health care that must be delivered because there's a lack of other options. Minister Hoffman, if PCNs are going to see funding cuts and you agree that we need to move away from a hospital-centric system, what is the alternative that your department is proposing for these smaller communities?

8:00

Ms Hoffman: I'm really proud of the fact that we've been having an ongoing dialogue with PCN leads provincially as well as with many of the leads from each of the individual PCNs. Actually, officials from my department were just meeting with them earlier today and last week as well. Of course, we are in a difficult fiscal climate right now, and restoring all of the cuts that were being proposed by the pervious government is not an easy undertaking.

But we also know that there were reasons why some of those were being considered, and one is that there were significant reserves in some of those PCNs. I don't believe that is the most responsible way to spend money, to sit on a surplus. If you're being allocated money to do primary health care, I think you spend it in the area that you're being allocated, and I think it's fair for the government to say what a reasonable margin for a surplus or carry-over might be. I don't think it's reasonable for taxpayers to be looking at significant reductions in service delivery when some of these PCNs are sitting on millions of dollars in surplus.

There is $168 million for PCNs, which is an increase of $35 million from what was being proposed in the March budget by the previous government. These funds represent grant funding on the $62 for every PCN, that they require annually for each Albertan enrolled in the network, and the PCNs will be required to use their accumulated surplus, those ones that were sitting on surpluses, for operating costs for the 2015-16 fiscal year. This reduction is about taking some of that money. Just like when a family is in tough times, if you've got some money in the bank, this is the time for us to be using it to really address the shortfall that we're facing in the provincial treasury but at the same time ensuring that that money is there so that we can actually use it to provide those front-line services.

We've had an ongoing dialogue with the PCN leads. I really appreciate their understanding around why doing a financial review was so important to me before we made any final decisions. While they might not be happy that not all of the funding was restored that they were hoping for, they are grateful that they've been part of the process and that it's been slower in rollout than what was being proposed previously.

Mr. Barnes: Okay. Thank you. Again, I'll just ask you to keep in mind how important they are to some rural communities. I personally think that with the proper direction, they can be hugely important in mental health, in preventative health, and in those areas that are lacking.

I'd like to move on and talk about the health projects on the capital plan list, particularly these capital health projects on page 44, starting with the addictions and detox centres. I see that this amount is being budgeted substantially lower over the next five years than the previous government had planned. We have $12 million, then $11 million, then $3 million, and dropping to zero in the final two years. Given the recent public health crisis with substances such as fentanyl do you really believe that the allocations here are adequate to meet Albertans' needs?

Ms Hoffman: Thanks for the question. The short answer is no. One of the reasons why we have zeros in those years, though, is because we weren't going to put a project in the budget that we hadn't done our due diligence on costing and making sure it was aligned with what was appropriate for funding. That's one of the reasons why we have this $4.4 billion fund, that is unallocated right now. We want to make sure that we do, like I said, that due diligence up front and do the planning and ensure that the right investment is going to be made before our numbers are put into the budget.

I'll tell you here first that I'm going to be asking for some of that money to be invested into mental health, addictions, and detox beds because we know we need them, but we're doing the planning piece up front now to make sure that it's done properly. That model has been acknowledged in the David Dodge report, where he says:

> While the final selection of competing projects for the provincial capital plan is of course a political prerogative, such prerogative

> should not be exercised until projects have been properly scoped and their capital and operating costs properly estimated.

That's one of the pieces around taking that evidence rather than just putting a number in and shooting for it. Taking the time to actually put the right number in the budget I think is really important.

Mr. Barnes: Okay. Thank you.

Although, with respect, Minister Hoffman, the Calgary cancer centre seems to be announcing the money before the planning is all done. You've got $5 million budgeted for this year and $42 million for next. I'm assuming that that's for planning purposes. There's been a great deal of discussion about moving away from exactly what you said, where announcement after announcement is made and you get into a cost-plus design/build situation and the costs run away. This project seems like a classic example, though, of making the funding announcement before the details are in. We don't have plans. We don't have a total cost estimate. We don't even have a timeline for completion beyond a vague promise of eight to nine years out. I'm wondering: how in the world did you come up with an $830 million funding commitment, then?

Ms Hoffman: That's over the first five years.

Mr. Barnes: On what?

Ms Hoffman: On the scope that they've – there has been a needs assessment done. You might remember that the last government had a few different numbers that they announced publicly. I haven't said a number, and one of the reasons why I haven't done that is because I want to make sure that our numbers are accurate and also that industry is compelled to bring forward their best possible bid. I've heard from more than one person in industry that when an announcement was made that a project was going to be – I don't know – let's say, $800 million, why would you put in bids for $750 million when you know that government is willing to spend $800? I think that part of this is around making sure that we have that functional program. We have the functional program complete already for the Calgary cancer, and that's why we're able to do these estimates for the five years out and feel confident in those numbers that are in the budget.

In terms of the Royal Alex and the Mis, for example, I know that the Member for Cypress-Medicine Hat has brought up in question period, Madam Chair, you know, that a $4.5 billion cost estimate was put out by Alberta Health Services. I'm not committing to that right now because we do really need to take what they've done around their needs assessment, what our vision is around community-based care and merge those two and then find out ways to incorporate them. We are committed to moving forward with planning money, and that's why we invested that $10 million in the short term. Several years of planning and scoping are important.

Infrastructure has to be thoughtful in terms of the Calgary cancer site, but the people of Calgary need to know that we are building a comprehensive cancer facility. It will be on the Foothills site. We are absolutely committed to that project, and I think we'll be able to see evidence of that very soon in Calgary itself.

Mr. Barnes: Okay. Thank you. Again, I think the best way, though, would be to figure out the plan, design the plan, get the finalized cost and timeline rather than what they, you know, quite often call scope creep, which leads to billions of dollars of extra costs.

But let's move on. On line 11.2 there is a budgeted increase of over $8 million to offer out-of-province health care services. First, is this to fund an increase in out-of-province services covered, or do you foresee a greater demand? Secondly, do you have any intention of allowing Albertans on unreasonably long waiting lists – easily the number one call in my constituency office the last three and half years is people that have gone to Montana for surgeries. Do you have any intention of allowing Albertans on unreasonably long waiting lists to access care in other provinces, publicly covered by Alberta Health?

Ms Hoffman: The piece around the increase: out-of-province health care services are increasing by $8 million, and that is due to an increase in the number of claims, the volume, as well as the rates that those claims are coming through at.

In terms of allowing people to queue-jump if they have the means, that to me and, I would say, many Albertans doesn't meet the objectives of the Canada Health Act. It's around universality and trying to ensure that we have the best quality care for all Albertans regardless of what their means might be to access out-of-province travel or to pay out of pocket. That certainly is the kind of Alberta I want to live in, one where everyone gets what they need. And I think we should strive for reasonable waits for everybody.

8:10

Mr. Barnes: Yeah. Minister Hoffman, the number one advertisers on radio stations in Medicine Hat are Kalispell and Great Falls clinics: come down here and get your services rather than wait. We need to do something.

I'd like to talk about page 57 of your business plan, 1.2. Your desired outcome is to create 2,000 public long-term care spaces over four years to improve seniors' care and take pressure off acute-care systems. Absolutely wonderful. I absolutely can't believe that the last government didn't do this when it's so much better to keep people in a healthier environment for them, never mind the cost savings. I just want you to talk about the word "public." Do you mean that things like the ASLI grants and working with private expertise and private capital will be no longer involved? Do you mean that our strong not-for-profit sector will not have an opportunity to share in helping Albertans? What do you mean by the word "public"?

Ms Hoffman: I mean publicly accessible, that they're going to be needs based, not means based. If you need to access a space, regardless of your personal income that's going to be available to you. As you'll see with the ASLI clarification, that our government took upon ourselves a few weeks ago, there is a mix of the three different types of service providers. We're really working to make sure that the needs of communities, the needs of those who are aging are the driving decision-making factors and making sure that we're investing in those highest level of need care beds. So long-term care and dementia beds are certainly where we're focusing our capital efforts because those are some of the citizens – every citizen deserves to live with dignity and respect in a place where they are safe. For the people who are living in long-term care and dementia care, unfortunately, for many of them today the only safe place is a hospital bed, and nobody wants to be in the hospital if they don't need to be there. We need to move on this. Yeah. It's around public accessibility.

Mr. Barnes: Okay. Thank you for that.

Ms Hoffman: Thank you.

Mr. Barnes: When we talk about expanding services into our communities in a cost-effective way, I've heard great success stories recently from nurse practitioners across the province. It's my understanding, of course, that nurse practitioners in Alberta do not have any funding model in place in spite of some very successful short-term pilot projects in Okotoks. I understand it's worked well

in Medicine Hat as well. Is there anything at all in this Health budget that addresses the creation of a funding model for nurse practitioners, or when can we expect to see this?

Ms Hoffman: One of the staff members that I didn't expect to see here tonight but who, clearly, is so excited about this budget that she's here is Val, who oversees our collaboration with all of our different nursing groups. This weekend we were both at a conference for nurse practitioners. Val is the first to say that there have been failed experiments in expanding the scope, at least two waves, since nurse practitioners first came into being in Alberta. That being said, we do have hundreds of nurse practitioners. I think we can have more. I know we can have more. That's one of the reasons why we're investing in their education.

One of the big tensions that nurse practitioners often talk to us about is the compensation model. We're trying to look at these collaborative teams. While currently the vast majority of physicians are receiving compensation through a fee-for-service model, nurse practitioners are salaried. If nurse practitioners under the salaried model are doing the work of physicians that physicians could be billing for, it creates tensions in the workplace because they're cutting in on the market share. Isn't that just the wrong model for us to be pushing, this market-share situation or this clash of compensation models? I'm not saying that the right solution is to go to fee for service for nurse practitioners; I'm saying that the right solution is for us to be working as a community of health practitioners, with nurse practitioners and physicians at the table.

In Alberta one of the areas where nurse practitioners are actually growing at a significant rate is the acute-care settings. There's a lot that they can do under their scope around doing that early level of care, admission, discharge, making sure that patients are set up with the right services. There is a human resources review under way right now, and nurse practitioners have been partners in that, and so have a number of physicians.

When I talk about that idea of there being a clash, that certainly isn't the norm across Alberta. We have amazing health professionals in every different area that are working to build . . .

The Chair: Thank you, Minister.

Now we'll move on to the third-party opposition, the Progressive Conservatives. Dr. Starke, I believe you wanted to go back and forth with the minister.

Dr. Starke: If that's permissible with the minister.

The Chair: Please go ahead.

Dr. Starke: Thank you. Well, Minister, thank you very much. Thank you, Chair, and thanks to all of the support staff from Alberta Health and the various other departments that are here tonight. I'm very appreciative of the work that you do on behalf of Albertans. I think our common goal both here tonight and in general is to improve those services wherever possible.

Working towards that, Minister, as you've probably heard from your colleagues, I take a lot of interest in the business plan, so we're going to go straight to the business plan if that's all right with you. I find the setting of objectives and targets to be useful in business. Even though sometimes it's considered by many that health shouldn't be considered a business, I do think that health can have targets, so I want to talk about some of those. I want to start with priority initiative 1.7, improve the effectiveness and efficiency of emergency and ambulance services. I was so pleased to see this. The rural health care review, that was recently completed, provided a series of recommendations on emergency medical services as they dealt with the rural areas especially. I'd like to know which of those initiatives have been adopted, and if they have not been adopted, why not?

Ms Hoffman: Thank you very much for the question. Can I just say that I really enjoy the tone that we are setting here tonight? I feel like it is around wanting to ensure success in the budget for Albertans and for the services that Albertans receive. First of all, I just want to say that. For my first time in the hot seat it feels warm, which is nice.

The hon. member is right that a great deal of work went into the rural health review as well as a review around EMS service provision in 2013. Really, there is a desire to have a complementary analysis of some of the pieces that were in the rural health review alongside the Health Quality Council 2013 report to ensure the very best care for Albertans no matter where they live.

In terms of specific recommendations that were outlined in the rural health review, I would be happy at a later date to have an opportunity to sit down with the hon. member one-on-one and talk through some of those if he would like to use his questions tonight to focus on the budget.

Dr. Starke: Sure. That's great.

I guess, then, I'd like to just follow up a little bit. During an exchange in question period on November 5 the hon. Member for Livingstone-Macleod said: "a total lack of nonemergency transfer units." I note that, as you often are in question period, you were very eager to refute some of the statements made by the hon. member, but you didn't take him on on this total lack of nonemergency transfer units. Now, as you know, I'm sure, these units do in fact exist, and the numbers of them have increased significantly over the last number of years, but more would be helpful. So, Minister, how many nonemergency transfer, or NET, vans are provided for in this budget, and what is the target for the number of these units to be deployed province-wide?

Ms Hoffman: Of course, consolidated EMS across the province is expected to decrease wait times and maximize efficiencies so that services can be directed wherever they are most needed. In terms of different regions there are a variety of different ways that that's going to be achieved. We do want EMS crews to be responding to calls and not tied up in hospitals. These vans, of course, are a piece of fulfilling that outcome. AHS works to get crews back on the road as quickly as possible. The specific number of vans we can certainly provide to you at a later date, but it isn't a number that's handy at this moment.

Dr. Starke: Okay. Are you planning on increasing the number? They have been very successful where they've been deployed.

Ms Hoffman: I'm going to ask the deputy minister or his designate to respond to that question, please, if that's appropriate, if you're comfortable with that.

Dr. Starke: Sure.

Dr. Amrhein: I don't have the information.

Ms Hoffman: Martin?

Mr. Chamberlain: The answer, I think, is that we have to wait for the AHS budget to be finalized to see if there are any in there.

8:20

Dr. Starke: I'd just like to say that I'd certainly encourage it. One of the great frustrations that we do see is where full-fledged ambulance crews with full-fledged paramedics are doing patient

transfers that are noncritical. It is really a misallocation of resources.

Let's move on. I want to talk about immunization – I love this topic, as you can probably appreciate – 2.5, to improve and protect the health of Albertans through a variety of strategies, including increased immunization rates. As you can probably appreciate, I'm all over that. But I note the numbers on page 58 are, I have to say, extremely ambitious and maybe a little bit unrealistic. For influenza immunization you're planning, or at least targeting, to go from 64 to 75 per cent for seniors 65 and over. For children aged six to 23 months you want to go from 34 to 75 per cent in one year, more than doubling the rate, and for residents in long-term care facilities from 88 to 95 per cent, also in one year. Then the other thing that disturbs me is that once you've made that great jump, it flatlines. There are no improvements subsequent to that.

Minister, I'm curious to know, first of all, how you're going to achieve the objectives in that one year to get to those much higher and much more desirable rates. I'll point out that the PC caucus sits at 78 per cent, so we feel we're doing pretty well. I'm just curious to know why you're not aiming for an increase in the out-years.

Ms Hoffman: I'm curious to know what your target is.

Dr. Starke: In the PC caucus?

Ms Hoffman: Yeah.

Dr. Starke: Well, it's a hundred per cent, actually, but I'm curious to know what the NDP caucus rate is.

Ms Hoffman: Many members of the caucus have been tweeting little updates about getting their flu shots, and of course those range in a variety of settings, from public health clinics to pharmacies. It's great that there are so many different choices out there for Albertans.

The targets that we've set are the national targets. We think it's more than appropriate to have the same targets for Alberta as we would want to see for Canada. I also have to point out the irony of some targets being perceived as being too cold and others being too hot. Maybe that means we're close to just right.

In terms of the strategies one of the pieces that we did this year with the front-line health professionals was to reach out to all their different labour representatives. They are our employees, but they're also members of their different unions. I was really proud that they all went with me and we got our shots together. I think that that clearly says how important their local leaders value their accessing those immunizations.

The targets are aggressive and high, and I really hope we achieve them this year.

Dr. Starke: I hope so, too, Minister. I think that it is unlikely without a specific strategy.

I'd like to actually move on to 2(b), childhood immunization rates by age two. For diphtheria, tetanus, pertussis, and polio – I understand we have a whooping cough outbreak in Edmonton, that was reported by AHS today – we're hoping to go from 74 per cent to 97 per cent and for MMR from 85 to 98 per cent, again, in one year with no subsequent increases. Okay. If those are the national targets, that's great. I guess my question is: what is your strategy for achieving these goals, and are you considering making the vaccination of children entering primary school mandatory?

Ms Hoffman: One of the things that we've talked about, that was raised by one of the other hon. members at this table, was around increasing information for parents and around the assumption that you're going to be immunized unless you choose to inform yourself and opt out, which I think is probably a way to ensure that parents still have choice but that we're enabling them and they're receiving as much information as possible around the benefits of a choice to protect their children. By protecting their own healthy children, it also protects immunosuppressed children out there as well. There are a lot of kids who can't protect themselves, but we can make decisions, those of us who have children who are healthy, to protect our kids, which provides that same protection to others in the community.

Some of the strategies are community health clinics. For example, in my own constituency Westmount mall has a community health clinic in it. They come out and work with low-income families. They have two nights a month where they do a dinner that's prepared, where you can bring your whole family. Most of the constituents who come to that event are new Canadians or First Nations, but the vast majority are living in poverty. The community health nurse is there to provide information on immunizations, smoking cessation – I'm sure that your colleague will be happy to hear about that – as well as the public library. It's really about increasing awareness of information and making it easy for people to make a decision to protect themselves and the people that they love.

Dr. Starke: Okay. Great.

I'd like to move back to page 57, 2.2, to modernize the food safety inspection system in partnership with Alberta Health Services and other government ministries. I look at that and I say: okay; you want to modernize the food inspection system. So I'm asking the question: what exactly in the current system is archaic?

Ms Hoffman: I imagine you've worked in some food inspection facilities from time to time.

Dr. Starke: Many. Many.

Ms Hoffman: Would you care to share any of your perceptions on that before I ask my deputy to respond to that?

Dr. Starke: Well, I'll be truthful with you, Minister. I actually think Canada has one of the strongest systems of food inspection of any nation. In fact, our food safety record – you know, albeit we have had incidents where food safety has been compromised, but in each of those cases the response has been excellent and has been rapid in the interest of the public.

When I see the word "modernize," I say: well, that implies that there's something wrong or outmoded or out of date with the current system. I'd be curious to know what it is that's out of date right now and how you intend to address it.

Ms Hoffman: Thank you for clarifying that and providing that.

Mr. Deputy.

Dr. Amrhein: I'll ask my colleagues if they have specifics, but there are a number of initiatives under way in a number of our auditing and inspection programs to increase the frequency, to use modern communications technology, to do it more rapidly, and to make the results more available to more people in a timely fashion. This is part of an initiative that is coming out of the federal government as well, so we're partnering with the federal government on some of these things. The risk-based inspections will be based on updating to the best practice, the modern science, the modern detection and testing techniques.

Dr. Starke: Okay. I guess my question, then, further to that would be: does that mean that there is going to be an increased level of intensity

by some of our overzealous health inspectors in rural areas for things like church bake sales and county fairs, food kiosks? In other words, are we going to see an even greater pervasiveness of the pie police and the perogy patrol, as they've become known in rural areas?

Ms Hoffman: If I could just start and then ask my deputy to supplement, the desire is always to make sure that people are acting in a way that's safe for consumers. There was an event right in this constituency this summer where past practice had been that food was prepared at home in individual kitchens. AHS through the health inspectors had been working for at least three years prior to try to make sure that it was prepared in commercial kitchens, that it was done in a way that was safe. Unfortunately, they had to act in the interests of individuals in protecting the food consumption.

The ultimate desire is always to work in tandem in making sure that things are done safely so that everyone can have confidence when they're buying something that it's going to be good for them and not harm them, but there are times where they do need to intervene if organizations aren't being compliant. The desire is compliance, not to shut down these good innovations.

Deputy Minister, did you want to supplement that?

Dr. Starke: Minister, if I could offer an observation from some of the feedback I have at least received. That is that it's not compliance, and it's certainly not education. It's more in terms of enforcement and penalizing these groups. It has not been a very positive public health or public relations exercise for the Health department.

Ms Hoffman: I'll go back to that. Deputy, did you want to add anything, please?

Dr. Amrhein: Public relations is not the goal in protecting the health of Albertans. The note I was just handed is that this is very sharply focused on meat inspection. We have seen some of the very unfortunate outcomes of lax meat inspection, so this is very sharply focused on meat inspections. It's to come up to the very, very best that science and technology allow us to achieve. I'm told it does not have anything to do with the sort of events that you're talking about.

Dr. Starke: I don't want to dwell on this too much longer, but meat inspection, for the most part, is in the purview of the Canadian Food Inspection Agency, which is federal, and I'm surprised that, you know, that would be part of it.

But let's move on. I just want to backtrack a little bit. The Member for Cypress-Medicine Hat asked a question with regard to the increased number of long-term health care spaces over the next four years. I noted that as well, an additional 2,000 long-term care spaces. But then when we go down to performance measure at 1(a), this may be one of those too hot, too cold situations, but the target at the last actual was 69 per cent, and the target for the next three years is only 70 per cent. Minister, I guess my question is: why is there so little progress? If you're adding 2,000 additional spaces over the next four years, would you not expect to see an improvement in that performance measure?

Ms Hoffman: Thank you very much for the question. Just to clarify, you're talking about page 57 in the business plan.

Dr. Starke: That's correct. Yeah.

8:30

Ms Hoffman: Okay. Part of the reason why the target is where it is, of course, is because of the increasing growth of demand. While there are far too many people currently waiting in hospital and also at home, our goal is to make sure that we get individuals out of places where they're unsafe and into these essential long-term care beds in a timely fashion. Thirty days is rather a definitive point in time, so you could be – it reminds me of when I was looking at school assessments, and you'd have the number of students hitting standard of excellence, which is 80 per cent. If they get 79 per cent, they're counted as not achieving standard of excellence. So there could be a range of 31 to 35 days that doesn't meet that 30-day standard. I think that the ultimate desire is to try to make sure that we're shortening the amount of time and moving in a thoughtful way to make sure that people are moved into the beds as quickly as possible.

Dr. Starke: I think that's a goal we all share, so that's great.

Let's jump over now to the expense side. This is within the fiscal plan book on page 14. Minister, I have to tell you that I applaud the efforts that you're making to bend the cost curve on health. I think it is very clear to all Albertans that that's something we have to engage in. While that's a laudable goal, I have to confess some concern with regard to a different level of scrutiny or at least a different level of effort when you compare AHS, which is about 70 per cent of the Health budget, as compared to your department, which is about 30 per cent of the Health budget. On page 14, if you do the math, over the next three years you're projecting a 6.2 per cent increase in the AHS operations budget, but the budget of the Department of Health is projected to increase by some 16.9 per cent over those three years. I guess my question would be: why is the level of restraint that you're exercising within your own department so much less, or why is the achievement so much less than what is being achieved within AHS?

Ms Hoffman: Thank you very much for the question. I've obsessed over a lot of pie charts over the last many years to see which pieces of the pie are growing the fastest, and as I mentioned earlier: hospitals, drugs, and physician compensation. Hospitals are AHS. It's a little bit easier to have some controls on what's happening in a building because you control how many buildings you have, you control the staffing levels, you have some more oversight.

In terms of physician compensation that again is primarily driven on a fee-for-service model, so if a physician feels they need to see a patient, they're going to do so. We have less control over that line item right now because of the way that the current funding system and the collective agreement has been struck in the past years as well as the drug piece. Albertans are living longer – that's great – but they also have more complex needs, and that can be expensive.

In terms of bending the cost curve on the drug side, I need help from my federal and provincial counterparts for us to be able to make some of the big shifts we need to in this province and in this country to be able to find those efficiencies because, in terms of the economies of scale, while 4 million people is not a small population, to a pharmaceutical company it is not big.

Dr. Starke: Absolutely. I think that in my next round we'll talk a little bit more about pharmaceutical costs.

I do want to just get back to physician compensation. Alberta has the highest rate of physicians who are compensated on a primarily fee-for-service basis, and that's considered to be one of our major cost drivers as compared to other provinces. Are you going to try in your conversations with AMA to move a higher percentage of Alberta physicians to alternate forms of compensation in an effort to get a greater level of control over the costs involved so that they are not as susceptible to some of the fluctuations that you described earlier?

Ms Hoffman: Yes, and it's not going to stop with the AMA. I think that when we look at the variety of health professionals that we

have, it's around working with them to provide both them and Albertans certainty around their accessibility, around what's happening with our budget line items. I am hopeful. I know that the leadership of AMA wants a sustainable system, too. I know that the physicians who practise here do so for a variety of reasons, that they really enjoy practising here. Of course, compensation is one of the pieces that helps with that, but there are many other drivers as well. We have discussions under way now even though there's an agreement to 2018, because I just don't think Alberta can wait that long and neither do our physicians, so I really appreciate their agreement to work collaboratively with us.

Dr. Starke: Thank you, Minister.

The Chair: Thank you, Minister.

We will now move on to 20 minutes for the independent/other caucus. Dr. Swann, I believe that you'll be sharing your time with Mr. Clark?

Dr. Swann: I'd like to do that if the minister is still up to it.

Ms Hoffman: Sure.

Dr. Swann: Thank you, Minister. Thank you, staff, for joining us tonight. Very impressive responses. They've taken away most of my questions, actually. However, I do have just 10 left.

Line item 2.5 if you will. Again, you did comment on the subcategory within Alberta Health Services that saw its operating budget cut, down $380 million over last year's $2.6 billion. Can you comment on the degree to which this shifted funds to front-line workers versus management positions and other costs?

Ms Hoffman: Yeah. The support services are the areas of efficiency which include that building operations piece, security, communications, admission/discharge administration, information technology, research, and education. AHS is focusing their efficiencies as much as they can on the administrative side. Again, the example of the cellphones and $5 million: that's a lot of front-line service providers simply by looking at the way our cellphone contracts are being bundled. So the intent is to try to keep as many resources on the front lines as possible.

Dr. Swann: Can you comment on any increase in front-line staffing in that, or does that not include any staff?

Ms Hoffman: I'm going to ask my deputy to answer. Again, AHS is still in the creating-the-budget phase. They don't have their final budget. They do have the documents that they are hoping to bring forward to their board in short order.

My deputy, having recently been the official administrator for AHS, may be able to provide further insight into this.

Dr. Amrhein: There are increases due to volume, there are increases in front-line staff due to increasing population, and there are increases in front-line staff due to the changing mix of severe chronic care that is presented. These numbers aren't complete yet because AHS is still going through their process of fine-tuning all of their forecasts based on what comes out of this exercise. Once we have the detailed spreadsheets from AHS by category, by location, then we should be able to provide you with a very detailed answer.

Dr. Swann: I guess my overarching question is on whether we've actually seen reduced numbers. With $380 million cut, it's hard to believe that some of those wouldn't be front-line workers, but you can't answer that yet, so I respect that if you can't say where we've lost front-line staff.

With respect to the reduction in primary care and addictions/mental health by about 10 per cent, can you specify where the reduction of 10 per cent, or $29.1 million under line item 4, reduced from last year, actually came from?

Ms Hoffman: Thank you for the question. Of course, mental health and addictions are a priority for us, and I'm really glad that the hon. member has agreed to support us in undertaking this important work for all Albertans.

That line item reduction is the PCN reduction. There's actually an increase in allocation for addictions and mental health but a decrease for the PCNs, and in the end, when you add those two numbers together, it ends up with a net decrease. But in terms of mental health and addictions there's about a $10 million increase there.

Dr. Swann: I'm confused. Line item 4 suggests $29.1 million lost from the $309 million of the previous year. Line item 4.3 indicates a $41 million reduction.

8:40

Ms Hoffman: I'll try my best to break this down a little bit. Primary health care/addictions and mental health, program support: the estimate is $6.749 million, which is actually an increase over actuals of about a million dollars. Family care clinics is an increase. It's going to be $5 million, which is an increase of about $800,000. We also have the primary care networks, which is where the reduction is. That was 4.3, primary care networks. The actual for '14-15 was $209 million, and the actual for this year is going to be $168 million. So that's where the reduction is, and that's because we're asking them to use their surpluses this year, some of their surpluses, not all. Then addictions and mental health is actually a net increase from $90 million to $100 million. When you look at those line items and you add them all up, you do see a decrease overall, but that's because of the reduction to the primary care networks.

Dr. Swann: Thank you.

With respect to the surpluses I'm informed that the primary care networks had to have a reserve fund, particularly as in the last few years there was a question of them being delisted. They had to have a fund in order to provide legal and transition costs if these physician practices went back to private practices from the PCNs, that that was a requirement under PCN legislation. They had to have a reserve fund in case they were delisted, to protect them.

Ms Hoffman: Those reserves we have not touched. It's surpluses in addition to that, and some of them had very significant surpluses. So those closing costs have not been touched, but we are also looking at whether or not that's the best model for the PCNs or whether we should offer some of those assurances rather than having them sit on millions of dollars of provincial allocations for many years when, hopefully, many of them will never need to close.

Dr. Swann: Thank you.

Under line item 6, Alberta Innovates: Health Solutions, the research budget is being cut, down $20 million from last year. I'm hearing serious concerns from the research community, who see, as I do, research as the very foundation for improving health care, to provide innovation and to actually increase jobs and innovation. I guess we're all asking about the 22 per cent reduction in research and if this is a review situation or whether this is a trend in Alberta Health, that we're going to reduce significantly in order to try and

reduce our budgets from the very foundation of improving our health care system.

Ms Hoffman: Thank you for the question. Of course, evidence from research is a driving value that I am proud of, and I know that you are, too, hon. member. There's a $20 million reduction. That's part of a $94 million surplus. So even asking them to spend $20 million of their surplus is not significant in the amount of surplus that they have been sitting on. Again, I don't think we allocate money in a budget in a fiscal year for it to be sat on. I think that the responsible thing for us to do is to work with them, monitor where their surplus rates are after this year and in the out-years, and work to ensure that we're using taxpayer dollars responsibly.

Dr. Swann: I guess it was my misunderstanding. I read this as a total budget of $71 million.

Ms Hoffman: Yeah, it is, and it's because we're asking them to spend . . .

Dr. Swann: Not a surplus of $71 million but a budget of $71 million, down from $91 million.

Ms Hoffman: Yes. The government will still be contributing $71 million in this year's allocation, but they have this surplus that we're speaking to.

I'm going to ask my very knowledgeable deputy and assistant deputy to give those details, but I've been assured and I have the confidence that what we're asking them to spend from their surplus is a fraction of what they actually have in surplus.

Dr. Amrhein.

Dr. Amrhein: The accumulated surplus was $94 million when this Treasury estimate was started. Historically the annual budget of the AIHS is something in the order of $86 million, so we've asked them to consume $20 million of the $94 million and then provided the $66 million to come up to what their spending is. So it's a multiyear plan to either have AIHS come back to government with their plans for their surplus or to use their surplus since it comes from the government of Alberta. The numbers for the surplus and a one-year budget are very close, so the numbers get confusing.

Dr. Swann: Thank you for that clarity.

I note in passing – and I'm sorry; I didn't document the line item – that the South Health Campus is going to have an increase of $20 million over the next two to three years. Having recently been built, I was curious about why they would need an extra $20 million over the next two to three years, if that's at hand. If not, you could get back to me on that very specific question.

Ms Hoffman: I'll tell you about my visit while we get it in hand. I did visit the South Health Campus not that long ago, when we were working with AHS around the patient first strategy, and that facility is amazing. The fact that the Y is incorporated, with a rock-climbing wall and a community kitchen for families to learn how to make meals that meet the dietary requirements that they are in, is really to be commended.

You're right. The five-year total: there's a $20 million investment in the first two years for that specific project. The project is complete, and the funding expenses are under review for the financial closure, so it's paying out for work that's being done currently or work that was recently completed. It's actually paying the bills to finish the outfitting of the work that has been completed. The work is done, so now we just need to make sure that it gets paid for.

Dr. Swann: It was already ordered in the initial build. Is that what you're saying?

Ms Hoffman: Yes. It's not going to be an expansion in these two years. It's about completing the funding expenses piece, paying for work that's been done.

Dr. Swann: For the record, I remember well, four or five years ago, when the budget was shooting over target and they decided to cut both the women's pavilion and the mental health services down there, which continues to be a very sore point in mental health and addiction services.

Switching to the business plan, 2.4, the chronic disease and injury prevention budget remains around 1.2 per cent of the Health budget. What plans, if any, does the minister have to try and shift that curve in a different direction from the acute-care curve?

Ms Hoffman: That was chronic disease and injury?

Dr. Swann: Yes, chronic disease and injury prevention, which consumes about 1 to 2 per cent of the budget and explains why our emergency rooms and our hospital beds are so full.

Ms Hoffman: Absolutely. As a physician I'm sure you've seen first-hand the impacts of not having the right supports in the community and why people in a state of crisis call on emergency, because it's there for those really difficult times. Of course, part of it is the platform commitments that we made around long-term care, home care, and mental health supports, and those are three areas within the primary system that I think will really help us address needs before they become acute.

Some will say: right now we have a health professional focused system; we want to move to a patient system. I want to move to a citizen system, one where people aren't becoming patients, one where we're keeping people as healthy as possible, certainly investing in those pieces like long-term care. Home care is a huge one. If you can prevent somebody from falling on their way into the bath and breaking their hip and ending up waiting for – well, emergency hip surgery times are not long – or ending up in an emergency situation. Of course, that investment is significant on the person's quality of life as well as the provincial treasury.

Dr. Swann: Other related prevention issues: I don't see a budget item for tobacco reduction. Is there a figure planned for tobacco reduction?

Ms Hoffman: Right now I'll do a plug while my staff find the right line item. I know some people who actually work in the building that we're in today that are taking the time to go online through the government website and fill out the AlbertaQuits information to develop their own strategies and support with technology, which is fantastic, as well as accessing addiction supports through 811.

Dr. Swann: They can get back to me.

Ms Hoffman: Line 4.4, addictions and mental health, would have a subcomponent for smoking cessation. The specific amount we can follow up on with you.

Dr. Swann: Tobacco reduction, prevention.

Ms Hoffman: Tobacco reduction. Okay.

Dr. Swann: The Alberta cancer legacy continues to receive $25 million a year, yet there's no annual report telling us how they're spending that money as far as I can see. Is there a willingness for

you to look into that, the $25 million cancer prevention legacy fund? It's been going since Ralph Klein was here, and we've had a very difficult time getting any kind of an annual report on where that money is actually going.

Ms Hoffman: Here is your report: $12.5 million goes to Alberta Health Services; $12.5 million goes to AIHS.

Dr. Swann: Could I get a little more detail on that?

Ms Hoffman: Yeah, we can. The specifics within their annual reports, of course, would be where we would flesh out some of that detail. That's the way the allocation is being split this year, and we'd be happy to follow up with you.

8:50

Dr. Swann: Thank you.

In the business plan line 2.1 indicates there's a need to strengthen environmental public health. Do you want to say anything about what that entails, what strengthening environmental public health services would mean, or do you want to get back to me on what that line item is dedicated to?

Ms Hoffman: Yeah. We have a little bit of a breakdown here.

Actually, I'll ask my assistant deputy minister, please, to respond to that question.

Mr. Chamberlain: I think, Minister, we're going to have to respond in writing.

Dr. Swann: Sure. That's fine.

In a similar vein, 2.6, increasing First Nations health services: can we get a little more information on what increasing and strengthening First Nations health services means?

Ms Hoffman: Yeah. A big piece of that will be, of course, work that I'm doing. The Premier gave each minister the responsibility of ensuring that the UN declaration on the rights of indigenous peoples was a lens that we do our work through, and we have a submission to the Premier's office due very early in the new year. I think that is the timing on that.

In terms of being able to respond in writing today, I would have some high-level information for you, but of course being able to give details around the specific projects as they align to the declaration is ongoing work: meeting with the grand chiefs, and we've been identifying a number of projects with the Blood Tribe, for example, around naloxone, access to those kits. When I visited their site, of course, they have a desire to provide long-term care on-site. They've already built a building, and they're really keen to take care of their elders in their own communities.

Dr. Swann: You're prepared to consider staffing on the reserves?

Ms Hoffman: We're in discussion about it. I know that Saskatchewan has done the courageous thing under a former government there, not the current one, around breaking down some of those boundaries because a patient is a patient.

Dr. Swann: Thank you. That's great.

Ms Hoffman: Thank you.

Dr. Swann: You alluded to emergency medical services and the pilot for EMS to actually do work in the community. They need protection under the health protection act if they're going to expand their scope of practice in seniors' homes, in emergency situations, where they don't feel it's essential to take that person to a hospital, because of the nature of the injury, and they can diagnose it and treat it on-site, saving an emergency room visit. Unless they get protection under the health protection act, which would be simply an order in council, which I'm hoping the minister is considering, it's hard for them to feel free and protected in providing some of these extra services in the community and reducing the demands on emergency.

Ms Hoffman: Can I say that an order in council is not nearly as simple as I thought it was?

Dr. Swann: Probably me, too, then.

Ms Hoffman: But it is certainly under discussion and one of the areas that we're looking at through regulation.

Dr. Swann: Oh, good. I'm very pleased.

Ms Hoffman: Thank you.

Dr. Swann: We now have pharmacists providing diagnostic and treatment services on a fee-for-service basis. I'm wondering if we have any estimate on the costs so far in that, which I felt was misguided. Another set of professionals getting a fee for service for various services is not the way to incent reduced costs in the health care system, from my view, but I'd be interested in knowing what benefits and what costs have come out of the new roles and responsibilities of pharmacists, which could be some significant benefits in helping identify conflicts in pharmacy. But it also adds to the whole, as you said, volume-driven incentive for pharmacists. Do we have any numbers in relation to pharmacists' expenses for the fee-for-service line item where they're providing services?

Ms Hoffman: Yeah. Pharmaceutical innovation and management is the line item. It's $42 million, specifically for pharmacy clinical services, and then pharmacy program support is another $3.8 million, so a total of $45.8 million.

Dr. Swann: Thank you. That will be an interesting one to watch. Obviously, we are concerned about physicians and the significant increase annually in physician costs on a fee-for-service arrangement.

On a peripheral note, the provincial health officer was let go this year. He was operating under the auspices of Alberta Health Services, so understandably you may not want to comment on that. But he, as an independent official looking over the public health issues and interests of Albertans, had some independence and, although reporting through Alberta Health Services, had some independence to speak out on issues of concern to public health without concern about his job or should be able to speak without concern about his job. I'm wondering if the minister has considered creating a provincial health officer reporting to the Legislature, just as other independent officers, like the Child and Youth Advocate, can make comments about risks to children's health and safety without concern about his job because he reports directly to the Alberta Legislature. So for consideration: the provincial health officer needs to have some independence from the minister in order be an independent spokesperson on health and health risks in the province.

The Chair: Thank you, Member and Minister.

I will now move on to the final 20-minute rotation for government caucus.

Mr. Westhead, would you like to go back and forth?

Mr. Clark: Excuse me.

The Chair: Yes, Mr. Clark.

Mr. Clark: Thank you. Do I have 20 minutes now as well?

The Chair: Dr. Swann used up your time. You have to wait until the next rotation for . . .

Mr. Clark: I'm not sure that's correct. I believe I am entitled to my 20 minutes now as well.

The Chair: No. It's 20 minutes for the independent caucuses or other caucuses. Under the standing orders it's 20 minutes for all.

Mr. Clark: I see. I'll wait for the next rotation. Fair enough. Thank you.

The Chair: Thank you.
Mr. Westhead.

Mr. Westhead: Thank you, Chair. Thank you, Minister, for providing this opportunity to ask questions. I used to be a nurse before being elected, so it's really a neat opportunity for me to be here with you this evening.

Obviously, the health and well-being of our citizens is one of the most important issues that we can face here, and we've had some really great questions from the opposition parties tonight as well that reflect how important that is. I also think it's really great that we have this opportunity tonight to learn a little bit more about how the government is prioritizing the health and well-being of Albertans.

I'd just sort of like to start off the discussion with a bit of a general question to sort of set the stage for some of the rest of my questioning. I'm just wondering if you can tell us a little bit more about the development of the Alberta Health business plan for the 2015-2018 time period, starting on page 55. I know that Albertans elected a new government for us to do things a little bit differently, so I would expect that the business plan that you and your ministry have created would reflect this. I'm just wondering if you can tell us a little bit more about your business plan and how it's perhaps unique from previous business plans.

Ms Hoffman: Thank you very much for the question and for referencing your experience. It's amazing; I'm so proud to be part of a caucus and a Legislature as well with so many health professionals in it.

In terms of the performance indicators they're used to report longer term outcomes. Those are influenced by a number of external factors as well. We have six new performance indicators that have been added to the business plan, and we're expecting to bridge with Alberta Health priority initiatives. Those include a focus on additional addiction and mental health needs as well as appropriate high-quality health care services, health disparity for vulnerable groups, maternal and infant health as well as sustainability of Alberta's health system. Those are sort of the six new performance indicators at a high level.

Thank you.

Mr. Westhead: I appreciate that you mentioned: at a high level. I'm just wondering if you can share a few more details about the performance indicators. Obviously, it's a way that we can measure the success of what we're doing and the programs that we're offering. I think it's important, and I just would ask if you're able to share a little more detail.

Ms Hoffman: Sure. Of course, using evidence-based information to move to a more community-based health delivery system and using the outcomes and recommendations from the mental health review will be a significant piece within that work. I think I'll stop at that point for this answer if that's all right.

Mr. Westhead: Sure. A little earlier this evening we talked about setting goals and where we should be setting those goals. Is it too high? Is it too low? Can you tell us a little bit more about how you expect to improve our performance on those indicators over time?

Ms Hoffman: Sorry. Would you mind just repeating that question?

Mr. Westhead: Yeah. Sure. Earlier this evening we talked a little bit about goal setting. Some were speculating that it was too high. Why are you just trying to attain the previous goal? Why don't you set your goals a little bit higher? I'm just wondering if you can sort of walk us through how you potentially expect to improve our goals over time.

Ms Hoffman: Yeah. Well, again this comes back to wanting to use evidence to help drive the decisions that we're making. This being our first time through this cycle but given that there will be five budgets in four years, I think we will certainly have an opportunity to own the process as we continue to move forward. Part of it is about working in collaboration with the service provider, Alberta Health Services, as well as using evidence derived from organizations such as CIHI, the Canadian Institute for Health Information. One of the new people that we've added to the board for Alberta Health Services was actually a former executive director there, a former federal Deputy Minister of Health. Certainly, she has been through many a business plan setting performance indicators and, I'm sure, will be keen to contribute on the Alberta Health Services side to complement the department's work in these areas.

9:00

Mr. Westhead: Thank you for explaining a little bit more about the business plan and the performance indicators. You know, it seems, though, as though – obviously we want to do a little bit better in the future – it's going to require a bit of increased investment in certain areas. I know you've talked about bending the spending curve over time, but obviously if we're going to see improvements in our performance indicators, it's probably going to have a budget impact somewhere down the line.

I know that to inform your decision-making, you travelled to quite a few different areas around the province over the course of the summer, and I know you were learning about the health care system and hearing from front-line health care workers and patients. I was wondering if you can tell us how those visits that you did over the summer helped inform your decision-making around the budget process.

Ms Hoffman: Thanks a lot for the question. I need to begin by apologizing for not making it to Banff-Cochrane yet. I thought it was just too lovely a place to visit in my first summer and the public scrutiny would be far too great a risk, but certainly having an opportunity to meet with you and some of the service providers in your own constituency would be a priority for me.

I did, however, have a chance to talk on the phone to the mayor of Canmore, and that was, of course, following the tragic construction incident that happened there, which jeopardized the safety of some of the people in the community and our ability to get some of the needed beds online in that community. Certainly, some of the risks that we've encountered are a piece of that.

I'll just touch on a couple of the visits if you don't mind. In Grande Prairie I visited Points West Living hospice, which has a really interesting integrated model, where they have all sorts of different care levels. Often on the same floor they'll have somebody in a supportive living level 4 bed next door to somebody in a dementia bed next door to somebody in a long-term care bed. It's really about trying to create a seamless transition for individuals. Change is one of the things that, especially in the later years, people have a great difficulty adapting to, so the more you can create a seamless model for integration of services, the better your likelihood of individuals living longer and staying healthier. Certainly, they're doing that in an informed way there. Part of that influences this 2,000 beds commitment. How do we make sure that we're building beds where needed that have the ability to adapt to needs that that community will have 10 years down the road? So that was certainly a very interesting visit.

Another seniors' facility: Bethany, in Calgary. The Bethany Care Society is one of the biggest long-term care providers that we have in Alberta, and I had a chance to visit one of the floors where right now it's dementia patients. It's a lockdown unit. These patients, in particular, are some of the more aggressive individuals. The age range of them: I was shocked by how many were suffering from dementia who were actually quite young. There was somebody who used to be a runner, and this is a top floor of a high-rise building with no access to outside because it's a lockdown unit. They have done some initiatives like taking them camping for a weekend and those types of things, but it needs to be highly supervised. The staffing ratios need to be higher than any other unit for good reason: to protect the patients but also to protect the staff who are working there.

This is one of the projects that had been announced previously or received a letter of intent from the previous government around replacing that space. Actually being able to see it first-hand, understand who's living there – the care they receive is top-notch, but that building does not demonstrate best place, best time, best care, you know, ensuring that Albertans have access to the right type of facility. Some of those work their way into the capital needs as well.

Some of them are really about reminding us why it is that when we got elected, we worked so quickly to try to reverse some of those cuts. For example, the Lamont health care centre is a really interesting model, where they have day surgeries, they have urgent care, they have lodge beds, they have higher level of care beds, all integrated into one system.

The hon. member who represents that area is here today. I was really grateful to be able to see the impacts. When you're walking around these facilities, you can't help but wonder: if we hadn't reversed those cuts right after we were elected, who wouldn't be here today? Would the person who's giving a bath to the resident be here? Part of it is about reminding ourselves that health care doesn't just happen in the ATB building or in this building. Health care happens in communities with human beings, and it's an investment that we are so proud to make as a society.

Yes, the Health budget is the biggest budget for any ministry, and it's for good reason. It's because when people don't get the right care, the consequences are too grave for us to just turn our backs on these individuals.

There are so many amazing facilities. I have many others, but maybe I'll have an opportunity to work them into a different answer in a future question. Thank you.

Mr. Westhead: Thank you.

I'd be doing a disservice to my former colleagues if I didn't ask a bit more about front-line services. One of the reasons that I ran for election is because I was worried for my colleagues, and I kind of wanted to stand up for front-line health care workers. You know, when the budget that was proposed by the former government was released, it really solidified my reason for running, so now I couldn't be happier to be here with you this evening.

I know that a lot of my colleagues were worried about whether they had jobs, and you did touch on that in your answer to my previous question. You also talked a little bit about restoring the spending cuts proposed by the previous government. You know, it was quite a lofty goal, about $1 billion in restored funding. I know that it's sort of peppered throughout your budget, so I'm just wondering if you can walk us through potentially some of the bigger areas where funding cuts were restored.

Ms Hoffman: Yeah. Thank you for the question. This budget increases funding in a number of key areas, including AHS-based operating funding. Physician compensation and development, addictions and mental health, allied health services, all drug programs, AISH, adult and child health benefit programs, the insulin pump therapy program, and out-of-province health care services are some of the key ones.

We're also working to find savings where appropriate and being able to realign some of those resources; for example, the recent RAPID program. Being able to move from a treatment that's $1,500 per patient and requiring a copay to a procedure that's less than $50 per patient and not requiring the patient to pay any out-of-pocket money not only saves that patient money but also provides an ability to reinvest some of those savings into other areas to align the system. As I mentioned, drug costs keep going up, so any time we can find opportunities to save on current drugs while continuing to provide that very safest level of care is incredibly important to us to make sure that we continue to have money to move the system forward in its evolution without impacting front-line services.

Mr. Westhead: Okay. You know, anybody who's been in Alberta for any period of time knows that this province can change rapidly. You've talked about that also in some of your previous answers. We have changing demographics, changing immigration trends, and even changing governments once in a while. I know that as a nurse I saw first-hand the impact on our health care system that migration trends and economic boom-and-bust cycles had. Obviously, we need to do what we can to plan for changes in our population and our workforce together. So what in the budget accounts for volume increases and population growth?

Ms Hoffman: Thank you very much. Yes, there certainly is some focus on volume increases. Part of this is around pieces that I mentioned previously like the RAPID program and areas where we know there are big drivers to the volume demands, finding ways to provide safe treatments to a greater number of people, but there is also a focus on efficiencies because, as I said, we're looking at a 4.4 per cent increase this year as opposed to almost 6 per cent in other areas, so we do need to find some of those efficiencies to continue to address demand and where our population is going to land.

9:10

I always thought it was hard to do budgeting in September for a school because you get your money on September 30, and it doesn't matter how many kids show up down the road. It's even harder, I think, in health care because you don't know how many patients are going to show up until they do, so you can't take your number and do your budgeting based on an arbitrary date and time. So that's certainly been interesting.

There is a projected 2 per cent population growth throughout, which is reflected in the drug budget and the physician increase.

The fee-for-service is another area where we have that increase projected.

Thank you.

Mr. Westhead: Thank you.

I was wondering if we could talk a little bit more about facility and home-based continuing care services. I'm just wondering. Why are facility and home-based continuing care services going up $70 million? That's line 2.2 in the estimates. Why are facility and home-based continuing care services going up by 5.4 per cent, or $70 million?

Ms Hoffman: AHS-based operating funding is increasing by $170 million from the '14-15 actual amounts. Again, I hate to do this, but AHS's budget hasn't been finalized yet, so they are going to have to give specifics once they do finalize their budget on what that will mean specifically for their line items. At this point I'm confident in saying that there will be an increased investment in those areas based on the preliminary budget that they're working through right now.

Mr. Westhead: Okay. What about community and population health services, line 2.3? That's going up by 7.7 per cent, or $92 million. That's quite an increase, too. Can you explain that for us?

Ms Hoffman: That's the AHS-based operating funding being increased by $117 million over the '14-15 actual amount. I hate to be this broken record, but further details around the AHS announcement will be forthcoming.

In terms of the kinds of services that are included under this item, it includes community and population health services items, such as community-based care, and promotion, prevention, protection services that maintain and improve the health of the population through promoting and protecting health and preventing disease and injury, as was mentioned earlier by the Member for Calgary-Mountain View. Services are provided in publicly accessible settings in the community, intended to maintain clients in place or within their community to avoid or delay admission for facility-based services and to facilitate and support early discharge from acute-care centres wherever possible. It also includes case co-ordination provisions of medical equipment and supplies and early intervention. So those are some of the areas that they'll be investing that money in.

Mr. Westhead: Thank you.

I was wondering if we can move on to information systems. Earlier in the evening there was a question about electronic health records, and I'm sort of hoping that you can maybe expand on that a little bit. Something in the capital budget caught my attention. It's the spending on information systems. Electronic health records was a small component of that, but I wonder if you can tell us a little bit more about what the increase for information systems will be spent on. Just for your reference, that's line 12 on page 137.

Ms Hoffman: Okay. Thanks a lot. The '15-16 budget was reduced by approximately $1 million from the previous year's budget, and the $1.4 million, or 21 per cent, increase from the '14-15 actual is due to the need to maintain those resource allocations in anticipation of workload requirements as well as a provision for negotiated salary contracts. Those are going to be honoured.

I could go on. The increase in external information system development in 2014-15 was due to the difficult economic circumstances. Some grants were reduced, or the projects were cancelled. This was in the past fiscal year, not the one we're discussing tonight. In '15-16 new projects are being evaluated to ensure that they support the direction of the health care system, a move to community-based care and disease and illness prevention as well.

Again, it's that piece around, for example, when I think about the '90s, when we were working so hard to make sure that we had these – was it brutal cuts? I forget what the language was that was being proposed. A number of areas were cut, and we're still playing catch-up today. Our forecasts for the economy are arguably no better, probably worse than they were at that time. But it would be irresponsible to allow for further deterioration of essential infrastructure, including IT infrastructure, because the information that we use to make good health care decisions is too important for somebody's life to be at stake because we failed to invest in the IT infrastructure to keep them healthy and safe. [A timer sounded]

The Chair: Oh, that was good timing.

Ms Hoffman: That was really good timing.

The Chair: That was really good timing.

All right. Moving on to the 10-minute rounds, we'll be returning to the Official Opposition. Mr. Barnes, are you again going back and forth?

Mr. Barnes: Yes, please, if I could go back and forth. I'll just ask three questions, and I'll turn it over to my colleague from Fort McMurray for our 10 minutes. Is that all right?

The Chair: Sounds great.

Mr. Barnes: Okay. Great. Thank you again, Minister Hoffman. I'm sorry, but I'm right back to the very first question I asked you.

Ms Hoffman: Sure. AHS line items.

Mr. Barnes: The big budget, $19.7 billion. Does your department come up with the number for AHS, or does AHS come to your department with: here's what we need? You've kind of answered it both ways, and I've heard a few times that Alberta Health Services hasn't finalized their budget. When does Alberta Health Services finalize to you and to the taxpayer of Alberta what the final number is going to be? If there is a material change from what's in these documents or from what you said tonight, how will you report back to us?

I very, very much want the best quality service I can have for all Albertans, but I also know that interest and debt take away from what we can provide for all Albertans. So I would wonder, as you answer this question, if you think the $47 billion of debt that we're headed towards in three years may have any impact on our 2017 budget estimates.

Thank you.

Ms Hoffman: Thank you very much for the question. In terms of the back and forth around creating the budget, a lot of that dialogue has happened over the last several months, actually. In terms of being offered assurances, should the Legislative Assembly pass the allocations that are in this budget, AHS will operate within those allocations. This is sort of step 1. If I were to give an analogy of having a job, you get hired for the job, you find out how much your compensation is going to be, and then you figure out how you are going to meet your household expenses within that allocation. We've done the back and forth to make sure that we're confident that we'll be able to have those assurances around quality front-line service access.

In terms of the specifics around their budget they are preparing it with their administration right now. They're operated currently under an official administrator, but very soon the board will – I

think the orientation is actually next week, and then the board is in place almost immediately after that. So I imagine that one of their very first public board meetings will be their analysis and determination around what they want to do officially with the budget. The board will do their due diligence in ensuring that the administration and their assumptions that they're moving forward with, whatever allocations they get from the Legislative Assembly, achieve their outcomes in the year.

Mr. Barnes: You're absolutely confident they'll stay within their budget?

Ms Hoffman: That's my expectation. That's my – I set the policy. I set the budget. The beauty of being a governor is that you get to say what, and then they get to figure out how. So we set the targets, including the budget, and they get to live to achieve those outcomes.

Mr. Barnes: Okay. Okay. The Auditor General, though, in his last, recent report pointed out some key areas of concern. I look at line 11.6. You have an increase in the amount allocated for monitoring, investigations, and licensing. Will this money be directed to addressing the problems of fraud identified by the Auditor General's report, which included improper billing and fraudulent use of Alberta health care insurance plans by nonresidents? Is that what that line, 11.6, is for?

Ms Hoffman: Sorry. What page number is that again, hon. member?

Mr. Barnes: Page 137. It's number 11.6 in your expenses.

9:20

Ms Hoffman: Certainly, we very much appreciate the office of the Auditor General and the work that the office does in ensuring responsible spending. Moving on those recommendations is, of course, paramount to ensuring that that investment that we make in the office of the Auditor General is achieved. I personally think that the Auditor General does a great job, but holding the Auditor General as the only check and balance for the entire government, I would say, is irresponsible and short sighted. I think that within our ministry we owe it to taxpayers to do above and beyond what is absolutely required by the Auditor General in providing additional oversight.

I'm going to ask my deputy to just explain a little bit more about what that line item means, please.

Dr. Amrhein: The specific line item has to do with supportive living and long-term care accommodations, that we monitor for compliance on an annual basis. The accommodation standards ensure that accommodations maintain a high quality of accommodation services that promote safety, security, and quality for Albertans living in these accommodations. Having said that, the department is reviewing all of our audit, compliance, and oversight procedures to see if there are some areas where we should redeploy existing resources to increase our capacity to provide confidence that all of the funds expended are being expended for the purposes intended.

Mr. Barnes: Thank you.

I want to talk about: since dispatch of ambulance services has been centralized, we've seen much of our provincial ambulance services tied up taking patients to cities. In small rural communities we have ambulances quite often being referred to as sucked into the vortex, where they're responding to calls once again into the cities, and they're not left for the service provided to their local communities. I see that your business plan mentions improving "the effectiveness and efficiency of emergency and ambulance services," but this goal contains absolutely no corresponding accountability measures. Specifically, I would suggest that we would be tracking response times and the frequency of code red situations, where no ambulance is available in a community. How do you plan to go about achieving your goal?

Ms Hoffman: Thank you for the question. I'm trying to recall when we asked about a specific measure. I think part of this is that you need to have longitudinal data going back to be able to have ongoing annual measures so that you can benchmark growth on some of these. In terms of moving some of the performance measures forward, because of some of the systems alignments being done in more recent years, it's difficult to have some of that data in a centralized way. I appreciate your, I'm going to say, recommendation to consider putting it in as an accountability pillar in the years moving forward.

I did visit a number of dispatch facilities; for example, in Stony Plain as well as Lethbridge. Both are done differently because Lethbridge is still doing a community-based model and Stony Plain is part of the Edmonton region. I have to say that there are advantages and struggles with either model.

But I think that using information from Alberta Health Services around response times as well as the Health Quality Council report that I mentioned, from 2013, speaks to – having the data to make sure that resources are being deployed in a cohesive way is really important to us. In terms of the benchmarks I appreciate that feedback and will certainly discuss it with the department around refreshing my memory about why we weren't able to work those in as measures this year and ways that they might be able to be incorporated in future years.

Mr. Barnes: Thank you for that.

Mr. Yao: Minister Hoffman, infrastructure: a huge cost is associated with infrastructure. Can you clarify how much is allocated to infrastructure, specifically primary care hospitals?

Ms Hoffman: The capital budget so far is – and I say, "so far" because there's still that $4.4 billion; some of that will be needed in Health, that has yet to be allocated. There's $2.2 billion for the capital plan for Health for the next five years that has already been allocated as well as that piece of $4.4 billion unallocated.

I'll ask my deputy to speak to the specific acute-care facilities.

Mr. Yao: That's all right. Let's go on.

Ms Hoffman: We have that number in the fiscal plan. I can tell you what page it is in the budget. That's pages 44 and 45 in the capital plan.

Mr. Yao: That's fine.

Hospitals are built, if I understand correctly, on the basis that all space can be converted to bed space, so some of the administrative space could be turned into bed space if possible. Is that correct?

Ms Hoffman: In some places it is. That is certainly not best practice. Best practice is to actually have beds in proper sightlines from where the nursing staff are taking care of patients.

Mr. Yao: But the floor plans can be manipulated. Ultimately, the actual infrastructure of the hospital is all designed for a primary care hospital. Is that correct?

Ms Hoffman: I think that the assumption that it's all standard and one design model – I'll have to get back to you on the specifics of

that. There are times where certain facilities have adapted their administrative spaces to be primary care, but I wouldn't want to say definitively one way or the other because, of course, we have over a hundred different acute-care hospital settings.

Mr. Yao: I'm fine if your deputy minister decides to answer any of these questions.

How much square footage is allocated to space that does not need to be in a primary care facility?

Ms Hoffman: So the percentage of space that we use for administration rather than for an acute-care bed?

Mr. Yao: Absolutely. When we look at the list of services provided in a hospital, depending on who you talk to . . .

The Chair: Thank you, Member.

We will now move on to the third-party opposition. Dr. Starke, you're going next?

Dr. Starke: Yes, please.

The Chair: Okay. Thank you.

Dr. Starke: If we could do the back and forth again with the minister, that'd be great.

Ms Hoffman: Sure.

Dr. Starke: Super. I just want to start by saying that I hope it wasn't meant as a backhanded compliment that while you didn't visit Banff-Cochrane because it was too nice, I do note that you visited Lloydminster. We do appreciate the visit, actually, Minister.

Ms Hoffman: I loved my visit to Lloyd.

Dr. Starke: I mean, we'll try and spruce things up a little bit, but we'd like you to come anyway.

Ms Hoffman: Okay.

Dr. Starke: Okay. In any case, I want to talk a little bit about pharmacy because you mentioned before that it is one of the major cost drivers, and you're absolutely correct. I mean, we know that drug costs are escalating and that they are not keeping to inflation by any means. You mentioned that a lot of it is in the hands of other levels of government, and some of that is true, but I wonder what level of consultation you've done with pharmacists. The reason I ask that question is that pharmacists have some really, really good ideas as to how we can do some cost savings in terms of things like therapeutic substitution, the use of trial amounts of certain medications to limit the amount of medication waste as well as looking again at the $25 ceiling for prescriptions for seniors. I'm not saying that we should change the $25 ceiling. I'm just saying that the size of the prescription that is sometimes requested – the pharmacists can give you more details on that. Have you consulted with the College of Pharmacists, and if so, what have they told you so far?

Ms Hoffman: Around specific discussions with the College of Pharmacists I'll call on my deputy to supplement.

I'll tell you that I can't go anywhere without people telling me their great ideas on how we can find efficiencies. My own personal pharmacist would be one great example. While the college is, of course, a valuable resource, so are the many front-line health professionals that we have. There are ongoing discussions with the college, and I'll ask my deputy to touch in further detail on those.

Dr. Amrhein: There are a number of areas where we're actively engaged in talking to the pharmacy regulators. There was a meeting this morning, for example, with AHS, that involved the pharmacy regulators, about expanding their prescription ability so that naloxone can be made available more readily in more locations across Canada. There's a proposal that we have from the faculty of pharmacy that would see the pharmacies expand their scope of practice in immunizations. There are discussions under way with the pharmacy regulators and the college around the role that they can play in creating the comprehensive, integrated Alberta patient care system. I can go on, but the conversations are frequent, and the conversations are ongoing.

Dr. Starke: I'm really glad to hear that because I really do think that our pharmacists and that community have some great ideas, specifically in the area of trying to get a handle on drug costs because, you know, they see it every day and they see a lot of areas for efficiencies.

I want to talk a little bit about the RAPID program, and I am not even going to try go through all the letters that it describes. But, Minister, we had our exchange in question period, and I understand what you're saying with regard to the safety of the drug and the confidence that we have in our retinal specialists. I have no question about that, and I recognize that there's a cost saving. I guess one of my questions would be: do we have a number as to what the anticipated cost savings will be? If we don't have it, you can get back to me on that.

9:30

I guess the discussion I want to have with you is a medical-ethical issue, and that is that if we use a drug that the company has not got an approval for, we take the company off the hook. This is an expensive process, as you've mentioned. You've said in your replies to me that it's up to the company to get the approval, and you're absolutely right. They have to go through that process. But if we start using the drug and if it's recommended or endorsed or condoned by government to use a drug that is not approved, where is the incentive for these large drug corporations, who are highly profitable, to actually go through the process of getting an approval?

Ms Hoffman: Thank you for the question. The anticipated savings to taxpayers – this isn't counting the $25 that's in the pocket of everyone who'd be paying it but specifically to the system – is between $23 million and $46 million over the next three years. The reason why there is a range is, of course, because patients still have the choice between whether they want to use Avastin or Lucentis. In the high range we're thinking about $46 million if it's prescribed at a high frequency.

In terms of incentive the company that makes Lucentis and the company that makes Avastin are essentially the same company. They have one drug right now that's on label, where they make 1,500 bucks. It costs money to get the $50 drug on label. Then they're not going to make 1,500 bucks because people are going to get the $50 drug. They have, clearly, a much smaller margin of profitability. So it's not just that we're letting them off the hook by not requiring them to go on label. It's that there actually is zero incentive. It's actually a disincentive to the company to get the less expensive drug on label because they're cutting into their market share right now on the $1,500 drug.

When I look at what's happening across Canada, we're the sixth jurisdiction to say that we're not going to let the drug companies hold us hostage by requiring it to be on label before we do the right thing to save taxpayers' and patients' money.

Dr. Starke: You know, Minister, I think we're probably going to agree to disagree on this one.

Ms Hoffman: No. I'm going to help you change your mind.

Dr. Starke: No. I doubt it. I doubt it.

With regard to the other jurisdictions I'll remind you that nine other jurisdictions have a sales tax, and I hope you're not using that as the rationale for adopting a policy here.

I do want to move through to the line item on administration and support services. This is on page 60 of your business plan, Minister. I noted that the amount for '14-15 was $2.428 million. Then I looked at the next three years, and I said: well, great; the actual amount for administration and support services is lower in each of the three out-years. I thought: we're making progress on administration costs. But then I dug out my copy of the March budget, and I looked at what the three out-years were, and I noted that you're projecting expenditures of $315 million in administrative costs over the next three years, higher than what was projected in the March budget. Now, clearly, administrative and support services: these are not front-line workers. These are not nurses or anything like that. Tell me, Minister: what are Alberta taxpayers getting for their additional $315 million investment?

Ms Hoffman: Administrative and support services. That's in the budget document under the business plan?

Dr. Starke: That's in the business plan, about halfway down the list of expenses.

Ms Hoffman: Okay. Great. The line item includes corporate and general admission, communications, financial, and personnel services as well as services that support health service delivery to patients, including residents and clients, facility and centralized training and support costs.

Maybe my deputy can speak specifically around services that support health service delivery to patients and what that means and why that's important for us to be investing in, please.

Dr. Amrhein: I would rather defer to my ADM.

Mr. Chamberlain: Thank you, Minister. I think the short answer is that part of restoring some of the funding that went into AHS was restoring the support services line and making sure that there was adequate funding in order to maintain all those critical housekeeping, maintenance, building, operational services. It's simply that. There was additional funding put into AHS from the previous March budget, that you referred to, and some of that money has gone into this line to maintain those critical support services.

Dr. Starke: Okay. There are a lot of ways we could interpret that, but I won't go too much farther into that.

Minister, my final question. In talking about information systems, you made a comment that information systems were allowed to fall into disrepair when you talked about the capital investment level at $24 million. Once again, looking at the March budget, the figure for information systems under capital investment was $143 million, some six times the amount that you've allocated in your budget. Now, either there's a different allocation that we're looking at here, or you've cut the budget by 83 per cent. So which is it?

Ms Hoffman: Part of it is around the timing in which we're going to do some of those investments. Of course, the price of oil is lower today than it was in the March projections as well. It's around making sure that we are thoughtful in how we move forward. I also think it's really important for us to have a bit of a dialogue as elected officials around how we're going to stagger this investment. A complete CIS overhaul is about a billion-dollar project, and while I can see that there was a desire by the last government to move in a more aggressive way in the first year or two, I want to make sure that if we're going to lock ourselves into that kind of a commitment, we're in a position to be able to do so in the out-years as well, not just in year 1. That's part of the rationale around that.

Dr. Amrhein, when he was on special assignment as AHS official administrator, spent a considerable amount of time of looking into this piece specifically. [A timer sounded] Oh, shoot. Sorry. If there's time again.

Dr. Starke: Thank you, Minister.

The Chair: Thank you, Minister. Thank you, Member.

We will now move on to the 10-minute rotation with Mr. Clark. Would you like to go back and forth?

Mr. Clark: I'd like to go back and forth, yes, please.

Thank you very much, Madam Chair and Madam Minister. It's good to be here. I'm going to ask, first, about preventative health care and acute care and the difference between preventative health care and acute care. We spend the vast majority of the budget on acute care. Can you give me the percentage of Alberta Health's budget that is spent on acute-care service provision or facilities versus what we spend on primary care prevention?

Ms Hoffman: Yeah. Acute care, for example, is highly focused around the AHS budget piece whereas with the prevention piece and some of the PCNs, most of that comes out of the department funding. I think we actually have a pie chart. Here we go. Great. In terms of the '15-16 budget acute-care services are 38 per cent of what we are looking at allocating. That's $5.3 billion. When I look at home-based continuing care services, which, of course, are part of that prevention, that's 10.9 per cent, or $1.5 billion; community and population health services, $1.6 billion, 11 per cent; diagnostic and therapeutic services, 16.7 per cent, $2.3 billion; and then support services are another 23 per cent. So acute care is about 38 per cent.

Mr. Clark: Okay. Thank you very much.

I was talking with someone the other day who has a great saying. He said that we should put a gate at the top of the cliff rather than send ambulances to the bottom. This means to put emphasis on prevention in our health care system in an effort to keep people healthier and eventually bend that cost curve. By some estimates chronic diseases like cancer, heart disease, and mental illness combined with injuries account for 90 per cent of health expenditures in our country. Now, much can be done to reduce the burden of chronic disease in Alberta, both on those who suffer from chronic illness and, of course, on the budget and our provincial health care system. Do you believe that our acute-care health system as it currently stands today can actually deliver on wellness when current results suggest otherwise?

Ms Hoffman: A gate is great. So is informing people about the risks at the top of the cliff as well. I think part of it is around ensuring that we have the right information in the hands of Albertans. When I look specifically at the fentanyl crisis that we're in, there are a number of different ways that we can address the drivers there. We can talk about prevention in schools, information around the drug, and why it's an illegal drug for people to be using without a prescription. We can talk about harm reduction initiatives and how we can make sure that we get naloxone kits in the hands

of those who need them. I think that the solution is tandem, that you need to look at reducing your needs for acute care as well as being able to respond in times of crisis where necessary.

Did you want to add to that, Deputy?

9:40

Dr. Amrhein: Some of the examples that we're working on require that the specialists in the acute-care setting and the specialists in the primary care setting begin to share their information. We have virtually all of the information we need in various depositories. The challenge we face is knitting together these various depositories in a fashion so that the information moves when it's needed, in a timely way.

One of the projects is really very exciting. Diabetes is becoming one of the very major pieces of very complex chronic care. There is best practice that suggests that when the family physician makes an entry on an electronic record that indicates diabetes, then an organization like the Alberta diabetes research institute should be able to send both the family physician and the patient the best information on the spot about how to deal with the emerging situation called diabetes. These information technology systems are not pie in the sky; they exist in certain jurisdictions. They're available to us. It's simply a matter of overcoming the restrictions placed on various professionals under various statutes of the government. These are under review. The technology is there. The funding will be there when we need it, and I think we're on the verge of creating a lot of these integrated health systems that will be possible once we turn on the universal patient portal later this year.

Mr. Clark: Thank you very much.

Are you open to new approaches to promote wellness? Something like a discrete provincial wellness foundation that focuses on best practice and preventative health care: is that something you would consider?

Ms Hoffman: I'll talk about a few of the other things that we're doing currently if you don't mind. One of them is around information to help prevent people from getting sick, which I think is what you're talking about, and, of course, immunization campaigns, education on things like fetal alcohol spectrum disorder, and additional prevention around limiting tobacco use, including the menthol ban. You have no idea how many angry letters I've had from people who've quit smoking now because they can't get menthol. As well, AHS has education on healthy eating, active living, managing your weight, preventing cancer, heart health, mental health, prevention of injuries, travel health, sexual health. I think that there are a lot of pieces that can be done within the system right now, and the need to create an additional body, when I think a lot of this responsibility currently falls under Alberta Health and Alberta Health Services, may not be necessary.

Mr. Clark: It sounds like a no.

Ms Hoffman: It sounds like I'm looking at what we can do within the current system, where I think the responsibility currently lies.

Mr. Clark: Okay. A couple more questions while I have time. Page 136 of the estimates, line 2.2, which we talked about earlier, facility and home-based continuing care services: is that where all home-care funding is categorized, or is there somewhere else that home-care funding is captured?

Ms Hoffman: Which page are you on?

Mr. Clark: Page 136 of the estimates, line 2.2.

Ms Hoffman: Yes. All of the home care is within that subline.

Mr. Clark: I'm curious. What strategy do you have to increase access to home care in an effort to keep people in their own homes, improve their quality of life, health outcomes, and, of course, to reduce costs?

Ms Hoffman: In the out-years – it's not on that page but in the five-year projections – of course, in line with the platform commitments, there's increased investment in long-term care, home care, and mental health. My ADM is just writing down a couple of numbers. Home care is $30 million next year, and long-term care is $40 million, so there will be $30 million beginning in the next fiscal for increased investment in those specific line items. As well, AHS has some allocations that go towards home care, and because their base funding has gone up, that means there is an opportunity to invest in those areas as well for AHS.

Mr. Clark: Thank you, Minister.

Jordan's principle is a child-first principle named in memory of Jordan River Anderson. Payment disputes between federal and provincial governments over services for First Nations children are not uncommon, sadly. First Nations children are often frequently left waiting for services they desperately need or are denied services that are available to other children. This includes services in education, health, child care, recreation, culture, and language. Jordan's principle calls on the government of first contact to pay for the services and seek reimbursement later so that the child does not tragically get caught in the middle of government red tape. It was unanimously passed by the House of Commons in 2007 but has not yet been implemented. Will you as minister commit to implementing Jordan's principle immediately? No child, I believe – I'm sure we all agree – should suffer or lose their life over a funding dispute.

Ms Hoffman: If a patient shows up in need, whether they are a First Nations Alberta citizen, have a health care card, don't have a health care card, if they have a health care need, they will receive health care. For example, there was a situation right after we were elected around a medicentre and accusations that an ill child had been turned away. That is not the direction and will never be the direction that is given through our department.

I know that the new federal government has made a commitment to moving on the UN declaration on the rights of indigenous peoples. Of course, a big part of that is access to quality health care. When the new Minister of Health was elected federally, we had a quick chat on the phone, and this was one of the items that we touched base on. I'm sure that it will be something that we continue to work collaboratively on to ensure that all children, no matter where they live, have access to the right health care.

Mr. Clark: Thank you very much, Minister.

On page 137, line item 11.5, protection for persons in care, the actual to budget in 2014-15 was 44 per cent below. The estimate is now up 55 per cent this year over actual for 2014-15. Can you explain the discrepancy there for spending on . . . [A timer sounded] Ah.

Ms Hoffman: I'll get you that one in writing.

Mr. Clark: Thank you. I appreciate that.

The Chair: Thank you, Member. Thank you, Minister.

We will move on to the government caucus. Mr. Westhead, I believe you have a question you'd like to ask.

Mr. Westhead: Yeah. Thank you. I'd like to just ask one question and then turn it over to my colleague from Edmonton-Whitemud.

The Chair: Thank you.

Mr. Westhead: I'd like to talk about the topic of rural physician recruitment. You know, as a nurse and also in my role as MLA I've heard various stories about the challenges of recruiting physicians and other medical professions like midwives, nurse practitioners to rural settings. I'm just wondering if you can tell us a bit about what the ministry is doing to address those challenges with recruitment in remote and rural settings, where it's normally been hard to recruit those individuals.

Ms Hoffman: Thank you very much for the question. When I was in Grande Prairie, another lovely community, I had the opportunity to meet with a number of medical students. One of the programs that's in play there is that they bring medical students up, before they're even residents, to have an opportunity to experience life as shadowing physicians – it's not that Grande Prairie is rural; Grande Prairie is very urban indeed – in the Grande Prairie region and give them an opportunity to work in a variety of health care facilities there. With those types of programs, whether they choose to practice there or greater understand the type of expertise that exists in these communities, either way, it's a great investment. It's about four years into the program, and they've already seen a number of students who have had a rotation there choose to come back to that area and to other rural areas. Certainly, exposure is one of the big things.

Alberta has a number of recruitment and retention programs to address challenges with recruiting physicians. These include the Alberta rural physician action plan, RPAP; physician locum services program; physician on-call program; rural remote northern program; rural integrated community clerkship; and the business costs program.

Even though the number of physicians in Alberta is increasing faster than our population, our problem is with the equitable distribution of physicians, especially in these rural areas. We need to ensure that they are aware of how great our rural communities are and feel excited to work in them.

Mr. Westhead: Thank you.

I'll just turn it over to my colleague from Edmonton-Whitemud now.

9:50

Dr. Turner: Thank you, and thank you to the minister as well as to all her staff for preparing so well for this. I want to go back to May 5 and the election. I don't think I would have won the election in Edmonton-Whitemud if it hadn't been for the leader of the New Democrats' pledge to have 2,000 long-term care beds, to have a Calgary cancer centre, to basically refund medical care as well as education. I think that what we see here tonight are some of the first steps of fulfilling that promise, and I'm very appreciative of that as the MLA for Edmonton-Whitemud.

I was also very pleased to hear Dr. Amrhein say that the patient portal in Netcare is going to be completed this year. The previous government actually promised it in 2012 and somehow couldn't get organized to have that very important facility for patients and for continuity of care implemented, so I'm really pleased to hear that. Just a comment about Netcare is that this is an Alberta-made, -developed, and -managed program that is the envy of Canada. There is not a single territory or province in this country that has anything comparable to it. The province of Ontario spent about five times more than we spent on this and still does not have the capability in their lab and radiology records as well as clinical notes that is in Netcare.

The Chair: Member, can we focus on estimates and budgets, please?

Dr. Turner: All right. I would like to return to a question about page 137. There's an increase in seniors' dental, optical, and supplemental health benefits. I think that sounds very good, but why is there an increase for seniors' dental, optical, and supplemental health benefits?

Ms Hoffman: Thank you very much for the question and for some of the content you added at the beginning as well as for your service as a physician to the people of Alberta. Seniors' dental, optical, and supplemental health benefits are increasing by $6 million, or 4.9 per cent. That increase represents anticipated higher demand for seniors' dental and optical services as well as ground ambulance and supplemental health benefits like orthotics and prostheses. That's for two reasons. Every day another hundred people in Alberta turn 65, so increasing numbers of people who are in that age category as well as the types of active, healthy seniors that we have, wanting to live very high-functioning lives. Making sure that they have access to theses types of essential supports to live lives as fully as possible is, of course, fundamental in that.

Dr. Turner: How is the government working to account for and control the future cost increases as a result of these demographic changes?

Ms Hoffman: Of course, we're focused on providing services more efficiently through the use of lower cost allied health practitioners, community-based care models, and that goes on. It's really about that right care, right place, right time, right professional piece. There are so many amazing health professionals in our community. Making sure that people know who to access when is a big piece of that.

Dr. Turner: I've had the great pleasure to work with nurse practitioners for over 20 years. In fact, I've been on training committees for nurse practitioners at the University of Alberta. At the Cross Cancer Institute we have about 30 nurse practitioners that work in concert with oncologists. One of the things that I'd like to ask about from the estimates is that there's another area where nurses are taking on roles that had been done by physicians, and that's midwives. I wonder if you could give us an update on the expansion of midwifery.

Ms Hoffman: Thank you very much. We did this year move to fund an additional 400 cycles of care, so that's a $1.8 million increase. One of the members from Calgary told me that she saw an announcement being circulated on Facebook, actually, between a young moms' group, that there were actually some midwives in Calgary who had cycles of care in May that had not yet been claimed. So if you wanted a midwife, there were actually in this one area, at least, of the province some cycles of care that had not yet been claimed. That was unheard of in the past. There was certainly a waiting list, and there are in a number of areas of the province.

In meeting with the association that represents midwives, there is a continued desire to practise midwifery not just in the two metro communities, Edmonton and Calgary, but in a variety of areas in the province. That's really good news because, of course, we want

to ensure that everyone has access to a variety of safe choices to exercise their rights around how they want to bring their babies into the world.

Dr. Turner: I wonder if you could expand on something you spoke of before, and that is an expansion of the EMS scope of practice, that might result in a reduction in the waiting times in the emergency rooms.

Ms Hoffman: I know I keep bringing up fentanyl, but that's because it's really top of mind because we're talking about such a lethal drug, where so many primarily young people are dying. Part of the discussions have included EMS on this because there are a number of EMS providers who have access to naloxone on their person and are able to administer it, and we want to make sure that we continue to grow that ability. It's not just around saving lives immediately but giving them the tools to be able to even prescribe because often they're closest to the patient. So there's certainly work happening in those areas to increase scope of practice where appropriate and safe.

Dr. Turner: All health care providers are interested in immunization. I was wondering how many Albertans have been immunized so far this year and what steps you're taking to promote immunization. Immunization is on page 137.

Ms Hoffman: As of November 7 – this is the most recent data I have – we'd already administered 688,309 doses of the influenza vaccine. So that is really good news.

In terms of working with front-line health service providers, including the range, anyone who works in a facility . . . [A timer sounded] Thank you for the questions.

The Chair: Thank you, Member. Thank you, Minister.

We have three minutes left for the Official Opposition if you have more questions.

Mr. Barnes: I do. Thank you. Thanks again for your continued effort right to the end, Minister Hoffman. I want to talk about the capital plan. The Grande Prairie regional hospital, of course, is also on the capital list. It's my understanding from the Infrastructure minister discussing his department's estimates the other night that the recently announced $89 million cost overrun is not factored into this list. If that is the case, if this unexpected cost increase is not factored into your capital projections here, then on what basis are these projections? Did you make this list without a full understanding of the status of the ongoing projects around the province?

Ms Hoffman: Thank you very much for the question. I'm going to ask my assistant deputy to speak to that specific project and how the fiscal years that are in the estimates align with the opening date of the facility.

Mr. Chamberlain: Thank you, Minister. Essentially, you're correct. We're anticipating a cost overrun at the moment, but the reality is that Infrastructure is in the process of trying to figure out how to retender it and how to minimize costs. Once we have better data on that, then there may be an application for additional funds in next year's capital plan. But at this point the completion date, I believe, is into 2017, 2018. So we don't know exactly what the cost overruns are, and we're looking for opportunities to cut them as much as possible.

Mr. Barnes: Okay. Thank you.

Are you aware of any others on this list? Are you aware of anything else that may make the deficit bigger?

Ms Hoffman: Just to clarify, we'd be coming in either for – I don't think we'll need to do supplementary supply given that we're halfway through the fiscal year. It would be in future capital plans, so it would be an amendment to next year's capital plan if we were needing to do that. Of course, if we receive any information on any of these items, we'll be open and transparent about that with the members and make sure that we update the estimates accordingly in the out-years.

Mr. Barnes: Okay. Thank you.

On page 57 of your business plan, line 2.7, one of your goals is to implement a wait-list management policy. Minister Hoffman, I'd like to hear your thoughts around what a wait-list management policy should be and where we're headed with that direction, the cost of oversight and the cost of improving the quality of services for Albertans.

Ms Hoffman: Well, of course, I would say that there's nothing more difficult than being diagnosed with something and wondering when things are going to start, when you're going to have a treatment start or when you're going to be able to access the long-term care you need or get that hip replacement. So implementing a wait time measurement and wait-list management policy to address the long wait times in the health care system, of course, is one of the ways to go about doing that.

In terms of, specifically, the wait-list management policy, that is an ongoing effort with the department and with our officials. I think, just speaking from personal experience, that when my mom was diagnosed with breast cancer . . . [A timer sounded] Sorry. I bring up mom, and then the timer goes. I'll tell you after.

Mr. Barnes: Okay, please. Thank you, though. Thank you again.

Ms Hoffman: Thank you.

The Chair: Well, thank you so much. I apologize for the interruption, but I must advise the committee that the time allotted for this item of business is concluded. Thank you so much for putting up with a very hot room and being so great during the debate.

I'd like to remind committee members that we are scheduled to meet again tomorrow, Tuesday, November 17, from 9 a.m. till 12 noon in the Foothills Room to consider the estimates of the Ministry of Status of Women.

Thank you so much. The meeting is adjourned.

[The committee adjourned at 10 p.m.]

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