Legislative Assembly of Alberta

The 29th Legislature
Second Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Thursday, May 12, 2016
9 a.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

Ministry of Health
Hon. Sarah Hoffman, Minister
Hon. Brandy Payne, Associate Minister
Carl Amrhein, Deputy Minister
Charlene Wong, Executive Director, Financial Planning

9 a.m. Thursday, May 12, 2016

[Ms Goehring in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: I would like to call this meeting to order and welcome everyone here. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2017.

I'd ask that we go around the table and have all MLAs introduce themselves for the record. Ministers, when we get to you, please introduce the staff that are joining you at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and chair of this committee. We'll continue starting to my right.

Mr. Clark: Good morning. Greg Clark, MLA, Calgary-Elbow.

Mr. Orr: Ron Orr, MLA for Lacombe-Ponoka.

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

Dr. Starke: Good morning. Richard Starke, MLA, Vermilion-Lloydminster.

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

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

Ms Hoffman: Good morning. I am Sarah Hoffman, honoured to be the minister. I will introduce Charlene Wong, who is our executive director of financial planning.

Ms Payne: Hi. Brandy Payne, Associate Minister of Health and MLA for Calgary-Acadia. With us is Dr. Carl Amrhein, our deputy minister.

Mr. Cyr: Scott Cyr, MLA for Bonnyville-Cold Lake.

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

Ms Drever: Deborah Drever, MLA for Calgary-Bow.

Mr. Hinkley: Good morning. Bruce Hinkley, MLA, Wetaskiwin-Camrose.

Ms Luff: Robyn Luff, MLA for Calgary-East.

Mr. Westhead: Cameron Westhead, MLA for Banff-Cochrane.

Mr. Horne: Trevor Horne, MLA for Spruce Grove-St. Albert.

Mr. Shepherd: David Shepherd, MLA, Edmonton-Centre.

The Chair: Thank you.

Please note that the microphones are being 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.

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 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 and the minister may speak. For the next 20 minutes the members of the third party, 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 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. Discussion should flow through the chair at all times regardless of whether or not their speaking time is combined. 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 with either the chair or committee clerk about this 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; however, the three-hour clock will continue to run. Does anyone oppose having the break?

Dr. Starke: Madam Chair, I object.

The Chair: Thank you. Noting that, we will not call a break.

Committee members, ministers, and other members who are not committee members may participate; however, only a committee member or an official substitute for a committee member may introduce an amendment during a committee's review of the estimates.

I would like to note for the record that we have the following substitutes: Mr. Barnes for Mr. Smith, Ms McKitrick for Ms McPherson, and Dr. Starke for Ms Jansen.

Ministry officials may be present, and at the direction of the minister officials from the ministry may address the committee. Ministry staff seated in the gallery, if called upon, have access to a microphone in the gallery area. 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 noon.

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

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

Again I will remind all meeting participants to address their questions and responses through the chair and not directly to one another.

The vote on the estimates is deferred until consideration of all ministry estimates has concluded and will occur in Committee of Supply on May 17, 2016.

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 amendments is deferred until Committee of Supply convenes on May 17, 2016. 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 with the original going to the committee clerk.

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

Ms Hoffman: Thank you very much, Madam Chair. My associate minister and I will share the time.

I just want to begin by saying good morning and by acknowledging the health care professionals and members of Alberta's public service for the work they're doing to support Fort McMurray and our evacuees. We're here to discuss my budget, but behind those numbers are people. People are being called upon to go beyond their already heavy workload to do something extraordinary.

We should all be proud of Alberta's health system and its front-line health care workers, and today we are, of course, even more proud. The staff at the Northern Lights health centre evacuated more than a hundred patients and residents in less than two hours. These included nine babies in the NICU and seniors from the long-term care facility. When Fort McMurray residents arrived at evacuation centres, they found health care professionals there as well, including those offering much-needed mental health support. Yes, our system has its challenges, but it's there when we need it most, and that's very clear in times like these.

Moving on to the estimates. This budget marks the beginning of our work to ensure that Alberta's health system has adequate, sustainable funding. This is perhaps my biggest challenge as Health minister, to transform our health system into one that provides better health outcomes in a sustainable way. This budget begins the process of laying out predictable increases so that we can meet Albertans' needs while slowing the rate of growth to one that's more sustainable into the future. Alberta has been among the highest in per capita spending on health care for many years, and we are taking reasonable, measured steps to slow the rate of growth.

The consolidated budget is $20.4 billion, which works out to $56 million a day, or $2.3 million per hour. With health spending making up about 40 per cent of the entire budget, we can and must take up this change and this challenge. Notwithstanding the financial support we will provide to Fort McMurray, we made a commitment to Albertans to start bending the cost curve on health spending. This year's operating increase is 3 per cent, and next year's will be 2.7. By 2018-19 health spending increases will be approximately 2 per cent. When combined with our plans to transform the health care system, lowering spending will help make sure that the system is there for Albertans well into the future.

Part of this transformation involves allocating $400 million to the Alberta Health Services clinical information system. This will consolidate several existing AHS information systems into one solution. It will streamline options. This also means that AHS health professionals will be working from a single source of information, and it will support team-based integrated care by ensuring that information follows patients as they access services throughout Alberta Health. This will reduce disjointed care, gaps, and overlaps as well as errors and delays.

Part of health system transformation is also based on controlling costs for things like physicians, hospitals, and drugs. We're hard at work on that front, including our ongoing negotiations with the Alberta Medical Association. In addition, AHS has received a base operating increase of 3.4 per cent, or $388 million, for this 2016-17 fiscal year. Much of the transformation is focused on moving the system away from acute care to one that's more patient centred, community based, providing care closer to homes and communities.

9:10

As part of this shift we remain committed to opening 2,000 new long-term care and dementia spaces throughout the province. Budget 2016 provides $165 million in support of this commitment. These new spaces will help ensure people can age in their communities, close to their friends and family. The spaces will also help ease pressure on our acute-care system by helping people transition out of hospital into care that better meets their needs. This will mean less pressure on our emergency rooms and more timely admissions for those who need acute care. Further, it will free up EMS resources to move on to others in need, shortening the amount of time that they need to spend transitioning patients in hallways.

At the end of the day, our goal is to make sure Albertans get – I'm sure you've heard me say this – the right care in the right place at the right time by the right health care professionals as a team, and of course we need the right information to make that possible. Budget 2016 gets us on a firm path to this vital work, and I sincerely hope that you share our vision for making our health system stronger and better able to meet the needs of Albertans.

I now ask Associate Minister Payne to provide her opening remarks.

Ms Payne: Thank you, Minister. I want to echo what the minister said about the situation in Fort McMurray. The images coming out of the fire are heartbreaking and hard to watch. I would also echo the Premier and let the people of Fort McMurray and area know that we have their backs. It will take time and resources to support rebuilding, and our government and all Albertans will be there to help lift them up.

As the minister said, there are real people behind our budget numbers, and our job is to make sure first responders and front-line health care workers can continue doing their best, whether it's in the back of an ambulance, in the operating room, or providing mental health support in an evacuation centre.

One of the key parts of this budget is its increase in support for mental health and addictions services. These will be needed more than ever in the coming weeks, months, and years as we assist the people of Fort McMurray and area. The budget allocates an additional $5.6 million to addictions and mental health, specifically to help implement the recommendations from the mental health review.

As part of this increase we're working with AHS and indigenous communities to access and implement review recommendations related specifically to suicide prevention. We know that First Nations youth are five to six times more likely to be affected by suicide than the general population. We will work with indigenous communities to understand these issues, to address the root causes, and to strengthen mental health supports for indigenous youth and communities.

Additionally, the capital budget allocates $17 million for addictions and detox centres, including programs in Edmonton and Red Deer, so more Albertans can get the supports they need in their communities. Detox programs and spaces are very important as we work to deal with the scourge of fentanyl. In February we began providing additional naloxone kits free of charge to Albertans with a prescription and hundreds of pharmacies across Alberta. As of this Friday naloxone kits will be available without a prescription at more than 600 pharmacies throughout our province.

We know that there's more work to do, so we're continuing to work with the federal government and our provincial and territorial counterparts on this important issue. Our fentanyl response team, made up of front-line health care workers, communities, First Nations and Métis representatives, and health experts, meets regularly to help co-ordinate the government's actions. This shows our commitment to strengthening addictions and mental health services for Albertans.

Primary care is one of the building blocks for helping Albertans maintain and improve their health. This includes primary care networks, where more than 3 million Albertans receive care every year. The budget for primary health care is increasing by almost 40 per cent. This reflects the reinstatement of $50 million that was funded by the network's accumulated surpluses in 2015-2016. This increased funding will help strengthen primary health care services for Albertans with better fiscal accountability and updated and refined policies.

One of the budget areas that I'm most pleased with is the increase in funding for midwifery services. Through Alberta Health Services we got an additional $1.8 million per year for the next three years to increase access for women who choose this option. Research has shown that women who give birth with the assistance of a midwife tend to have shorter lengths of stay in hospital, are more likely to breastfeed, and require fewer medical interventions. Midwifery is a safe, alternative option for maternity services, and we're proud to support it.

That covers some of the additional highlights of our Budget 2016, as we work towards a health care system that helps make sure that Albertans get the right care in the right place at the right time by the right health care team with the right information. Thank you, and we're prepared to take questions.

The Chair: Thank you very much, ministers.

For the hour that follows, members of the Official Opposition and the ministers may speak. Would you like the timer to be set for 20-minute intervals so that you're aware of time, or would you prefer to let the full hour flow without interruption?

Mr. Barnes: I'd like 20-minute intervals, please.

The Chair: Thank you. Are you wanting to share your time with the ministers?

Mr. Barnes: If it's okay with the ministers, let's go back and forth, please.

The Chair: Thank you. Go ahead.

Mr. Barnes: Okay. Thank you very much, Madam Chair. First of all, thanks to the minister and the associate minister, to Dr. Amrhein and Ms Wong and all the Alberta Health people here for all the work you do for Alberta. We greatly appreciate it. I, too, will second the thanks to all of our health workers in Fort McMurray for the work they've done and the tremendous work still ahead of them. It's wonderful that that's there.

Ministers, when we go back and forth – I have a lot of questions; there's a lot to get through when we're talking about over $20 billion – please excuse me if from time to time I ask for an interruption if I feel I've had enough of an answer to the question I've asked. Please indulge me with your forgiveness up front.

I'd like to start with the business plan, the final page. Your ministry is claiming a small increase year over year. If we look at the forecasted 2015-2016 figure compared to the '16-17 budget, we're looking at a 3 per cent increase, as you said. I'm wondering how fair and objective this measurement is. Last year your department overshot the 2015-16 budget by $240 million, so I'm concerned that there is a disconnect between what the ministry puts on the page and in the budget and the results that are actually attained. Among the categories with overruns: administration and support services, facility-based patient services, care-based services, physician compensation and development. Because our system is patient based, patient facing, driven by demand, are current cost estimates just wishful thinking? Minister, I'm concerned that you have understated demand on the system. That's what it appears when you were $240 million over budget last year. Have you underestimated demand on the system?

Ms Hoffman: Thank you, Madam Chair. It sounds to me like the member is proposing a budget increase, so that's exciting news.

In terms of demand, certainly, we were well aware of some of the shortcomings and some of the difficulties in controlling costs in some specific line items. For example, one of the line items you mentioned is physician compensation. That's one of the reasons why we've been really quite committed to making sure that we do reach a new collective agreement even though there are two years left on the current contract. We're back at the table. Alberta's physicians know – they're also Albertans – that budget overruns in the range of about 10 per cent a year are not sustainable or in the best interests of the citizens. Certainly, having some ability to maintain patient access, obviously, is a high priority, but to have some controls around the compensation side is a priority for us, and I think it is for physicians as well. That's one of the reasons why we've been at the table for much of the last six months.

Mr. Barnes: Okay. Thank you.

Yeah, it was pointed out to me by a health professional that your five Rs need a sixth R, and that is right value. That is, of course, one of my main concerns.

What are your projections for future population growth, and how do you feel this will affect demand growth for our health system? Does your ministry believe that the current estimates for patient care items are in line with the expected demand increase?

Ms Hoffman: Patient care items? Which line item are you referring to in the business plan?

Mr. Barnes: Again, the last line in the business plan, net operating result, on page 70.

Ms Hoffman: Sure. The rolled-up figure. Certainly, one of the things that we're working on with our partners at Alberta Health Services is around operational best practices, looking at other jurisdictions and ways that we can streamline expenditures when it comes to acquisition of supplies, something as simple as finding ways that we can purchase the beds that we need rather than having to do them through lease agreements and doing that on a rotating basis. I know that there's sometimes frustration with having one large, integrated system in terms of feeling disconnected from the senior leadership, but certainly one of the benefits is that there is the ability to share resources in a more systemic way.

The work around operational best practices has certainly allowed, within Alberta Health Services, hospitals to work with each other but also to work with hospitals in other jurisdictions to best meet their needs when it comes to things like supplies, equipment, and services.

9:20

Mr. Barnes: Okay. Thank you.

I'd like to talk now about some of the physician issues, and I'll cite here line 3 of the estimates and the business plan. The AMA President's Letter from April 15:

> It is difficult to see how the budget can be satisfied without a reduction in service.

The AMA president, again, on April 29:

> Government has made a commitment that there will not be cuts to services. At the same time, the budget's amounts for physician services appears low when considering the impact of service levels, population growth and aging.

Minister, this ties into what I was saying earlier with regard to demand projections. It seems that the AMA does not think that this cost-curve bending can be reconciled with future projections unless it is accompanied by some form of rationing. Is that your plan?

Ms Hoffman: Our plan is to make sure that we do get the right return on the investment, which certainly is a priority for us. While population increase has not been at 10 per cent, certainly that line item in many years has gone up about 10 per cent. That simply isn't sustainable. Today we're looking at $4.6 billion, so about 10 per cent of the total provincial treasury. There are challenges with meeting those expectations.

That's one of the reasons why we're at the table with the AMA. I have to say that I think we're making good progress. We certainly need to make sure that we meet citizen needs moving forward, but some of the pieces that we are able to work on at the table around fair compensation – of course, we don't want anyone to be inappropriately compensated, but we need to make sure that growth is sustainable and reasonable. Certainly, having 10 per cent overruns in any budget line item would make that very difficult. We are making good progress, and we are going to continue to work with the AMA to reach a line item that has the controls necessary that our government requires but also addresses patient needs.

Mr. Barnes: Thank you.

Do you foresee an amended agreement being finalized this fiscal year, and do you have any expectations of what you'll expect to save in these negotiations? Do your cost estimates assume savings from reduced fees?

Ms Hoffman: My cost estimates, of course, are our estimates, where we hope to get and where we plan to get working in collaboration with our partners at the table through negotiations. I, yes, would like to get an agreement, of course, sooner rather than later, and we're certainly working in collaboration with the AMA. Doctors are Albertans, and this is their budget, too. I know that they are on the receiving end of this line of compensation, but they're also in it with all of us to make sure that we have a sustainable public health care system that's here for decades to come, one that we're all proud of.

Mr. Barnes: Thank you, Minister.

One of our strengths in Alberta is a high per capita number of doctors. Has your ministry conducted an analysis of how remuneration affects supply of physicians practising here and where they decide to practice?

Ms Hoffman: We're certainly working with the AMA to discuss how we ensure that we meet the demands throughout the province, and while the number of physicians in Edmonton and Calgary as a percentage has continued to increase, it hasn't increased to the same extent in other parts of the province. We need to make sure that we get the right physicians going to the right communities. There are times when there are certain specialists that we need to attract to certain communities as well, and these are pieces that we're working on with the AMA. I always think it's better to work with people at the table than otherwise. We're committed to moving forward in that way.

At some point, if you want, my associate minister can talk about some of the shifts in primary care around physicians as well.

Ms Payne: Yes. Thank you. With respect to some of the questions around addressing the population growth and demand, a big focus within the ministry is on moving towards more community-based care so that we're able to have Albertans be able to access the care that they need within their communities, whether that's a rural or remote community or whether that's through a primary care network within one of our cities, which then will help with reducing the demand on our hospital system, which will in turn help reduce some of the costs around acute care.

Mr. Barnes: Thank you.

Are there any other labour agreements that your ministry is exploring reopening?

Ms Hoffman: In terms of collective agreements, the collective agreements all have timelines that are approaching conclusion in the short term. This was a contract, which makes it slightly different. Our relationship with the AMA supported us in being able to work collaboratively and return to the table. So no would be the short answer.

Mr. Barnes: Okay. Again I'm unclear as to where bending the cost curve will come from.

Let's switch gears, and let's talk about primary care networks. Access to appropriate primary care has been identified as a need for many years now, especially given our heavy reliance on hospitals as a principal point of contact with our health system. Core spending, as you mentioned in your opening remarks, last year was reduced as you depleted surpluses. Now I see that line 4 of the estimates has been brought back up. In fact, it's beyond the previous level. I have three questions that relate to that.

First of all, what goes into line 4? Is line 4 exclusively for primary care networks?

Ms Hoffman: Funding to support the primary care network structure, which allows family physicians and other health care providers to operate within Alberta Health Services, is part of the strength, I think, that we have in our system, and it enables physicians, of course, to take a leadership role in their teams, improving the integration of care. This element also includes funding for primary health care initiatives outside of PCNs, including some of the options that we have around community health centres. I think that maybe you went with your leader as well just last week – or maybe it was the week before – to Boyle McCauley. Those would be some of the types of centres that would be part of this work as well.

Mr. Barnes: Okay. How much of that $233 million is for primary care networks, and is the $62 capitation rate still in effect?

Ms Hoffman: We are continuing to move forward with our review of how best to compensate. Of course, it's at $62 per patient regardless of where you live or what those patient needs are for the long term. We're in conversations with the AMA as well as with the PCN leads on how best to utilize those resources to meet the health needs of all Albertans.

Mr. Barnes: So that would change in this budget even?

Ms Hoffman: At this point we're still in conversation. Our budget is based on the assumptions around $62, but we have, certainly, the ability to work with them to find ways to best allocate. If some areas might need to see an increase or some areas might be able to

reallocate resources to other parts of the province, that's certainly part of the discussion, but the assumptions in this budget are based on the $62.

Mr. Barnes: Okay. That leads me back to my opening remarks about the $240 million over budget. Potentially, is this an area where you can end up being over budget again?

Ms Hoffman: The $240 million, just for a little bit of context – nobody ever wants to be over budget – is just a little bit over 1 per cent. So $240 million is a big number; as a percentage it's not as significant as it might be if you were looking at a $240 million overrun in other ministries in the government. Not to justify the overrun; obviously, nobody ever wants to have an overrun. I'd like us to be on budget or to have a small surplus at the end. I think that's, obviously, the target that we're aiming for.

In terms of this, no, we're starting with a fixed pot of money. Discussions around how we might use that money to determine how to best achieve the needs within that resource is something that certainly we could discuss. The allocation that we're asking for from the Assembly is based on the assumptions of the $62. If that $62 formula ends up being amended, it would be within the budget that we're asking to be allocated today.

Mr. Barnes: Okay. Thank you, Minister.

Let's look at another physician-related issue, the rural physician action plan and the good work that happens there. I mentioned that we have a good supply of doctors, but unfortunately we do not have a great distribution of them across the province. That's where a program like this comes in and can be very effective. In terms of bang for our buck, RPAP, the rural physician program, seems to have been a great investment in ensuring adequate placement of physicians in rural Alberta through its advocacy work in medical student and resident education components. I also understand that within our system there is less of a focus on general practitioners and family medicine, which again plays into our high-cost system and its lack of focus on primary and family care.

I'm going to assume the program is funded somewhere under line 3, perhaps 3.4, physician development. Maybe you could clarify that. In any case, I see no physician line item going down, so we can assume that RPAP has been funded through the end of fiscal year 2017.

9:30

Ms Hoffman: Thank you very much for the question. Yes, rural allocations would fall under line 3.4, and RPAP is about 10 per cent of the money that we spend on rural supports for physician and other health professional development and training. This budget funds several physician development initiatives, including programs such as the medical residents services allowances, which provide salaries and benefits for medical residents; RPAP, which was mentioned, which provides focused, comprehensive, integrated, and sustained programming for the education, recruitment, and retention of physicians in rural practices. We also have a physician locum program, that's a separate program from that, and a postgraduate medical education program, which supports physician preceptors and operational costs of the program. So there are a variety of different components within that line item.

The rural allocation is the same this year as it was for last year, and we have extended the period of time for discussion around specific pieces within the contracts that were up through to, I believe, the end of the summer, at which point – between now and then we'll be determining the very specifics. Certainly, I would say that the responsible thing at the end of any fiscal cycle for our grant is to review if the outcomes desired have been achieved and how best to use those resources to achieve the desired outcomes, and we'll continue to do that.

Mr. Barnes: Thank you, Minister.

There's great, great concern in rural Alberta, especially amongst our municipalities and our councillors, that RPAP will not be administered the way it has been. They feel – and I agree – that the local ability they have to make decisions and influence it has been effective. Do you have any plans to change how RPAP will be administered and funded and how the oversight will change?

Ms Hoffman: Well, certainly, RPAP is an important piece of our rural physician strategy and has in the past served many individual communities quite well. I think, though, that when you look at the numbers, we're still not at the point where I'd say that we're being successful. I think we've got some success, but I think that overall there are certainly ways that we can work with our universities, the two medical schools that we're proud to have in the province, to find ways to best attract and retain physicians as well as work to make sure that when physicians are coming from out of country, we're aligning their abilities to where they're most needed in the province.

Mr. Barnes: So it sounds like you are looking at a change.

Ms Hoffman: Certainly, at the end of any fiscal cycle with a contract I think it's the responsible thing to review it and see if it's meeting the outcomes, but one hundred per cent I can offer you the assurance that RPAP will continue to exist. We will continue to fund it. The specifics around the contract: I think certainly the responsible thing to do is to review them and see how best to use those resources. But we are committed to making sure that RPAP is there for rural communities and works effectively well into the future.

Mr. Barnes: Well, again, rural municipalities and rural communities are quite satisfied with the way it is.

I'd like to go back to midwives. You mentioned a $1.8 million increase, I believe, and that's good, but of course there will still be a sizable waiting list of women with low-risk pregnancies who would like to access a midwife yet cannot even after this change. My question is twofold. Why don't we eliminate the cap altogether so anyone who desires a safe birth at home or a birthing clinic can access it, especially with the potential cost savings? Why not fund these courses of care from Alberta Health? Are plans in the works to do either of these two things?

Ms Payne: Thank you. The current funding model is the one that was brought in under the previous government, when midwifery funding was first offered by the province. There have been challenges identified with the model, and we are working with our partners in the Alberta Association of Midwives to find the best way to move forward. The investment that we have put forward in this budget adds an extra $1.8 million increase over the next three years, so over the course of the next three years we'll be adding an additional $11 million to midwifery services. We are currently in discussions with our partners in the Alberta Association of Midwives, looking at ways that we can maximize the number of courses of care that we're able to provide through that funding envelope so that we can ensure that as many Albertan women as possible are able to access midwifery services.

One of the challenges that we are currently facing with the model, of course, is that the funding is allocated as a course of care. That starts from a first prenatal appointment at around week 6 to week 10, depending, and then continues on through six weeks postpartum, including the birth of the baby.

Mr. Barnes: There might be other savings, then.

Ms Payne: Yes. One of the areas where we've definitely identified that midwifery provides cost savings is that midwifery clients who give birth in hospital tend to have shorter hospital stays. As we move forward in our negotiations with the Alberta Medical Association, we're able to find other options or ways to . . .

Mr. Barnes: So it makes sense to me to pick up those savings and increase choice in service.

Can we move on to nurse practitioners? We talked about nurse practitioners at last year's estimates, and nurse practitioners, of course, have called your budget underwhelming. I think it's something that people want. The AUMA at its last convention voted to adopt a resolution calling for the government of Alberta to "allocate funding to models of remuneration that support the integration of nurse practitioners within the Alberta healthcare system." I also understand that our Alberta Chambers of Commerce is a strong advocate for this as well. When will nurse practitioners be brought into our system in a thorough, predictable, and strategic way with the creation of a funding model that works, works for them, and works for Albertans? Having them work as AHS employees is one thing, but it really limits their opportunity to go to work and use their full scope of practice. When are we going to use the great services that nurse practitioners offer?

Ms Hoffman: Thank you very much for the question. Certainly, there are many great examples of nurse practitioners providing excellent service within Alberta today. Obviously, this has been something that's been under way for about 30 years across North America. In different ways we've seen pockets of success, and in other ways challenges have emerged.

Certainly, I think that at this point it would be appropriate to call on my deputy minister. If he wants to call on any of his team around nursing expertise, we have somebody dedicated to this file who has made significant progress. More still needs to be made, though.

Dr. Amrhein.

Dr. Amrhein: Thank you, Minister. We have under active negotiation with care providers outside of AHS six different pilot projects that would see nurse practitioners join existing teams in existing clinics to provide primary care. We have a lot of detail. Miin Alikhan is the assistant deputy minister whose division is working on these. If you want the details of all of the pilots, we can provide them. We expect the negotiations on the streams of funding for these pilots to be finished in the next couple of months and the funding to start flowing and the nurse practitioners to be engaged. Once we establish the various types of funding pathways for nurse practitioners in primary care, then we will have the precedents and the models to allow the numbers to expand.

Mr. Barnes: Thank you.

I would appreciate seeing the six pilot projects you're talking about if you could submit that information to the committee.

Dr. Amrhein: Or we can provide the details now if you like.

Mr. Barnes: Just wondering: last year when we were discussing nurse practitioners, you noted that a human resources review was under way. Does the ministry have the results of that review now, and if not, what is the timeline for completion, and when will you be sharing it with us and the public?

Ms Hoffman: I'll call on Dr. Amrhein again.

Dr. Amrhein: I received it yesterday, not because we're here today; it just happened to arrive yesterday. We will put it through the ministry review. We will share it with our senior management team. We will begin to understand the implications of the various recommendations. It will have to go through reviews based on changes in regulation, changes in budget funding. When we are finished with it at the department level, we will share it with the minister and her colleagues. I'm not exactly sure when it will roll out into the public domain. But it did just arrive yesterday, and it's a pretty dense and thick set of documents.

Mr. Barnes: Okay. Thank you.

Let's move on to ambulance services and follow up on some of the things we discussed last year. I know my colleague from Vermilion-Lloydminster has a keen interest in this as well. I'm sure you're aware that there are some very real concerns and problems with the way that EMS centralization has impacted communities, big and small. Your business plan on page 65 once again notes that a key strategy is to "improve the effectiveness and efficiency of emergency and ambulance services." Just as I spoke about this last year, there is no corresponding accountability or performance measure here. How can we expect results when the ministry itself sets no expectations? How do we measure the results?

9:40

Ms Hoffman: I'm on page 65. Are you referring to one of the key strategies?

Mr. Barnes: Yes.

Ms Hoffman: Sorry. Which one are you referring to?

Mr. Barnes: To 1.6.

Ms Hoffman: Thank you for the question. Certainly, we do track our response times throughout Alberta. That information is important to us, to making sure that we're addressing the right care in the right place components from that return-on-investment piece. As well, the acuity of the calls is also triaged and tracked. There are times, obviously, when getting there within a few minutes is a life-or-death instance. That information is certainly tracked and used in an ongoing way by Alberta Health Services in day-to-day allocations, not just waiting till the end of a fiscal year and then seeing if there needs to be a way to reallocate. They certainly have ways of measuring the accessibility of ambulances throughout the province so that they can react on a minute-by-minute response basis to address those. Certainly, the information is ongoing and used in a comprehensive way to address whether or not we're achieving those outcomes.

Mr. Barnes: Okay. Thank you, Minister.

One of the major frustrations, that for four years I've continually heard about, is the vortex whereby ambulances transfer patients to other facilities in other communities and then get stuck there, either waiting with patients in the hospital or taking calls as they try to head back to cover their local communities. One of the simplest remedies for this is to increase the use of nonambulance transfer vans for low-risk situations so that crucially important ambulances don't get pulled into this vortex. However, it seems there's a lot of difficulty out there – and I'm thinking particularly of municipalities in the south – in getting Alberta Health Services to acknowledge the importance of these nonemergency units and to actually use them. I understand that communities have gone so far as to take the initiative themselves to purchase vans and to support local transfer

services but then find that Alberta Health Services is not a willing partner.

I'm concerned about this centralization and the lack of listening to Albertans throughout the province. I wonder: what is your ministry doing to correct these challenges that centralization has caused and to support more local initiatives in ambulance and medical transportation?

Ms Hoffman: Certainly, there are municipalities and operators throughout the province that do have operating contracts with Alberta Health Services and that have been quite successful, I'd say, in meeting the needs of their immediate municipality and also a neighbouring community that might just be a few minutes away. Again, one of the strengths of having an integrated system is that if your neighbour in a neighbouring community needs those resources, centralizing dispatch certainly enables those calls to go out to operators who have contracts in the region. Certainly, there needs to be agreement that they'll operate within Alberta Health Services, not just be an island unto themselves. That can be challenging, I know, for communities because, of course, your number one responsibility is the people who have put you in that position, but Alberta Health Services also has responsibilities to all Albertans.

Certainly, there are many operating contracts with local operators throughout Alberta. I would encourage those contractors, including municipalities who'd be interested in approaching those, to continue to work with Alberta Health Services and understand what options might be available. They do need to make sure that they're meeting certain safety standards. We have quite a rigorous standard, I'd say, in Alberta. That's not something that we want to apologize for. We want to make sure that you're in the best hands when those first responders do show up.

Mr. Barnes: Minister, what I hear continually is that central dispatch doesn't understand local addresses, local situations, and it's delaying the response. I hear continually that ambulances aren't in rural communities when they need to be. I'm hearing about municipalities in the south that have actually approached Alberta Health Services after purchasing vans for nonemergency transport and are being turned down. We're missing opportunities to save the taxpayer money, and we're missing opportunities for better service. That concerns me.

Ms Hoffman: I've met with some municipalities as well, and again I'd encourage them to work with the procurer of those services, who is Alberta Health Services. There are certain components around the operation that need to be honoured, including the ability from time to time to have to respond to a call in a neighbouring community. Obviously, your first priority is the people in your municipality. One of the benefits of this integrated system, thinking about the town that I grew up in, is that if there's a call 15 minutes away, there's somebody only 15 minutes away as opposed to somebody an hour away having to come and do that transport.

Certainly, I would encourage them to continue working with Alberta Health Services to come up with a win-win, and I really do think that there are many. Many other municipalities have found those to date, and so have other local contractors from all parts of our province. I understand the frustration, but we do have some safety concerns as well as making sure that we get that right return on investment for every taxpayer.

Mr. Barnes: Gee, I don't know. What could be less safe than an ambulance not being available? Thank you for your answer.

Let's move on to the capital plan. There's lots to cover here, so I'll try to be as concise as I can. Let's start with the biggest item, the Calgary cancer centre. Last year money was allocated to planning, and this year it appears that we have a much more definitive cost projection. I'm assuming that the $1.2 billion listed here is the result of previous planning. If Alberta Health Services and Alberta Infrastructure have come together to provide this construction cost estimate over the next five years, can you share those Infrastructure planning reports with the Assembly and with Albertans so that we can all see how the projection breaks down? The last part of that question: in addition to seeing how the $1.2 billion breaks down, is the $1.2 billion allocated the total price tag, or can we expect more capital costs associated that will go beyond the $1.2 billion again?

Ms Hoffman: Thank you for the question. The budget includes $3.5 billion for health infrastructure over the next five years, and this includes the $1.2 billion to continue the work on the Calgary cancer centre as well as $500 million to continue health facility projects in Edson, Grande Prairie, High Prairie, Lethbridge, Medicine Hat, and Red Deer and $20 million for planning and development at the Royal Alex as well as the Misericordia hospitals. Certainly, the lessons learned, I think, from some of the projects like Grande Prairie around announcing a dollar amount at the beginning and then having to scope the project to fit that dollar allocation after the fact are lessons that the public service and certainly our government don't want to repeat.

Mr. Barnes: Was Grande Prairie scaled back?

Ms Hoffman: No. It was scaled up. The dollar was announced, and certain things came in different pieces. After the construction began, certain areas of the hospital did need to be shelled in and planned for future growth. Certainly, I am not interested in making dollar announcements and then having to make the public service work to achieve those commitments through their projects.

Mr. Barnes: So $1.2 billion is a hard number for the cancer centre?

Ms Hoffman: Well, $1.2 billion is the money that we've allocated in this five-year cycle. Certainly, the construction of a 109,000-square-metre facility with 160 beds is complex, and as the cost of labour continues to change day by day, we're working to make sure that we get the best returns for the taxpayer. Its projected cost today is closer to $1.4 billion. That is something that is fluid, of course, because this is a many-years project. We've planned $1.2 billion over the next five years. If we can get better returns than that budget that we're asking for, we will certainly apply those savings in the out-years. This project will take more than five years. The project cost is estimated at $1.4 billion.

Mr. Barnes: Okay. So $1.4 billion, with the last $200 million in year 6.

Ms Hoffman: In the years beyond year 5, yeah.

9:50

Mr. Barnes: Okay. Thank you for that.

Let's talk about the unfunded list, the Misericordia and the Royal Alex. I believe this ties into the $500 million that's unallocated. It's easy to see with these kinds of numbers how money could be used up quickly, you know, especially with the Edmonton and north zone lab situation still outstanding, and I'll be coming to that next. I see that you have allocated planning dollars to the Royal Alex and the Misericordia, but it's very hard to imagine how either of these or, in fact, most of these projects on the unfunded list of the capital plan could get built, especially when we estimate what is going to be the cost of the labs. I know that the NDP made a huge push in the

campaign with your New Mis Now campaign, but can you confirm that the promise of the Misericordia will be falling by the wayside? Even if you use the entire $500 million on the Misericordia, it still wouldn't get built, would it?

Ms Hoffman: I will not confirm your assertion. Certainly, our priority is to make sure that we're using the resources most effectively to meet the needs of Albertans. There is significant deferred maintenance at both the Alex and the Mis. AHS has had those on their capital submissions for many years either at the top or very near the top. There are needs in those facilities. The way that, again, we're moving forward as a government is to have the information, have the research, have the data before we announce dollar figures and specific dates and timelines. I think we've learned a lot from watching those failed announcements of the past from the last government.

Mr. Barnes: So money for the Misericordia and the Royal Alex is not in the five-year capital plan, then?

Ms Hoffman: Right now we have the planning money. Obviously, we don't want to put in dollar figures until we've done the appropriate planning so that we can put the right dollar figures. The $20 million that's being used for the planning piece will inform numbers for next year and future capital plans as we move forward.

Mr. Barnes: Okay. Let's talk some more about the ambiguously titled Future Health Facility Projects (Unallocated). I'm going to switch gears and talk about the Edmonton and north zone labs. The Health Quality Council report came out in January, and while it says that the public option wasn't adequately considered, it doesn't give any costing or firm plans about what such a public lab would entail. It appears the government's mind is made up to go publicly. My concern – and it was last year when we talked about this, and it was the summer when it first became an issue – is that the current situation and the current facility are untenable. We need to move on a change and improvement, and it's been made more than clear that the status quo isn't tenable either.

We've been quite clear that the request for proposal process was flawed, but now we're starting from square one. In fact, I think we might be throwing some of the good elements out, too. It's clear we need a new lab facility hub for the Edmonton and north zones, and part of the original request for proposal was a new, state-of-the-art, $325 million megalab. My first question is: if this report was on your desk since January and your mind has apparently been made up, why was a new lab project not costed in this capital plan, or is it just going to use up the vast majority of the $500 million that's allocated? Did you cost for this?

Ms Hoffman: Thank you, Madam Chair. We're certainly moving forward in a fashion that's stable, reasonable, and focused on the best outcomes for Albertans. Obviously, the work that labs do is fundamental to making sure that the health care workers have the right information to be able to make the right decisions around keeping everyone their healthiest and treating any conditions that are detrimental. We have made good progress. There's been a committee struck moving forward around the public oversight to having an integrated lab system.

My deputy minister is the chair of that committee. If you don't mind, Deputy Minister, commenting on some of the next steps.

Dr. Amrhein: On the committee that I chair we have the Ministry of Infrastructure with us. We have AHS with us, and HQCA also is with us as well as the Ministry of Advanced Education. We have started meeting. We will soon work with a group of organizations that have a stake in the conversation, and the individuals that we've retained to lead the project are fanning out to talk to the various stakeholder groups now.

There is a province-wide component to this to try to make sure that all of the various parts of labs are organized in a way that we can make the most effective use of the capacities and the capabilities of the various parts like Calgary Lab Services and the labs that are in some of the larger hospitals. That is a sort of province-wide portion of this initiative.

At the same time, there's a very sharp focus on Edmonton and north, and the Edmonton and north piece will be going through its own process within the larger process that will take a look at the capacity of the existing facility as well as the need for additional space and, potentially, the entirely new facility that you mentioned.

There will be people from Alberta Infrastructure that will start looking at opportunities for location of a new facility. We do not expect that we will need the capital funding in this fiscal year. We do expect that there will be a capital component in the following set of capital expenditures. We haven't sorted out any of the details yet. We haven't yet brought forward a detailed proposal to the minister, but that would be something we expect to do during the current fiscal year. There are a number of options that Alberta Infrastructure will work through with us, and we will also be at the same time addressing the scope that we'd need for the service provider. The minister's comments have been clear that we are to bring back the best ideas, and there is no decision at this point to go in one direction or another.

Mr. Barnes: Thank you.

That brings me, though, to the concern about whether this may affect the current service levels. I understand the situation between AIMCo and DynaLife, that there's a lease in place. Even if you can extend it, you know, how much longer can this situation go on before we start to affect service levels?

Dr. Amrhein: AHS assures us that there is no risk to the current level of service that is being provided. AHS is responsible for ensuring a steady, high-quality, sustained provision of laboratory services from a variety of their different laboratory components. We rely on Alberta Health Services to maintain the current range and quality and capacity of laboratory work, and we are assured by AHS that this is exactly what they're doing.

Mr. Barnes: Okay. Thank you.

Time frame: not this year. Can you give me any other certainty as to what the time frame would be and the costs? Again, I want it back to the right value. How will the costs stack up compared to the original request for proposal, the one that was so public last summer?

Dr. Amrhein: I think it's premature for me to speculate. The various individuals and experts that we have assembled to do the work have not really yet had time to work through all of the options, work through all the details, consult with all the relative stakeholders, and bring back an estimate or a set of scenarios that we've been able to work through.

Mr. Barnes: Okay. Thank you.

Have any outside analysts or experts been called in to look at the situation of laboratory service and how best to provide it?

Dr. Amrhein: Yes.

Mr. Barnes: Thank you.

Can I ask who?

Dr. Amrhein: Penny Ballem from British Columbia. She has built such labs in previous career opportunities, and she has very broad and deep experience in large public-sector initiatives.

Mr. Barnes: Is there a report . . .

Ms Hoffman: This was through the Health Quality Council report, Madam Chair, and the Health Quality Council did ascertain Dr. Ballem as one of their sources contributing to the content of the report and developing recommendations around next steps. The Health Quality Council will continue to be a partner in the committee that's being led by my deputy minister moving forward. Dr. Ballem is a former Deputy Minister of Health for British Columbia and a former city operator for the city of Vancouver.

Mr. Barnes: Okay. Is her report public or only through the Health Quality Council?

Ms Hoffman: She contributed to the Health Quality Council report.

Mr. Barnes: Thank you.

We've ascertained that the money is not here for the lab, the Misericordia. Of course, the Royal Alex: you know, a number of $4.2 billion was thrown out some time ago for redoing that. We're seeing, you know, that current spending projections in the overall budget have us hitting approximately $58 billion in debt by 2019. Is this funded capital list of $3.4 billion for new health infrastructure subject to additions this year, and if so, are we assuming that the projection of $58 billion of debt by the end of your government's term could be just a starting point?

10:00

Ms Hoffman: Thank you for that loaded question, Madam Chair. Certainly, we are proposing a capital plan that we think is striking the right balance of addressing significant deferred maintenance that really started to pile up under some of the, as I think they were called, deep and brutal cuts of the 1990s, when some of this deferred maintenance that we're speaking to at sites like the Alex and the Mis certainly did begin to grow very, very quickly.

Increasing our capital plan projections and our proposals through estimates by 15 per cent over what was planned by the previous government not only is, in our opinion, the right thing to do in addressing the assets that we own as a province but also is getting Albertans, many of whom have exceptional skills in the trades and aren't being employed as fully as they were when oil prices were more than double what they are today, back to work building the necessary infrastructure required for our province.

Our proposal through the capital plan is exactly what we're asking the House to approve. We think this is the right way to move forward. The money that we put into these budgets for planning, including planning for the Alex and the Mis, and the money we have in the capital plan for the Edmonton and north lab zone will enable us to have the right numbers in future budgets to move forward in a responsible way without having what we've seen historically as significant overruns. We want to make sure we're using the right information to populate our budget and not make political announcements and then have to play catch-up to make sure that the projects meet the announcement that was made up front.

We're proud of our capital submission. As is evidenced from questions asked in the House almost every day for additional increases in local infrastructure investment in MLA ridings, I think that the needs are significant across Alberta, and this will do a big part to helping us tackle some of that deficit moving forward.

Mr. Barnes: Okay. Thank you, Minister.

I want to switch gears, staying in the capital plan, but I want to talk about electronic health records. It concerns me, and it saddens me. I've had people come to me, a number of them, whose adult children or people they know have passed away or their sickness has worsened, and they feel that part of the problem was not having access, patient facing, electronic health records, that could have allowed them to have more care, more involvement, more information about their personal situation. Our Alberta Innovates had an excellent speaker here about two or three months ago, a gentleman from Calgary that runs six hospitals, and he showed many of the ways that electronic health records could help our good front-line workers to just improve their jobs here and there and do many, many things that it seems our system is lacking.

I understand that the Alberta citizen has put over $800 million into electronic health records already, and of course your government is now putting another $400 million into it. I see three lines in various places in the capital plan for various electronic health information infrastructure: actually, $400 million on page 50 for clinical information system, another $110 million on page 49 for health IT systems development, and again on page 49 is $75 million for electronic health records. Could I get a brief clarification of what each line item entails? I'd like to hear what oversight and accountability you're planning on implementing with hard-earned tax dollars.

Ms Hoffman: Yeah, absolutely. Thank you very much for the question. I'll speak to the high-level response, and then for the specifics on those three line items either Dr. Amrhein or Ms Wong will supplement.

Certainly, in the past some of the work that's been done on Netcare – this is one of the challenges, I think, around having different pieces of the system that used to be operated in different ways and trying to integrate them into one system, and it's the opportunity that exists as well. Right now there are about 1,300 systems that are not connected throughout the province, and they do not necessarily share information to meet current needs. For example, if you go to most acute-care hospitals, they are operating on a charting system that's primarily paper driven. They enter it into an operating system that's, I think, older than I am. Then they have another monitor, often beside it, that's got the information from Netcare, with your lab results. Then they enter that into, again, that hospital operating system. This has been something that hospitals have expressed their desire to upgrade to have more predictability when it comes to the patient medical record within Alberta Health Services.

It's okay to have an old system if you have people who understand how to code for that old system, but some of those people are nearing the end of their careers as well. We haven't been training people in postsecondary on how to do coding for those operating systems for the last 20 years, so certainly, I would say, we have significant deficit in that area. Having a clinical information system: we have allocated $400 million, and it's all capital funding, to do this much-needed upgrade to the system to move information from disjointed facilities throughout Alberta Health Services to have integrated, seamless access.

Of course, people that I've spoken to, that I imagine you have as well – for example, David Price and the report that was done on the tragic situation that no parent should have to go through. You shouldn't have to wait and wonder if your referral to the specialist got in. You should be able to have confidence that the system has an integrated way of communicating from one facility to another. While, of course, $400 million is a significant investment, this work has the ability to improve response times for staff working in

facilities but also to save lives. Certainly, the analysis that's been done shows that this is going to be monetarily a very wise return on investment when it comes to staff efficiency but also to improve access to important life-saving information.

On the three line items, Dr. Amrhein or Ms Wong?

Ms Wong: Sure. I'm sorry. I heard you say page 49. What other page were you referring to?

Mr. Barnes: Page 50, the $400 million for clinical information system; then health IT systems development, page 49, $110 million; and $75 million for electronic health records on the same page.

Ms Wong: Thank you. Okay. The minister was very clear on how the $400 million was going to be spent on the clinical information system for AHS.

The numbers on page 49, the first number, health IT systems development, is to support a variety of health systems that we need to gather the information, do monitoring, et cetera. So that's just sort of a continuation.

Then the electronic health record. We've been operating that system for over 10 years. Of course, things need to be replaced, upgraded, et cetera, so that's just funding to make sure that we're able to do that.

Mr. Barnes: Okay. Thank you.

Can I ask the minister: I believe it's over $800 million that we've spent on this so far, so did we get value for that $800 million? I'm still unclear, Minister Hoffman, as to what oversight and accountability measures you're going to put on this huge amount of money being spent.

Ms Hoffman: Sure. The $800 million that you're referring to, I believe, is for Netcare, which is usually tied to clinics, and it's not acute-care driven. That is a significant dollar amount, but unfortunately when I rolled up my sleeves and started digging through the files, the way that you track admissions to hospitals, tests in hospitals: it's a different operating system that's being used in that area.

In terms of the oversight, making sure that the contract provides good return on investment for the taxpayers, I've grilled my deputy as well as the interim CEO of Alberta Health Services on this, and he has given me great assurances, and I'll have him give them to you and to all members of the committee at this point.

10:10

Dr. Amrhein: This could be a very long answer. You'll have to tell me when you've heard enough. There are four major initiatives under way within the Ministry of Health, all of which are variously referred to as one-patient, one-record clinical information system health record systems. There's the initiative that was announced in the current budget, that is the Alberta health systems' effort to update and modernize all of their various 1,300 information systems pieces. This will start in the University hospital in Edmonton, and it will then fan out within Edmonton and northern Alberta. Then they will access the effectiveness and move on from there. So that's the first piece.

The second piece is to liberate all of the various databases held in primary care and primary health care organizations and move their patient records into Netcare. Once the information is in Netcare, then the hospitals can look into Netcare and the various health providers can look into Netcare, long-term care, and so on.

The third issue is to organize the data within the health information and all of the relevant privacy and security statutes in an anonymized way so that the health system can do research in a secondary-use data environment to extract insights into the macro health conditions of the Alberta population and compare our results with comparable results that are generated in provinces like Quebec and Ontario.

The fourth piece is to continue to evolve the Netcare system, because the $800 million number refers to a large number of initiatives that have created highly specialized databases like the pharmacy information system and the diagnostic imaging information system and, coming later this year, the personal health record system. All of these different sets of data are deposited into Netcare, and Netcare becomes a sort of organized clearing house.

So the $400 million allows AHS to update over what has been sort of a lack of investment for a long time so that it, too, can contribute its hospital information in a more comprehensive way and also so that it can see what is out there in other environments.

The oversight is layered on the Alberta health system CIS. There will be a committee, chaired by myself, that will oversee the evolution. Again, we have brought in outside experts to help with this. AHS has an expert, and we are accessing talent so that we have external views on what we're doing. There is the Health Information Executive Committee, that I chair, that brings the relevant stakeholders together, including AI, AHS, the AMA, and HQCA, an alphabet soup of people who are involved in health information.

We are also building a data governance committee that will help us sort through some of the issues that evolve when you move data from various repositories into an environment where it can provide better and faster insight to the benefit of the patients and their health care. This is the issue that we confronted some years ago in the case that Mr. Price and his family, unfortunately, had to contend with. So those are the first layer of oversight.

We have Assistant Deputy Minister Kim Wieringa, who oversees a second level of committees that deal with the very specific issues; for example, of one type of data versus another type of data. We are working with all of the health care providers to establish a standardized bundle of personal health information. The Canadian Institute for Health Information has declared a standard that is roughly 65 or 70 data elements. We are in the process of adopting those standards and working with all of the relevant data owners to make sure we stay abreast.

Generally outside of Alberta the $800 million – the Netcare bundle, as it's usually called – is still viewed as one of the very best in class. It is certainly among of the best in class in public systems in North America. It is not as good as some of the Scandinavian systems, but we're moving.

Mr. Barnes: What percentage of Albertans does it not have access to, though?

Dr. Amrhein: If you mean: what percentage of Albertans don't yet have access to their health records . . .

Mr. Barnes: Yeah. Thank you.

Dr. Amrhein: . . . I don't have the exact number. It is a number larger than it should be, but once we turn on the personal health record, then every Albertan will have access to their information in the Netcare depository.

Mr. Barnes: Okay. Thank you.

In the minute that's left, on line 7 of the estimates, human tissue and blood services, we have a 7 per cent increase, and I think that relates to the blood plasma issue. What does it cost the province to source from outside Alberta? What does blood plasma cost?

Ms Hoffman: Thank you. Certainly, we are, I think, very proud as Canadians of our Canadian Blood Services system that we do have established today. Some of the difficulties that we faced in the tainted-blood scandal of the past make it even more important for us to continue to have a solid, voluntary system.

The Chair: I apologize for the interruption, Minister. However, the time allotted for this portion of the meeting has concluded.

I now would like to invite members of the third-party opposition and the ministers to speak. Hon. member, would you like me to set the timer at 10 minutes to identify the halfway point?

Dr. Starke: No. I think we'll just go straight through.

The Chair: Are you wanting to share your time with the minister?

Dr. Starke: If that's acceptable to the minister, yes, please.

Ms Hoffman: It's ideal.

The Chair: Go ahead.

Dr. Starke: Perfect.

Well, thank you very much, Chair. Thank you, Minister and your officials and the associate minister, of course, and all of the officials both within AHS and Alberta Health. As others have said, I think that with the challenges like the wildfires we've experienced these past two weeks and certainly the similar experience we had with the flooding in southern Alberta in 2013, I think we would all concur that that brings out the best in Albertans and shows that our system is, in fact, resilient and responsive. That's a great encouragement to all of us, and it's a credit to everybody involved in the system. I'd like to thank you and everyone in Alberta Health and AHS for their leadership in that regard.

You know, I have a number of questions in a number of different areas, and in all cases I'll try to refer back to sections within either the business plan or line items of the budget.

Also, to your opening comments, Minister, certainly you talked about bending the cost curve. That's, of course, a term or a phrase that we hear here frequently. I guess my concern, Minister, quite frankly, is that my experience in medicine is that bending the cost curve is done most effectively when we transform our system from what it is now, a disease and injury response system, to a health care system. I would argue that what we have now is not a health care system but, in fact, a disease and injury response system.

I look at key strategies 2.3 and 2.4 on page 66 of the business plan. Strategy 2.3: "develop a whole-of-government approach to wellness and collaborate with key partners to build community capacity." Strategy 2.4: "improve and protect the health of Albertans through a variety of strategies, including increased immunization rates." I think, as you can probably suspect, I'm all in favour of immunization. Minister, what exactly and where exactly within your budget do you have programs to act on those key strategies?

Ms Hoffman: Thank you very much for the question. While my team finds the right line items, I'll just talk about some of the challenges and successes we've seen this year around immunizations. Certainly, I'd say that one of the great successes is that it wasn't as bad a flu season, probably at least in part because of the weather conditions. Part of the challenges of that is that humans naturally, when they hear about a disaster that's happening, usually go out and access immunizations to a greater extent when they hear about those types of things. While we did have fewer instances of fatalities and admissions to hospitals because of the flu, for example, this year, our immunization rates, at least in the preliminary data, didn't see significant increases. So good news and not great news, I guess I'd say, at the same time. Certainly, we're glad that there were fewer people who were impacted this year to an extreme extent by the flu.

In terms of child immunizations certainly we've been undergoing a review of ways that we can increase information for parents. We respect the fact that parents have the right to make that decision about immunizations, but I'd say that as government we have a responsibility to make sure parents know what precautions and safety measures are put into making sure that immunizations are safe. We're certainly working to increase information so that parents can make an informed decision, but it will still be the parents' decision. Of course, in times of outbreak the government and other orders of government have responsibilities to protect those who might not be safe. Having ways to access those files is certainly important.

Element 9 on page 129 is for prevention initiatives, including immunization, so that would probably be the most appropriate line item. That's page 129, item 9.

10:20

Dr. Starke: Okay. Minister, let's maybe just shift slightly. I know that one of the areas that you've talked about and that has been designed to provide a more wraparound set of services for Albertans is the primary care networks, and certainly a team-based approach to preventative medicine is one that we support. I understand that the PCN review, which was initiated, is still under way. Is that what I heard you say earlier?

Ms Hoffman: We have completed our review, and we've shared the data with our partners who are involved in that, including the PCN leads and the AMA. We think it's important for them to make adjustments within a timely fashion as well on the oversight that they have of PCNs. The decisions around what steps to take moving forward: we're still working on those details.

Dr. Starke: Are the results of the review public at this point?

Ms Hoffman: Not yet, no.

Dr. Starke: Okay. Do you have a timeline for when you'll release those publicly?

Ms Hoffman: I think we could do it soon. I wanted to make sure, obviously, that the number one demographic we wanted to connect with were people who had the ability and oversight to address some of the items that were identified, but certainly we'll be able to share that with yourself and all members of the House soon.

Dr. Starke: You mentioned – and it was stated – that one of the things that was done this past year was, you know, working through the $50 million in surplus that had been accumulated in the PCNs. Are steps being taken to ensure that that doesn't start happening again? My concern, quite frankly, with PCNs is that the ones that work well work extremely well and that there are PCNs, I feel, in this province that aren't serving patients well and that, quite frankly, we have an accumulation of surpluses within these PCNs. I'm just wondering: are adjustments being made to make sure that that doesn't start happening again?

Ms Hoffman: Well, thank you very much for the question. I'll ask my associate to expand on it. Certainly, I would say that if people don't feel they need to spend their full allocation, we're not saying: you have to spend it. We want to make sure they get the right allocation to address the community health needs. I would agree

with your summary around that some are doing really innovative work. I wouldn't say that it's necessarily because of the system. I'd say that it's because they're driven by a team-based care model; they want to address the social determinants of health that are impacting their patients.

Certainly, I think it's important for us to learn from best practices. For example, Grande Prairie has extended after-hours care that the PCN has launched, and keeping people who don't need to be in a hospital in other places in community care is certainly a driver.

Did you want to add to that, Associate Minister?

Ms Payne: Yeah. With some of the work we're doing around both the PCN review and moving forward with that, a big piece of it is ensuring that the governance model for PCNs is appropriate. As you alluded to, each of the communities has slightly different needs. Ensuring that the PCN that is operating in any given community is able to support those health needs is quite critical. As well, expanding the use of interdisciplinary teams and finding ways to support the PCNs in expanding the role of our other health professionals is, I think, really critical for us moving forward.

Dr. Starke: Great. Okay. Thank you.

Your opening remarks – actually, this was the associate minister – mentioned an increase to mental health and addictions of $5.6 million arising out of the mental health review, that was completed under the leadership of Dr. Swann. That was certainly an excellent review. I think Dr. Swann and others mentioned at the time that a concern – of course, you know, we've had reviews in the past – is to move forward with the recommendations, so I'm encouraged to see that. I think mental health and addictions is an area that needs, certainly, attention more and more going forward.

I guess I'd like to refer back to another review, and, Minister, you know where this one is going. You've identified a $5.6 million increase for mental health. How much is allocated in this budget for implementation of recommendations from the rural health review?

Ms Hoffman: Thank you very much for the question. Certainly, the rural health review, I think, had many components that were exciting and that we're moving on integrating in a systemic way throughout the system, including Alberta Health Services; for example, some of the recommendations around nonemergency transport – ambulance transport for example – and using a more efficient means with, again, that right level of care to transport patients. We've increased Alberta Health Services' budget this year. I believe it's 3.4 per cent. Certainly, those pieces would be integrated within their budget.

Dr. Starke: That's one. That's great. On that note, how many more NAT vans are on the road now compared to a year ago?

Ms Hoffman: I'll follow up with Alberta Health Services, and we can have conversations with them about that specific initiative but also other types of transport that flow from that recommendation.

Dr. Starke: Good. Okay. In a broader context, Minister, when I asked you on June 17 of last year about the rural health review, you said:

> In terms of making sure that we acknowledge the recommendations in the rural health review, that's absolutely been one of the items that we've been paying attention to and that I'll continue to update this House on when we have opportunities to do so.

I was very encouraged by that. You know, you've mentioned a couple of times in the House the 811 number, which is good. You also mentioned today about the NAT vans. Is there anything else that you can report to us today that is specifically arising from the rural health review? I will tell you that from the stakeholders that approached me and talked to me about that review, that participated in the review, they're not seeing those initiatives. They're not seeing them at all.

Ms Hoffman: Any of the recommendations that were in the report?

Dr. Starke: They're not seeing the implementation of the report. In fact, they're asking me why it's not being implemented.

Ms Hoffman: Thank you very much for the question. Certainly, when I had the opportunity to meet with you, Dr. Starke, outside of the House as well to talk about some of the pressing recommendations, I appreciated the expertise and commitment to that process. Moving forward, I'd be happy to provide a written response in a timely fashion around some of the recommendations at a higher level, and I would be happy to share that with the House.

When you look at rural health care, some of the components that were in the report around attracting and retaining staff certainly fit within the line items that we've mentioned previously: physician compensation, attraction, and retention. But we'll be happy to provide you a written response.

Dr. Starke: Minister, thank you. I'll look forward to that. Trust me. Like I said, I'm eager to share that information with the people that challenge me, you know, because they view it in part as being a failure on my part for not having followed through on the report as opposed to a failure for government. Rather than pointing fingers or laying blame, I think that's something that we're all interested in improving.

I want to talk a little bit about – I'm not going to call it strictly physician recruitment because I think that oversimplifies the issue. That certainly was something that we talked about during the rural health review. In fact, one of our recommendations was expanding the mandate of the rural physician action plan to a rural health workforce strategy as opposed to strictly concentrating on physicians. In the House you've said – and I absolutely agree with you – that we need to talk about other health care providers. In the course of doing the review on RPAP, are you considering expanding RPAP to a more broadly based rural health care workforce strategy? In terms of that, are you planning on increasing the role of nurse practitioners, LPNs, midwives, dietitians, chiropractors? We could go down the list of health care providers.

Ms Hoffman: Thank you very much for the question. Certainly, we're dedicated to making sure that we get the variety of health experts throughout Alberta. For example, last year, when we announced the increase in funding – again, it was about $1.8 million for 400 more cycles of care – there was a priority, as I think is evident from some of the allocations, to make sure that women have access not just on the wait-list where there is currently access to midwives but in other parts of the province where they don't even bother putting themselves on a wait-list because there is no midwife. Some of the examples, like Plamondon, I think are a really good testament to some of the work that's happening in that area.

Again, RPAP is about 10 per cent of the work that we're doing around rural recruitment and attraction in terms of money and the investment spent in that area. One of our partners is the universities as well.

Dr. Amrhein, if you wouldn't mind touching base on some of the other work you're doing in making sure that we attract the right health professionals to communities throughout the province and, particularly, maybe some of the partnerships with the universities.

10:30

Dr. Amrhein: We've met with the two medical schools. We have a council on academic medicine that brings all of the major players into the same room at the same time with the different ministries. We've also been meeting, for example, with the nurse leadership council to explore opportunities for various types of nursing but especially nurse practitioners in the primary care. And I've mentioned the pilot projects that are exploring ways of funding.

The goal in the case of nurse practitioners is to not replicate the fee-for-service model but to make dramatic progress on the minister's comments around the right teams of health professions. AHS works with us. We are worried about the range of health professionals outside of Edmonton and Calgary or outside the major urban areas. AHS has their own process of recruiting health professionals to rural communities. This is in addition to RPAP-funded programs.

Dr. Starke: Excuse me, Chair. Thank you. If I could just cut in there. I guess I want to actually address that very point. The impression I get with health care professional recruitment retention in this province – and forgive me if I use an animal reference. It's a lot of dogs chasing the same ball. We know what the goal is; it's to get the ball. But when you have that many dogs chasing it, they get in each other's way. I guess what I'm wondering is: what is the department doing to try to co-ordinate the various efforts? We have community-based efforts, RPAP, we have AHS, and we have Alberta Health. All have got strategies, and they don't always work in a co-ordinated manner. So what is being done to co-ordinate, you know, that overall, and what is being done to make sure that it's not restricted just to physicians but that it's an overall addressing of the health care workforce needs that we have throughout the province?

Ms Hoffman: Dr. Amrhein.

Dr. Amrhein: We've had two sessions recently. We had one session, with over 60 health care providers, that focused on the traditional, formal AHS-type organizations. For the second one we had over 60 community health provider organizations in the room together. This was a mediated conversation. The question was: what do these providers advise that the department undertake to better organize all of the different efforts to create the right team approach in the right places? We have had for quite a while a fairly standard approach to building teams, and that's proven to be successful in some areas and less successful in other areas because the needs of the specific communities vary dramatically.

The best answer I can give you today is that we have started a conversation with a much wider array of health professionals, including the NGOs, and in part this has been informed by some of the discussions we've had on the fentanyl task force response. We have, for example, in the mental health review 37 different organizations coming together to advise us on how to build the right teams.

Dr. Starke: Thank you, Doctor. I think co-ordination of the number of players that are within the health care system has to be one of the biggest challenges we have. We're all working towards the same goal. We've got different ideas about how to get there, and sometimes, unfortunately, the co-ordination is not always there.

I just want to loop back for a second to the conversations with the medical schools. We talked to the directors of the rural medical education programs at both the U of C and U of A. I think, quite frankly, they're doing excellent work. I think they're doing a great job getting more of our medical students to consider rural practice. They have in fact doubled the percentage of students that are considering general practice as opposed to specialization. That number has gone from 20 to 40 per cent in the last five years, and I think that's very encouraging, certainly, to rural communities, that tend to look more for generalists, the people wanting to enter a family practice. One of the requests they had was to have the funding that currently is being channelled through RPAP to the med school programs flow directly from the department to the medical schools. I guess my question is: is that something you're considering? Is that going to be part of the overall RPAP review?

Dr. Amrhein: Yes, it is.

Dr. Starke: Okay. Great. I would recommend that, quite frankly. I think that that would streamline things.

I know that our time is very limited going into the last little bit, but I do want to ask a question. You mentioned addictions and detoxification centres. I'd be remiss and certainly would be hearing it from back home if I didn't ask whether the Thorpe Recovery Centre outside Lloydminster, which is a brand new facility and has unutilized capacity, would also be considered in terms of a potential place to do addictions and detox treatment. It's got a fantastic record. It's run by a nonprofit board. You know, I think it would be something that we could look at. I'm just wondering if that's being considered.

Ms Hoffman: Minister Payne.

Ms Payne: Thanks. Ultimately, the challenge facing us with addictions and mental health is that there are many great programs, but we are working really diligently to ensure that we're getting the best use of the resources. I would strongly encourage for that facility to be in touch with AHS as we move forward with the implementation.

The Chair: I apologize for the interruption, Minister. However, the time allotted for this portion has expired.

For the next portion of the meeting my understanding is that Dr. Swann and Mr. Clark will share the 20 minutes, with Dr. Swann going first. Would you like to share your time with the minister?

Dr. Swann: Yes. Thank you very much.

The Chair: Go ahead.

Dr. Swann: Thank you, Madam Chair. Thank you, Minister, Associate Minister, staff. Great to see you all out, and I'll give a special shout-out to my former colleague and medical officer Karen Grimsrud, who is now the provincial health officer. Welcome.

Let me start by saying how impressed I am with the minister and what she has done in a year in office. In one of the most difficult if not the most difficult ministry in government she's shown diligence and competence and compassion in some very challenging times, especially recently. I wanted to congratulate the ministry on providing stability over the last year, on establishing a new board, the gap from which has created chaos throughout the health care system and a lack of direction and a lack of co-ordination that is still rippling through a lot of the health system, a lack of certainty, demoralization through the system that I hear about on an intermittent basis.

I do hope we will be able to move quickly on clarifying roles and responsibilities between Alberta Health and Alberta Health Services, an ongoing sore that continues to rankle most and results in a lower quality of health care and a lower efficiency of care.

I thank her and the Premier for honouring me with involvement with the mental health review and remind them that 6 per cent of

the Health budget is 30 per cent below what is recommended by the national council on mental health. The small increase in mental health this year doesn't bring us anywhere near what would be an effective resource for mental health and addictions, let alone moving towards more preventive programs in mental health and addictions.

I applaud the increase in home care. That is going to reduce pressures on emergencies in hospitals. Long overdue. I see the AISH supports have gone up this year 15 per cent, which is, again, going to provide a substantial reduction in demands on health care services.

I want to focus on two areas primarily: public health – prevention – and primary care networks. In relation to public health, 2.6, 9.3, 9.1 all relate to public health. Unfortunately, what we see again is that this is the poor, poor, poor sister in the health care system, and the result is, of course, that we continue to spend much more in terms of mop-up, crisis management, treatment after the fact, and we continue to see our hospitals overloaded. We're not meeting our targets in emergency wait times. How are you going to start shifting more resources into prevention and public health?

Ms Hoffman: Sister – sorry. Minister Payne. I call her my sister minister.

Ms Payne: It's the first time I've been called that on record.

Absolutely, preventative care and primary care go hand in hand. We know that if we want to achieve our long-term goals of bending the cost curve for health, we really do have to work to shift that focus away from acute and emergency care to some more of that preventative and that wellness piece. A lot of the work that we're doing around that will be coming through the primary care networks and some of the work we're doing around that, really working to expand the work of the interdisciplinary teams and, frankly, make full use of the scope of the various health practitioners that are available in our system.

10:40

We know that traditionally our system has had a strong reliance on physicians, and we absolutely value the work that physicians do. However, there's, I think, room for expanded roles for a variety of practitioners. Today we've already talked about nurse practitioners, midwives, and there are many others. As part of the AHS work plan we're working quite closely with them on finding ways to maximize some of those other health resources within the system so that we can also, then, shift some of the additional dollars towards that preventative focus.

Dr. Swann: Yeah. I don't see how you're talking about the public health system. You're talking about primary care. I'm talking about getting into schools, shifting lifestyles, investing in exercise program advocacy.

Ms Payne: Right.

Dr. Swann: I'm talking about diet. I'm talking about stress management. These are the big killers and the big demands on our health system, and we have a public health system. Public health nurses used to be in the schools. They now don't have the resources to do that. We used to have a public health dental program that got in to teach kids about dental hygiene and to actually provide services to low income – that's under tremendous stress. How are you going to shift funds from where they are to some of the primary prevention programs that need to be in schools and communities and workplaces?

The talk goes on every year. I hear the same talk every year. I don't see the shifting of resources. We've gone from 5 per cent in prevention to 3 per cent in prevention in the last 15 years.

Ms Payne: I'll turn it over to Minister Hoffman.

Ms Hoffman: Sure. Thank you very much, Ms Payne. Certainly, a lot of this is happening through Alberta Health Services through the community health centres that we have throughout the province. Just during the last constituency break I had the opportunity to visit one of our construction sites up in High Prairie where we are building a new acute-care facility. About half of that facility itself is dedicated to health and wellness wraparound services, so there's going to be a mental health and wellness area within that acute-care facility. Each of the physicians who is new to the community – there are five who are coming – is going to be part of an ARP model where they'll be doing a lot of wellness work within clinic space in the hospital as well. A lot of this leadership in terms of the budget piece is within Alberta Health Services as we continue to move forward.

I hear your frustration and share it. Obviously, resources are tight, but prevention and wellness is one of the best ways to bend the curve. Unfortunately, it takes time to see it reflected in the budget outcomes. We'll continue to make efforts on that area, but obviously we're not in a position financially to be moving mountains this year.

Dr. Swann: Can you give me any sense of where new funding or new resources could go into public health primary prevention supports, or is it going to be the status quo?

Ms Hoffman: Certainly, the allocation to Alberta Health Services, seeing an increase greater than our overall budget increase, shows that we are trying to make sure that money gets out to the front lines. They will be presenting a detailed budget once our budget process goes through, and we'll be able to share some information with you through their public budget as a result of our completing our provincial process.

Dr. Swann: That relates to some extent to the health system indicators. We've seen changes to health indicators almost on an annual basis over the last four or five years. Have we established some standard indicators that we can count on in order to try to evaluate how the system is working and how access and quality are shifting, or are we going to continue to see changes to the reporting and the timing of the reporting of health indicators?

Ms Hoffman: Just to clarify, the indicators that are in the business plan?

Dr. Swann: Yes.

Ms Hoffman: Yeah. Okay. We'll find the right page on that.

Certainly, very recently we signed a protocol agreement with Treaty 8, and obviously one of the big things I'm hoping to accomplish in working with the leadership of First Nations is finding ways to close the gap in particular on infant mortality rates, life expectancy rates. These are all indicators of your population health that, I'd say, right now the evidence shows are failing, and failing in significant ways, when you look at certain demographics, particularly within Alberta.

There are two new performance measures that have been introduced in this business plan. The first is 1(b), "Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital," which I think flows well from the

recommendations of the mental health report. Obviously, we want to find ways to support everyone while they're on a discharge plan to have the right supports in the community. If they do need to be readmitted, we're not going to turn them away, but we'd like to have the right supports in the community. The second one is 1(c): "access to the provincial Electronic Health Record." So that's the number of health care professionals that can access their EHR and share it with the people that they're encountering throughout the system.

Dr. Swann: Thank you.

I noticed you've reinvested the $50 million in primary care networks. That's a good sign. The reports I hear from the primary care folks are that they've been involved in five to 10 years of committee work and have not seen substantial change or direction around primary care networks. Many of them are disengaged and frustrated with the lack of clear direction on primary care networks, especially if as they save money, that money is having to be lost, when they want to have a plan for the next three to five years and invest that money that they've saved in some new programs and expand the services that they have. So I needed to say that with respect to some of the return of the investment.

The Chair: I apologize for the interruption, but the agreed-upon time has expired.

I would now like to invite Mr. Clark and the ministers to speak. Are you wanting to share your time?

Mr. Clark: Yes, please, if that's all right with the ministers.

The Chair: Go ahead.

Mr. Clark: Thank you very much. Again, I will just echo the comments of everyone else on the tremendous work that has happened. I am absolutely impressed by the work that went on to evacuate the hospital, in particular, in Fort McMurray. It's heroism. I mean, there's no other word for it. It's remarkable. Through you to everyone who's been involved in that and in the continuing recovery efforts: thank you very much for everything that you've done.

Thank you for being here. Very briefly, I just want to start with a question that I'm asking every minister, and that is that as we prepare for estimates here in the opposition, it would be tremendously helpful to have all of this data in Excel format, not just a PDF but an actual manipulable Excel format. I recognize that that's not your job as the Health minister – it's Treasury Board and Finance – but perhaps it's something that you can talk about as you prepare for Budget '17. It would be very helpful for all of us, so I'll put that out there.

Just as my first question, I wanted to pick up on what Dr. Starke had raised in terms of Alberta having, I think, a very good, absolutely world-class acute-care system, but we're not very good at preventative medicine, at wellness. I think that we have a sickness care system, perhaps, more than a health or wellness system.

The other thing. I know we all hear stories, and more than just stories, I think, some fairly clear evidence, about bureaucratic barriers, ongoing disconnects or overlap between Alberta Health and Alberta Health Services, perhaps the wrong sort of behaviours being rewarded, thinking about some of the people who perhaps work part-time plus overtime that essentially makes up a full-time job but would cost more than an ordinary true FTE.

As part of that plan that you talk about to bend the curve, what are you doing to empower the many great people in the system, who work on the front lines but also in administration, to create a true culture of innovation and shift towards things that are going to permanently and structurally reduce costs for health care without compromising quality of care, in fact perhaps enhancing quality of care and at the same time improving the culture of the entire organization? Is this an area of focus for you at all, and if so, what exactly are you doing to address that?

Ms Hoffman: Thank you very much for the question. Madam Chair, certainly, it's an area of priority. When we looked at the three areas of the budget that were growing the fastest, they were acute care, physician compensation, and drugs. Physician compensation: we're certainly working hand in hand with the Alberta Medical Association. With pharmaceuticals we're making many efforts to work collaboratively with other jurisdictions across Canada to have better bulk-buying rates as well as looking at best practices around generics and other pieces that we can move forward on.

In terms of acute care, just as you've mentioned, one of the projects that we're doing right now is the operational best practices work. I think that we talked about this in estimates last year, actually, where we took some of our largest facilities and partnered them up with comparable facilities – for example, the Stollery hospital here in Edmonton, the Alberta Children's hospital in Calgary, and then Sick Kids in Toronto – looking unit by unit at ways they might be able to increase outcomes and operate more efficiently.

10:50

Obviously, staff teams that are operating efficiently are not just good for the bottom line; it's good for the morale. Everyone wants to show up at work, feeling like they're working to their highest capacity and that their contributions are making a significant difference. So unit by unit the managers are working with their teams around that operational best practices work, and certainly we're seeing returns on that time investment. Again, it isn't about somebody from a tower coming in and telling you how to streamline your efficiency. It's people who do the same type of work in other units talking about some of their successes. Certainly, we're able to share things with other jurisdictions about our success as well.

Mr. Clark: Okay. Thank you.

You talked about physician compensation, and I want to pick up on that. It was a question asked earlier by Mr. Barnes, and I just want to get some absolute clarity here. Do the estimates presented in the budget assume lower physician compensation than is in the current contract, or does your budget reflect the current agreement amount? Have you assumed some savings in the budget?

Ms Hoffman: We had to work with some assumptions around savings. We're working to achieve those in collaboration with the AMA.

Mr. Clark: Is it really in collaboration? You've assumed some savings, so you've essentially gone into a negotiation saying: we're going to pay you less than your contract currently says. Is that a negotiation?

Ms Hoffman: Well, the interesting thing about the contract is that there aren't controls, really, around the supply side, right? Certainly, there are pieces in other parts of the budget that have greater predictability than these do in this budget. So the assumption around having a 10 per cent escalator every year: we're not moving forward with that assumption. We need to work with the AMA in collaboration in finding ways to – and we're not talking

about cuts here. We're talking about slowing the rate of growth, right? So this is about finding ways that we can work with them. There are pieces outside of the contract, too, that we can work on in partnership with them because, of course, the best ways to achieve good outcomes are working together at the table and finding ways to use the resources we have responsibly well into the future.

Certainly, I understand that there might be some frustration, but I don't think anyone is elated by the $10 billion deficit either.

Mr. Clark: Certainly not. I mean, I think it's an interesting question about, you know, the approach, and I suppose time will tell in terms of how effective it is. But I do find it very interesting that physicians are the only group, so far as I can tell, in the entire government of Alberta that you've taken this approach with. And while I agree – I think we do need to address that deficit – I'm curious if you're going to extend this same mindset and principle within your ministry to other contracts and look at reopening those contracts, or if there's something particularly unique about physicians that you feel needs to be targeted.

Ms Hoffman: I think one of the pieces – and, again, my appreciation to the AMA – is that they had two years left on their current contract. Looking at the numbers and at the provincial price of oil – it was a very long contract that was signed previously – it had many clauses in it that weren't sustainable. And there are ways that physicians themselves want to see the system evolve. Obviously, if one line item within a budget that is already 40 per cent of the total provincial budget grows at a faster rate than is sustainable, it's going to impact their ability to help us transform the system and to play a leadership role.

One of the pieces that they're working on, for example, is Choosing Wisely projects, where physicians themselves have talked about best practices in terms of using different types of tests, using different types of scans, and how they themselves can be a benchmark for the profession to help use the money that we have in the wisest way so that they can address some of the other pressures they have within health care.

Mr. Clark: Yeah. I think physicians certainly deserve credit for coming to the table, and I'm a big believer in the Choosing Wisely program. I don't have a huge concern with it. I guess what I would encourage you to do in your ministry directly, of course, but also in the rest of government is perhaps adopt a similar approach and mindset, take that very open, apparently collaborative approach – and I take your word that that's the approach you've taken – because I do think that there are some substantial challenges we need to deal with.

Now, just carrying on with this physician compensation discussion, is part of the discussion around how we can shift towards a more primary care model? The concern I would have is that primary care physicians, in particular, would be unduly impacted. There's a real need, I think, to move towards that preventative wellness model. Is that part of the discussion as you're working with physicians?

Ms Hoffman: Thank you for the question. I certainly appreciate the tone and the content. When I look at some communities that we're making new investments in – like High Prairie, for example, where we are opening an acute-care facility that is also the hub for the community health centre – we have physicians who are working in both worlds. They have agreed to work a certain number of shifts in the emergency department to provide that continuity of care in the community and also to help us have a team-based model and some predictability around budget.

Certainly, those types of initiatives – and it's physicians who are putting their hands up and saying that, yes, I want to move to that community and be a part of that model – have the potential to help us have a very strong acute-care system but also move some of the resources into the primary care system. And the better work they do on the primary care side, the fewer people we're going to have in the emergency department, so the fewer hours they'll be having to put in in those areas as well. Certainly, that's very positive.

Mr. Clark: Okay. I just want to move on to your business plan, page 67, 2(a), your influenza immunization performance measures, the remarkable jump you're expecting for children aged six to 23 months. I'm a huge believer in vaccinations, but I'm interested to know how you're going to get from the 34 per cent last year actual to a target of 80 per cent this year. I'd love to see that. I'm just curious how you feel we can achieve such a remarkable jump in a single year. In 20 seconds or less.

Ms Hoffman: Yeah. Thank you very much. Certainly, moving in that demographic of six to 23 months is a significant improvement. Efforts to increase influenza immunization in children six months and up, including . . .

The Chair: I apologize for the interruption. However, the time allotted for this portion of the meeting has concluded.

I would now like to invite members from government caucus to speak for the next 20 minutes. Are you wanting to share your time with the minister?

Mr. Westhead: Yes, please.

The Chair: Go ahead.

Mr. Westhead: Thank you very much. Thank you, Minister, for all your answers so far today and to the associate minister as well.

I'd like to add our thoughts for the Fort McMurray evacuees and the first responders as well.

I wanted to start off with a question that's really been front and centre in my constituency, for sure, and that's about midwives. I know we talked a little bit about that earlier in the committee; some questions have come up. But given the public attention that's been paid to that topic, you know, I think it deserves a little bit more elaboration. Minister, you recently announced that there was going to be an $11 million increase to midwifery care over the next three years. I was wondering if you can sort of walk us through where we can find that in the budget so that we can be clear about that. Also, can you expand on how this money translates into the number of spots available to Albertans who wish to access midwifery services?

Ms Payne: Yes. Thank you to the member for the question. Alberta Health Services is where the midwifery funding currently is in the budget. It's funded out of the base operating budget, particularly element 2.1, which is continuing and community care, within the budget estimates. The number of courses of care is determined by the funding model that was negotiated with Alberta Health Services and the Alberta Association of Midwives.

The 2016-2017 allocation will see 400 additional courses of care under the current model. Then with the dollars that have been allocated in this budget from the past budget year, there will be an additional 800 in 2017-2018 and an additional 1,200 spots from current numbers for 2018-2019. So by the end of those three years that will bring the expected total courses of care within Alberta to 5,174, which is a 55 per cent increase over the next three years. Perhaps what is more exciting to me as someone who strongly

believes in the value of midwifery care, as a repeat client, in fact, of midwives, is that Alberta Health Services and the Alberta Association of Midwives are working in conjunction to see how we can expand the number of courses of care within that funding envelope.

As we know, midwifery care is an area that Alberta women are very interested in. Alberta Health Services and the Alberta Association of Midwives are also working in collaboration around the allocation of those new spaces so that we're not just seeing increases within our major centres but to ensure that there is availability of midwifery services across the province, particularly targeting some more rural communities as well as allocations for First Nations mothers, just kind of ensuring that we've got an appropriate distribution across the province for where the need is for midwifery services.

11:00

Mr. Westhead: Great. Thank you very much for that. I think it's really indicative that your ministry has been listening to the needs of Albertans and increasing the courses of care. It's great to see that attention you've been paying to that topic.

Minister, in the midst of this economic climate that we find ourselves in, we've got difficult decisions to make. I'm just wondering if you can walk us through why the overall 2016 budget for the Ministry of Health has increased over the previous budget, considering the economic times we're in?

Ms Payne: Thank you for the question. Absolutely, our province is facing a challenging economic climate, but Albertans expect and deserve access to high-quality care while we're maintaining the long-term sustainable spending. So while there is a slight increase in this year, we've taken quite a number of steps within the ministry to ensure that the rate of growth we were seeing for health spending is actually coming down a little bit.

Members may recall that last year we saw a 6 per cent increase to the budget, and that had been kind of the trend for the last several years. We've been working really diligently. Some of our programs and service areas are seeing a small increase, and we're also having some decreases for specific areas such as the ministers' and deputy ministers' offices, Alberta Health Services research and education as well as in administration.

We have a consolidated budget for 2016-17 of $20.4 billion, which is a 3 per cent increase for 2016-2017 over the budget from last year. It is our belief in the ministry that this budget meets Albertans' needs while slowing the spending to a rate that's a little more sustainable for the future.

Mr. Westhead: Thank you. That sounds like a very responsible path forward.

Minister, based on the estimates in this current budget, can you outline how much the government will spend on health care every day in 2016-2017?

Ms Payne: Yes. Every day during the 2016-17 fiscal year we will be spending approximately $56 million, which works out to $2.3 million every hour, on Alberta's health care system and the various ways in which it's delivered across the province.

Mr. Westhead: Thank you.

Minister, how does the budget account for volume increases and population growth?

Ms Payne: There are increases in funding within the budget for demand-driven areas such as drugs and supplemental health benefits, allied health services, and out-of-province health care services to meet volume increases and population growth. Alberta Health Services is also receiving an increase in their base operating funding to meet the needs of Albertans.

We do have an increase in the funding for physician compensation and development. However, it is less than the anticipated increase in population growth due to negotiations that are currently under way between Alberta Health Services and the Alberta Medical Association, with the aim of managing the rate of growth in the physician services budget as well as improving the effective provision of health care to Albertans and jointly ensuring the sustainability of our health system.

Mr. Westhead: Thank you.

One of the promises of the government was an increased availability of long-term care beds. You know, these were previously underfunded and remain a much-needed commodity in the province in the treatment of Albertans with complex and serious health care needs. The goal is outlined in your business plan in key strategy 1.2 on page 65. Additionally, line 2.1 on page 128 of the government estimates indicates that there's going to be an increase to the continuing and community care funding. Minister, can you speak to us a bit about the role that the funding plays in providing care to Albertans?

Ms Payne: Yeah, absolutely. As I'm sure members from all around the province have heard, many Albertans are concerned about their ability to age in their communities, close to their family and friends. We also know that due to a lack of long-term and community care beds in our communities we're finding that more of our seniors are staying in acute-care beds when ultimately they would get the exact care that they would need and in some cases better care within community care facilities. Helping Albertans transition from hospital to care that better meets their needs is going to help to reduce some of the pressure on our emergency rooms and our EMS resources but will also allow for timely admission for those who need acute care.

Additionally, we expect that this will lead to some long-term savings in that goal of continuing to bend the cost curve and find ways to really deploy our resources in a way that ensures Albertans are getting the right care at the right time with the right health professionals.

Mr. Westhead: Thank you.

Just to follow up on that, if you can let us know: does this funding support increases for long-term care bed availability, and if not, where in the budget is that funding allocated?

Ms Payne: The government committed $365 million between 2016 and 2020 to expand access to continuing care to provide relief for families and to ease the pressure on overcrowded hospitals. This will be actioned through the development of affordable supportive living and long-term care spaces that will assist in diverting seniors with support needs from higher level of care facilities as well as from settings that maybe aren't meeting their health care needs within the community. The funding will include $165 million in 2016-17 and 2017-18 for 25 affordable supportive living initiative, or ASLI, projects which were announced in the fall of 2015. The government is in development of a new approach to add some more much-needed capacity in the coming years, with funding of $100 million in each of 2018-19 and 2019-2020.

Mr. Westhead: Thank you.

Minister, Alberta Health Services is going to receive a significant amount of money in the budget. My constituents have given me a lot of feedback about and health organizations and people in the

nonprofit sector have commended our government for protecting front-line services and workers that Albertans rely on, especially during these difficult economic times. Obviously, Albertans should be confident that they have a government that's going to protect the essential services that they rely on.

With that said, increases shouldn't just occur for the sake of increasing. I'm just wondering if you can tell us: is there a formula that you used to determine the increased funding to Alberta Health Services?

Ms Payne: Yeah, absolutely. In Budget 2016 Alberta Health Services is receiving a base operating increase of 3.4 per cent. This increase reflects government's commitment around meeting existing collective bargaining agreements as well as supporting increased demand due to population growth by opening and expanding facilities as well as any of the drivers around increased demands on the health system with the growing population. It also supports new investments in priority services to meet clinical needs and service pressures.

In addition, I would also note that there's about $536 million in cost savings that are accounted for, I guess, measured against that 3.4 per cent funding increase. Those are from things such as the operational best practices that are being developed within Alberta Health Services to make sure that we are utilizing the resources that we have in the most efficient way possible and that we also continue to deliver that really high quality of care that Albertans have come to expect and, frankly, deserve from their health care system.

Mr. Westhead: Thank you.

Just to follow up on that, can you talk to us about any strategies that you've got in place that guarantee a responsible fiscal management strategy and ensure that Albertans are getting the best value for their tax dollars?

Ms Payne: Yeah, absolutely. Budget 2016 begins the process of predictable increases to meet Albertans' needs while still slowing spending to a sustainable rate. As you may note in the budget document, the consolidated operating increase is budgeted at 3 per cent for this current fiscal year, for next year is budgeted at 2.7 per cent, with a 1.8 per cent increase for 2018-2019. In particular – and I touched on this a little bit earlier – Alberta Health Services will continue its cost-saving efforts and has committed to maintaining quality service and patient care while implementing controls to keep administrative costs low. We've also highlighted the negotiations currently under way between Alberta Health and the Alberta Medical Association, with the aim of managing the rate of growth of the physician services budget as well as improving the effective provision of health care to Albertans and jointly ensuring the sustainability of the health care system.

Another key area that we're working on is around the integration of other health care practitioners within both the primary and acute-care systems so that we can ensure, you know, that Albertans are getting the care that they need with their practitioners and that, frankly, we're utilizing the full scope of the resources available to us.

11:10

Mr. Westhead: Thank you.

We talked a little bit about physician compensation earlier today, but, you know, it is a topic that comes up a lot, especially in my constituency. Our physician salaries come out at about 23 per cent of our operating expense budget, and with the fiscal challenges our government is experiencing, Albertans are expecting our government to increase fiscal efficiency. On page 128 of the government estimates it indicates that the total operating expense for physician compensation and development has increased by about 2.6 per cent compared to the previous budget. I know you talked about this earlier, but I just wonder if there are any more things that you want you add. Has the ministry begun looking at strategies or speaking with stakeholders to ensure that physician costs are maintained at a reasonable level so that they don't affect front-line services?

Ms Payne: Yes, absolutely. Although spending on health care has increased by an average of 5.8 per cent annually over the past 20 years, Alberta hasn't always been achieving the best health outcomes compared to other provinces. Alberta's health care system must be on a solid financial footing for the future so that all Albertans have access to the right care by the right professional in the right place at the right time for the right value.

On February 25 of this year Alberta Health and the Alberta Medical Association began formal negotiations to find ways to jointly problem solve this issue around the fiscal sustainability of our province's health system while also improving quality and value. Those negotiations are still under way, with the goal to manage the rate of growth of the physician services budget, improve the effective provision of health care to Albertans, and jointly ensure the sustainability of the health care system. Any changes to the existing AMA agreement would need to be approved by both parties, and until then the existing agreement continues to be in place.

Mr. Westhead: Thank you.

I'd like to shift gears a bit to talk about mental health. It's estimated that about 1 in 5 Albertans will experience a mental health issue during their lifetime. I'm very proud of the work our government has undertaken to reduce the barriers and have proper support services in place for Albertans requiring mental health care, but when I meet with my constituents, it's obvious that there is a lot more work to be completed to limit the gaps. Budget 2016 increases support for mental health and addictions by 15.7 per cent compared to our previous budget, as heading 5 on page 128 of government estimates indicates. Can you tell us a little bit more about the strategies in place to ensure Albertans are receiving the care that they need and how the budget supports mental health and treatment services?

Ms Payne: Improving the addiction and mental health system is a high priority for this government. As members are aware, in June 2015 Premier Notley called for a comprehensive review of Alberta's addiction and mental health system by establishing the review committee. The committee engaged a number of stakeholders: front-line workers, first responders, government employees, schools, practitioners, organizations, community groups, and people with lived experience as well as researchers and municipalities.

The Valuing Mental Health report includes 32 different recommendations of varying scope and complexity. The Alberta government accepted the report on February 22 of this year and is taking immediate action to move forward on six of the recommendations, one of which is the creation of an implementation team within Alberta Health to lead work with our partners to implement the recommendations from the report.

Just to kind of comment on that for a few moments, the implementation team is going to have a really key role in ensuring that we are drawing on the experience of stakeholders across the spectrum of mental health and addiction and ensuring that we're able to best use the resources at our disposal to achieve the best outcomes that we can in mental health for Albertans.

Among the other six recommendations: introducing a child and youth mental health website to strengthen technology-based services as well as working in partnership with First Nations, Métis, and Inuit communities on a comprehensive opioid addictions plan as well as adding at least six medically supported detox beds in Lethbridge and upgrading 20 beds from social to medically supported detox in Red Deer and also opening three new social detox beds for children and youth in Calgary under support services for the Protection of Children Abusing Drugs Act. I'm pleased to say that we've actually been able to open a number of those beds already.

Valuing Mental Health builds on the foundational success of Creating Connections, which was Alberta's addiction and mental health strategy 2011-2016 report. Creating Connections brought together and integrated the work of government of Alberta initiatives in ministries, Alberta Health Services, and community partners to begin transformation of our addictions and mental health system within Alberta. As a result, more Albertans have been served by their community support teams in their communities, Albertans across the province have improved access to children's mental health services, and more Albertans with complex needs are getting the right level of intensity of care.

Our government is committed to working really closely with stakeholders, including crossministry representatives, service providers, community-based organizations, indigenous representatives, municipalities, and persons with experience, to identify and implement the remaining evaluated mental health recommendations over the next few years of our mandate as well as making sure through the work with the implementation team that the programs that we roll out and that have been rolled out are meeting the needs and that the issues of system access and navigability are addressed as we move forward.

Mr. Westhead: Thank you.

Again shifting gears a bit here, I've had some constituents refer to end-stage organ failure as a silent epidemic given the low proportion of Albertans affected by organ failure. The impact, obviously, is not silent on the families. It has a major impact. I note that about 361 transplants were performed in 2014 and about 751 Albertans remain waiting for a transplant; 457 of them require a kidney. We all know that low organ donation rates remain a public health concern both nationally and internationally. Given that transplants . . .

The Chair: I apologize for the interruption, but the time allotted for this portion of the meeting has concluded.

I would now like to invite members from the Official Opposition to speak for the next 10 minutes. Are you wanting to share your time with the minister?

Mr. Barnes: Yes, I am. Is it 10 or 20?

The Chair: It's 10.

Mr. Barnes: Okay. Thank you, Madam Chair.

If we can share again.

The Chair: Go ahead.

Mr. Barnes: Okay. I appreciate it.

I want to go back to where we left off, and that is on page 128, line item 7, the $30 million increase in human tissue and blood services. What is that sizable increase targeted at, and what does it cost the province to source blood plasma from outside Alberta?

Ms Hoffman: Thank you very much for the opportunity to answer that question and not have to respond in writing. That's great. Certainly, a substantial part of the increase is because of the exchange rate. We do purchase much of our plasma products, medications that are part of the plasma, from south of the border, and of course the exchange rate has significantly impacted that budget line item over the last year and will continue to.

The specific dollar amount: do we have that handy, Ms Wong?

Ms Wong: No, we don't.

Mr. Barnes: Could you get that for us, please?

Ms Hoffman: Yeah. We can respond with that.

Mr. Barnes: Thank you.

I want to go back to the capital plan and continuing care. One of the biggest organizational changes I see here is moving continuing care and the affordable supportive living initiative from Seniors to Health. That, of course, is mentioned on page 3 of the estimates and is reflected by the addition of line 14.1 for $43 million and again in the capital plan on page 50. Your budget also talks about the need to build 2,000 long-term care spaces. I have two questions. Does the $365 million given in the capital plan over the next five years cover the full 2,000 spaces, and is the full $365 million for public long-term care? Is there anything left for not-for-profit, for private, or community service providers?

Ms Hoffman: Thank you very much for the question. The spaces are in areas of identified need by Alberta Health and Alberta Health Services. We're looking at data like the number of individuals in alternate levels of care in hospitals. Certainly, we're moving forward. Last fall we announced our steps around moving forward with the ASLI grants that had been previously announced by the last government, how we're going to move forward with those. As you can see from the movement we're making there, there is a mix of private, not-for-profit, and public delivery.

Mr. Barnes: How long is the commitment with ASLI for?

Ms Hoffman: The announcements that were already made?

Mr. Barnes: Yeah, and going forward, the future continuation of the plan.

11:20

Ms Hoffman: Oh, we haven't made decisions around how we're going to be moving forward, but we're certainly fulfilling the announcements that we announced in the fall. Those are a significant number of beds. Actually, we were able to work with the proponents. Previous announcements had been made for lower levels of care in many of those communities, but we were able to get the applicants to increase the mix of long-term care and dementia care spaces. We will have more projects moving forward, but the number of beds being built through those announcements and the work we're doing to increase the level of care are something that I think we can all be very proud of.

Mr. Barnes: Yeah. Thank you, Minister.

For $365 million how many beds are we getting? How many beds are we building?

Ms Hoffman: We will certainly meet our 2,000 beds commitment within the allocation that we have there, and we are continuing to work with proponents to find ways during the current recession that

we can maximize those dollars to get even more, so stay tuned for future announcements.

Mr. Barnes: Okay. What are your ministry's projected construction costs per bed, including your ministry standard for facility square footage per resident and projected square-foot or square-metre costs? What is your projected construction cost per bed?

Ms Hoffman: That is an interesting way to ask a question about the main estimates because, of course, we're looking at the rolled-up numbers. There are many different ways that we'll be moving forward with the construction. Some of them are brand new beds, obviously. Some areas of the province have already had parts of facilities constructed, but they'd be happy to do conversions and meet the needs of the citizens in the area. They really vary depending on where the project is located and if we're starting from scratch or if we have demolition or if we have a conversion, so certainly they vary. Alberta Infrastructure may have been able to provide – Infrastructure already had its estimates, did they not?

Mr. Barnes: I think so. Yeah.

Ms Hoffman: Yeah. I imagine you may have asked something related there.

Mr. Barnes: So it seems that we might get the 2,000 beds for the money, or we might not.

Ms Hoffman: Oh, we will definitely get to 2,000.

Mr. Barnes: For the money, though?

Ms Hoffman: Yeah.

Mr. Barnes: The business plan on page 66 sets a long-term target of 68 per cent for patients placed in continuing care within 30 days. Currently we're at only 60 per cent. For $365 million we can only move the bar 8 per cent? I'd just like to note that the target for 2014-15 was 73 per cent, and while that target wasn't reached either, Health in that year did reach 69 per cent. So here we are with $365 million more spent, and we hope to get by 2019 not even to where we were two years ago, in 2014. Again, I'm concerned about accountability measures. What are your thoughts on improving access for Albertans?

Ms Hoffman: Thank you very much for the question, Madam Chair. Certainly, we are moving forward with increasing supply. The demand also increases. The target on that population – that population is not static. We obviously have an aging demographic; the numbers are growing at significant rates. The population health: while we have a greater life expectancy, which is fantastic, we also have a greater complexity of needs end of life. The actual net increase in the number of beds is growing significantly. So is the demand. That's one of the reasons why we put in our platform a commitment to expanding on those numbers of beds.

We also need to make sure that we have access to the beds in the right communities. We don't want to move somebody to the first available bed if it means a three-hour commute by their family to get to them. Certainly, making sure that construction happens in the right place is important.

Lowering the target temporarily from the previous target of 70 per cent will support stabilization and performance improvement as the new continuing care capacity is developed. These targets, of course, will be reviewed annually, but the demand on the system is increasing. Certainly, we would be seeing a greater increase in terms of reaching that target if we didn't have greater needs in the community, but we obviously do.

Mr. Barnes: I guess I'm concerned, though, that when a target is not reached, instead of improving, we lower the target.

Madam Chair, I would like at this point to move my amendment, please.

The Chair: Absolutely. I would request that you wait to read it until I've received a copy as well as the original for the clerk.

Mr. Barnes: Okay. I think we've provided that.

The Chair: Thank you. Go ahead.

Mr. Barnes: Thank you. I move that

> the 2016-17 main estimates of the Ministry of Health be reduced as follows:
>
> (a) for communications under reference 1.4 at page 128 by $314,000
>
> (b) for strategic corporate support under reference 1.5 at page 128 by $3,331,000
>
> (c) for policy development and strategic support under reference 1.6 at page 128 by $1,619,000
>
> so that the amount to be voted at page 127 for expense is $19,311,610,000.

Ms Hoffman: Madam Chair, if I could just ask about process. I know in the introduction you said that they would be voted on at the main estimates.

The Chair: At another time. It's not going to be dealt with today. It's just simply being entered today.

Ms Hoffman: So entered, and then debate is at the later time as well?

The Chair: At Committee of Supply.

Ms Hoffman: Okay. I have some thoughts that I'd like to share. Does that mean I have to save these?

Mr. Barnes: I think so.

The Chair: Not at this time.

Ms Hoffman: Okay. If anyone wants to ask me about any of these line items, feel free.

Mr. Barnes: Minister, in the short time that's left I'd like to ask about your matrix and your criteria. Albertans have told me time and time again that they're less concerned about it being public, community, not-for-profit than they are about the best value for Albertans. I'd like to hear a little bit about your matrix for ensuring that Albertans get the most value for their tax dollars.

Ms Hoffman: Certainly. As you know, in our election platform we talked about ending experiments in privatization. There are certainly many examples that I think we've seen in the past about making a decision.

The Chair: I apologize for the interruption; however, the time allotted for this portion of this meeting has concluded.

I would now like to invite the member from the third party opposition to speak for the next 10 minutes. Are you wanting to share your time with the minister?

Mr. Fraser: Yes, please, Madam Chair.

The Chair: Go ahead.

Mr. Fraser: Thank you. Minister, it's always great to see you. You're always really co-operative and responsive to any of the needs that I have, and I thank you and your staff. We're a hundred per cent behind you in the response to the Fort McMurray fires. You have our support in anything you need. We're happy to help in any way we can.

I just want to move on to your business plan on page 65 under Emergency Preparedness. I'll read it into the record.

> Whether it's an economic downturn, severe weather event, environmental pollution, cyber-security attack, or global health scare, society expects government to not only manage the consequences of these types of risks if they occur, but also to anticipate and handle issues before they impact government services and public health, or become catastrophic. It is essential that robust surveillance systems and comprehensive emergency response plans are in place to support resilience of the health system.

Then I want to move on again down to key strategy 1.6: "Improve the effectiveness and efficiency of emergency and ambulance services."

Minister, we've seen two events now, and the second one I'm just going to make the assumption. In the first one we saw the public health crisis around fentanyl, and we had to create a ministerial order for the ambulance services, for emergency medical technicians, kind of the first line of help before you become an advanced care paramedic. It not being in their scope to deliver naloxone, the life-saving drug for fentanyl overdose, there was a ministerial order put in place. So that's the first piece on that.

Secondly, what we have here is that there was a call out to Nova Scotia for paramedics to come and work under this latest public emergency, the provincial state of emergency in Fort McMurray, to help with what sounds like comfort centres. That would require the Alberta College of Paramedics under a ministerial order to have temporary registers, which again would put the government at risk in terms of liability.

So there are two instances there. Thinking of just basically what I've read, "Improve the effectiveness and efficiency of emergency and ambulance services," Minister, when will we see paramedics come under the Health Professions Act so that in those two instances it wouldn't require your staff up to two weeks to a month to create a ministerial order, or the college could deal with that directly in a more timely manner without having to go through a ministerial order and all of that?

11:30

Ms Hoffman: Thank you very much, Madam Chair and Mr. Fraser, for the points that you raise. Certainly, we are very grateful that the staff and the teams moved very quickly. But, yes, one of the benefits of moving the paramedics under the Health Professions Act, the HPA, is that we'll be able to work with the college more expeditiously, as we have been able to do with some of the other prescribers, for example, in the process of working with the college around that scope of practice.

There will still be times when ministerial orders are required, but certainly my intention is that this spring – I know we're well into spring right now – we'll be through that process. Certainly, we're bringing forth some amendments right now to the act, but there will be regulatory changes as well in the days to come to make sure that we are moving forward with this. As I understand, this is something that's been ongoing for many years, and I'll be happy to cross that finish line with our teams of professionals.

With regard to health professionals from across the country helping Alberta, certainly everyone wants to help Alberta. Albertans want to help first, and we're so proud of that. We've had many individuals step up through Alberta Health Services to offer to volunteer and work in those reception centres as well as throughout the province. Albertans first, obviously, will be working, but there is no shortage of needs right now. We certainly want to express our appreciation to our partners from across the country for wanting to step up and support that as well.

Mr. Fraser: Thanks, Minister.

On another front you spoke about long-term care, and again we're pleased that you're moving ahead with ASLI grants and that you're providing more long-term care beds. You know, you estimate that long-term care beds, not having many of those – you refer that to EMS hospital waits. Would you say that that is the only issue around hospital waits or that there are more?

Ms Hoffman: No, there certainly are more. One announcement that we had right after releasing the budget was around having an area for people who can be admitted for transitions at the University hospital, for example. We're able to move something that was a pilot project, that required porters to travel hundreds of metres to be able to put people in an area where they would be safe, so ambulances can get back on the road. That's just one example, but I'm happy to hear more from you. Certainly, addressing some of the backlog and alternate levels of care is one.

Mr. Fraser: Is there an estimate or line item in terms of the overall costs – I won't wait for an answer on that – in terms of hospital waits? I would say that a rough or a very modest estimate is that 24 hours a day, on average, an ambulance is waiting in the hospital. You had mentioned that it was $2.3 million a day that we spend on care in Alberta.

Ms Hoffman: An hour.

Mr. Fraser: Pardon me. An hour. So if we use that modest term and 365 days of the year, that's roughly $1.3 million and change. And that's a very modest estimate of 24 hours a day.

My colleague from the opposition has talked about the nonemergent transfers. Now, we've been trying to work on this, and I know that within the department, you know, they're trying to talk about the nonemergent transfers. Minister, I'll put it forward to you again, an opportunity. In B.C., in a unionized environment, they used a group called Hospital Transfers. They implemented that group to work with long-term care facilities, just transporting from long-term care facilities to diagnostic testing over and over again. What it did was that it reduced overall ambulance usage for nonemergent by 40 per cent. That doesn't mean that ambulances won't be used for critical care transfers or care when they're needed. But the nonemergent piece: that's 40 per cent, so that's a huge cost savings.

Then I just want to go back – I don't know what my time is. Again, as we wind down, I do also want to speak about one more thing, and that is the dispatch centre in Calgary. We know currently that the city of Calgary charges roughly $14 million a year for that service. We know that the same trained staff within Alberta Health Services can provide that service at almost 50 per cent less. That's a cost savings right there.

The consolidated dispatch is the right way to go in terms of the efficiencies that that would provide. Knowing where every single ambulance is in the province at any given time through a GPS computer-aided dispatch system, which is on every single ambulance, is not only going to save money, but it is going to save lives. I come from an area where we used to go: go to the third house on the right; it might be brown or red, depending on whether

they painted it yesterday. That's not the way to save lives, and that's not the dispatch that we need in this province. We need a dispatch centre that knows where every single ambulance is so as to provide the right care at the right time under the right practitioner. So I would encourage you to follow through with that because right there you would save close to $7 million in your upcoming budget.

Moving forward, Minister, can you also speak to how paramedics play a role in your strategic planning to save money in terms of a collaborative practice, where paramedics can also transport to alternate destinations rather than funnelling them through the very expensive emergency room doors?

Ms Hoffman: Thank you very much for the feedback and the question. Certainly, there are lots of examples of paramedics working to their full scope and in innovative ways. For example, when I think about the community paramedic model in Calgary, where a paramedic isn't just somebody who picks you up and transports you from A to B but has a very extensive skill set and can often do assessments on-site and determine where the best place is for you to move, if you need to move, or provide that initial care and screening, certainly we've seen some really great success through that project. We're expanding it in a similar fashion here in Edmonton, a made-in-Edmonton model. Certainly, the professionalism and skill sets of our health experts throughout the system are valued, and we need to be using them to their highest scope.

Mr. Fraser: Minister, just as we start to wrap up here, I know that in recent years, even under the former government, which I was a part of, emergency medical services always seem to be an afterthought. So when we think about infrastructure, when we talk about long-term care spaces where we would transport a high volume of a group of patients, wouldn't it make sense to start putting our ambulance service bays in there to provide care on scene? When we think about infrastructure, it's just something to put forward. I think there's interest with our partners around being able to do that.

Ms Hoffman: Thank you for that feedback.

Mr. Fraser: Thank you.

I'm done with my time, Madam Chair. Thank you.

The Chair: Thank you, hon. member.

I would now like to invite the independent member from the Alberta Party, Mr. Clark, to speak for the next 10 minutes. Are you wanting to share your time with the minister?

Mr. Clark: Yes, please.

The Chair: Go ahead.

Mr. Clark: Thank you. Minister, I'll carry on with the question I had previously, page 67, the immunization rates. Again, please speak to the difference between 34 per cent, last year's actual, and the target of 80 per cent. That's a remarkable jump, and I'm curious. Three questions. Why do you feel that jump is feasible? Two, how are you going to achieve it? Three, where do you get 80 per cent as a target?

Ms Hoffman: Thank you very much. AHS zones have used a large number of strategies to work towards meeting these objectives.

Continuing with the large public clinics that many of us probably have in our home constituencies as well as offering influenza immunization to children: some zones offered their parents, as they presented, the routine childhood immunizations. Obviously, getting the most health care for one visit is a really efficient use.

Using targeted postcard mail-outs: obviously, when we have registrations of when children are being born, we can help parents be ahead of the curve.

Offering immunizations in day- and child care centres, schools, and especially clinics that book appointments for parents and children: all zones have had a type of recall system set up to remind parents of the need for their eligible child to receive a second dose, for those that have had their first done as well.

National goals and targets for immunization have been adopted as provincial targets and standards. I think that the only way we're going to reach our national targets is if each jurisdiction works to achieve those. It is expected that immunization rates will increase incrementally each year based on innovative implementation by AHS.

As well, the travel clinics: any time parents are in one facility, if we can maximize the interactions we have with them, certainly it makes their lives easier but also the lives of our public officials who are working on these causes.

Mr. Clark: I mean, I'm enthusiastically supportive of all of those efforts. I think that that's really, really important.

If we look at 2(b), diphtheria, tetanus, pertussis, polio, Hib: even going from the actual of 76 per cent up to 97 per cent is a stretch of a goal. I guess what I'm just curious about: I understand that these targets come perhaps from either those national standards or global standards, and while I think that that's a laudable goal, is it realistic and an accurate reflection of what you feel is a reasonable pathway? Can we jump from 76 to 97 per cent in two years? Can we jump from 34 to 80 per cent, or are we setting targets that are, frankly, unattainable in that short period of time? Is it perhaps more accurate to have a target that is more realistic, or do you genuinely feel that we can hit these numbers?

11:40

Ms Hoffman: I'm going to draw on my background, being trained as a teacher, and I think that if you were talking about something where you're trying to acquire knowledge, moving from 67 per cent on a report card to 97 in one term might be very difficult because there's lots of background work that needs to happen. When you're talking about an immunization, we need to make sure that we have one right encounter. With the volume, it is a very aggressive target, but I think we need to aim for it and put our efforts into these areas. This connects back to public health, as was mentioned by Dr. Swann.

Mr. Clark: I want to ask how your department, how your ministry is fighting against the antivaccination, antiscience, frankly, agenda that seems to be out there. Do you have specific strategies beyond the ones you've talked about here to address that?

Ms Hoffman: The number one strategy is information – right? – knowledge acquisition and making sure that we're working with our partners in the science and medical communities to share evidence around the safety and the benefits. Certainly, I don't know parents who want their children to take unnecessary risks. Even before the seat belt law my parents always put my seat belt on me. I think it's because they knew the return on life-saving capacity. We're certainly working around information being our primary target. There are some jurisdictions where, obviously, it's still parental choice, but you have to sign saying that you've received the information before you can say no. These are some of the ideas that I think are worth pursuing as we move forward.

Mr. Clark: Okay. Good.

I'll move on to what I think, frankly, is a related topic. You've indicated that you're considering, you're reviewing naturopaths, the college of naturopathy, in light of the deeply troubling and tragic situation in Lethbridge, and there are some other cases forthcoming out there. I'm just curious if you are considering changes to the scope of practice for naturopaths, including further restrictions on pediatric practice, removing their ability to call themselves doctors, restricting their practices only to evidence-based practices, and an explicit prohibition on counselling against vaccinations. Are you considering those things?

Ms Hoffman: I'm really tempted, based on your question saying to remove the title "doctor," to call on Dr. Amrhein, who's not a medical doctor, but I won't do that. If you're sick, don't ask him for advice on how to treat a medical condition, but he sure has lots of expertise and, I think, appropriately is referred to as a doctor, as are many professionals throughout Alberta. Certainly, with what happened to Ezekiel, you know, everyone in our province is heartbroken. The parents clearly had a medical responsibility, that was not followed. The actual college came into play a few months after that fatality, and one of the questions we first asked the department was: if the college and the oversight that is offered today were in place, would the situation have been any different? I think that's where we need to start, but certainly working to make sure that naturopaths are held to a high standard, as are any people working in the health care field in any way, I think, is important. I think we need to protect the vulnerable and also ensure that there is some oversight.

Mr. Clark: There absolutely must be. You know, Dr. Amrhein is a doctor because he followed a very rigorous and evidence-based process to acquire that honorific. I'm not convinced that in every case that's actually true of naturopathy. If it's evidence-based and with scientific rigour, that's great. But I think there's a big risk when people are led to believe that they are seeking what they believe to be medical treatment when, in fact, they're given a potion of herbs. You know, in the extreme case, as we've seen with Ezekiel, we end up with death, but there are potentially, certainly, other adverse outcomes. First do no harm should be our principle in every case, and I'm not sure that that's the case.

I will ask again, then, specifically a subset of that. Is there currently an explicit prohibition against naturopaths or anyone else counselling against vaccination, and if so, do you feel that that prohibition is being enforced enthusiastically, as it should be?

Ms Hoffman: There was some advertising happening by naturopaths in the past, but after the college came into force, saying – I'm trying to remember what the pressure points were. It was that there was a way to treat immunizations without actually giving an immunization, that there was a pressure point that could be activated. The department followed up immediately with the college. The college was able to enforce with the naturopaths in question that they were in breach of their responsibilities, that they needed to stop counselling that way; otherwise, they would lose their licence through the college. Certainly, being able to hold members of a designation to account is one of the roles of a college.

If you have any other instances where there are these types of advisements happening, please let me know so that we can follow up appropriately with the college and with any of the practitioners. Certainly, there is no replacement for immunization.

Mr. Clark: How many naturopaths have lost their licence as a result of advertising that there's an alternative to vaccinations?

Ms Hoffman: I think what happened in these situations is that they stopped doing that. They actually heeded the feedback from the college, and they acted in accordance with the direction from their own college. So I'm not sure. It would probably be best to raise that question with the college itself as they're the ones who govern the naturopaths.

Mr. Clark: Okay. All right. I'll ask, then, just continuing on page 67, about 2(c), the healthy Alberta trend index. Again, you know, that's a very remarkable improvement that you're proposing, a 7 per cent improvement target from last year to this year and a 10 per cent improvement going forward thereafter. Do you feel that we have sufficient preventative health care in place in such a short period of time to achieve that outcome? And what are the consequences if we don't?

Ms Hoffman: Again, thank you for acknowledging the aspirations that we have as a department and, I'd say, as a society to make sure that we're taking care of each other and that we're doing everything we can around population health and well-being, to address having a wellness system as well as dealing with an acute-care health system.

The Chair: I apologize for the interruption. However, the allotted time for this portion of the meeting has concluded.

I would now like to invite members from the government caucus and the minister to speak for the next 10 minutes. Are you wanting to share your time?

Mr. Westhead: Yes, please.

The Chair: Go ahead.

Mr. Westhead: Thank you very much. Minister, I got cut off on our last rotation, so I just wanted to finish up on a question regarding transplants. I've personally had the privilege in the operating room of being part of transplants both on the donating end and on the receiving end, and it's an incredibly moving experience to be part of that.

After this question I'd like to hand it over to my colleague Ms Luff to ask some questions as well.

I sort of left off asking about organ donation rates remaining a public health concern. Given that transplanting patients is a fiscally efficient method compared to treatment such as dialysis, how does the nearly $200 million that is allocated to human tissue and blood services, which is found on line 7, page 128 of the estimates, support Albertans with end-stage organ failure?

Ms Payne: Thank you for the question. I had the honour not long ago of meeting with several transplant recipients and hearing their stories as well as the stories of their families and just seeing first-hand the impact that it can have. I would encourage anyone who hasn't already done so to please sign their organ donor card because it can make such a difference.

The $200 million in the 2016-17 human tissue and blood services is primarily allocated for transfusable blood products such as red blood cells, platelets, and plasma, and for plasma protein products, which include biological drugs used to treat a variety of bleeding and immune disorders.

Organ donation funds are primarily within element 9.3, community-based health services. We have funding of $2.6 million in there to support the operations of the Alberta organ and tissue donation registry as well as to reimburse living donors for expenses incurred when they donate, promoting awareness of organ and tissue donation, completing an audit to determine Alberta's

deceased organ donor potential, and educating health professionals about donation. Of course, we want to make sure that as many people as are able to donate organs and tissues do so.

Donation and transplantation is a life-saving service that, depending on the organ type, can be more cost-effective than other treatment alternatives. Data from AHS for 2015 showed that of the 382 transplants done in Alberta, we have about 650 people still waiting for a transplant. Obviously, we want to continue to improve those numbers of transplants that are taking place, and a key part of that is ensuring that as many people as possible are signed up as donors so that should they be able to donate, we are able to help connect the folks on the waiting list.

11:50

Mr. Westhead: Thank you very much.

I'd now like to hand it over to my colleague Ms Luff to ask a few more questions.

Ms Luff: Thanks.

I just have a few questions about some specific line items in the budget, mostly under ministry support services. I do notice that line item 1.4, which is communications, actually decreased from the 2015 estimates but is actually a slight increase from the actual amount that you ended up spending on that. I'm just a little bit curious whether you could expand on what types of communications and what things fall under that line item.

Ms Hoffman: Thank you very much for the question. Madam Chair, certainly, as was mentioned in the remarks shared by Ms Luff, the line item itself is below the target from last year, from the estimates that were approved. One of the reasons why we've done that is – we did hold off on filling positions, but there reaches a brink where the workload is just not sustainable or doesn't meet the needs of collective Albertans, including being able to respond to questions raised by MLAs through the correspondence unit, doing general communications support to address issues that members from all parties, of course, are validly raising and that they and Albertans deserve a response to. So that's one of the reasons why. We do feel it's necessary to address some of those gaps.

I'll take this time, because this does relate to one of the amendments that was brought forward, to say that some of those line items that are identified include our internal audit function, which, obviously, we use to make sure that there isn't fraud in the system and that we're addressing efficiencies throughout the health care system. We certainly have seen people in the past propose a 5 per cent across-the-top cut. I think one of them was named Mr. Prentice, and we all know how that turned out. I think it's important that we be strategic and thoughtful in where we're finding efficiencies.

Ms Luff: Yeah. Absolutely. I think I can say that, you know, as an MLA who often directs questions to your department, your communications office does a great job. We appreciate that.

I just want to continue on. Under line item 1.5, which is strategic corporate support, that item also is a decrease from the budget estimates of last year but an increase from the actual amount in spending. Is that where you're talking about the auditing functions, under that particular item, or are there other things there?

Ms Hoffman: Sorry. The communications line item?

Ms Luff: Strategic corporate support, line item 1.5.

Ms Hoffman: Strategic corporate support. Absolutely. The internal audit function is housed under that area of the department.

Dr. Amrhein, do you mind touching a little bit more around strategic support?

Dr. Amrhein: The rapid expansion in the number of transactions that defines the Ministry of Health suggests that we need also to expand our capacity to monitor and keep an eye on all the various transactions that move through the ministry. This is not just the payment to physicians through the fee-for-service schedules; it's also the many contracts that we have and all of the many relationships that we have through AHS with long-term care providers.

The plan is to increase our capacity for audit and oversight not because we think that people are abusing the system but because, if nothing else, there are a lot of mistakes in a very, very complicated system. So we'll be increasing, we expect, the audit and oversight capacity of the ministry. We'll be working with the provincial Auditor General, and we'll be working with the internal auditor of the government of Alberta to make sure that we are not overlapping with work being done elsewhere but that we are expanding our ability to make sure that every dollar, every expenditure through the Ministry of Health works to the best advantage of the priority set by government.

Ms Luff: Yeah. That's fantastic. I'm excited to hear the Auditor General report on that in the Public Accounts Committee.

Just moving on, there's one more line item that I just have a question about. The next one is 1.6, policy development and strategic support. I have noticed that that line item has decreased significantly from the projected 2015-16 budget. I don't know if you could speak to the reasons for that decrease or some of the policies you're developing under that line item.

Ms Hoffman: Yeah. Thank you for the question. Certainly, while there are vacancies, the team worked very diligently to cover off that workload, but the past workload levels, given the important work of any ministry – but I'm thinking particularly in our ministry – were not sustainable well into the future. So we do have a provision for honoured unionized employee agreements as well as to fill a couple of critically required positions.

Some of the work that is happening in that area, of course, includes work on meeting the Supreme Court decision around medical assistance in dying. We need to make sure that we are well aware of what's happening in the federal government, well aware of what's happened with the Supreme Court decision. We've done quite extensive consultation on that item in particular, over 10,000 Alberta responses, many focus meetings. We need to get this one right. We really do.

We have been able to find savings in that line item, however, in areas like travel, hosting, and contracts. Certainly, we take our responsibility as stewards of the public trust and the public treasury in this area and in all areas of government very seriously and want to make sure that we're doing important work that serves Albertans well and that any of the optional areas are, certainly, under a microscope.

Ms Luff: Thanks very much. I think I absolutely agree that the assisted dying item is something that's really important and something that I heard about from my constituents almost right away in being elected. It's something Albertans really care about. I absolutely agree with you that that's something that we need to get right.

I guess, shifting gears a little bit . . . [A timer sounded] Oh, I'm out of time.

The Chair: I apologize for the interruption. However, the allotted time for this portion of the meeting has expired.

I would now like to invite members from the Official Opposition to speak for the remaining time of this meeting.

Mr. Barnes: Thank you. I have a question, and then I'll turn it over to my colleague from Fort McMurray.

In addition to me wanting to help you bend the cost curve or, at the very least, not go $240 million over budget again, I'm concerned about the lack of accountability measures. Sexually transmitted infections: rates are spiking, and it looks like the performance measures have been removed from your business plan. Can you elaborate on that, please?

Ms Hoffman: Certainly, we are being very transparent. One of the reasons why we know that the rates are up publicly is because as soon as we found out that they were, we immediately worked with the chief medical officer of health to develop a strategy on how to share that information more broadly with the public and then, of course, address ways that we can do testing in a timely fashion and access the right information to help protect Albertans. Unfortunately – or fortunately – this isn't something that Alberta is experiencing alone. This is something that's happening in many jurisdictions across North America right now.

Of course, public information is important to our government and, I'd say, to Albertans to make sure that they're taking measures to protect their own health and wellness. It doesn't need to be in an annual report or in a budget for us to make sure we're doing the right thing in getting information out to the public in as timely a fashion as possible.

Mr. Barnes: Thank you. Minister, it appears to me, though, that we already had a performance measure and a strategy, just that your department wasn't committed to hitting it.

With that, I'll turn it over to my colleague.

Ms Hoffman: I feel like I need to respond to that – sorry – and just say that certainly the number has continued to rise, but this year is a particular peak. I know that the department was committed, so I just want to say that this wasn't anything to do with them. Certainly, with a new chief medical officer of health we have expertise that can help in this area.

But I do hear your concern. I just needed to defend the work that they were doing as well.

The Chair: I apologize for the interruption, but I must advise the committee that the time allotted for this item of business has concluded.

This meeting completes the committee's schedule for the consideration of the 2016-2017 main estimates for the ministries within its mandate.

Thank you to the ministers and to the staff for coming. Thank you, everyone on the committee, for being here.

This meeting is adjourned.

[The committee adjourned at 12 p.m.]

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