Legislative Assembly of Alberta

The 29th Legislature
Third Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Monday, April 10, 2017
7 p.m.

Transcript No. 29-3-5

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Standing Committee on Families and Communities

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Transcript produced by *Alberta Hansard*

Standing Committee on Families and Communities

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Ministry of Health
Hon. Sarah Hoffman, Minister
Carl Amrhein, Deputy Minister
Chad Mitchell, Acting Executive Director, Pharmaceuticals and Supplementary Health Benefits
Charlene Wong, Acting Assistant Deputy Minister, Financial and Corporate Services

7 p.m. **Monday, April 10, 2017**

[Ms Goehring in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: I would like to call the meeting to order and welcome everyone. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2018.

I'd ask that we go around the table and have all MLAs introduce themselves for the record. Minister, please introduce the officials that are joining you today at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and chair of the committee, and we'll continue, starting to my right with the deputy chair.

Mr. Smith: Mark Smith, Drayton Valley-Devon.

Mr. Yao: Tany Yao, Fort McMurray-Wood Buffalo, and my assistant, Laila Goodridge.

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

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

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

Ms Hoffman: Sarah Hoffman, the MLA for Edmonton-Glenora and also honoured to be the Deputy Premier and Minister of Health. Joining me this evening on my right is Dr. Carl Amrhein, the Deputy Minister of Health; to my left, the associate deputy minister, Andre Tremblay; as well as Charlene Wong, who is acting assistant deputy minister of financial and corporate services. Thank you all for being here.

Drever: Deborah Drever, MLA for Calgary-Bow.

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

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

Ms Jansen: Sandra Jansen, Calgary-North West.

Ms Miller: Good evening. Barb Miller, MLA, Red Deer-South.

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

Ms McKitrick: Bonsoir. Annie McKitrick, MLA, Sherwood Park.

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

The Chair: I'd like to note the following substitution for the record. Dr. Starke is here for Mr. Rodney.

Please note that the microphones are being operated by *Hansard*, and the committee proceedings are being audio- and video streamed live. Please set your cellphones and other devices to silent for the duration of the meeting.

Hon. members, the standing orders set out the process for consideration of the main estimates. Before we proceed with the consideration of 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). The speaking rotation is set out in the standing orders, and members wishing to participate must be present during the appropriate portion of the meeting.

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 rotations, with speaking times of five minutes, once again a minister and a member may combine their speaking times for a maximum total of 10 minutes. Discussion should flow through the chair at all times regardless of whether or not speaking time has been combined. Members are asked to advise the chair at the beginning of their rotation if any wish to combine their time with the minister's time. If members have questions regarding speaking times or the rotation, please feel free to send a note or speak directly with either myself or the committee clerk about this process.

A total of six hours have been scheduled to consider the estimates for 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 this break? Hearing no opposition, we will call the five-minute break at the midpoint.

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 estimates.

Ministry officials may be present and at the direction of the minister may address the committee. Ministry officials seated in the gallery, if called upon by the minister, have access to a microphone in the gallery area. We have pages available to make deliveries should any notes or other materials need to pass between staff in the gallery and the table. Members' staff may be present and seated along the committee room wall. Space permitting, opposition caucus staff may sit at the table; however, members have priority for seating at the table at all times.

If debate is exhausted prior to six hours, the ministry's estimates are deemed to have been considered for the time allotted in the schedule, and we will adjourn. Tonight we will adjourn at 10 o'clock.

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.

The vote on estimates is deferred until consideration of all ministry estimates has concluded and will occur in Committee of Supply on April 19, 2017.

If there are amendments, an amendment to the estimates cannot seek to increase the amount of the estimate being considered, change the destination of a grant, or change the destination or purpose of a subsidy. An amendment may be proposed to reduce the 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 April 19, 2017.

Amendments must be in writing and approved by Parliamentary Counsel prior to the meeting at which they are being moved. Twenty copies of amendments, including the original, must be provided at the meeting for committee members and staff.

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

Ms Hoffman: Good evening. Thank you, Madam Chair. I'm pleased to be here today to present the Health estimates for 2017-18. At the table with me, as noted, are Deputy Minister Dr. Carl Amrhein; Andre Tremblay, associate deputy minister; and Charlene Wong, acting ADM of financial and corporate services. I also have some staff here from my office as well as from Alberta Health ready to help if we require additional information. As I think you all know, Associate Minister Payne will be present for the second of our two sessions. While I'm happy to respond to questions that you have in areas where she is taking the lead, you may wish to save some of those for tomorrow afternoon if you require a more detailed response.

With that said, I'm very pleased to present the 2017-18 Health budget. I'm proud that this budget delivers on the commitments that Albertans elected us on. The most important of those must be to provide quality, reliable health care services to every Albertan. This includes acute care and also continuing care and home care, mental health supports, addictions and treatment services, and care in the community closer to home. We must do this in a financially sustainable way with prudent and predictable funding.

Albertans rely on the health system to take care of them and their loved ones when they are sick, injured, aging, or vulnerable. This budget protects that health system with key investments in home care and continuing care, mental health, family doctors and specialized physicians, and addictions treatments for Albertans and families struggling with opioid use. That investment is balanced with a move to slowing the rate of growth in health care spending and by working closely with our partners, including physicians and Alberta Health Services, to find savings in the health system without hurting the front-line staff or much-needed health services that Albertans rely on. We are not in the business of doing things to communities or to health care professionals. We work in partnership with them collaboratively, and we've gotten real results and are making life better for Albertans.

I'll start with a top line number. The consolidated Health budget for 2017-18 is $21.4 billion. That's a 3.2 per cent consolidated operating expense increase from last year's forecast. This is an increase that will meet the needs of Albertans while helping make it more sustainable in the future. For many years Alberta has been one of the highest per capita spending jurisdictions on health care in our country. This budget shows that we are taking reasonable, measured steps to slow that rate of growth. For instance, in this budget Alberta Health Services is receiving a 2.5 per cent increase to their base operating fund. Under previous governments increases for the system have been about 6 per cent. Alberta Health Services continues to find ways to operate more efficiently by comparing costs across jurisdictions both within Alberta and in other parts of the country.

Alberta doctors are also working hard to find more savings as outlined under the amending agreement between the Alberta Medical Association and Alberta Health. While our budget includes $4.8 billion for physician compensation and development, a 3 per cent increase, the amount would have been $400 million higher under the previous government's agreement. Physicians have also agreed to review their fees and consider other compensation models to bring their costs down. Doctors recognize that they must be part of the solution to ensure that Albertans' health system is sustainable well into the future. This is a fine example of what can be achieved through a respectful conversation.

Yet this budget also acknowledges the need to increase spending in certain priority areas. This includes community care and home care. From base operating funding we are giving a funding increase of $214 million to Alberta Health Services to boost community and home care. That's a 14 per cent increase, which will help us and Alberta Health Services shift the focus from hospitals and acute care to more community-based, closer to home, and even in-home care.

7:10

Our goal is for a health system that provides the right care in the right place at the right time by the right professional with the right information, helping people stay healthy and well in their home communities with the proper supports nearby. That's why we are also boosting the Alberta Health Services funding for continuing care by 4.4 per cent, or $45 million. This will ensure that seniors who cannot be at home will receive help and support in long-term care and continuing care facilities rather than in hospitals or emergency rooms. I think and I hope that this is something that we can all support. I don't think anyone would want their parent or grandparent to live in a hospital or a facility if they were able to live safely at home. In previous years many aging Albertans simply didn't have that choice. This budget will begin to change that.

Budget 2017 also sustainably increases support for addictions and mental health to $80 million from $49 million. That's a 64 per cent increase, or an extra $31 million. It includes $15 million to implement the recommendations of the Valuing Mental Health report plus millions more to address the opioid crisis. That's key since we know that 1 in 5 Albertans will experience a mental illness in his or her lifetime and that approximately 1 out of every 10 Albertans suffers from substance abuse issues. We aim to transform Alberta's addictions and mental system so that Albertans have the care they need where and when they need it. We want to diagnose and treat mental illness early, and we're going to do that by working on children and youth, people with multiple and complex needs, and those who have addictions.

Altogether, Budget 2017 includes $44 million to fight the opioid crisis. That's $30 million in new money on top of the $14 million in ongoing base funding that will continue to support naloxone distribution for those who overdose, help bring supervised consumption services to Alberta, make opioid replacement therapy more widely available through new and expanded clinics, and support more family doctors in treating patients with opioid issues. In addition to the funding in Budget 2017, we received $6 million in emergency funding from the federal government, and we matched that with $6 million more available from the 2016-17 budget. Both Minister Payne and I have met with Albertans who have lost loved ones. As Minister Payne says, I'm not sure that we'll ever feel like we're doing enough, but we are multiplying our efforts to respond to this crisis.

On the capital side these priorities on services are matched with the investment in health infrastructure. We're spending $7 million over the next three years to build a new safe house in Red Deer for children with drug and alcohol addictions. The Royal Alexandra hospital is in the process of opening 16 more beds for adults with addiction and mental health concerns.

Staying on capital, in terms of continuing care over the next four years we are spending $131 million for complex continuing care at Bridgeland in Calgary. It will have 200 beds for people with Alzheimer's, dementia, and other complex conditions. Another $364 million will be spent on a redevelopment of the Norwood long-term care facility here in Edmonton. This project will be for

350 beds, an increase of 145. Another $322 million will continue our work to build 2,000 long-term care beds and dementia care beds across the province.

Zooming out on health care capital investment more broadly, $1.2 billion will continue the work at the Calgary cancer centre; $427 million will continue health facility projects in Edson, Grande Prairie, High Prairie, Lethbridge, and Medicine Hat; $400 million will begin work on a new hospital in Edmonton; and $20 million will plan needed renovations to both the Royal Alexandra and Misericordia hospitals. That's $10 million in each hospital. This is in addition to the $65 million for the new emergency department at the Mis and $155 million for the child and adolescent mental health building at the Alex. Continuing to invest in these projects is crucial not only for the future of our health system but for the well-being of Alberta families.

In conclusion, our government strongly commits to protecting health care services that Albertans and their families rely on each and every day. This budget does that and boosts the priority areas of continuing care, mental health care, and care for those with opioid dependency issues. Budget 2017 moves Alberta forward towards more community-based care, shifting the focus from hospitals and facilities to closer to home. At the same time, we are taking steps to bring down our rate of growth, doing so carefully and responsibly with the help of our partners in health care.

To close, I would like to share an experience I had in Calgary a few months ago. I think that sometimes the scale and complexity of the Health budget can desensitize us to the real human experiences on the ground. I was at the Alberta Children's hospital. We have some extraordinary people working there, really, at the front lines of medicine to make life better for sick kids in our province. I was meeting with physicians in the genetics unit, and on my way out I met this little girl, Shannon. She was there with her grandfather, who was helping her parents have a moment away from the hospital. They were generous enough to let me sit with them and talk to them for a while. That family definitely had a tough journey ahead of them.

When I asked Shannon how she was doing, she didn't say anything. She doesn't speak. She did smile an amazing smile and gave me a huge thumbs-up. Moments like this really bring home to me the importance of universal public health care. That family was not wealthy. They were not going to be able to travel out of the province, but they could bring their little girl to receive the very best care right here in Alberta, and that's important to me.

Thank you. I'd be happy to take your questions.

The Chair: Thank you, Minister.

For the hour that follows, members of the Official Opposition and the minister may speak. Mr. Yao, 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. Yao: Twenty minutes would be nice.

The Chair: Twenty minutes?

Mr. Yao: Yes, please.

The Chair: Absolutely.

Just a few reminders. Members are asked to advise the chair at the beginning of the rotation if they wish to combine their time with the minister, and discussion should flow through the chair at all times regardless of whether or not the speaking time is combined.

Mr. Yao, do you want to combine your time with the minister?

Mr. Yao: That's fine.

The Chair: Go ahead, please.

Mr. Yao: Thank you all for being here today. Let's start off with something simple, something I'm a bit more familiar with: 2.4, page 152, ambulance services. I guess my first question is: why is ambulance broken out from everything else compared to Alberta Health Services? I notice in your accounting here that it's not even broken down by the nine departments, like your nine vice-presidents under Alberta Health Services. Why is that?

Ms Hoffman: Yeah. Thank you for the question. When we first took office, I had conversations with the Premier. As a researcher in the past working in opposition I can tell you how frustrated I was. There were only about five line items at that time. I thought that that didn't bring about a great degree of transparency. While it's very complicated, my goal is to continue to work to have further broken-down items so that we can see and align with how the government's priorities are going to be implemented by their service providers. While there still aren't as many line items as some might like, we are definitely making progress over the way things were two years ago.

Mr. Yao: Fair enough. I chose ambulance services because this is one of your feel-good items. You had a reduction here from $405 million to $402 million. Why the savings?

Ms Hoffman: This is one of the areas where we have had follow-up conversations with both Alberta Health Services and with the Health Sciences Association. I've made it very clear that we want to ensure that there are no plans that will result in a decreased number or impact of services in any way for those on the front lines. We are making sure that EMS response times to life-threatening events in metro and urban areas find a way to – while there was a small increase in that area last year, we're working to make sure that we drive those down and want to make sure that in the remote areas, where populations are less than 3,000, we also see reductions there. There is some of this that is because of amortization, but ultimately, at the end of the day, when AHS submits their budget back to us for final approval, we'll be looking to ensure that they haven't impacted front lines and the investment in that area.

Mr. Yao: Can you explain the savings in ambulance services?

Ms Hoffman: Yeah. The decrease was mainly because of the number of ambulances that were paid off through amortization – paid in full, some might say – but there were other expected savings that AHS thought that they might be able to achieve. They have to work through their budget process to be able to finalize their numbers, but definitely making sure that we have people back on the streets as quickly as possible in terms of policy will be one of the areas where we might be able to see some of that. The AHS budget comes after we've finalized our budget. I'll be watching for that, and it is definitely available publicly on their website.

Mr. Yao: I see. Your savings in EMS were solely, mainly due to ambulance infrastructure, then?

Ms Hoffman: That was one of the areas where they thought they'd be able to see some savings. They also thought that there might be other efficiencies down the road. Again, I've told them that my expectation is that we not see any reduction to the front lines. We'll make sure that they fulfill that commitment.

7:20

Mr. Yao: Yeah. If I might comment, you know, proper budgeting and forecasting for fleet and ambulance services involves a staggered approach to managing ambulances; otherwise, you run the risk of fleet depletion being condensed. Recognizing that ambulance purchasing can also take upwards of a year due to wait times and manufacturing, do you not think that this decision could affect EMS in future years?

Ms Hoffman: My direction – and AHS is accountable to me, at the end of the day, and to all Albertans – is that they need to make sure that there are no impacts to front lines. They have assured me that they'll be able to do that. We will see their final budget come forward, once the board has ratified it, for my approval following ours. But, definitely, this budget process has to complete before they can begin their formal budget process. We've also made it very clear that we want them to continue to make efforts to achieve the targets that have been outlined in terms of response times and ensure that responses, particularly in areas where it's life-threatening, see improvement.

Mr. Yao: That's fine.

Let's change subjects here. Line 1.7, page 152, the Health Advocate's office. You budgeted $1.72 million in 2015-16, but you only spent $1.335 million. For 2016-17 in this budget you stated $1.893 million. Are you on track currently? Why the decreased spending in 2015?

Ms Hoffman: Yeah. There were some vacancies that had to be filled. I'm confident that that's part of the experience from this last year. We are working to make sure that we have proper staffing levels in all these areas. The office serves, of course, as that independent investigative body which responds to the minister and works to resolve citizens' concerns. We're going to make sure that they have the resources that they require to do that in a way that respects the patients and their access to health care.

Mr. Yao: Is the mental health advocate also in this budget here, or is it a separate line item?

Ms Hoffman: It assists patients under the Mental Health Act who have been detained in hospital under one or two admissions or renewal certificates and who are subject to the community treatment orders. I'm looking for confirmation that the mental health advocate is under this line item. That position, of course, we're in the process of filling right now.

Mr. Yao: Can you briefly clarify the positions of the Health Advocate and the mental health advocate roles?

Ms Hoffman: Yeah. Definitely, that information is available on the websites. The job posting for the mental health advocate is publicly available. But, again, just to sort of summarize, it's around people who've been detained in hospital under one or two admissions or renewal certificates that are under a community treatment order who want to access their rights to get that independent support and advocacy.

The patient advocate does a lot of work. Probably some have come through casework from constituency offices. I know a number of them have been in areas that I've been engaged with, those files. In a lot of situations it's working as an effective mediator between the system and the patient and/or family member.

Mr. Yao: Is it fair to say that they do things like help measure the situation, monitor, assess the system, help identify safe practices, make recommendations, things like that?

Ms Hoffman: Yeah, and I'll be happy to pull it off the website and table it in the House. We have the role of the Mental Health Patient Advocate if you would like me to read that for you at this point.

Mr. Yao: No. That's fine.

Ms Hoffman: It is publicly available. Are you requesting that I table this information?

Mr. Yao: Not at this time. Thank you very much.

Why don't we go to 10.2, page 153, the Health Quality Council of Alberta, another area where you're increasing from $6.6 million to $7.1 million, an increase of $575,000. That's not substantial. You know, this is reasonable, right? You have references to quality permeating your business plan as well as your mission statements, all your mandates, and your department objectives. Is that fair to say? You believe in quality?

Ms Hoffman: Quality is one of the key pillars of health care. That's why we have a Health Quality Council. Some of the initiatives that they're engaged in currently include developing frameworks for system improvement; partnering with others to deliver quality and safe courses of educational programs aimed at helping Albertans deliver understanding and navigate the health care system; working with patient-family safety advisory panels; and delivering patient experience awards and surveys in primary care, emergency departments, supportive living, and long-term care facilities. Those are just a few.

Mr. Yao: Yeah. How effectively do they work with our health provider, AHS?

Ms Hoffman: There are two separate organizations, but they do both report to me and at times share information. The emergency wait times are one good example or some of the different reports that they've done around continuing care. Definitely, I think the information feeds one into the other, and they have a good working relationship. But they're both ultimately responsible to report to the minister.

Mr. Yao: If you can confirm this for me or not, again, that their mandate is also to measure, to monitor, to assess health quality, to help identify safe practices, make recommendations, assist in implementing and evaluation, and survey Albertans on experiences. Is it fair to say that that's what their mandate is? Did I get all that?

Ms Hoffman: Again, it's all on their website, but you did touch on a few of the points. I'll read out the mandate for the HQCA, which is set forth in the Health Quality Council of Alberta Act, so it's very detailed. It's to "promote and improve patient safety [overall] and health service quality on a province-wide basis." Those are the highest, overarching, but there is an act that relates specifically to them, and that's available through Queen's Printer as well.

Mr. Yao: Okay. I'll also go to line 2, page 152, Alberta Health Services. You're increasing it from $11 billion and change to $12 billion and change. You know, in 2009 the total budget of the amalgamated health regions was $8 billion and involved approximately 90,000 employees. Can you tell us how many employees AHS has today?

Ms Hoffman: The total in all aspects of Health is approximately 100,000. Now, that's if you look at each of the health regions and Alberta Health as a whole, and that is, of course, with some rounding. But it is, arguably, the fourth-largest employer. Maybe AH isn't included. I think that's 100,000 for AHS, actually. I believe it's the fourth-largest employer in Canada, with an operating budget comparable to the Department of National Defence. This is a large, very sophisticated organization that we require to serve many Albertans.

Mr. Yao: Uh-huh. So this increase of approximately $295 million to AHS's budget: how many of those were for front-line staff?

Ms Hoffman: I'll be happy to pull these details, and while we do that, I'll just also reiterate that when you asked previously about HQCA and AHS integration, there are regular meetings between the leads administratively for AHS: Dr. Verna Yiu, the head of the Health Quality Council, and Mr. Andrew Neuner as well as my deputy minister, Dr. Carl Amrhein. Those three do have regular meetings as well.

Okay. In terms of additional staff for AHS there are 900 clinical staff that have been added – those would definitely be front lines – and clinical support, which, again, are front-line staff that do support the work that's happening on the front lines. That's 600, so many of those would be working, arguably, in acute care as well.

Mr. Yao: Thank you.

You brought up the Health Quality Council and the advocate's office. Let's reflect this with AHS. AHS has departments under titles such as finance, and you have community engagement. In the department of safe, healthy environments you have a division called performance measures and quality. In primary health care you have the department of integration and innovation. In quality and health care improvement you have performance improvement, patient safety, process improvement, clinical quality metrics. Another department is called patient concerns and relations. Another one is called engagement and patient experience. In research innovation analytics you have the department of engagement, education, and capacity. In EMS you have the department of quality and patient safety.

You have consultants, managers, directors, and other various position titles under process improvement, under quality, under system performance and improvement, under compliance, under quality management planning and performance, under quality initiatives and program support. And for all of these, you also have them in the north, south, central, Edmonton, and Calgary regions. You also have some other major departments called community engagement and communications, another one called community engagement, another one called integrated quality management, another called operational best practices and safe, healthy environments.

How do all these various departments, with positions numbering in the hundreds, work with our various advocate offices and arm's-length corporations like the Health Quality Council?

Ms Hoffman: Yeah. Thank you very much for your question. As I mentioned, being one of the fourth-largest employers in the country, with a budget similar to the Department of National Defence, when you look at how many commanding generals there are within the military, there are far more than we have in terms of senior leadership positions in AHS. I know that the two organizations are different and have different mandates, but I think it's important to look at the scope and scale of a service that, arguably, over 4 million Albertans are shareholders in, and that's the public health care system. There are over a hundred hospitals, and we also have long-term care facilities.

7:30

I regularly hear people in parts of the province, including in the north, say that they appreciate having accountability and points of check-in close to their communities. Sometimes they don't feel that they're close enough, still. Definitely, I feel that regularly there are people pushing for more of a regional voice and opportunities rather than less, as the question was asked about the different zones within the province.

Mr. Yao: Thank you.

Ms Hoffman: I think we're sharing time, so I have a little bit more.

Mr. Yao: If you're saying something that we can work with.

Ms Hoffman: Your point is taken, but we are sharing time, so I'd appreciate it if that was reflected in the way that we're conducting ourselves this evening.

That being said, AHS definitely is making sure that they're being accountable through their budget process, and that does begin once the provincial budget is finalized. Their meetings are public, and their budget is definitely posted on the website.

These questions are actually about the agency of Alberta Health Services as opposed to the government of Alberta. I'd be very happy to talk about the ministry itself if there are questions about that and areas of focus there as well.

Mr. Yao: I suppose I'm wondering: has this government done its due diligence in analyzing and reviewing the departments in Health since being elected, and have you found any overlap or repetition in these areas? You're increasing the budget for the Health Quality Council. You're looking at increased money for the Health Advocate's office. Again, if we go through Alberta Health Services, as an example, which provides a lot of these services, they have multiple departments upon departments that provide these very same things. Have you done your due diligence?

Ms Hoffman: Yes, we believe we have. One of the reasons why we have these areas of focus – and if you're proposing that any of them be cut to the service operator, I'd be happy to pass along your comments.

For example, operational best practices was one that was highlighted. Over $80 million in the last fiscal year was realized by having areas and leadership focus specifically on those initiatives. Again, that's doing the comparison between jurisdictions to make sure that they're aligned in a way that reflects the most efficient and respectful workplace for the workers and outcomes for the patients.

I believe that there is always room for continued improvement, but I do think that the areas of quality, safety, and patient access are areas that we probably shouldn't be looking at reducing. But if you have proposals that you'd like me to pass along to the service provider that would be within their budget allocation and how they align those resources, I'd be more than happy to pass those along.

Mr. Yao: Let's change subjects a little bit here. We'll come back to that.

Line 3, page 152, physician compensation and development: you've increased the budget here by approximately $339 million. Just to clarify, this is total compensation for doctors that is broken out separate from Alberta Health budgets?

Ms Hoffman: Yeah. So within the budget Alberta Health Services has a small piece that would be paid through hospitals, but the vast

majority of billing that happens in the province is through the Ministry of Health, not through AHS, and that would be physicians on both alternative remuneration programs as well as fee-for-service programs. So physician compensation is a line item that we've made sure is broken out and clearly identified. I'd be happy to go into further detail if you request.

Mr. Yao: Okay. Boy, physicians are sure compensated well – just to clarify, they get a paycheque from you, and they have things like their group medical insurance on that paycheque, CPP, EI, their tax in general – but then I also hear about the overhead that physicians are expected to pay. Does that mean that there are lines on their paycheques that indicate how much they can spend on furniture or leasing expenditures? How does the compensation model work for these physicians?

Ms Hoffman: In most areas, for example, if you were to picture a typical community health clinic, they are privately owned. They're a business that's set up, and they have a code that they can bill for based on procedures that are done.

Sometimes patients have complained about having notes up in some of the physician rooms saying: no more than one medical issue per appointment. Part of the motivation is that in the past they were paid for medical appointments almost exclusively, so we're working at having other ways of having what we call blended capitation – and it's being worked on through the agreement – so that there is some certainty based on the patient roster. You're not just billing specifically for individual services or procedures. You're offered some more stability, but it's also looking at interactions being more focused around patient care, less time in the waiting room and more time actually working with a front-line health provider.

Mr. Yao: Did you say that the cheques aren't payable directly to the physicians? Did you say that they're paid to businesses?

Ms Hoffman: Most physicians are incorporated. They, in turn, are a small business, and they are billing that way, so there's no EI, CPP, et cetera. They're not an employee. They're a business, a contractor essentially, that bills the province.

Mr. Yao: Well, corporations and businesses: Alberta must be the outlier in this, right? We're the only province paying money to this effect?

Ms Hoffman: No.

Mr. Yao: Is this country-wide?

Ms Hoffman: It's very common. We are working on having a number of ARPs and different compensation models. Alberta has one of the lowest levels of doctors who work in more of an employee environment. We have the highest level of fee-for-service. But the vast majority, if not all jurisdictions, have a fee-for-service model of some type, and almost all would not be employees but, rather, contractors or businesses.

Mr. Yao: What is this minister's definition of private health care?

Ms Hoffman: Would you care to elaborate on your question? Like, what is it that you're asking me to answer here?

Mr. Yao: Well, in the Legislature you're always implying that we're going to impose private health care on people. So, again, I'm asking you for your definition of what private health care is.

Ms Hoffman: Sure. Okay. So there are publicly funded services, and there's the Canada Health Act. The Canada Health Act outlines what cannot have two-tiered health care, what's part of the inclusive public system. [A timer sounded]

The Chair: Keep going.

Ms Hoffman: Thank you.

In terms of universal access and public accessibility, having a single-payer system, having a universally accessible system, not enabling queue-jumping for those who can pay premiums, those types of things: this is Canada's public health care system, that Alberta is happy to implement and make accessible to Albertans.

Mr. Yao: Okay. There are increases across the board in this section. In the fall a deal was reached that looked at a change in the way that doctors were paid – you've skirted that – namely, beginning to step towards a blended fee-for-service payment structure. What percentage of doctors are paid in a fee-for-service way? Is it most?

Ms Hoffman: Yeah. I think we're over 90 per cent, still, about 90 per cent currently in the province of Alberta.

Mr. Yao: Could you table the billing structure for physicians?

Ms Hoffman: The amending agreement is a public document that was posted on both the government website and the Alberta Medical Association website. The agreement that they have with the people of Alberta is a public document, and you'd certainly be able to access that from either our website or theirs.

Mr. Yao: Okay. Beginning with this agreement, are you moving towards salary pay for physicians? Is that your objective?

Ms Hoffman: We had brought about a pilot project that physicians brought forward to the table as well, and that's the blended capitation model. It does have recognition that we obviously want to ensure that physicians are working to a large scope, that they have a substantial patient roster, and that they're recognizing exceptional care in terms of: not all patients can be seen in five minutes and have a good health outcome. Some require more intensive.

For example, I was recently at the clinic in Calgary for refugees. Most of their initial appointments are over an hour because you're working with a whole family. You're setting them up with supports from within the community. That type of more intense engagement with patients deserves recognition through compensation.

There are a number of PCNs that have stepped up and clinics that have put forward applications to be part of the blended capitation model, and this is something that is taking place through this amending agreement. We're going to continue to monitor the outcomes and see if there are ways to continue to expand that in the best interests of patients and a stable budget.

Mr. Yao: Radiologists. Now, if I understand it correctly, they're another contractor that actually has to pay for equipment that is actually a little bit more expensive than your regular general practitioner.

Ms Hoffman: Uh-huh.

Mr. Yao: Didn't you make an announcement here recently, to be implemented at the end of March, that they were getting cut? How can they get cut when so few others did?

Ms Hoffman: Okay. So there are working groups through the AMA and the department that have been working on the fee-for-service components within each of the specialization areas. The AMA, their representative, has been at these tables and very vocal in collaborating to make sure that we get the most efficiency and equity within the health bundle for patients.

Some of the technology that existed, for example, 20 years ago in terms of radiation therapy is far more sophisticated and efficient now. With a rate of compensation where maybe you could only do two procedures in an hour 20 years ago, now you can do far more procedures per hour because of the increased technology and equipment. So they were able to negotiate a reduction to some of the fee-for-service for some of those components while ensuring that compensation is fair.

Overall, the average reduction was about 9.5 per cent across the board for fee-for-service pieces. That, again, was done in partnership. We're now negotiating with clinics as well.

7:40

Mr. Yao: Line 3.4, page 152, physician development: can you explain that, please?

Ms Hoffman: Yeah. I am confident that this is a piece within the amending agreement, again, where they've put some money back on the table. There are some pieces that they are making themselves be accountable to, to make sure that they reach their budget targets, where they're putting their money where their mouth is. In terms of physician development it includes funding for initiatives like the rural physician action plan, RPAP, that I imagine you've heard of; the Alberta international medical graduate program; the postgraduate medical education program; the internationally educated health professionals program, a lot of physicians who are educated in other countries; and the medical residents service allowance.

The forecast in the last year was lower due to a surplus in the workforce plan, the postgraduate medical education program, and international education health program grants due to prior-year surpluses, so we were able to realize those.

Mr. Yao: What about 3.3, specialist physician remuneration? Can you explain, actually, all of these bullet points: primary care physician remuneration, program support as well as physician benefits? Like, under 3, physician compensation and development, what is the definition of each of these program areas?

Ms Hoffman: Why don't I begin by asking my department to expand on that in some detail.

Dr. Amrhein: If we start at the top, we break down compensation for physicians into three large buckets. The first bucket is primary care physicians. Primary care physicians are generally thought of as family physicians as well as some pediatricians, and you can see the total number there in the estimates. Specialists are all of those who deliver their services primarily through the AHS hospitals: surgeons, psychiatrists, cardiologists, pediatricians, and the list goes on. In addition to the payments under the fee-for-service schedule or the schedule of medical benefits, then there are additional benefits paid to the physicians such as assistance with their liability insurance. Those are the three main ways in which we flow funds to various physicians, and most of the physicians, if not all of them, who are not full-time employees of AHS, in fact, have professional corporations.

The schedule of medical benefits is a stipulated amount of money defined by government, and that's the entirety of what the physician is entitled to receive. Within that stipulated number – for example, administering a flu shot I think is $9.40 – a component of that is to cover the overhead. There are thousands and thousands of fees based on a whole wide range of medical benefits. We split them into primary care and specialists because the specialists primarily work through or with AHS, and the primary care physicians are organized into clinics, usually family physician clinics, and those clinics then are organized into primary care networks at the level of 80 per cent.

Mr. Yao: What about physician benefits here?

Dr. Amrhein: Physician benefits include things like subsidies to their liability insurance, education programs, and things of that sort.

Mr. Yao: I suppose why I'm wondering that is that if physicians are private contractors, aren't they responsible for a lot of these things that would be under, say, physician benefits, as an example? Wouldn't they be responsible for their own insurances and that sort of thing?

Ms Hoffman: I'll start on this one, and then if you'd like to supplement.

Most of this was agreed to, maybe all of it, actually, through negotiations with the Alberta Medical Association. For example, some of the payments for their insurance or things that they've negotiated through their process of negotiations – I want to say bargaining, but it's an association, so it's a slightly different model. These are negotiated services that have taken place over many contracts.

Did you want to expand on that at all, Dr. Amrhein?

Dr. Amrhein: Some of the more specialized benefits are initiatives negotiated to work with the physicians to help improve their practice. For example, toward optimized practice, TOP, is a program where we work with the various physician groups to help them develop their office procedures, their digital record capacity, their electronic health records, and electronic medical records. We also work in partnership with the Alberta Medical Association to help our physicians maintain their professional competencies through a series of physician continuing education programs that are a requirement for their continued licensure. So it's not benefits like health insurance and dentist and the kind of benefits that an employer would provide. These are benefits in addition to their stipulated payment under the fee-for-service program that we have agreed with the Alberta Medical Association are in the interests of the health system to help maintain the cutting-edge standards of our physician community.

Mr. Yao: All right. Let's change subject again. Another feel-good story: line 2.8 on page 152, IT. You have a reduction there. Good job. Can you explain how you found these cost savings?

Ms Hoffman: Yes. Like everyone, if there are opportunities to find ways to realize savings and maximize investments, we are always interested in pursuing opportunities where we can do that, particularly while ensuring that we protect patient access.

In terms of the information technology line item, it refers to service to design, develop, and implement as well as maintain effective management support systems. The decrease is mainly due to the changing of the mix of projects expected in 2017-18. We anticipate fewer capital projects and more operational projects, resulting in that lower amortization of the expenses. Like you said, this is good news. We're moving ahead with the creation of the AHS province-wide clinical information system, starting with the Edmonton zone, where I'm pretty sure the hospital software – if I

was born yet, I was definitely in elementary school when it was implemented. With more up-to-date technologies come more efficiencies as well.

Mr. Yao: You have IT on lines 2.8 and 12. Why do you have it separated like that?

Ms Hoffman: Thank you very much. Line 2.8 is the AHS line item for technology, and 12 is the department line item. Just like the Ministry of Education would have IT needs and then school districts would also have IT needs, it's the same with Alberta Health Services.

Mr. Yao: So we technically have two different groups working with IT.

Ms Hoffman: We have the government and we have Alberta Health Services, Alberta Health Services being the service provider, but it is consolidated. Line items 12 and 2.8 are consolidated. We try to outline their budget pieces within our own budget, but it's two separate organizations.

Mr. Yao: I see. When I worked municipally, I know that IT was the fastest growing in all municipal governments right across North America for the last 10 years. I assume it's the same with other levels of government as well as corporations. Computers are supposed to make work easier for us with information at our fingertips. What efficiencies have taken place in AHS as a result of these computers?

Ms Hoffman: I'll touch on a couple of them on the AHS side. One, of course, is making sure that Netcare is available to access things. Like, patients regularly, when they go in for procedures, need to have blood work done. If you can have that blood work done ahead of time in clinic and that information can be accessed, which it can, through Netcare, then you're certainly saving on having to do that blood work twice, once for the primary care physician and the other time for the acute-care physician. So it is not just about efficiencies in terms of paperwork but also in terms of ensuring that the valuable resources that we require, that information, including labs, diagnostics, is shareable. We do have more work to do on sharing that information to make sure that it's fully integrated, but we're definitely on the right track.

7:50

Mr. Yao: In your business plan you mention that "a single source of information will support team-based, integrated care." I assume we don't have a single source of information. How many software programs within AHS and Health must our medical professionals navigate in order to get the information that they require?

Ms Hoffman: Part of it depends on where they're working in the province. One of the reasons why we're working towards that integrated health record, or one system, is so that it doesn't matter which part of the province you're in, so that information can be shared seamlessly. I'm sure that if you had a health incident when you were in Edmonton, you'd want the information from home to be accessible, and that definitely is what health care providers also want to be able to make the best information-based decision – that's that right information piece – to guide the right care. The electronic health record is a concept that supports the integration of all these various systems, and there are several throughout the province.

Currently information relevant to an individual's medical history is fragmented across various organizations. That's something that you may have seen in the Health Quality Council report around Greg Price, where definitely there were a number of areas where the system didn't follow him. His individual encounters with the health system weren't connected. They weren't available to him – that's for sure – and they weren't available to a number of the different specialists he saw. Making sure that that system is integrated and that information is accessible we think has the potential to save lives, and it definitely has the potential to save resources within health care as well.

Mr. Yao: So you don't know how many software programs are out there that professionals have to navigate? I have heard a number.

Ms Hoffman: Well, when you ask about AHS specifically, AHS, of course . . .

Mr. Yao: And Health.

Ms Hoffman: Yes, I understand that. AHS has a significant number of different programs. I'll ask the deputy if he wants to speak to that.

In Health we have far fewer because it's the department, of course, and most of it is run through Service Alberta through procurement, in that way. In terms of the different zones within the province – of course, AHS is one consolidated region now – we have a historical legacy of many of the different jurisdictions having purchased their own software throughout the many years, that were inherited. So it's about aligning those.

Dr. Amrhein, if you'd like to elaborate.

Dr. Amrhein: It depends on what kind of physician you happen to be. If you're a family physician, then you have an electronic health record system, so that's one. You have the billing system through which you submit your activity; that would be two. Then if you access Netcare, within Netcare you would have access to the database on drugs, diagnostic imaging, diagnostic labs, and hospital discharge records. If you're a family physician, you can live with three health-related systems, one of them a compilation of several. If you're a hospital specialist, then you might have to interface with more systems than that.

We are trying with the AHS clinical information system to reduce that to a single integrated system. Now, these would not be medical systems per se, but AHS in total, as a legacy of their creation out of several regions, has over 1,300 software systems of various types, large and small. The estimate is that when the AHS CIS, which would be chosen sometime in the next several months, is up and running, that number would plummet to a few dozen. Now, even a few dozen might sound like a large number, but we have some . . .

Mr. Yao: It's better than 1,300.

Dr. Amrhein: It's better than 1,300.

We have some very, very highly specialized software systems like environmental pollutants, that would not be accessed by anyone other than the public health officials. The immunization system would be accessed rarely by a hospital specialist and often by a family physician. The goal is not to go to a single system. That would be very expensive and probably an inferior solution. The goal is for a family physician to have one stop to go to, Netcare, and for most hospital physicians to have two stops, the Alberta clinical information system and Netcare. These, then, would be in addition to their business systems. We do have some really good examples of the value of this integration. If you're interested in some of those examples, I can go into some detail.

Mr. Yao: Sorry; I'm still trying to grasp that number.

Well, let's go to your business plan – shall we? – under IT and the personal health record. Under expense you have $594 million budgeted for IT in 2017-18. Last year there was $632 million budgeted. Can you explain this cost reduction?

Ms Hoffman: Yes, and while we grab those specific details, I hope you'll understand why that 1,300 number wasn't top of mind. It's definitely a significant one, and there are many areas in other parts of the country that are still fragmented. While there are challenges with coming to one integrated system, it does give us opportunities to have increased sharing of information as well as expertise and economies of scale, to be frank, as well. Those are very helpful.

Mr. Yao: To that effect, are you actually working with any other provinces to find a solution that everyone could use, recognizing that every province is probably dealing with the same issue?

Ms Hoffman: Which one are you referring to at this moment?

Mr. Yao: Software like a health record tracking system and whatnot.

Ms Hoffman: Oh, definitely. We meet regularly. We have federal-provincial-territorial meetings, and items including technology systems, ITS, are regularly on the agenda. Every department has partners in other jurisdictions that they work with on a regular basis, too. Definitely, we have certain partners that we work with more frequently, some of the reasons being that we share resources and touch points. For example, Newfoundland and Nunavut regularly send their patients here for general services, and we talk a lot about some of the initiatives in those areas in particular. [A timer sounded]

Mr. Yao: That's 40 minutes already? You have to make your comments shorter.

Ms Hoffman: Pardon me? We can divide our time and go back and . . .

Mr. Yao: As 40 minutes have gone by, we can – so you guys can't find that last question? We can move on.

Ms Hoffman: The deputy can respond to that.

Dr. Amrhein: One of the largest, most important projects that has been part of the 13 different conversations with the federal ministry is a project through a Canadian organization called Canada Health Infoway. Canada Health Infoway has been up and running for quite some time. Alberta is one of the leaders. In fact, Alberta has the most sophisticated set of digital health information systems in all of Canada. The Canada Health Infoway project has embarked on a nation-wide project to build a single drug-information system. The value of a single drug-information system, especially in a province like Alberta, where we have military and where we have First Nations health systems, is that it will allow us for the first time to have a single platform to track the use of all prescription drugs. That's one example.

We also have ongoing discussions with other provinces around how they are engaging in projects like the personal health record, that we are in the process of getting ready to turn on. We also keep in close touch with the other provinces that use a shared set of electronic health record, electronic medical records, operated by the Telus Corporation. Those are three or four specific examples.

Mr. Yao: All right. Let's change the subject yet again. Page 153, line 11: out-of-province health care services, seeing as we're talking federally here, increased from $150 million and change to $167 million and change, an increase of almost $17 million. What measures are in place to ensure that this budget is respected?

Ms Hoffman: Regularly there are questions that come up to MLAs about people wanting to access procedures or treatments outside the province. One area, of course, is gender confirmation surgery. The only place in Canada that provides that service is in Montreal. There is a budget that's set for that and a certain number that are done every year.

There's also a committee that oversees applications for out of province, an out-of-province appeal committee that reviews that. It's definitely based on the science. We don't want people to lose opportunities for treatments that are scientifically proven, that there's evidence for. They'll back them up if they're not available in the province. It's important that we work to make that opportunity available, ideally, within Canada, but there are times when that isn't even possible.

Mr. Yao: I see.

Besides robbing us of transfer payments – the rest of the provinces, that is – we also suffer from uncollected fees from interprovincial and international patients. This is something that is not discussed often. For example, during the peak years of the boom cycle around Fort McMurray the Northern Lights hospital experienced approximately a million dollars a year in losses from uncollected fees due to patients being from out of province. They would work in Fort McMurray, they would fly home, but they didn't pay their health services anywhere, as an example. Also, we have Americans that come up, maybe use the services, and their insurance companies won't pay because it's Canada, so I've heard. Could you clarify a lot of these comments for me, and can you confirm any numbers for how much our province in general loses in these uncollected fees?

8:00

Ms Hoffman: We'll look for that. I don't think there's a line item for it in the estimates as, of course, we're not budgeting to have uncollected fees. We do move forward in a way that is legal. But we also have it on the other side. I regularly have Albertans reach out. One actually came through the MLA for Olds-Didsbury-Three Hills. They were Albertans who received care in British Columbia and had an ambulance fee that was associated with that, and they didn't have out-of-province travel insurance for those services. This is very difficult to get right now. It isn't a line item within our budget because we don't budget for it. But it does work both ways, too, hon. member.

Mr. Yao: But it is something that we must account for. Certainly, I do remember having to fly out of province to pick up patients because it was cheaper for Alberta Health to fly a team there to pick up that patient than it was to pay these out-of-province fees or international fees if they were from the States.

Mr. Cyr: Page 161, other revenue.

Mr. Yao: Page 161, under other revenue?

Ms Hoffman: Sorry. I couldn't hear that. Would you say that again?

Mr. Yao: Page 161, other revenue. Is that where that would be?

Ms Hoffman: We'll look for the breakdown of what that line item specifically is.

Mr. Yao: I'm just relying on my accountant friend over here.

We can come back to this, certainly.

Ms Hoffman: I don't know if it's revenue that we anticipate, to be honest, because this is for extraordinary instances. It's not like we're planning on having uncollected fees. But we'll look for that breakdown.

Mr. Yao: No, but it is a relevant one, and it is a relevant conversation to have with other provinces as well.

Ms Hoffman: We do regularly have that around the specific instances. But, again, we're not going to anticipate that we're going to have patients who don't have proper travel insurance and those types of things, right?

Mr. Yao: No one anticipates that.

Do you think you could come back with that number later on and table those?

Ms Hoffman: If we can, I will share it at the beginning of estimates tomorrow.

Mr. Yao: All right. You know, a missing portion also that's been explained to me by health care professionals is regarding uninsured persons, people that use our system using fraudulent means like using their friend's health care card if they're a visitor from out of town or even a family member who is not from here. The same thing: do you have a rough estimate of this loss? The thing about this thing is that if we do start to work on a single health file, this can actually be detrimental to someone's health. If their brother or someone decides to use our health care system and then some different health facts get put onto their record, this could have detrimental effects to the actual person who is the holder of that health care card. What are your thoughts on that, and how do you anticipate us resolving this issue?

Ms Hoffman: Yeah. There definitely is academic research on anticipated costs based on audits in some jurisdictions. Obviously, if we knew that somebody was behaving in a way that was fraudulent, we would ensure that we followed up appropriately with the proper authorities to make sure that that was done.

Service Alberta has a project for the new integrated program just like the issuance of driver's licence is done through Service Alberta. I am definitely looking for us to continually find ways to reduce the fraud within the system. The Auditor General has definitely recommended some components such as having a photo ID component. Feel free to raise that with my colleague in Service Alberta. This would definitely be a costly investment, but if this is something that I think has some – I think we should at least have a fulsome discussion about that. Another piece they talked about was an expiry date on your Alberta health care card because currently there isn't one.

Mr. Yao: Yeah. I'd have to agree with your associate that photo ID is necessary. There are a lot of people that could use some identification. They don't have passports; they don't have drivers' licences. Photograph ID would help. Also, we could possibly track our social services through this very same number. We could align a lot of different ministries with these benefits. Does this also blend in with your key strategy related to enhancing data sharing and enabling robust health analytics under a single health record?

Ms Hoffman: Yes. We're very interested in doing that. That's that right information piece. With precision medicine nowadays treatments can be so fine-tuned. Obviously, having a full understanding of the health record of that patient enables the health care providers to make the very best decisions if it is to inform that.

Mr. Yao: You bet. A single system with photo ID, complete with identification proper, would certainly help. It would certainly reduce a lot of the potential for loss. I'd be disappointed if you guys couldn't come up with that number if we recognize that. In Fort McMurray alone Northern Lights hospital had a million dollars a year annually in losses from this. I'd like to know what the combined total is of all of our hospitals because we're talking multimillions of dollars annually.

Ms Hoffman: We'll do our best to share that with you tomorrow afternoon.

Mr. Yao: Broken down by region would certainly be nice.

Let's change it one more time. Let's go to 2.9, page 152. Support services increased from $1.5 billion to $1.6 billion. What does support services include, and what will this increase cover?

Ms Hoffman: Support services are services that support the health service delivery such as building maintenance, including utilities; materials management, including purchasing, centralized warehousing distribution, and sterilization; housekeeping, laundry, and food services; patient registration and admissions/discharge; and emergency preparedness. These are a number of the different pieces that are aligned in that area. Utility expenses as well as lower than expected savings and efficiencies were some of the reasons why the forecast had to be greater than originally budgeted.

Mr. Yao: You mentioned laundry and linen. That's always been a hot topic over the years, not just while you and I have been here as elected officials but far previous to that.

Ms Hoffman: Yeah.

Mr. Yao: I'm assuming that's under AHS, line 2? Or is it indeed under this support services? Where exactly are laundry services?

Ms Hoffman: Laundry would be under support services as well, 2.9.

Mr. Yao: These are the departments that are under AHS?

Ms Hoffman: Well, and people, the staff that are working in these different areas, yes. It could be in a hospital, for example.

Mr. Yao: In the summer of 2016 you were adamant about bringing an end to the privatization of AHS's laundry services, and that stance was often repeated throughout the fall. However, on March 22 during debate in the House on Bill 4 you mentioned "maintaining the current mix of private and public laundry service delivery in the province."

Ms Hoffman: Yeah.

Mr. Yao: Have you changed your mind and course on the delivery of laundry services?

Ms Hoffman: I think, actually, that people conflated the change that was proposed for the north zone with what's currently happening in Edmonton and Calgary. Many years ago there were situations of labour unrest when Edmonton and Calgary were privatized, and they are currently privatized. There was a proposal under the former government that they would privatize further in the north and central and, eventually, south zones as well. What we've done is that we've put a halt to that further privatization and

outsourcing, so we're asking that the current mix at the current level be maintained.

Mr. Yao: So in Edmonton and Calgary they're privatized, but I noticed under AHS that there's one executive director and five directors for linen services. What is the pay level of these people?

Ms Hoffman: They're AHS employees?

Mr. Yao: Yes.

Ms Hoffman: Again, AHS is a separate organization. This is about the Health allocation. It would be like asking for the pay level of individual principals within a school system from the Education minister. That's information that we do not have direct access to, and it's not in this budget. It's in the AHS budget process, which takes place after government has set their budget.

Mr. Yao: Again, that's why I was asking earlier about why AHS is such a broad number, why it wasn't broken down further. I mean, how do you expect me to come up with a shadow budget, good minister, if we don't have a lot of the details regarding Health?

Ms Hoffman: I'm sure you could ask your colleague the Member for Vermilion-Lloydminster about the work that he did in creating a shadow budget or the Member for Calgary-Elbow. Certainly, it has been done, and they might have advice for you on how you might do that.

Mr. Yao: Yeah, but when we're dealing with health, there are a lot of personal issues here that could affect people and lives. I think health is one of those things where we need more details. You'd never be able to get me to provide a shadow budget unless you were able to provide me with some more information.

Ms Hoffman: AHS does post their budgets annually on their website. They are open, public documents. You can see last year's budget, and then once they've finalized their budget for this year, that'll be public as well.

Mr. Yao: Okay. That's the sunshine list you're referring to?

Ms Hoffman: No. That's the budget.

Mr. Yao: Okay. Let's look at line 8, page 153, allied health services. You've increased this budget by $10 million approximately. Can you explain what allied health services is? Where is this money going to go?

8:10

Ms Hoffman: Allied health services are insured additional benefits provided to Albertans by optometrists, podiatrists, and dentists, oral surgeons. These services typically have a maximum annual limit. The oral maxillofacial device program is also included in this line item.

Mr. Yao: On your website under allied health there is a link to a Harlem Shake video. How much money and resources went to producing that?

Ms Hoffman: Sorry. Which video was this?

Mr. Yao: A Harlem Shake video. It's a dance craze.

Ms Hoffman: Yeah, I'm familiar with what the dance is. I actually spend a lot of time in junior highs. I imagine that's a question – if it's already been completed, it would have been something from last year. So if you wanted to ask about that at Public Accounts, that definitely would be an item from last year's budget if it has already been completed.

Mr. Yao: Do you think it was a responsible use of taxpayer dollars?

Ms Hoffman: I think that there are many different ways to ensure morale and front-line engagement. Sometimes there are different types of public awareness campaigns. I am not familiar with the specific video that you're referring to. Was it Alberta Health or Alberta Health Services again?

Mr. Yao: It was under allied health services.

Ms Hoffman: The video? It might have been under the healthy schools program, so it could have been one of the initiatives around daily physical activity and wellness. So if it's students, it could have been connected to that. Again, without having the video in front of me, I'm just trying to guess how it could have potentially fit into these estimates.

Mr. Yao: Fair enough.

You mentioned morale. You know, certainly, AHS has issues with morale and whatnot, and this was probably just a harmless excuse to incorporate some enjoyment into the lives of those medical professionals. Do you think that was part of the total rewards department, and can you explain this department? Total rewards has 36 positions in it within AHS.

Ms Hoffman: Is this an AHS line item again?

Mr. Yao: Absolutely.

Ms Hoffman: Yeah. Again, we're here to debate the Health estimates, and AHS has a public process for debating their estimates. Again, it would be like asking the Minister of Seniors and Housing about a specific line item to do with a specific seniors' lodge in a community through their housing management body. So I can't speak to that level of detail as that is not my budget; that's the Alberta Health Services budget.

Mr. Yao: Why didn't you invite them along to this, recognizing that they have over $12 billion in the budget?

Ms Hoffman: Just like we don't ask other service providers to come and defend the budget of the government of Alberta, we wouldn't invite the 61 school boards to be part of the Education estimates. They have a public process. They have a way to be accountable to the citizens who rely on them, and AHS does the same. This is about the Alberta Health budget. Just like Transportation wouldn't ask people who do road maintenance or those contractors to come to their estimates.

Mr. Yao: I see.

Ms Hoffman: Yeah.

Mr. Yao: The department of culture, transformation, and innovation. That sounds impressive, too. That's under AHS as well, so you won't answer any questions on the department of culture, transformation, and innovation? That's another 43 staff.

Ms Hoffman: That again isn't a line item within our budget or a component within Alberta Health. That's one of the programs that would be under Alberta Health Services. If you have questions that you would like me to pass along, I would be happy to do that.

Mr. Yao: Yeah, certainly. All these questions I would like to pass on. I thought that perhaps you and your team of professionals might have the answers for some of this.

Ms Hoffman: Because it's Alberta Health Services and not Alberta Health and we're debating the Alberta Health estimates, again, it's . . .

Mr. Yao: Ultimately, these are all under the auspices of yourself, which is money that you allocate in the budget towards that. It is under the line item of Alberta Health Services.

The Chair: Hon. member, I would just like to reiterate that we are here today to talk about the estimates that we have outlined. If you could make your references to the budget line items that we're here to discuss, that would be greatly appreciated.

Mr. Yao: Again, this is all under line item 2 on page 152, albeit it's not broken down the way that the general public who's watching right now would prefer, but certainly these are departments within Alberta Health Services. If the minister is not familiar with them, you can just simply say so.

Ms Hoffman: I think that is trying to ascribe something to this discussion which is not necessarily becoming of the process that we have in place. The government of Alberta sets their budget, which we're in the process of. Then our budget is passed along to Alberta Health Services. They develop their own budget from within that process as well as a business plan. That comes back to my office for approval after their recommendations. So there are accountability measures that come back to the government of Alberta.

With the specific questions you're asking about with regard to one of the service providers, I'd be happy to share those with the service provider. If you'd like to put them in writing, I'd be very happy to facilitate that process.

Mr. Yao: Is AHS's business plan online?

Ms Hoffman: Yes.

Mr. Yao: All right. Line 13, page 153, cancer research and prevention investment. Year over year it's under budget. I am a conservative. I can't fault you for being under budget, but in the last couple of years you've been approximately $2 million under budget. Jeez, a young fellow I knew passed away because he had to raise money for his own health treatment stateside. That could have been covered with this money. Why didn't you consider that at least?

Ms Hoffman: I believe that this is cancer prevention investment. Yeah. I'm assuming you're talking about Bo?

Mr. Yao: Absolutely.

Ms Hoffman: Again, I believe there was an application for out-of-province – of course, everybody's hearts are with his widow and with the community as they continue to feel that loss. I'm glad that at the end of the day physicians sometimes make exemptions to provide services like the treatment that I believe he did receive in the end. Part of this is around making sure that there's evidence that the treatments are going to work. It's heartbreaking when they don't, but we do need to make sure that these decisions are made by physicians, including the physician out-of-province appeal board, that reviews these types of decisions.

In terms of this fund, again, that's . . .

The Chair: Thank you.

For the next 20 minutes I would like to invite Dr. Starke, from the third-party opposition, and the minister to speak. Dr. Starke, are you wanting to combine your time with the minister?

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

Ms Hoffman: Yes, please.

The Chair: Go ahead.

Dr. Starke: Well, thank you, Chair, and thank you, Minister and to all the members of the Health ministry team that are here tonight. I want to thank you for being here. I also want you to know that Albertans are very appreciative of the work that they receive from the health care system. Health and universal health care, in my view, are fundamentally Canadian values that date back, you know, basically to the 1960s. Now, some of you will remember that there was a survey back in 2004 by the CBC on the greatest Canadians of all time. Like all lists, we can debate all kinds of reasons why people should or shouldn't be on those lists, but it should be noted that Tommy Douglas was voted number 1 by Canadians. I would suggest that that ranking reflects not only an admiration of Mr. Douglas but a strong belief in Canadian medicare.

That said, Chair, medicare and indeed our health care system writ large is not a sacred cow. We must be prepared to examine all aspects critically – I am familiar already with examining cows – and be prepared to adjust with the times. My questions both tonight and tomorrow are intended to try to help find those cost savings which, I would argue, we must find in order to protect both the universality and the quality of our health care.

Minister, I'm going to shift gears a little bit. I know that we've been talking largely about operational expenses, but I want to talk about the Health department's capital plan. If I could ask you to take a look at page 46 in the fiscal plan document, in which the four-year capital plan is outlined for your department. I'm going to start with a question that I've asked other ministers as well – curiously, I'm getting different answers from different ministries – and that is: why have we shifted from a five-year time horizon to a four-year time horizon on the capital plan?

Ms Hoffman: I'm just trying to google how many stomachs a cow has.

Dr. Starke: Four.

Ms Hoffman: I thought it was four. I was questioning myself there. Definitely, I'll tell you that when I came into this role and saw some of the areas of growth moving the fastest – they were physician compensation, hospitals, and pharmaceuticals – I felt like those stomachs were doing more than their fair share some years, so I just wanted to start by saying thank you for your analogy.

In terms of the four years versus the five years, I think that there are some questions that are still to be considered about some of the funding models that might be moving forward. I think that there are some policy decisions that might have to be made. We are in the second year of the five-year plan as well, so that would mean that it would end in year 4 because last year was the first year of our five-year plan.

Dr. Starke: Yeah. That's somewhat similar to a response that I got from another minister. I guess what I would just say is that I would really encourage you to continue a program of four- or five-year – land on one – planning for capital. I know that that's very common in municipalities. In fact, they quite often have 10-year capital

plans. I think that's helpful in terms of giving some indication of a direction for what is being planned.

In looking at these documents, Minister, the comparison of this year's four-year capital plan to last year's five-year capital plan: this year's capital plan is actually over a billion dollars additional, more than last year's capital plan. It's, like, a 29 per cent increase. You know, that's pretty significant especially when we're considering a shorter time frame. So I guess my question to you would be: what's the anticipated impact of adding an additional 29 per cent of capital spending to the operational budget of the department?

8:20

Ms Hoffman: Thank you very much for the question. Some of the capital spending is about replacing outdated, deferred maintenance, obviously areas that have been neglected for a significant period of time. Regularly in the House I hear about more areas that we haven't even been able to fund with this increased allocation.

Some of it is about making sure that we bring projects online like the needed Calgary cancer hospital, which definitely will have some increased capacity but is more than needed. For example, right now because of the physical limitations of the space, staff have regularly expanded the hours to include evenings and weekends because there are just too many patients for the space that's available. So some of the service that's being done in those exceptional hours would be moved to more traditional hours for the patients and for the families. Rather than having to have your chemotherapy at 9 p.m., you would be able to go during the day. I think that some of that will be shifted in those ways.

There are some areas where we're going to certainly see some increased costs. It's because there's increased need in those health care areas, Grande Prairie hospital, for example, being one.

Dr. Starke: Just on that note, though, the capacity issues: I guess what I'm wondering is that for some of the capacity issues – first of all, I'm asking whether those are occurring primarily in urban hospitals, or is it widely spread across the province?

The second question I would have is that during the course of the rural health study we found that there's quite a bit of underutilized capacity in rural hospitals that are in fairly close proximity to urban areas. I'm wondering: what has been done or what initiatives have been pursued in terms of making better use of existing infrastructure in rural hospitals that may, you know, take some of the stress off urban hospitals?

Ms Hoffman: Yeah. I think a great example of that was when in Red Deer we had a flood in some of the operating rooms, and a lot of those surgeries were moved to Stettler, Consort, definitely a bit of a drive that people from Stettler are used to doing into Red Deer but not necessarily the other way round.

Dr. Starke: Same distance.

Ms Hoffman: It is the same distance, yeah.

Definitely, the patients who were in need of those treatments appreciated communities stepping up and increasing access, and so did the people in Red Deer, who, of course, were working to get those spaces back online as quickly as possible.

In terms of the spread of some of the investment, as you asked about, through some of the other areas; for example, the Edson health care centre in this year's budget. We recently opened it, but we have $14 million in this upcoming budget that needs to be added to that. Fort McMurray resident care centre, $43 million; Grande Prairie, $353 million . . .

Dr. Starke: Actually, Minister, I have the list in front of me here.

Ms Hoffman: Okay. That was just my way of responding to the question around cost.

Dr. Starke: I appreciate that.

I guess parenthetically I'll also mention – and I hope, Chair, that this isn't getting too far down a rabbit hole – that I know one of the concerns that has been expressed to me by some of our physicians that practise in Vermilion, and that is that currently the therapeutic guideline for a positive FIT test is to have a colonoscopy done within three months. Right now the wait time, at least in Edmonton, is some eight months, which is outside of clinical guidelines. But if folks are prepared to make a drive out to Vermilion, we'll scope your colon in six weeks. And the good thing is you can park for free and close to the door. After 24 hours of GoLytely you want to be really close to the door. Just a possible suggestion. That's something that the doctors actually suggested to me, so I'll pass that on to you.

Ms Hoffman: That's great. We do have a project that's under way now where Hinton is receiving colonoscopy patients, for example, as well. That's something that I regularly encourage people to say to their health practitioner, that they're willing to travel a bit further if it gets them in faster.

Dr. Starke: Great. I think that's very helpful.

Back to our capital list. If we look at 2017 versus 2016, there were 30 projects on last year's list. Five of those projects have dropped off, I'm going to assume, because they've been completed although in one case I was a little bit curious. Red Deer obstetrical, which was on last year's list, is now completely off. Now, has that been fully funded already? Like, I know the announcement was made.

Ms Hoffman: Yeah. It opened, actually. We had the official opening today.

Dr. Starke: Okay. Great. That's fantastic. I congratulate you on doing that.

The other four projects are ones that you'd be familiar with, but we've also added eight new projects, and those eight new projects carry a forecasted cost of $1.2 billion for the next four years. Minister, how many of those new projects were on the unfunded project list last year?

Ms Hoffman: The list formerly known as the sunshine list?

Dr. Starke: Sure.

Ms Hoffman: Yeah. I think that was the list. While my officials flip to the appropriate pages for me, I'll say that the unfunded list is certainly – and in my time on the school board I came to know this, too. Sometimes, based on pressures and demands, either the state of a building that might be unsafe for future use or massive increases in population or demands, those lists do need to change, but they're definitely there for a guide. I think that that list, as we present it outward – assuming that all conditions stay standard, we would like to see those projects move forward as quickly as possible.

They are just looking for the page, but we haven't found it quite yet. We'll try to get it in the next couple of minutes.

Dr. Starke: Sure. Well, I've taken a look at it, Minister. From my looking at it – and I could be wrong. I stand to be corrected here. Of the projects that were on the unfunded list – you had six projects on the unfunded list last year – one of them, the Norwood long-term

care facility, was moved from unfunded to funded. I actually want to say to you and to your Finance minister: thank you for doing an unfunded projects list. I think that it's very helpful.

But of the six projects that were unfunded last year, three are still on the unfunded list: the in-patient unit fit-outs at the Chinook regional in Lethbridge; the medical device reprocessing upgrade, which was renamed the provincial sterile instrument reprocessing upgrade; and the Peter Lougheed Centre emergency department and laboratory. Those three projects are still on the unfunded list.

But two of the unfunded projects have disappeared entirely, one being the A.R. Schrag renovations at Alberta Hospital in Edmonton and the second the Cross Cancer Institute, phase one, in Edmonton as well. Are they still on the department's radar? Is there any reason – should we be concerned that they've dropped off the unfunded list? Does that mean that they are now at a lower priority level? What's the status on those projects?

Ms Hoffman: I'll provide a little bit of rationale for both of them and thank you. Your analysis appears to be consistent with the analysis of the folks here at the table. In terms of the Schrag renovations at Alberta Hospital, the child and adolescent mental health bed project was considered a higher priority by AHS in this year's submission. It's still something that is in the awareness, but we did move forward with that project at the Royal Alex this year consistent with the AHS submission that was amended.

In terms of the Cross, the project was lowered on the priority list due to other operational and system pressures with regard to re-evaluation of Edmonton's service plan. That is under way. AHS wants to make sure, expanding cancer care, that they've considered the variety of projects that will be available, including the new Edmonton hospital, when they're trying to decide where to align some of these resources in the next year. But I expect that we'll continue to see investments in mental health for youth as well as in the Cross Cancer Institute or other cancer care.

Dr. Starke: Yeah. On that topic, Minister, one thing I was just going to mention is that you'd mentioned a little bit earlier about expansion of services for mental illness and addictions treatment, especially with our opioid crisis that we're dealing with. Just as an aside, the Thorpe recovery centre, which was opened in Lloydminster in 2012 with a lot of Alberta government funding involved, is presently operating at less than capacity. We have four Alberta government funded beds. There are a number of empty beds in that facility that would be ready, and there would be no additional capital expenditure. The staff is there. So that's, you know, something that you and the associate minister may want to take a look at. I certainly would encourage you to do so.

Ms Hoffman: Thank you.

Dr. Starke: I want to have a little closer look at, drill down on the eight facilities that jumped up onto the funded list. You know, I'm not going to quibble with the facilities. I think that for the most part these are all worthy sorts of things to have on a wish list. I note that most of them are very heavily back-loaded in the out-years of the funding, that there's very little funding for the next couple of years but a lot of funding for the last two years. Depending on how construction and planning goes, we may achieve that, or we may not.

But one that jumped out at me was the provincial pharmacy central drug production and distribution centre. Are we in the business of making drugs now?

Ms Hoffman: One of my colleagues asked a very similar question at Treasury Board. This is more around aligning and packaging and then later distributing these drugs, but it is around consolidating them, I believe.

I'll ask my deputy to expand on that a little further.

8:30

Dr. Amrhein: There are an increasing number of pharmaceutical compounds that need to be created right away. They're mixtures. They don't come premade, prepackaged. We have a number of pharmacy facilities in some of our hospitals that are struggling to maintain accreditation, so the idea is to aggregate these into two large hubs for the major urban areas. We don't make the drugs, but sometimes you have to mix things together to make the drug that is then administered. This is particularly the case in medical assistance in dying, for example.

The other area where we are struggling to maintain accreditation is that some of the more modern pharmacy dispensing equipment is large and digitally controlled, and we simply cannot fit it into the spaces that are still available in some of our older facilities. So we're not getting into the manufacturing business, but maybe call it partial assembly.

Dr. Starke: But you are compounding. You are compounding . . .

Dr. Amrhein: Yes.

Dr. Starke: . . . and there are a whole slew of regulations and requirements for compounding. I mean, they apply also to the veterinary profession.

Dr. Amrhein: Yes.

Dr. Starke: I would caution the government that this is something that you want to proceed with with a great deal of caution and that you should have a long discussion with the RxA, with the pharmacists, before proceeding down this road. In getting into the compounding business or the compounding job – I know it happens in hospitals – getting into it on a larger scale, you know, I urge caution on this because there are private companies that are doing this already. They have the accreditation. They have the staff that are already providing that particular function. You know, we've got $40 million allocated for the capital side of this, so I'm taking that it's a new facility, and that's a significant investment. I didn't recall any conversation about us as a province getting involved in this activity. I think it is something that should be raised with the general public before we go down this road.

Dr. Amrhein: It's not a massive expansion of what we're already doing. It's handled by AHS in conversations with the pharmacy regulators and the pharmacy associations.

Dr. Starke: Okay. Well, we'll leave that one for right now.

Minister, last year we had a discussion about primary care networks. Primary care networks, as you know, when they work ideally, provide team-based, multidisciplinary care to hopefully provide a lot of preventative care and keep people out of the hospital as opposed to dealing with them after they've become ill. It's also critically important for the management of chronic and long-term disease situations and patients that are coping with those. I'm unable to find, though, in the budget what the estimated expenditure on PCNs is for the coming year and how it compares to 2016-17.

Ms Hoffman: I have that here.

Dr. Starke: Great. Am I missing it? Is it a specific line item, or is it embedded?

Ms Hoffman: I think it's listed here in this description. Here we go. It's under primary health care, item 6.2. The funding in that line item is to support the PCNs, the structure which allows the physicians who decide to work in collaboration with AHS and other health care providers to harness the collective strengths of members of the team to work together in that area. Last year we saw 41 per cent, from $60 million to $71.78 million, and it's because last year we accessed some of the reserves that were set aside. This year we don't have those reserves to access.

Dr. Starke: Okay. Sorry, Minister. You're saying line item 6.2, primary health care?

Ms Hoffman: Yeah.

Dr. Starke: So it's embedded within that number, I take it, because the number I've got in 6.2 is, for this year at least, $244 million.

Ms Hoffman: Can you explain, if you don't mind, Charlene, what the yellow-shaded number is, indeed. This is Charlene Wong, acting ADM.

Dr. Starke: Thank you.

Ms Wong: Yeah. Sorry. I don't have the exact number for PCNs. I can pull that out for you for tomorrow.

Dr. Starke: Please.

Ms Wong: But the numbers the minister was referring to, the $60 million and the $71 million, are the changes from the budgeted forecast to the forecast to the estimate, not the total allocations. So just to clarify that. But I will get that number for you.

Dr. Starke: Okay. Well, thanks.

Minister, as you know, there's been a fair bit of discussion about the functioning of PCNs since they were instituted a few years back. You know, I think that most Albertans share the concern about the variability with which they provide service. Some PCNs are doing a fabulous job; with some PCNs it's a little bit questionable. I guess the real question is accountability back to the taxpayer. On the capitation formula, you know, they're providing services. The $62 per patient rostered is going to the PCN, but we don't necessarily get a lot of feedback. What measures are being looked at in order to improve the measurement and the metrics and the accountability for PCNs in the province?

Ms Hoffman: Yes. I'll start and then, again, welcome my deputy to supplement.

One of the first things we did was launch a review, a financial review. You're right: not only does the level of service vary across the province, but the level of head-nodding expenditures varies as well throughout the province. We worked to ensure that we were very clear that things like buying presents for the staff are not appropriate expenditures for money that's supposed to be supplementary to these Health expenditures, that buying alcohol for your Christmas party is not an appropriate expenditure for the $62 per patient per year that is intended for these services.

Part of it was beginning to look at how money was currently being used, and of course as we move forward, I have to really commend the PCN leads on being partners and stepping up to the table with us. I know it's not easy to give money back that's been in reserve, but they know that equity was not alive and well under the former model, and they want to work with us as partners in developing the new model. They're at the table, and we are doing a review of the funding model as we speak.

The Chair: Thank you.

Dr. Starke: Thank you.

The Chair: For the next 20 minutes I would now like to invite Dr. Swann, leader of the Alberta Liberal Party, and the minister to speak. Dr. Swann, did you want to combine your time with the minister?

Dr. Swann: Yes. Thanks.

The Chair: Go ahead.

Dr. Swann: Thank you, Minister, and thank you, staff, for spending an evening with us. This is the largest budget item in our government, and there are clearly lots of pressures and demands on that. I appreciate many of the changes that have been initiated by the government and also have a number of questions, particularly around some issues that would save a tremendous amount of money, and that relates to prevention programs.

It's hard to understand where the prevention money is going and what kind of value we're getting for the current prevention programs. I assume lines 2.6 and 7 relate to the prevention programs for population and public health. I wonder if you could give us some more detail about how that money is being spent and what kinds of results we're getting.

Ms Hoffman: Yeah. Thank you very much for the question. Wellness is built into our work, whether it's enhancing primary care, as was just asked about by the last member, or the cancer plan or the multiple sclerosis strategy that's in play.

In addition, specific wellness programs are supported through the community-based health service budget. For example, Alberta Health funds Communities ChooseWell. This free-of-charge program supports Alberta communities to increase their participation in local actions to improve health and wellness; increase local capacity to assess plans; implement, evaluate, and sustain activities; and so forth. This program currently reaches 260 Alberta communities, including many rural, remote, and indigenous communities. That's one example as well as the healthy school community wellness fund.

I could go on, but I respect that you may have other questions and want to probe into other areas.

Dr. Swann: Well, I guess I'm equally interested in what kinds of outcomes you feel you're getting, what kinds of impacts those programs are having and if they're valid or not, and whether we will ever see an increase beyond 3 per cent of our Health budget.

Ms Hoffman: Well, I think a lot of that depends on a number of factors, of course moving care from acute closer to community, and I would argue that the investments that we're making in mental health and addictions as well as investments that we're making in home care are investments in wellness. I think that these are areas that we've often dealt with in a reactionary nature in the past, that if somebody falls and breaks their hip, we take them to hospital. Now we're working in a much more integrated way to provide home-care support, OT assessments, physio assessments, and through partner ministries like Seniors, through the seniors' home adaptation and repair program. I would argue that in some ways that's an investment in wellness as well.

I think your point is well taken. There are many areas, and the transition will not happen immediately, but I think that the investments we've made in programs like smoking cessation and

cancer prevention are paying dividends. Sometimes it takes a few fiscal years to realize them, though.

8:40

Dr. Swann: Thank you.

Can you help me distinguish between line item 2.6, then, and line item 7?

Ms Hoffman: I'm sure we will.

Dr. Amrhein: My turn?

Ms Hoffman: Sure. If you want to. Okay.

Dr. Amrhein: Line 2.6 is the population and public health program, and that includes a lot of things like immunizations. Line 2.7 . . .

Dr. Swann: No, no. Not line 2.7 but line 7, which is also population and public health, on page 153. You've budgeted $93 million under line 7, but under line 2.6 the population and public health budget is $328 million.

The Chair: I'd just like to remind the members that are joining the minister at the table to introduce themselves before speaking.

Ms Hoffman: Dr. Amrhein will supplement his previous response.

The Chair: Thank you.

Dr. Amrhein: I believe that line 2.6 is part of the AHS section, and line 7 is the office of the chief medical officer of health. That's the biggest piece.

Dr. Swann: Okay. Thank you.

With respect to mental health and addiction, 5.2, I know that it's under AHS, but I guess that since you were the minister and still have involvement with mental health and addiction issues, can we expect a progress report on Valuing Mental Health?

Ms Hoffman: Yes, sir. Stay tuned.

Dr. Swann: What a question, eh?

Ms Hoffman: I love that question, and I anticipated it was coming.

I wish that we had had it out earlier than today, but we are working diligently to make sure that it does happen, so please do stay tuned.

Dr. Swann: With respect to the mental health and addictions program it's clear that we're increasing our spending, that we're focusing on some of the right areas with substitute opioid therapy, with increasing numbers of practitioners providing supports. It's not clear to me that the hours of operation are compatible with many of the folks that need it, and I wonder why we're still charging for Suboxone for those people who obviously will be deterred from getting onto substitute therapy if we're not paying for it, especially with the rural areas outside Calgary and Edmonton that are still lacking access to addictions therapy. Those are a couple of questions. Do you expect these issues to change in the next while with this new funding?

Ms Hoffman: I think we are making great progress. I think that Dr. Theman wrote a piece publicly, that was published today, I believe, that talks about the role and responsibility of physicians in working with their patients. Community-based health services are seeing their funding more than double this year, so it will be going to $72 million from the $35 million previously. That includes $14 million for the opioid response initiative to ensure that uninsured Albertans have access to that opioid replacement therapy. You mentioned methadone and Suboxone access, receiving medication in a day program. If you can continue to be living at home and highly functioning, you shouldn't have to be admitted to have access to that medication. We're looking at ways that we can increase access through potential coverage there.

As well, other areas – sorry; these are other areas of community-based health that don't relate to addictions and mental health. I will ask my associate to supplement on that when she's here tomorrow as well.

Dr. Swann: Very good. Along with that, she could comment on a provincial strategy?

Ms Hoffman: She can.

Dr. Swann: Thank you.

With respect to the mental health advocate, it's clear to me that the mental health advocate has a critical role for assessing violations of people's basic rights or perceived violations of their independent human rights. If they are incarcerated against their will and there are extenuating circumstances or if they're harmed in care, it's the role of the mental health advocate to champion their rights. According to her last annual report she was not able to do a single – maybe one – formal review of a complaint, out of many complaints that she receives, simply because of a lack of staff.

I guess I'm concerned, number one, that the mental health advocate doesn't have the resources. Number two, I wonder if the minister would consider what we've done with the child advocate, which is to make the advocate independent of the minister so that she could be free to comment clearly on issues that are obviously sensitive, both politically sensitive and financially sensitive.

Ms Hoffman: Thank you very much for the questions. You're right that everyone deserves to feel like they have somebody in their corner, particularly when people feel like they have no rights. Whether it's something that family did thinking that it was in their best interests or not, they have a right to have somebody advocate in due course.

To date the advocate's office has opened 1,255 new client files. They also have resource and education files which generated 3,920 responses to requests for information. They have had over 7,000 contacts with Albertans. They did conduct 401 investigations. I'm not sure of the timeline for that.

Dr. Swann: The mental health advocate or the health advocate, you're talking about?

Ms Hoffman: This is the mental health advocate.

Dr. Swann: Okay.

Ms Hoffman: So 401 investigations into complaints about detention, rights, treatment, and care as well as providing 113 educational services, including presentations to agencies out in the community.

We are working to make sure that we are able to fill that position. We want to make sure we get the right fit. This is a really important area. We thank Deb Prowse for the work that she's done in this area while she's straddled both worlds, but we do think it's important to ensure that this position is filled so that somebody can work in this area in a dedicated way.

Dr. Swann: I just want to emphasize that the previous mental health advocate was not able to do a single, or maybe one, formal review. All of these reviews that were done on complaints were

done by telephone. Formal complaints involve a visit, a hearing of both sides, an attempt to adjudicate what, if any, rights were violated. A mental health advocate that can't do more than one formal investigation a year is seriously underfunded, understaffed, and is not performing due diligence on some of the concerns. I hope, in fact, that some of the new mental health funding might be considering expanding the mental health advocate's staffing, which is simply inadequate if we're serious about advocating for patients' rights.

Ms Hoffman: I'm going to have to follow up tomorrow about the number, around the one, because I definitely don't think we've had 400 years of mental health advocates. They have done 401 investigations, so I'll make sure that we get a breakdown of the different years.

Dr. Swann: Those are not formal. Formal investigations, unfortunately, require a visit. That's where you actually get to the heart of the matter. So thank you for looking into that.

Ms Hoffman: Sure. Happy to.

Dr. Swann: Primary care, as some of my colleagues have indicated, is not fulfilling it's mandate, the primary care networks. I guess I would ask you to consider some of the proposals over the last few years that involve the Canterbury approach to reforming the primary care system that has medical pathways identified that ensure that for everyone in the primary care system, both in and out of the medical system, their roles are more clearly defined to require physicians to fulfill their role. Without some of this reform, I'm afraid that we're not going to see primary care networks fulfill their mandate and improve patient care outcomes, and we're going to continue to see the excessive referrals instead of handling them in-house.

The pathway system that was modelled in New Zealand transformed their primary care, and it has been discussed now for at least four or five years in Alberta. I'm hoping that the minister will provide some leadership for this much-needed reform within primary care networks.

Ms Hoffman: Yeah. Thank you very much for your questions. Definitely the Canterbury model is something that the PCNs themselves as well as with support from the department and from AHS have been pursuing. At the very first PCN conference I attended after becoming Health minister, so over a year ago, they had a specific plenary dedicated just to that specific topic. It is definitely an initiative that has been well considered, and we'll continue to find ways to adapt pieces of it and integrate it within Alberta's system.

8:50

There are a number of complementary health services, of course. They are not in all parts of the province. One of the guiding values that we've asked the PCN leads as they work with us on the evolution of the primary care networks to keep as a guiding factor is that equity piece, so making sure that the social determinants, which I think are important considerations in the patient's journey, are driving factors. Definitely, Canterbury is one everyone is well familiar with, and there are a number of ways that it is going to be integrated. In some areas it already has been.

Dr. Swann: Where is the leadership on the primary care reform? Does that come from your office? Does it come from the primary care leadership?

Ms Hoffman: There's a partnership. The PCN leads that I'm referring to are from within the PCNs themselves. Each of them have identified a lead from each of the five zones, and they have a seat at the table.

Dr. Swann: But the leadership for reform. I'm referring to leadership for reform.

Ms Hoffman: Yeah. There are working groups that we have under way, and the deputy, I'm sure, would be happy to elaborate more fully on that.

I also have to say that one of the great moves that they've made more recently is inviting AHS to be a part of the working group in the evolution of the PCNs. The leadership for reform is within the department, but of course we're working with partnerships, including the PCN leads themselves.

Dr. Swann: How are we doing with progress, then, might be the question.

Dr. Amrhein: When the ministry launched the financial review of PCNs, the response from the PCNs themselves was to ask the ministry for assistance in a couple of key areas. One of the key areas is that historically the ministry has managed 42 different contracts, and as a result, there was one template for all 42 PCNs, one set of reports, one set of accountabilities. The PCNs' view was that this was very unsatisfactory, that the big PCNs in Edmonton and Calgary simply didn't work like the PCNs, for example, in the north zone or the south zone. So the PCNs organized themselves. They've now aggregated the 42 into five groups coterminous with the zones of AHS. They have added an AHS primary health care zone lead. So we now have built a committee, if you like, the PCN consultation committee. They've come up with a set of proposals that we will have zone-specific agreements with the PCNs in the zone.

Dr. Swann: How would that fit with a shift to a Canterbury-type model, with a pathway system? Is that on the agenda, do you think?

Dr. Amrhein: The Canterbury model, if we take it at its simplest, is a pathway of care. The pathway of care, for example, in diabetes in the north zone, I'm told by medical experts, is substantially different from the diabetes pathway of care in Edmonton and Calgary.

Dr. Swann: Right. Okay. So some challenges.

Dr. Amrhein: So that's an example where we've customized to the geography, especially transportation, and a different composition of the team.

Soon to come will be a review of the funding mechanism, the capitation model. We'll be asking the PCNs to explain to us appropriate to their location how they do after-hours care, how they do assessment of frail elderly, how they step up to mental health, and we will then be able to fund zone-specific initiatives rather than a one size fits all.

Dr. Swann: Thank you.

With respect to the lab, Minister, I haven't heard much about the Edmonton lab. Could you update us on where that is and what kind of funding?

Ms Hoffman: Yes. We've made really good progress. We look forward to being able to release details and some work that the Health Quality Council has done as a request that we've initiated. I was joking with the department about the one time that a minister said: in the fullness of time this will become public. It stands for

this answer as this is something that we are continuing to move forward on. We've got $20 million over two years for the clinical lab hub, and that money, I guess, is within one of the line items in this budget.

Dr. Swann: Yeah. Thanks very much.

With respect to home care, I'm delighted with the new investments in home care. It's going to make a big difference to keeping people in the community and preventing, as you say, some of the demands. I note the Health Quality Council report indicated about 50 per cent satisfaction with professional services and 44 per cent, on average, satisfaction with the staff. It's clear that more home care isn't necessarily going to solve the problem of quality. How are you addressing the quality of home care and the consistency of home care?

Ms Hoffman: Without having the report in front of me but going off memory – I looked at some of the zonal data as well for satisfaction, and it seemed to me at the time, at least as I recall off the top of my head, that in rural communities there was a greater sense of satisfaction. I wonder if some of that has to do with the fact that you know the person who's coming to help take care of you – you have fewer people working in the industry, so there might be more continuity of care – that there is a different relationship there. One of the questions that I've asked AHS to consider as we move forward is: what are ways that we can take some of those principles from areas in the province that had higher confidence rates and higher success rates and implement some of those strategies?

Thinking as a family member who had home care when my dad was home, palliative, there weren't a lot of nurses that we got to see more than once. The ones that we did: it was a better interaction because we had that relationship already established. I have to say that that was in a downtown condo in Edmonton 10 years ago. We were grateful to have somebody there when they did arrive, but obviously when you have that continuity, that relationship, I think that when it's ongoing, it's certainly better for the patient as well as for the family. So these are some of the areas that we're looking at.

In terms of hours of service we're also looking at ways that we can use the community paramedic program to enhance some of the work that we're doing in home care and work that can be done in terms of respite for individuals as well, so supporting the family through the journey as well as the patient.

Dr. Swann: Thank you.

With respect to IT we've had a long history in Alberta of spending money. [Dr. Swann's speaking time expired] And that's where we'll leave it.

The Chair: I hesitate to interrupt; however, the time allotted for this portion has expired.

I would now like to inform members that we are going to be breaking for five minutes. We will set the timer and resume when the timer goes off.

[The committee adjourned from 8:57 p.m. to 9:03 p.m.]

The Chair: Thank you, Members. I would now like to call this meeting back to order.

For the next 20 minutes I would like to invite Ms Luff from government caucus and the minister to speak. Ms Luff, are you wanting to combine your time with the minister?

Ms Luff: Yeah, if it's all right with the minister.

Ms Hoffman: Yes, please.

The Chair: Go ahead.

Ms Luff: Fantastic. Thanks so much for being here. Thanks, everybody, for being here. We really appreciate it. I just want to start with sort of a general question about the direction of the ministry in general with this budget and this business plan. I was fortunate to be at the budget consultation in Calgary, and one of the things that came up was Health. Given that Health is the largest chunk of the budget, a lot of the conversation that we had at that consultation was around health care and moving towards more preventative health care, moving towards the idea of, you know, doing health care in the community and preventative care, which is going to help us save money down the road.

In the budget and in your introductory remarks I heard you say that part of the work that you're doing is to move away from hospital-based care and toward more care in the community. I'm just wondering if you could expand a little bit for me on what exactly that means and why your ministry is choosing to take this approach.

Ms Hoffman: Yeah, I'm happy to discuss this. Really, it comes back to that sort of mantra. Sometimes people laugh because I say it so much, but it really is about the right care in the right place. Often it's for a better investment, to be frank. If it's safe for you to be at home and what you do need is somebody to check in and make sure you're taking your medication and help you with daily hygiene, it's more cost effective, but it also brings about a greater sense of dignity for many folks who want to stay in their home, are very proud of the fact that they've lived there for a number of years. It doesn't just support their physical health, the costs within the ministry, but also their social and emotional well-being as well.

A big part of it is about ensuring that we have adequate investment in terms of home care – that is important, it's significant, and it's something that we're really proud we have increased substantially this year – as well as making sure that we're working with the PCNs and with others in primary care to expand the range of services. Now I think we're at the point where family physicians feel better about treating things like addictions in terms of smoking cessation than maybe they did 10 or 20 years ago. I think we still have a long way to go in terms of lipid replacement therapy, for example.

In terms of mental health in general, I don't know how many primary health care providers feel confident treating mental health. When 1 in 10 Albertans will struggle with addictions and 1 in 5 will struggle with mental health at some point in their life, this is a big part now of what I think is primary care and can be better served. Not everyone needs to see a psychiatrist at a congregated site. It's important that we do have them available for those who are best served in those specific environments, but there are a lot of people who can get great care with a primary health care provider through proper education supports and scope of practice.

Another one is expanding the community paramedic program. When I've met with some folks in long-term care and continuing care, this is one of the areas where they talk about opportunities for efficiencies. Obviously, if you can have a paramedic come into the home, do a diagnosis, and determine whether or not that patient needs to be transported as opposed to a paramedic always being seen as a transportation service to a hospital, there's a greater sense of care and less chaos in that individual's life as well as, again, a more cost-effective health outcome. Some of the work we've done with the scope of practice and with moving paramedics under the HPA have expanded in that area as well.

We're going to continue to work with local community groups to make sure that we're addressing their needs as close to community

as possible. I think a good example is the need that we've seen in some of the remote communities in the north around access to dialysis. Sometimes community-based means at a hospital but one that's less than a three-hour drive away. When you're having dialysis multiple times a week and having to travel a long distance, it can definitely impact patient and family morale and mental health as well.

These are a few of the areas where we're investing in community-based care.

Ms Luff: Yeah. Awesome. I mean, just for a follow-up, those are some things that I have definitely seen. You know, I've had a paramedic in my house when I was worried about my son. They checked him out and said he was okay and probably didn't need to go to a hospital and that I could go to a doctor the next day. I've definitely had a positive experience there.

In terms of primary care networks in my riding we have the Mosaic primary care network, which you visited, the refugee health care clinic. They do a fairly good job of looking at what the needs are in our community. In terms of mental health, you know, they have mental health counsellors that people can see and can be referred to by doctors. They have walking programs to encourage physical activity, and they do a lot of programs that address things particular to our community. So that's working there.

I did notice that in performance measure 1(c) in the business plan it states that government aims to have 81 per cent of Albertans enrolled in primary care networks by 2020. That still leaves 20 per cent of folks without access to these health care teams. I'm just curious how the government can remain optimistic that people will get the care that they need when there's still 20 per cent of people falling outside of these networks.

9:10

Ms Hoffman: Thank you very much for the question. The target has increased steadily over the years, as have the percentages as well. Enrolment in PCNs as a measurement of Alberta's involvement is based on visits with family physicians who are part of PCNs. Still not every family physician in Alberta is part of a PCN.

The calculation is based on visits over a rolling 36-month period. There are many Albertans, probably even in this room, who aren't aware of the fact that their physician is connected to a PCN. Part of it is around ensuring that physicians and other primary care providers, including nurse practitioners, know what opportunities are available for enhanced services to serve the patients' needs, and the other part of it is ensuring that they're connecting folks with those services. This doesn't mean that non PCN affiliated family physicians are not providing team-based care, but they're not part of a formal PCN model. Some are part of family care clinics, which again have a lot of the support services integrated but would be under a different model, as well as the nurse practitioner led clinics.

I think there's room for additional partners at the PCN table. We, of course, want it to be something that the partners themselves, the physicians and primary care professionals, want. We don't want to do it to them; we want to do things with them. We're going to continue to find opportunities for those types of collaborations to take place. We're not going to force it on the physicians. In turn, not necessarily all of their patients will become part of a PCN.

I believe that our target is within reach, so I'm excited about that.

Ms Luff: Thanks.

I'm just curious. In the budget, then, what's included in community-based health services, element 7.3 on page 153? There's an increase there. What is the increase going to be used for?

Ms Hoffman: Thanks very much. Community and home care health services are provided in a community or homelike setting intended to maintain clients in their community or ideally at home when possible to avoid or delay admission to facility-based services and to support early discharge from acute and continuing care facilities as well. Examples include sometimes group homes; enhanced lodges, where there's enhanced nursing support; supportive living facilities; health services provided in one's own home, like through home care.

The funding decreased from the '16-17 budget to forecast as a result of vacancies and delayed opening of beds in terms of community care. Funding is increasing in '17-18 to move forward with a planned investment in home care, as you've mentioned, as well as the increased capacity that we're going to have in supportive living beds as well as mental health. This is reflective of our government's commitment in these areas. Sometimes it takes a while to get the capital aligned, but when it is, we know that this is an important area to invest in.

Ms Luff: For sure. I have a lot of seniors, as I'm sure many folks do in their riding, and I hear from a lot of them that having access to home care is huge as well as knowing, you know, that there's going to be somewhere for a parent when they need a place. An issue I hear a lot about every day is people struggling to find a good place for their parents, so I've been encouraged by this government's commitment to expand health care for seniors and long-term care for seniors. It's indicated in performance measure 1(b), which focuses on the platform commitment of 2,000 new long-term care beds. Even with these beds, even with all the new beds, the government's 2019-2020 target for access to continuing care still sits at 71 per cent, which could be some of the frustration that people are experiencing with the system. I'm just curious why this target isn't a hundred per cent to ensure that all people who need long-term care can find an appropriate space.

Ms Hoffman: Yeah. Part of it is that not everyone being assessed for continuing care needs to go into long-term care, for example. Continuing care beds also include that piece around home care and supportive living. As with the last budget, 2017 increases funding for home care through AHS, home care and community care. The government continues to work to meet our 2,000-bed commitment.

The other part is that we have a significant shortfall, and we aren't going to be able to catch up in one or even two or probably even four years. There are many folks who are currently living in hospital beds, some who have for years. To get those spaces online takes some time. We are moving forward with our partners through the ASLI projects that were confirmed shortly after our election. Some of those spaces will come on in this fiscal year. That's very good news.

As well, this budget has money for public builds at Norwood and Bridgeland. I think that that will make significant improvements. We will continue to work on developing a model to make sure that we address the backlog, but it is going to take time. If we can keep people at home in a safe way, maybe not their own house but in a lodge with enhanced supports, it certainly is going to help us address some of the pressure. Our seniors population is high, it's going to get higher, and we do have a deficit that we need to address in terms of the space. But we are on track to meet the 2,000-bed commitment, and we'll continue to push along that line as we move forward.

Ms Luff: For sure. I know that people I talk to in Calgary are very excited about the 200 public beds in Calgary because, when I speak with people, a lot of the concern that they cite is often with private care facilities. So people are really excited to hear that.

I just have a couple of questions about some of the line items with seniors and home care. There are two AHS items. You know, they've separated continuing care as its own item, and then they've linked community and home care whereas last budget continuing care was combined with community care. So I'm just curious if that indicates an area of focus that's shifted.

Ms Hoffman: Yeah. It's about us trying to increase levels of transparency by desegregating some of that data as well. We're trying to provide more meaningful information to Albertans and to all members of the public who are interested. Community and home care fit naturally together since both focus on the care services provided to people in their community while continuing care offers services provided in long-term care as well as other facilities, like assisted living. More than a thousand continuing care spaces will be opening in a number of communities, including Calgary, Medicine Hat, Red Deer, Edmonton, Hythe, and Lloydminster, through the coming year as these projects that are currently under construction reach completion, and these facilities will be ready for patients and residents to move into them very quickly.

We're wanting to break down those line items so that long-term care and supportive living aren't necessarily tied into one line item but putting home care and community-based care into one line item as a solution.

Ms Luff: Thank you.

I'm just going to shift focus a little bit now to look at some questions surrounding vaccination. I know that we're moving out of flu season now, which is good, and I also know that the flu shot is an excellent way to prevent people from getting sick. I always got a flu shot. I still do. When I was a teacher, they would come to my school and give them to me, which I thought was really fantastic because being a teacher is one of those things where you often got sick every year. I have definitely noticed since I've been getting the flu shot that I get less sick than I used to.

I'm just curious. Performance measure 2(a), which is annual flu immunization: why is the target for flu immunizations set so high for children aged six to 23 months, and why is the actual so low? I as a parent of young children can speculate on that, but I'm curious as to the reasons that you . . .

Ms Hoffman: I'll share our information and would be happy to hear your experiences as a mom and community leader as well.

We know that influenza can cause serious illness, especially for vulnerable people such as seniors, young children, pregnant women, and those with chronic medical conditions. Sometimes we see people actually die from influenza. This is not uncommon, unfortunately. The last actual result for immunizations was up over the previous year. For example, in '15-16 it was 36 per cent; in '14-15 it was 34 per cent. But that's still a long way from herd immunity, as some would refer to it.

We will continue to work with Alberta Health Services to educate patients about the importance of flu immunization for their children and provide more convenient options – I think that's one of the things you mentioned, being a teacher and having them come into your workplace; I know some churches have expressed interest in potentially hosting flu clinics – putting them in convenient, public drop-in centres. For example, I go to a public health centre that's in the middle of a shopping mall to get my immunization, and many others are there at the same time. It's close to the library. It's by the grocery store. It's on your way.

9:20

It doesn't take that long to potentially save your life or the life of somebody else who could be susceptible to this being deadly. It's definitely something that we're trying to increase access to. As well, most pharmacists are able to do it. So while you're waiting to pick up that prescription, you can have it done very quickly.

We're trying to address many of the myths that might exist in the public perception as well around potential negative impacts. I think it's important for us to be evidenced-based and share information so that parents can make a choice that can save their lives, the lives of their children, and other people who are vulnerable in society.

Ms Luff: Yeah. For sure. I think, from my experience anyway, convenience certainly, especially around my children, has a lot to do with it. Being that I got elected when my daughter was eight months old, you know, we got off schedule a little with her immunizations, and because we were off schedule, the health centre in my community transferred us to a different health centre. We had to go to a different centre than usual in order to get my daughter immunized because she was off schedule. And they don't always answer the phone when I call to book an appointment. So sometimes it's difficult to actually book an appointment and get her in. That's one of the reasons that I sometimes find it challenging, not because I don't want to vaccinate my children but because just scheduling sometimes is a challenge.

I mean, that's the same thing around – you know, I have been concerned to see the resurgence of preventable childhood diseases, like the outbreak of mumps. Because I was coming to Edmonton with my daughter, I was like: has she had all her doses of MMR? And I think she has, but it was something that caused me pause, to be sure.

I was certainly proud to support the health amendment act last fall because it is important to make sure that we get that herd immunity rate up. In terms of performance measure 2(b) on page 83, which is childhood immunization rates, outside of the flu vaccine what are you doing to increase the actual rate up to the target rate, and in what ways will the legislation assist in that effort?

Ms Hoffman: Yeah. I'm very proud of the bill that we did pass last year and was pleased to see all members join in that support.

I think, as you've mentioned, sometimes families get busy and forget. This is one of the things that we're hoping to address through the legislation as well as through work we're doing around the electronic health records so that you can have those reminders automatically in your portal, you can get those reminders on a regular basis as well as having public health follow up if you do get behind, and making sure that when children are in school, it's easy for them to get caught up, with their parent's permission, of course.

We're definitely moving around education as our focus, making sure that people know about the importance of all types of immunizations for their children, and that we provide convenient options, as you've mentioned, for those to take place such as immunizations in daycares or at schools, community health centres. AHS also reminds parents of the need for their children to receive their second doses and runs advocacy and marketing campaigns to reinforce the message about the importance of vaccinations. In addition, recent amendments to the Public Health Act, including allowing for easier identification of students with incomplete immunization records, are meant to better protect children.

The Chair: Thank you.

For the next 10 minutes I would now like to invite Mr. Cyr from the Official Opposition and the minister to speak. Mr. Cyr, are you wanting to combine your time with the minister?

Mr. Cyr: If she's okay with that.

Ms Hoffman: Sounds like fun.

The Chair: Please go ahead.

Mr. Cyr: Okay. Thank you, Madam Chair. Thank you, Minister. I have several questions, so I'm going to try to fit it into the 10 minutes. We had some guests on the Legislature doorstep, if you will, I believe at the end of March. We had an AUPE rally in front, particularly about a facility within my riding, Points West. One of the concerns that I'm hearing from both the seniors within the facility and some of the employees of the facility is that they're looking for a change or a review in the Protection for Persons in Care Act and an update in regulations. This would be on page 84, under 4.4. Are we looking to go in that direction at all? What are we doing to alleviate the concerns that the union has regarding levels of care at that facility?

Ms Hoffman: Well, I did meet with some of the workers as well as their elected union leadership the same day as they held that rally, actually prior to, and I asked that we speak to general concerns, feedback, advice around the continuing care system. They definitely highlighted a number of concerns they had around the for-profit model and some of the motivations that might be in place there.

All Albertans deserve to live in a safe environment, of course, and protection for persons in care receives concerns related to possible abuse of adults receiving care or supportive services that are publicly funded regardless of who the delivery is done by as long as there is public funding within the government of Alberta. Protection for persons in care reviews and reports abuse if they are determined, and the reports are investigated under their act and discontinued or referred elsewhere if they are confirmed.

This means that not all reports of abuse received are investigated by PPIC, and if the alleged abuse is an offence under the Criminal Code, the complaint is referred, of course, to those appropriate offices. But service providers must comply with PPIC directives to prevent abuse, and public postings of the decision summaries or allegations of abuse involving persons in care demonstrate that we're committed to being transparent about that.

That's the way the legislation functions currently, and I think that, of course, we're open to specific feedback that you or other members of the public have around amendments. I think that it is a quite useful piece of information and legislation to protect those who are vulnerable and to protect consumers as well.

Mr. Cyr: Thank you, Minister.

Just to be clear on the record, we're not looking to review any of the regulation around nursing homes and care facilities?

Ms Hoffman: Oh, yeah. Sorry. There is a review happening for that. It's the PPIC that I thought the question was about. There is definitely – we're in the midst of a review right now. It has been open for a number of months, and the Nursing Homes Act regulations are required to be updated. So we'll be considering that, and there has been a public process for giving that feedback.

Mr. Cyr: When are we expecting the review to be finished?

Ms Hoffman: It's under way right now. I'm thinking that we'll possibly – again, it depends on what information comes up and our need to maybe delve deeper. I think our target is for it to be completed within 2017, not in the next few weeks but probably in the next six months or so, and for us to be able to take that information to determine how we want to move forward, whether we require further probing or whether we're ready to bring forward potential amendments.

Mr. Cyr: Thank you, Minister. You were very clear. Thank you very much.

Ms Hoffman: Thank you.

Mr. Cyr: I've got three First Nation bands within my riding and two Métis settlements within my riding as well. Now, if we go to the business plan, page 83, 2(a), we can see that life expectancy for First Nations has been decreasing. I'm very thankful that AHS invited me to go to one of the meetings talking about concerns within our local constituency, specifically fentanyl. One of the concerns . . .

Ms Hoffman: Sorry. It was a strategy. I thought it was a business plan component. We found it.

Mr. Cyr: Okay. One of the concerns that was brought up during that brainstorm session was that it would be nice to have a liaison from AHS at the Cold Lake hospital that would act between the different bands and Métis settlements within my constituency as a way of being able to make sure health care gets facilitated within those groups. Sorry; I've already done this. Is this something you have considered investigating, or are we going to continue to see these, I guess, very upsetting numbers of life expectancy continuing to drop?

9:30

Ms Hoffman: And definitely while they've been improving in the nonindigenous population, this is troublesome. I think that if we have ways to increase life expectancy under the other demographics, we should be able to do it for all. I stand with you on that.

A number of our health facilities do have cultural liaisons of sorts. I think they have a different name than that under AHS, but there are a number working in hospitals, and there are some videos on the AHS website. I think there have been some successful ones in your riding. I think Bonnyville has one that has been quite effective. Am I right on that?

Mr. Cyr: That's the concern. Bonnyville has one, and it seems to be very effective, but Cold Lake doesn't.

Ms Hoffman: Yeah. Sometimes it's about finding that right fit for the many communities that rely on that resource, for sure. I think it is something that AHS is continuing to consider but, of course, wanting to make sure that it's the right fit. I think part of it is having the staff member in the hospital to help create a greater sense of understanding on both sides, for the staff as well as for the patient. Also, staff training, I think, overall is an area that is being pursued in a number of different hospitals because having one person responsible for creating a welcoming environment for all isn't entirely acceptable. We are looking at places where they're working effectively and trying to find ways to continue to grow on that. I am aware of Cold Lake's desire and have raised that with AHS, and it's something that they're continuing to pursue. But I'm really proud of the fact that Bonnyville has seen such success.

Mr. Cyr: I'm very proud of them as well, Minister.

I do know that our First Nations in the area have also been impacted by the downturn, so positions that they have been able to fund in the past are starting to disappear, which means that there's more strain on the reserve to make sure that there's facilitation there. So I would really appreciate it if you could explore that more fully, Minister.

Ms Hoffman: Thank you.

Mr. Cyr: Under 2(c) on that same page, emergency visits due to substance use, everything else on that page is broken down for First Nations and non First Nations. Do you have those numbers available, or is there a reason why we don't see that breakdown here?

Ms Hoffman: If I'm to guess – and if I am wrong, I'll make sure that we follow up with subsequent information tomorrow when we're back together again – I think that part of it is around self-declaring indigeneity, but I will ask my department to confirm if that is indeed why we don't have that breakdown. I will ask that question tonight. This is one of the joys of having two days of estimates.

Mr. Cyr: I agree. Thank you, Minister.

Page 84, key strategy 4.1. There was a study done on the Cold Lake hospital by Stantec 15 years ago, and I was wondering: is there any way that we could get a copy of that study tabled in the House or sent to my office?

Ms Hoffman: I will ask my department a couple of things: one, around the ability to share that more broadly and . . .

The Chair: Thank you.

Mr. Cyr: Thank you.

The Chair: For the next 10 minutes I would now like to invite Dr. Starke from the third-party opposition and the minister to speak. Dr. Starke, did you want to go back and forth with the minister?

Dr. Starke: Yes, please.

The Chair: Go ahead.

Dr. Starke: Well, thank you. Minster, for this section I'd like to concentrate on the operational side of things. We talked a fair bit about capital. As you are extremely familiar with, the three main cost drivers in your department are physicians, hospitals, and drugs. Of course, that is the same challenge that is shared by your colleagues right across Canada. I'm looking actually right now at a chart that was produced by the Canadian Institute for Health Information for 2014. I'm sure there's been a more updated one. It shows per capita health spending in basically six of the largest provinces. It doesn't include the Maritime provinces. I'm sure that you're very familiar with the numbers.

I am concerned, Minister, when I look at this year's estimates. For example, section 4 on page 152 of the main estimates shows an increase of some 9.86 per cent on drugs over last year's budget. The increase on physicians is 7.08 per cent. I'm having a little bit of difficulty finding out which line item in the budget would be the most apropos for comparing the budgetary expense for hospitals. In any case, of those six provinces Alberta has the dubious honour of being number one in per capita expenditures on physicians, number one in per capita expenditures on hospitals, and number three in per capita expenditures on drugs.

I'm just wondering. Let's maybe start with drugs first. What specific measures are you taking in this year's budget to try to bend that cost curve, which I know is very challenging as generic and less expensive pharmaceuticals are being replaced by ever more increasingly expensive pharmaceuticals that may well have therapeutic efficacy but are also very expensive?

Ms Hoffman: Thank you very much for that. There are some things that your caucus says, "You're welcome," for. I'm assuming this is not one of them because there's still a lot of work that needs to be done in this area.

I'm going to touch a little bit on drugs first, as that was your main focus, in saying that there are a number of drugs that are continuing to come online that are costly up front but have significant savings down the road. For example, there are new hepatitis medications that are coming online this year that can actually cure hepatitis, types that before would be chronic conditions for patients for years. Arguably, this upfront cost that we see for one or two years in the medication could save significantly on the acute-care pressures that the hospitals are facing, but those are significant costs for those drugs in the first place.

Some of the work that we're doing with the Pan-Canadian Pharmaceutical Alliance around pricing has already reduced the prices for 113 brand and generic drugs. That is because we're working collaboratively with these other provinces that, like you said, are seeing similar pressures. There was an estimated savings of $712 million annually in the last few years, well, last year, since we've been able to get these 113 on.

That is not driving the total cost down, though, because new drugs continue to come online. People are living longer and are having more complex care later in life as well.

Dr. Starke: Sorry, Minister. Excuse me. That $700 million: is that Canada-wide?

Ms Hoffman: Nope. I believe that was our – oh; it was Canada-wide. Sorry. Alberta saved more than $100 million over the last three years. That's our share of the $700 million, so that's good.

Dr. Starke: That's nothing to sneeze at.

Ms Hoffman: Thank you.

As of April of 2016 the Pan-Canadian Pharmaceutical Alliance, the prices of those – oh; sorry. That's doubled up there. That was the change that we were referring to.

Dr. Starke: Okay.

Ms Hoffman: The prices of 18 generic drugs have been reduced to 18 per cent of the brand name prices.

Dr. Starke: Right. Minister, last year we had the discussion. I'm just wondering what the follow-up has been in terms of sitting down with prescribing physicians, obviously, but also with the pharmacies that fill a lot of these prescriptions because pharmacists have a number of ideas, including therapeutic substitution and the increased use, especially when somebody is starting a medication for the first time, of using a trial prescription that is relatively short – let's say a week to 10 days – during which time a patient's tolerance for a drug can be determined.

This may be a little bit getting into details, but what is happening currently is that somebody will come in with a new prescription on a new medication. They might get three months' worth, find out that they don't tolerate that prescription really well, and, you know, two and a half months' worth of the prescription ends up getting pitched because it can't be reused, obviously. So I'm just wondering whether those or other means that the pharmacy profession have suggested have been looked into in terms of trying to reduce that overall pressure on the drug costs.

Ms Hoffman: Yeah. That's a great point and something that I think will probably need to be looked at with the patient's condition as well as access to pharmacy as one of the guiding principles there. There are some communities where there isn't a pharmacy. You

wouldn't want to have somebody drive another hour eight days later, but I think that there are many instances where that could possibly be the situation.

One of the examples that I'll touch on is around biologics, which are incredibly expensive, and biosimilars coming on. They're asking physicians to prescribe the biosimilars first, see if they work, and try those rather than going to the most expensive version. We do have the executive director for pharmacy here, our drug guy. If you'd like to hear from Chad, I'd be happy to call on him.

9:40

Dr. Starke: Sure. Just really briefly – we're limited in time – give us your best 90-second précis on how we can save a few hundred million dollars on drugs.

The Chair: And say your name and title, please.

Mr. Mitchell: Good evening. My name is Chad Mitchell, and I'm the executive director of the pharmaceutical and health benefits branch at Alberta Health.

We work with the association of pharmacists on expanding their scope of practice but also remuneration for cognitive services, what we call pharmacy services.

Dr. Starke: Right. Okay. I'm familiar with that.

Mr. Mitchell: This allows pharmacists to do patient assessments, especially on the complex ones, and create plans for their care.

Dr. Starke: All fantastic. I'm just wondering if there's additional work being done in terms of expanding the use of generics, in terms of therapeutic substitution, especially therapeutic substitution. It's something that's already being done in hospitals, and it would result in a huge cost saving in terms of reducing, you know, the use of brand name drugs, the newer drugs that sometimes, in terms of therapeutic efficacy, are not specifically better than a drug that's been around for 15 or 20 years.

Mr. Mitchell: We have launched a couple of initiatives, one being the proton pump inhibitors review. The minister has the Expert Committee on Drug Evaluation and Therapeutics, that can take a look at the best practices out in the community, and we can work with our pharmacy association and our college to make sure that the pharmacists have the right support. That is an area that we are focusing on in the coming year, sitting down with their association and the college to make sure that we have the right support in place for the pharmacists.

Dr. Starke: Well, while you're there, I'll just ask maybe one more question, Chair, that is drug related. We've had a number of discussions in the past with regard to the RAPID eye program. I'm just wondering: now that it has been operational for roughly a year, where are we at? What are the estimated savings? Are we hitting those 80-20 mandated targets amongst the ophthalmologists for treating macular degeneration and some of the other conditions?

Mr. Mitchell: Yeah. The program has been successful. We are achieving those targets of the 80-20 split between the brand name innovator product and the additional part we added on. We are taking steps to add another choice.

Dr. Starke: Eylea?

Mr. Mitchell: Correct, to access for the clinicians that are having those injections.

Dr. Starke: Okay.

Mr. Mitchell: Overall we've reduced our budget by approximately $50 million as a result of this RAPID eye program, and that's reflected in the budget estimates.

Dr. Starke: Good. Thank you very much.

Finally, Minister, just in the last minute and a half that we have, we've had quite a bit of discussion in the first segment about physician compensation. I want to say, and I've said this before, that I applaud both you and the AMA for the efforts you've made.

Ms Hoffman: Thank you.

Dr. Starke: I think we have to keep working on this. This is not a closed book by any means. I'm a little bit concerned about differing numbers that are getting tossed around for fee for service. Certainly, when we did the rural health review, the predominance of fee-for-service compensation amongst our physicians is problematic. It leads to turf protection, and it also leads almost to the point of patient hoarding in some communities. It's not good for the community or the patients.

I'm just wondering. The number that I have is that 87 per cent of our physicians are compensated primarily on a fee-for-service basis. It's the highest of any province. What specific methods are being used – and maybe Dr. Amrhein can help with this – in terms of reducing that number? How amenable is the AMA to this? As I understand it, younger medical graduates are more interested in working through alternative remuneration programs.

Ms Hoffman: Yeah. I'll start, and then I'll ask Dr. Amrhein to add if he'd like to.

Definitely this has been an item of discussion at the AMA, I think, for a number of years and definitely is something of interest. We have welcomed clinics where all of the physicians are interested in moving . . .

The Chair: Thank you.

As there is no independent or other party member present, I would now like to invite Ms Miller from government caucus to share the next 10 minutes with the minister. Are you wanting to combine your time?

Ms Miller: Yes.

The Chair: Please go ahead.

Ms Miller: Thank you, Chair. You've spoken at length about the major cost drivers in the health care system, and it's clear that drugs are near the top of that list. Why are drugs and supplemental health benefits going up $158 million, or 8 per cent, as shown in element 4 on page 152 of the estimates?

Ms Hoffman: Part of it is around that piece including drugs that have been waiting for Canada Health's approval that we know are going to come online, like the drugs to treat hepatitis. There is a price and a volume increase for most categories, including cancer drugs. Great research happening there, new drugs being identified and ways to treat, but they do come with a cost, so we need to be prepared for that.

There are several high-cost drugs, seniors' drugs, Alberta assured income for the severely handicapped health benefits as well as the adult health benefits. More people have been subscribing to the Alberta health benefits programs in recent years with the recent downturn, that we are starting to see some hope of coming out of. But in the meanwhile people have been relying on government programs more than they may have in the past.

In addition, the approved drugs list is regularly updated, which adds new drugs and does remove some that are no longer effective. New drugs are added to the approved list at a premium price as no generics are usually available in those initial stages. That, again, creates new hope and opportunity for patients but does add to the costs, particularly around these rare and orphan drugs that specifically treat conditions that are unusual. But now there's hope.

Ms Miller: Thank you.

My senior constituents frequently reach out to me about the cost of drugs, and they're concerned about the impact of changes to drug benefit plans. Why is there an increase for seniors' drug benefits and, as well, seniors' dental, optical, and supplemental health benefits?

Ms Hoffman: Again, these are primarily driven by volume demand. As the age of Albertans increases and more and more people are entering that senior category, they move onto our senior drug plans and other benefit plans. They are increasing by $38.4 million, or 6.8 per cent. Seniors' dental, optical, and supplemental health benefits are increasing as well, by 5.2 per cent. And more seniors are accessing those brand name drugs where there are no generic alternatives yet. The increase is also due to the price and volume increases to seniors' dental and optical services as well as ground ambulance and supplementary health benefits like orthotics and prosthetics.

I have spent considerable time – and the department continues to – looking at some of the other jurisdictions in Canada where their drug costs per capita are lower than ours are, and the almost exclusive reason why is because they charge higher copays, and they're passing a greater portion of the burden on to those senior populations. I know that's something that has been considered in this province in the past, and it's something that I think concerns a lot of individuals when it's not easy to increase your income. When you're on a fixed income, the possibility of having significantly increased drug costs is very scary to Albertans, so we want to make sure that we're making life better for Alberta families, which includes our seniors, and working to make their lives more affordable. What happens, though, is that somebody's got to pick up the cost, so we're prepared for this to be a line item increase in this year's budget, to make sure that we don't pass on additional costs to those seniors, like we've seen in some other provinces.

Ms Miller: Thank you.

In the fall of 2015 the government announced the pilot project RAPID to provide more treatment options to Albertans who have lost some vision due to macular degeneration or specific retinal conditions. The program was expected to save between $23 million and $46 million over three years. Did that occur, and where can we see these cost savings in the budget document? Is the ministry looking at similar measures to reduce costs for other types of drugs?

Ms Hoffman: We are very interested. The RAPID program is an excellent example of how government and health professionals can partner in innovative ways to provide better, more convenient care to Albertans while also saving millions of health dollars both for patients and for the operator, for the system. The pilot project did begin in 2015, as was mentioned, with the Retina Society of Alberta. This project has been very successful. Through the RAPID program and its 16 clinicians we've managed to reduce program expenditure by approximately $50 million. This program has not only reduced costs; it's also provided more access to patients by removing some of the financial barriers that existed previously.

9:50

In the year prior to RAPID, October 2014 to September 2015, $76 million was spent on Lucentis across all government drug plans, not including rebates. Over the course of the first year of RAPID, that being October 2015 to 2016, total expenditures on Lucentis and Avastin were $26 million combined. That is a significant savings, about $50 million. The line item would be under drugs and supplemental benefits, I believe. It would be that line item in the budget.

Ms Miller: Thank you. I want to thank you for that. My husband is one of the Avastin users.

Ms Hoffman: Win-win.

Ms Miller: Without a doubt, persons with disabilities and other people with ongoing health challenges are some of the most vulnerable Albertans. The Minister of Community and Social Services just announced plans to completely overhaul the AISH system last week, which is long overdue. Clearly, your ministry works closely with the AISH program as well, and this will have an impact on health. What is the AISH health benefit listed in element 4.8, and what does the increase mean for vulnerable Albertans?

Ms Hoffman: The assured income for the severely handicapped, or AISH, health benefit provides those benefits to assist clients and cohabitating partners and dependent children with expenses related to their medical needs. The AISH health benefit is increasing $8.4 million, or 3.5 per cent, due to caseload volume increases and the use of higher cost products. This means that more people with disabilities can feel more secure about accessing their health benefits and supports that help to make their lives better, more secure, and more dignified. That 3.5 per cent increase, I think, is an important investment.

Ms Miller: Thank you.

Our government's increased funding for child benefits is something I'm very proud of. It is a direct way that we are working to make life better for Albertans. I see that the child health benefit listed in element 4.9 is also showing significant increases this year, 5.7 per cent. Why is this item going up by $1.7 million, and what does this mean for Albertan families?

Ms Hoffman: Thanks. Again, this category, child health benefits, is focused on families who are low income, who have children under the age of 18, and up to the age of 20 if they live at home and are attending high school, so there is the opportunity for it to potentially expand into those areas. This increase is a provision for claim volume and cost-per-claim increase. The reduction in the number of children enrolled in the child health benefit program between 2015-16 and '16-17 is because of more families signing up for the adult health benefit program, so they would have more people in the family program as opposed to just being in the children's program.

Children transition from being enrolled in the child health benefit program to being included as dependants when their parents are enrolled in the Alberta health benefit program. Part of the reason why it had a reduced number is because the number went up, actually, for the family program. It is us making sure that we are able to meet the demands, though, that we expect might go up next year. As the economy continues to pick up, we know that more families will move off the Alberta adult health benefit program, which might mean that their children would need to access the children's program, so we want to make sure that that money is

there and that it's available to support them as they return to the workforce but their children still require these benefits. So that is an area that we want to be prepared for.

Ms Miller: Thank you.
How much time is left?

The Chair: Five seconds.

Ms Miller: Okay.

Ms Hoffman: Thank you for your questions.

The Chair: Thank you.
I would now like to invite Mr. Yao from the Official Opposition and the minister to speak for the remainder of the meeting. Did you want to go back and forth?

Mr. Yao: Sure. Please.

The Chair: Go ahead.

Mr. Yao: Line 1, page 152, ministry support services, increased from $78 million in 2016-17 to $85 million and change, an increase of almost $7 million. That's a sizable increase. But also if we look back at 2015-16 to '16-17, there's a $15 million increase. That's over $20 million over two years. Can you explain this large increase in your ministry support services line, please?

Ms Hoffman: Thank you. The increase is due to the expectation of filling critical staff vacancies, a provision for Health's share of some costs in the Public Affairs Bureau, corporate costs related to government-wide publications, public opinion research as well as digital communications. This includes types of communications around public health initiatives, including immunization, and increased costs for department systems to support a variety of activities, including the physician payment. We have used the PAB for advice on potential public awareness campaigns, media monitoring, research, as we mentioned, AV technical support for announcements as well as strategic support on social media to increase awareness of public health initiatives.

Mr. Yao: Let's end it off with one last note here. You know, Minister, we're already spending over $2,000 more per capita than B.C. on health care. We have an organization, AHS, which is at over $12 billion, over 100,000 employees. If you look at the statistics over last – let's just go back 10 years, say. Surgical times have not changed much. It's been, like, many, many weeks, as many as 40-plus weeks, for surgeries. People are still continuing to wait upwards of eight hours in the emergency departments. Can you provide us with any information that dictates that perhaps they are improving these systems? Or what are you doing to address these issues, this bureaucracy within Alberta Health Services that we so commonly hear?

Ms Hoffman: Thank you for the questions. I want to start by reinforcing that one of the main reasons why B.C. is saving particularly in their drug line item is because they're passing those costs on to British Columbians. For example, with the seniors' drug plan there are many seniors in this province who would see their copays double, triple, even quadruple if we were to implement a B.C. style model for the drug plan for seniors.

Mr. Yao: But you understand your money is not free either. That comes from Albertans as well, right?

Ms Hoffman: I think we're sharing the time here, right? Sorry; I work really hard to try to not interrupt you when you're asking questions.

Certainly, if you're proposing that we increase copays for sick and injured seniors in this province, I'm happy to consider that policy proposal if that's something you're proposing. But I'm telling you that one of the big ways that they're saving in British Columbia is by passing those costs directly on to the people who are in requirement of those medications and treatments.

In terms of some of the other items that you've asked about in terms of wait times, there have been some good improvements in wait times in areas like hip fracture repair, radiation therapy. Our 17 stroke treatment centres are now among the finest in the world. There is absolutely more work to be done, and that work doesn't happen for free. It happens with focused, targeted investment and clear policy strategies. So we're open to hearing your recommendations on those areas as well.

Mr. Yao: Again, when you look at some of the spending that you're doing, increasing, like, some Health Quality Council and whatnot, have you reviewed the departments within AHS to recognize that there are about 28 departments plus, not including the regional ones in north, south, central as well as Edmonton and Calgary, that look like they have a lot of crossover as well as repetition in their mandates? Have you reviewed any of that?

Ms Hoffman: Well, Health Quality Council is around the review and publication of data, and AHS is around front-line service provision. I appreciate that on paper it looks like there is some duplication and that there very well could be. That's one of the reasons why the deputy minister, Andrew Neuner, as well as Vickie Kaminski do meet to make sure that they are finding ways to align resources. At all times it's important to make sure we're getting the very best return on investment, and that's one of the reasons why they do that face-to-face work as well as align their business plans to make sure that they are effective. We are moving forward to make sure that we're aligning resources, and that's one of the reasons why operational best practices is one of the areas within the AHS website that you've identified.

Mr. Yao: Thank you very much for that.

All right. On line 1.3, page 152, the deputy minister's office increased from $1.1 million to $1.5 million, an increase of almost $400,000. Looking at the estimates in ministry support services, it looks like you're holding the line on the minister's and associate minister's offices. However, on the DM's office what are the extra costs to justify an increase of 35 per cent?

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

I'd like to remind committee members that we are scheduled to meet tomorrow, April 11, 2017, from 3:30 p.m. to 6:30 p.m. in this room to continue our consideration of the estimates of the Ministry of Health.

Thank you, everyone, for being here.

This meeting is adjourned.

[The committee adjourned at 10 p.m.]

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of the Legislative Assembly of Alberta