Legislative Assembly of Alberta

The 29th Legislature
Third Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Tuesday, April 11, 2017
3:30 p.m.

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Standing Committee on Families and Communities

Goehring, Nicole, Edmonton-Castle Downs (ND), Chair
Smith, Mark W., Drayton Valley-Devon (W), Deputy Chair

Aheer, Leela Sharon, Chestermere-Rocky View (W)
Drever, Deborah, Calgary-Bow (ND)
Hinkley, Bruce, Wetaskiwin-Camrose (ND)
Horne, Trevor A.R., Spruce Grove-St. Albert (ND)
Jansen, Sandra, Calgary-North West (ND)
Luff, Robyn, Calgary-East (ND)
McKitrick, Annie, Sherwood Park (ND)
Miller, Barb, Red Deer-South (ND)
Pitt, Angela D., Airdrie (W)
Rodney, Dave, Calgary-Lougheed (PC)
Shepherd, David, Edmonton-Centre (ND)
Starke, Dr. Richard, Vermilion-Lloydminster (PC)*
Swann, Dr. David, Calgary-Mountain View (AL)
Yao, Tany, Fort McMurray-Wood Buffalo (W)

* substitution for Dave Rodney

Also in Attendance

Clark, Greg, Calgary-Elbow (AP)
Dach, Lorne, Edmonton-McClung (ND)
Loewen, Todd, Grande Prairie-Smoky (W)
Strankman, Rick, Drumheller-Stettler (W)

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Jeanette Dotimas	Communications Consultant
Tracey Sales	Communications Consultant
Janet Schwegel	Managing Editor of *Alberta Hansard*

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Standing Committee on Families and Communities

Participants

Ministry of Health
Hon. Sarah Hoffman, Minister
Hon. Brandy Payne, Associate Minister
Carl Amrhein, Deputy Minister
Jessica Ellison, Executive Director, Health and Wellness Promotion

3:30 p.m. Tuesday, April 11, 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 is continuing the consideration of estimates for 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 at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and chair of this committee. We'll continue, starting at my right.

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

Mrs. Pitt: Angela Pitt, MLA, Airdrie.

Mr. Strankman: Rick Strankman, MLA, Drumheller-Stettler.

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

Mr. Loewen: Todd Loewen, MLA, Grande Prairie-Smoky.

Mr. Clark: Good afternoon. Greg Clark, MLA, Calgary-Elbow, and my assistant, Barbara Currie.

Dr. Starke: Good afternoon. Richard Starke, MLA for Vermilion-Lloydminster.

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

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora and Minister of Health and Deputy Premier.

Ms Payne: Brandy Payne, Associate Minister of Health and MLA for Calgary-Acadia, and also I'll introduce our officials at the table. At the far end we have Charlene Wong, who is our ADM of finance. Beside her we have Andre Tremblay, who is our associate deputy minister, and then to my right is Carl Amrhein, who is our deputy minister.

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

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

Drever: Good afternoon. Deborah Drever, MLA for Calgary-Bow.

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

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

Ms Jansen: Sandra Jansen, Calgary-North West.

Ms McKitrick: Bon après-midi. Annie McKitrick, Sherwood Park.

Mr. Dach: Lorne Dach, Edmonton-McClung.

Mr. Shepherd: David Shepherd, Edmonton-Centre.

The Chair: Thank you. 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 this meeting.

A total of six hours has been scheduled for consideration of the estimates for the Ministry of Health. For the record I would like to note that the Standing Committee on Families and Communities has already completed three hours of debate in this respect. As we enter our fourth hour of debate, I will remind everyone that the speaking rotation for these meetings is provided for in Standing Order 59.01(6), and we are now at the point in the rotation where speaking times are limited to a maximum of five minutes. Members have the option of combining their speaking time with the minister for a maximum of 10 minutes. Please remember to advise the chair at the beginning of your rotation if you wish to combine your time with the minister, and discussion should flow through the chair at all times, regardless of whether or not the speaking time has been combined.

The speaking rotation is set out in the standing orders, and members wishing to participate must be present during the appropriate portion of this meeting. If members have any questions regarding speaking times or the rotation, please feel free to send a note or speak directly to either myself or the committee clerk about the process.

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. Is anyone opposed to having the break? Seeing no opposition, we will call the break at the midpoint.

Committee members, ministers, and other members who are not committee members may participate. A committee member or an official substitute for a committee member may introduce an amendment, which must be in writing and approved by Parliamentary Counsel prior to the meeting. Twenty copies of amendments, including the original, must be provided at the meeting for committee members and staff. Ministry officials may be present and at the discretion 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. Ministry officials are reminded to introduce themselves prior to responding to a question.

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.

Pages are available to make deliveries of notes or other materials between staff in the gallery and the table. 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.

When we adjourned on April 10, 2017, we were five minutes into the exchange between Mr. Yao and the minister. I will now invite Mr. Yao or other members from the Official Opposition to complete the remaining time of the rotation. You have five minutes.

Mr. Yao: Thank you. Thanks for being here again. Under diagnostic, therapeutic, and other patient services on page 86 of your business plan, under expense, for 2016-17 it was $2.49 billion. This year it's $2.38 billion, $110 million less than the year before. How are you achieving this goal of savings? Congratulations, by the way.

Ms Hoffman: Always happy to receive some congratulations. While we just flip to the right page, I'll just tell you that in every part of Alberta Health Services as well as within the ministry we are looking to find efficiencies wherever we can without impacting front-line patient care, so that's essentially the driving value that's leading to this.

Would you mind just saying the page number again?

Mr. Yao: Page 86.

Ms Hoffman: Thank you very much.

Mr. Yao: I can go on with some other questions related to this.

Ms Hoffman: I think so, and we'll answer them both together.

Mr. Yao: I'm just kind of curious: how does this department's compensation model work? How many salaries are under this heading? Are there additional expenses besides salaries? Do we include equipment under this heading as well?

Ms Hoffman: Of diagnostic and therapeutic?

Mr. Yao: Yes. I understand there might be a difference between direct delivery and contracted delivery. How much of this is provided by contractors, and how much is direct delivery, please?

Ms Hoffman: Through AHS as opposed to being contracted to some organization like DynaLife.

Mr. Yao: Agreed.

Ms Hoffman: Yeah. Okay. Excellent questions. Somebody found the page? Sorry. Keep asking more questions, and we'll make sure we get all three of them if you don't mind.

Mr. Yao: Certainly. Throughout the business plan and your estimates that you've provided, where else do we have substantial contracted services? What percentage of our ambulance services are contracted? Under population and public health: is that where primary care networks would be located, PCNs? What percentage of those are contracted? Also, under research and education the same question: how much of that is contracted out as with information technology, community and home care, as well as continuing care?

Ms Hoffman: Great. Thank you for questions. These are certainly a number of areas that you've highlighted where there are contracted services that are provided through either grant arrangements or through RFP processes, where contractors are secured.

Mr. Yao: I recognize that you don't have much time to answer to the question. Could you table any of this information that you can provide, please?

Ms Hoffman: The deputy will take an opportunity. Thank you.

Dr. Amrhein: In the case of primary care networks I'm not sure what the concept of contracted out would mean.

Mr. Yao: Versus direct delivery by the government.

Dr. Amrhein: A hundred per cent of the primary care networks are delivered by general practice physicians, which are either family physicians or pediatricians, and these individuals as physicians would be compensated through their family clinics on a fee-for-service basis for the work they do as family physicians. So none of the primary care network medical doctors would be employees of the government of Alberta. The per capitation funding, the $62 per year, that the PCNs receive for each of the patients that they have listed, would be paid to corporations that are physician-managed corporations. Those corporations are separate legal entities, and those corporations hire various health professionals as the so-called team bundle. As far as I know, none of the employees of the PCN corporations are directly employees of the government of Alberta. In the case of PCNs if the definition of outsourcing is that they are not employees of the government of Alberta, then the answer would be that 100 per cent of the activity is done by payment from the government of Alberta either through the Alberta medical agreement or through the PCN contracts.

In the case of ambulances these are approximate numbers, but roughly just under 400 ambulances are owned by Alberta Health Services, and something over 120, maybe 130 ambulances are contractors to Alberta Health Services. Some of those ambulances are private, for-profit, and more than not are private, not for profit, including ambulances provided by companies like Covenant Health. That is probably the single largest subcontractor to Alberta Health Services.

3:40

The Chair: Thank you.

I would now like to invite Dr. Starke from the third-party opposition and the ministers to speak for the next 10 minutes. Dr. Starke, are you wanting to combine your time?

Dr. Starke: Yes, please.

The Chair: Go ahead.

Dr. Starke: Well, thank you, Chair. Thank you, again, Minister, and to staff and the associate minister, welcome. You missed a riveting session last night, but we'll try to match it today.

Minister, I have a number of questions flowing out of the business plan that deal to a large extent about performance measures and monitoring of the overall performance of the system. I'd like to start by asking: you know, we acknowledge the desire and the need to prove the quality of our health care system, but I'm curious to know why the government is discontinuing the Health Quality Council of Alberta, the biannual survey that is being done. Why is that being discontinued?

Ms Hoffman: Thank you very much for the question. I look forward to you telling us more about Tommy Douglas in subsequent opportunities, I hope.

Dr. Starke: I could give the cream separator story, but it's a long one, and I only have 10 minutes.

Ms Hoffman: You got 10.

With regard to the question about the biannual survey, HQCA submits their proposed business plan to us every year, and I believe that they wanted to focus some energies on other areas. I'll confirm that, but that's my recollection.

The response rate without land lines is problematic. We're aware, I'm sure, for all of us who've tried to do outreach to a number of individuals, that it's more complicated now than it was 30 years ago, so I think that that was one of the pieces. But I will confirm that it was the HQCA. If it was not, I'll be sure to follow up in a written response.

Dr. Starke: Sure. Okay. Thank you for that.

Minister, I want to just go back a little bit. I was looking through the 2016 business plan, outcomes and targets. I recognize we're

looking at the 2017 budget, but there were some things in the 2016 budget that are now not there in 2017, so I guess I am interested to see what the performance in some of these key strategies was. Just as an example, key strategy 1.2 in 2016 was to create 2,000 public long-term care and dementia spaces over four years. I'm just wondering how many spaces were created in this past year, and how many do you anticipate to produce in the coming year?

Ms Hoffman: Yeah. Thank you very much for the question. There was some rewording, as you've rightfully noted. The key strategy on adding the 2,000 continuing care beds has been amended slightly to include dementia beds as well. We've definitely heard from folks in the community, so those won't all be public long-term care beds. Many will have to be DSL level 4D beds. As a number of projects are continuing to move forward and as we announced in the most recent budget, the 550 new spaces in this year's budget – last year there were a number of projects where through ASLI we were able to successfully upgrade the beds from lower levels, as were announced previously, to dementia beds and to long-term care beds. So some of those that will open this year include Calgary, Medicine Hat, Red Deer, Edmonton, Hythe, and the lovely community . . .

Dr. Starke: Forty-four beds in Lloydminster.

Ms Hoffman: . . . of Lloydminster.

Dr. Starke: I want to thank the minister for that. We're anticipating that expansion to our services very much.

Minister, on the same light, strategy 1.3 in 2016 talks about: to "implement an addiction and mental health strategy." I know that that was the Valuing Mental Health work that was chaired by Dr. Swann and was, I think, another good blueprint for the implementation of improved mental health care for Albertans. So we know where the strategy is. We know how Albertans can see the strategy, I guess. What is the progress being made? I know there were five high-priority items that were initially implemented, and then there were a number of other recommendations. I'm sure Dr. Swann could tell me the exact number, but there were a number of other recommendations that were sort of in the hopper, and we were going to get around to them as well. Where are we at with that?

Ms Payne: Thank you for the question. As you rightly noted, the last year's budget included progress on a number of the recommendations coming from the Valuing Mental Health report. From there a big piece of the work that's been ongoing in that time has been around, basically, just fleshing out the implementation plan as well as bringing together not just officials from within Alberta Health and Alberta Health Services but, indeed, across government and community groups to ensure that we have kind of a better sense of the work that's being done across the province around mental health. So we continue to move forward on that in the coming year and have set forward quite a – sorry; the exact number is escaping my brain right now. But we've got several million dollars allocated in this year to continue with the recommendations along that line. Additionally, one of the pieces was around opening some youth detox beds in Red Deer. I'm pleased to say that the tender for that has gone out, and we expect to be moving forward with that project shortly.

Dr. Starke: Okay. Well, thank you for that. I'll also mention, as I did to the minister last night, that as far as youth detox and adult detox beds, for that matter, there's a facility in Lloydminster that actually was built largely with Alberta government capital funding that is underutilized currently and has vacant beds and so certainly could be used.

Moving along to outcome 2 in the 2016 business plan. Key strategy 2.3 at that time was to "develop a whole-of-government approach to wellness and collaborate with key partners to build community capacity in support of wellness." Now, that I cannot find in this year's business plan, so I'm taking, then, that indeed you have developed a strategy. I'm curious. What is the approach that was developed, and how is this working across government?

Ms Hoffman: Thank you very much for the question and the opportunity to elaborate a little bit on that. We definitely held consultations with 120 participants and AHS health professionals, I believe, and we're working with them in an advisory process to make sure that we identify the best way to implement that in partnership with AHS. We are continuing to work on this initiative. It just hasn't been identified as one of the measures in this year's business plan.

Dr. Starke: It is ongoing, though?

Ms Hoffman: It is ongoing. Yeah.

Dr. Starke: Okay. Well, I would certainly encourage that. I think that's a positive thing. I mean, I absolutely concur with the statements Dr. Swann made last night about additional resources and additional emphasis placed on preventive health care and primary care and access to primary care not just through primary care networks but primary care professionals, whether they be nurse practitioners or LPNs, by whatever means to develop a team-based system.

Key strategy 2.7 in the 2016 business plan was to implement a wait time measurement and wait-list management policy to address long wait times in the health care system. Now, that's also absent from this year's business plan. Again I'm curious. What measurements and policies have been developed, what are the metrics, and how are things going? Are we seeing improvements? Are we seeing some measures improve and some measures maybe deteriorate a little bit? I know CIHI does reports on these on a regular basis as well.

Ms Hoffman: They do. I'll start by saying some the areas probably we've seen improvement.

Dr. Starke: Sure. Start with the good.

Ms Hoffman: Sure. There we go. Thanks. Hip fracture repair rates, radiation therapy, stroke treatment centres: these are definitely areas where we've been able to see, address success in terms of reducing wait times. There aren't enough areas. We certainly have far further to go, and we know that all Albertans deserve the fastest response times we can possibly do within the resources that we have. A few other areas where we've made improvements: a 25 per cent decrease in wait times for neurosurgery between the 2015 dates and present. As well, decreased wait times from specialist to treatment in a number of areas: 20 per cent for general surgery; 21 per cent for internal medicine; 14 per cent for specialists focusing on ears, necks, and throats; a number of areas.

One of the areas where we're struggling the most right now is around cataract surgery wait times. That is an area that we have far more to do as the population continues to grow and the number of people in need of cataract eye surgery continues to increase.

Dr. Starke: That's interesting because I had cataract surgery in February a year ago here at the Royal Alex and – I don't know – I think I waited six months. I could see, so it wasn't a really urgent issue. The care was excellent. I will say that.

Finally, Minister, are we measuring the delay or the wait time? One area that I hear a lot from constituents on is the wait time from seeing their GP to seeing the specialist. A referral was made, but there seem to be in some cases inordinately long waits to see a specific specialist. Some areas, I think, of special concern are psychiatry. Where there seems to be a shortage as well is some of the more specialized areas where a wait can be a real critical problem. Certainly, oncology is one area. If we have a wait that's inordinately long, obviously, the condition can progress.

3:50

Ms Hoffman: These are absolutely some of the priority areas that we're looking at, and I think that there can be a few different ways. You shared a personal health story, so I'll share one, too.

Dr. Starke: You've got seven seconds.

Ms Hoffman: Oh. In terms of enabling patients to be partners in their health care, having an electronic health record will help with that.

Dr. Starke: Okay. Thank you.

The Chair: Thank you.

For the next 10 minutes I would like to invite Mr. Clark, leader of the Alberta Party, and the minister to speak. Mr. Clark, would you like to combine your time?

Mr. Clark: I would, yes. Thank you very much.

The Chair: Go ahead.

Mr. Clark: And, yes, Dr. Swann and I are going to alternate our time slots here as we go through the rotation.

Thank you for the opportunity to be here, both to the minister and to the associate minister. Again, having had some very recent personal experience in the health care system, I just wanted to be on the record again that the care I received was absolutely excellent and world class and that we have some remarkable front-line staff in this province. I just again want to make sure that I share that with your administration here as well. Notwithstanding some concerns and challenges in areas, overall acute care in this province is strong.

I am going to start today with talking about home care and some concerns that have been raised to me by a constituent in a particular situation, though I think it speaks broadly to the importance of home care and perhaps some opportunities for improvement as well as some of those things that happen in government that seem to be disconnected between different departments.

While I see on page 14 of the fiscal plan that the community and home-care budget has increased substantially – and I think that is a wise investment – I just want to talk about some of the challenges for people who are caring for loved ones, for their children who are profoundly disabled. For some of the supports that they receive when those children are not yet 18, which happens primarily under what was human services, when they turn 18, that funding now comes from family support for children with disabilities, which is a mix of funding from home care and PDD, the family-managed services, I understand. Just if I can confirm, is family-managed services part of Health and of Community and Social Services?

Ms Hoffman: Thanks for that. While we get the confirmation, I will say how pleased I am that you had a positive experience in the acute-care system. That's certainly appreciated.

I also wanted to note, just because we didn't have time in the 35-second exchange, that laundry services in the cities of Edmonton and Calgary are outsourced, so if there was an $8 laundry fee, I'd be happy to talk to you about that for that specific blanket because that certainly would be likely very high for that contracted service.

In terms of family supports for children with disabilities, social services is certainly one of the areas of lead, and PDD is the overall file where that's housed. We do have some budget line items that relate to that.

Perhaps my deputy would like to expand.

Dr. Amrhein: Family-managed services apparently are not part of the ministry of Health. That would be another ministry.

Ms Hoffman: Community and Social Services. Yeah. Just to clarify, FSCD is under Children's Services, and PDD is under Community and Social Services.

Mr. Clark: Okay. I understand that some of the funding now that this person is over 18 is – when funding was under PDD, when they were younger than 18, the total funding that they received was $23.69 per hour for care, which includes employer deductions. But for home care, I understand, it sounds like what's happened is that once the child has turned 18, there are now multiple funding envelopes, one of which comes from home care, and some of the home-care supports that they receive seem to be substantially – it looks like about $4.50 an hour less. One of the challenges that they've identified to me is that home care doesn't seem to differentiate between care levels and acuity. It just is a matter of hours that are required, and it really doesn't have anything to do with acuity. Can I just confirm that?

Ms Hoffman: You know, we're getting to a level of specificity that I don't want to misspeak on. So I would welcome you to contact my office, or we can actually contact you, sit down, and do some work to support this constituent.

Mr. Clark: Sure. Why don't I do that? That probably makes more sense.

Ms Hoffman: I'd be happy to follow up in further detail, but I want to get you the right information.

Mr. Clark: That's fair. What I will do is write you a letter with some of these specific details.

Ms Hoffman: Sure. Yeah, whatever you prefer.

Mr. Clark: And if it's possible, we can delve into it.

Ms Hoffman: Happy to meet face to face or do the letter, whatever you prefer.

Mr. Clark: Okay. Sure. I would very much appreciate that.

We'll go, then, to the business plan. On the Valuing Mental Health action plan, outcome 1 on page 81 of the business plan, you've said, "Implementing a system-wide response to chronic conditions" as the fourth bullet point under key strategy 1.1. Can you just talk in a little more detail about what exactly that means? That's a pretty broad statement, and chronic conditions are wide and varied. I'm just curious. If you could speak a little more about specifically what you're doing to address chronic conditions.

Ms Hoffman: Back to the associate minister.

Ms Payne: Thanks. Yes. A big piece of that is around, you know, ensuring that we're delivering appropriate care for people who maybe have chronic and oftentimes multiple conditions, making sure that we have a co-ordinated system in place as well as ensuring that we have more of that information being shared with different

health practitioners, going back to the conversation around the personal health worker that my ministerial colleague referred to.

Another big piece of that is around, you know, keeping a bit of monitoring around the return of mental health patients with unplanned readmissions within 30 days of leaving hospitals, a key part, of course, under item 1(a) on page 81. We certainly want to make sure that Albertans are attached to a primary health care provider who is able to have that continuity of care between discharge from hospital to the care in the community. Certainly, we've heard from patients and through the work of the mental health panel that sometimes there can be that disconnect from discharge to community care and that in that sometimes patient care isn't as robust as it could be, which can sometimes then lead to concerns around readmission. So really focusing on that continuity of care across different levels in the system.

Mr. Clark: Okay. I'm looking at the performance measures on the same page, on page 81 of the business plan. You've spoken to a couple of them, but they seem to be not fulsome enough measures to truly address the breadth of the key strategies that we have here. I'm just curious. Are there further performance measures under development that would speak to some more specific outcomes that you anticipate in terms of addressing chronic conditions in particular?

Ms Payne: With respect to mental health chronic conditions in particular we're certainly doing some of that work through the implementation of the Valuing Mental Health. As well, in addition to the ones outlined in the business plan, we'll be, you know, tracking measures around patient outcomes, things like readmission as well as any other metrics that are relevant, so wait times, things like that. It is something we are continuously doing.

A key part of the implementation of the Valuing Mental Health report is ensuring that we do have that framework in place for that evaluation of the services that are being provided to Albertans. That is a piece that has sometimes been missing. A lot of pilot projects have happened in the past, and there hasn't always been that evaluation of how they're working as well as that evaluation of how they can be scaled up, perhaps, across the province and tailored to the individual needs of different communities.

Mr. Clark: Moving on just to the next bullet point there on page 81, the fifth one, supporting appropriate and reasonable access to pharmaceuticals and supplemental health benefits, are you looking at any new models for pharmaceutical procurement, banding together with other provinces in terms of bulk buying, anything like that?

Ms Payne: Yeah. That's absolutely a key piece of the work that we're doing in collaboration with health officials across the country and, you know, kind of co-ordinating around ensuring that each province is able to work together to secure, perhaps, better deals from manufacturers and the like. We want to make sure that we're able to get as far as we possibly can with Albertans' resources.

We do have a member from our department here, Michele Evans, who is able to speak a little bit more about that issue.

4:00

Mr. Clark: No. That's fine. I think we'll wait till next go-around, and then we'll start again.

The Chair: For the next 10 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?

Ms Luff: Yes, please.

The Chair: Go ahead.

Ms Luff: Thanks. I just wanted to ask a bit of a follow-up question. I was asking questions about vaccinations and immunization rates when we were last speaking. You know, given that discussion that we've been having, I did notice – and I've lost it now – line item 7, population and public health. There's been an increase to that budget, so I was just curious, if some of that money is being used to address the vaccination rates and those performance measures, how it will be used in order to possibly boost those things. I did also just notice that the forecast for 2016-17 is, you know, lower than what was budgeted for '16-17, so – I don't know – why the discrepancy there, perhaps?

Ms Hoffman: No. Thank you very much for the question. It is a significant increase, an increase of $39.7 million, or 74 per cent, which is definitely the largest percentage increase in any one given area within our Health budget. This area will receive this boost because it includes the incremental cost to providing opioid replacement therapy treatment to all Albertans, including those who are not government sponsored.

One of the members yesterday, I think – I believe it was Dr. Swann – talked about how, when people want to transition from an addiction to a street drug to opioid replacement therapy, if they don't have drug coverage, that's often an impediment. Certainly, if people are on their journey away from addictions, we want to support them and make sure that that doesn't become a barrier. We know the cost to families and to communities as well as the cost to the system when people's only option is through the acute-care system. We want to support the transition from acute care to community, and one of the easiest ways is to make sure that people have access to drugs that they would only have access to in acute care. This is one of the key areas.

Also, with the bill that we did bring forward, that did see unanimous support, around increased awareness through public health officers and specifically reaching out to families, there will be some needs in that area. But the biggest area of increased investment within this line item is around the opioid replacement therapy.

Ms Luff: Okay. Thank you.

I guess, seeing that we are discussing some of the issues with the fentanyl crisis and opioid use, I know it's certainly a problem that we're seeing in my community. I heard just the other day that there was a young person who unfortunately overdosed in my community. Outside of downtown Calgary we see some of the cases of overdoses happening in my area and in my community. So I do know, you know, the number of deaths, unfortunately, is still on the rise, but the actions that have been taken have undoubtedly saved lives and prevented even greater harm. Taking into account harm reduction efforts, education and prevention, and treatment and recovery – you've just spoken to it a little bit, but perhaps you could tell us how much money was spent on responding to the opioid crisis in 2016.

Ms Payne: Yeah, and thank you for the question. With respect to the 2016 budget we had spent approximately $14.5 million on the opioid crisis in 2016-17. That does not include the $12 million in one-time funding, which was a combined $6 million from the federal government, which was announced on March 10, as well as a matching $6 million from Alberta Health. Specifically, over the course of the year with the funds we were able to spend $7.75

million for Suboxone and methadone treatment, including the associated dispensing fees.

We spent about $900,000 on expanding the province's take-home naloxone program, which included the purchase as well as distribution of the kits and training for those handing out the kits.

From there as well there was a $230,000 grant to the Access to Medically Supervised Injection Services Edmonton group, more commonly known as AMSISE, to continue its application to the federal government for supervised consumption services as well as some funding for other communities to begin some of the legwork around evaluating the need for supervised consumption in those communities.

Additionally, we were able to support work already under way by Alberta's indigenous communities to address opioid use.

Additionally, $60,000 is for an interim public awareness campaign, the get naloxone one, to help make sure that people were aware of the take-home naloxone program and to help get more information out there. You know, while it is true that a naloxone kit really does act as a Band-Aid in the case of an overdose and more medical attention is still required, we are hearing from first responders and from community members that these kits are having a real impact on being able to save people's lives and make sure that they're able to get access to the medical services that they need. Especially given that they're available without prescription and free of charge, I would really encourage every Albertan who has a family member or a loved one who they're concerned about to access a kit.

We've also been working with primary care givers and primary care providers around expanding access to opioid dependency treatment – so that's Suboxone and methadone – within the communities.

Additionally, we have one-time capital funding primarily for renovations for detox beds for people for whom detox is an appropriate treatment method as well as an overall $3.4 million for operational costs for treatment beds.

Ms Luff: Thanks. That was very detailed.

I do hear from people very frequently that it's great to hear that there is an awareness program for the naloxone kits. Are there any other awareness programs that are happening or being planned? I do hear often that sometimes kids, you know, are at a party and someone offers them a pill, and it's not something that they're aware of. Is there any partnering with the Education department to maybe get the word out to young people about the severity of this drug?

Ms Payne: Yeah, absolutely. We've been working with our partners in the Ministry of Education around getting a little bit more information. We've been working with a lot of community partners on this issue as well. Just earlier today, in fact, I met with some representatives from a group called Moms Stop the Harm as well as a group called Get Prescription Drugs off the Street to talk about ways that we can incorporate more targeted messaging.

One of the challenges facing us with the opioid crisis is that there are many different pieces to this puzzle. There's a variety of people who are using drugs and who are overdosing. Some are people who have a long-running substance use concern. Other people are, you know, as you said, trying a pill at a party. So making sure that we're able to reach all those people involves some targeted messaging. We'll have more to say on that in the coming weeks.

I'll turn this over to the minister as well.

Ms Hoffman: Thank you very much. I just can't help myself. Two little anecdotes I want to share. One was that, like you, my riding isn't in the downtown core. My riding stretches through much of the west end here in Edmonton and many affluent neighbourhoods. When I was touring a fire hall last week, one of the firefighters there said that just since January he has administered 18 doses of Narcan out in the community and thanked us for giving him the ability to feel that he can do something when he comes on a scene.

Regularly people are taking pills and often even splitting them. The best analogy I can give is that if you split a chocolate chip cookie, some people get more chocolate chips than others. You just don't know where those little grains of the substance fall within that pill. There were examples of one pill being split between two men. One went in the shower to get ready – they were going out to a nightclub – came out, and his friend had been unconscious for 20 minutes. Fortunately, that Narcan kit saved that gentleman's life. Naloxone can save lives. These guys thought that they were streetwise. They thought they had Oxy. They had no idea. You just can't take enough precautions. Fortunately, those guys who encountered that situation – hopefully, they don't use again. If they do, they know that they can get a naloxone kit even if they don't think they're going use, but they just want to have it on-site.

4:10

I've heard from many people in the downtown core who said: I have a kit just in case because sometimes I walk by somebody, and I don't if they're overdosing or not. These kits are absolutely not the sole solution, but at least they're a tool to give somebody another day to have an opportunity to make another choice. In some pockets of the population they've been using them since 2005, but we've only made them widely available recently, and they are fortunately saving lives almost every day.

No matter what you think – your kid could be the best kid in the world. But if you want to have this tool, there are over a thousand distribution sites, I believe, now in the province. You can call 811, Health Link, and ask them where you can get one, or go to a pharmacy.

The Chair: Thank you.

For the next 10 minutes I would now like to call on Mr. Loewen from the Official Opposition and the minister to speak.

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

Mr. Loewen: Yes, I do.

The Chair: Go ahead.

Mr. Loewen: Thank you, Minister, Associate Minister, and staff, for being here today. What I would like to talk about is the Grande Prairie hospital. Surprise, surprise. I see there are some additional funds that have come out in this budget for the hospital. I'm just wondering what additional things are going to be done on that hospital.

Ms Hoffman: Yeah. Thank you. This is one of those projects that has been a significant headache for the residents of Grande Prairie, for the ministries of both Health and Infrastructure. I think it's, hopefully, a lesson for all who were involved at the time these decisions were made that you shouldn't make an announcement without having done due diligence in costing the project, making sure you have the right scope, that you're not just announcing a number, that you're actually doing it based on the needs of the community.

The additional funding that's required for the Grande Prairie hospital is in a few key areas. This project was approved by the

former government with a budget of $647.5 million, and the basis of the project was for their functional program, which articulated the project costs and scope. The design is completed, and the project is currently under construction with a target of 2019.

There are two components to the additional funding that are required for this project that we have in this budget. That's $39 million, unfortunately, for cost overruns – this was for some areas that weren't properly costed previously – as well as $33 million to complete two of the in-patient units that were anticipated to be shelled-in space. We know that that space is needed, so it's going to complete them so that we can consolidate all of the beds that are at the current QE II into the new facility. This $33 million will be to enable the staff to work in one facility. We consider this a good investment, and it will be able to see efficiencies having all staff work in the one facility.

Mr. Loewen: Okay. The two in-patient units: is that the two operating rooms?

Ms Hoffman: No. I believe these are in-patient beds. I think they're mental health beds primarily that were planned to stay at the QE II, but now we're going to move the beds over to the new hospital. So they were going to be shelled-in space, but now they'll be fully functional for mental health supports.

Mr. Loewen: Okay. Just so I'm clear, there's the mental health wing of the new hospital that was previously going to be shelled in. Is that going to be opened now?

Ms Hoffman: That's right.

Mr. Loewen: Okay.

Ms Hoffman: So instead we're opening those units with this $33 million.

Mr. Loewen: I wasn't sure how many beds were going to be included in that. You said two units?

Ms Hoffman: Units.

Mr. Loewen: Okay. Perfect.

Ms Hoffman: The sizes of the units vary, but it will ensure that those two are open instead of shelled in.

Mr. Loewen: Yeah. The mental health unit will move over and be in the new hospital, then.

Ms Hoffman: Yeah.

Mr. Loewen: That's great to hear.

I understood there were two surgery rooms that were not going to be fully functional or were not going to be functional. Do you know anything on those two?

Ms Hoffman: I believe that's still the plan. We anticipate there will be growth in the region. Again, there were announcements made with different numbers, but having shelled-in space can have potential benefits when it comes to needing room to grow rather than being full on day one, so the plan is still to have some shelled-in OR space. As demand continues to grow, we'll be able to grow the programs.

Mr. Loewen: Okay. No problem.

And then parking. Was there anything with parking there?

Ms Hoffman: Oh, I love parking. Parking is something that is cost recovery, so AHS usually takes a loan from us that allows them to build the parkades and then pays us back that loan primarily through parking fees that are acquired because we don't want to spend money building parkades if we can spend it building ORs and hiring staff to work in those ORs. That's where we're at today.

Mr. Loewen: Okay. So you don't know for sure whether it's being completed. It's not, obviously, in this budget.

Ms Hoffman: Would the deputy like to expand? I know that usually they give us an application for a loan, and they build the parking. But do you have details on this specific project?

Dr. Amrhein: Parking would not appear in the Ministry of Health budget. It would be under Alberta Health Services' ancillary operations. The government of Alberta would have to approve the borrowing from the government's financial arm, but the asset value and the depreciation would be handled though AHS's non public funded ancillary company accounts.

Mr. Loewen: Okay. So you don't know if it's going to happen or not?

Ms Hoffman: It's not in this budget. If you want to ask me about that outside of budget deliberations, I'd be happy to get you the information. We can either do it through e-mail or set up a phone call. But it isn't in the budget, so I'm not able to answer that piece today.

Mr. Loewen: No problem. Thank you very much. We'll chat after. That's fine.

Ms Hoffman: Great.

If I have a moment, I just wanted to clarify for the record that the contracted out services that were asked about by your colleague Mr. Yao, around contracting out for things like diagnostics and other areas, are AHS contracts. All AHS contracts are posted. They began that process in 2014-15, so they're all on their website. You'll be able to see whether they're sole sourced or whether there was a bid process. You'll be able to see all the contracts, be able to accumulate how many were done outside of AHS.

Thank you.

Mr. Loewen: Thanks.

When I had done the calculations, it looked like an extra $130 million going to the Grande Prairie hospital, and you've said $39 million on cost overruns, $33 million for mental health. Do you know where the other monies went there? If you want, you can undertake on that.

Ms Hoffman: Yeah. Sorry. I have those two pieces on my note. Let's see if I can find a third one. Oh, yeah. Here we go. Capital funding requirements in construction approved in 2010 – Deputy Minister, would you like to add to how the number is larger, or perhaps Ms Wong if you'd like to send it there.

Dr. Amrhein: We may have to give you more detail in written form.

Mr. Loewen: That's fine.

Dr. Amrhein: There are three components. There's the ongoing money, which was approved in previous years, which would be spent in '17-18. There's some cost overrun money that Alberta Infrastructure is covering through some of their lines. Then

there's the reprocessing for the two in-patient units, which will move from the old hospital to the new hospital. If it's okay, we will consult with Alberta Infrastructure and get you the detailed breakdown.

Mr. Loewen: Sure. That sounds good. Thank you very much.

Next question, on the town of Beaverlodge and their hospital: I understood, I think, that last year there was some money going to be set aside for doing some sort of study or some sort of prework on that. I don't see anything about the Beaverlodge hospital in the budget, and I'm wondering if you could give us an idea of what's going on with that.

Ms Hoffman: Yeah. Beaverlodge is one of many communities that has aging facilities and wants to ensure, for the confidence of their citizens as well as for their community's future growth, that they have a vision well into the future. I had the opportunity to tour the current facility recently and to meet with a lovely former nurse who has generously donated a piece of land, valued at about $600,000, that has lots of potential. Her family would like to be partners in supporting us through the construction of a new facility.

To make sure that we have the best plan not just for Beaverlodge but for all rural communities that have aging infrastructure, we did invest I believe it was $10 million in a rural health facility study. That work is still ongoing. Our goal is to make sure that we have a potential tool that we can use in a variety of situations because while Beaverlodge's hospital is definitely old, there are many older hospitals in this province. We want to make sure that the facilities meet the needs of a variety of communities, both communities that have growing populations, like I believe Beaverlodge does, but also communities that have declining populations still. We want to make sure that we have the right mix of services in good, safe buildings for years to come.

Mr. Loewen: Okay. Thank you very much.

I'll turn the time over to my colleague now.

Mr. Yao: All right. Let's go back to contracted services. You said that a lot of that is on Alberta Health's website, but can you give me an idea of what percentage of the $20 billion budget is allocated to contractors?

Ms Hoffman: You were specifically referring to contracts like diagnostic imaging, and these are through AHS. Alberta Health and AHS have their separate allocations. Money is allocated to AHS to deliver these health services, and some of those are contracted out. It's actually the Alberta Health Services' website where you'd have the breakdown. Just like the government has their blue book, AHS also posts their contracts online, with the amounts that were applied either through sole-source or rolled up. All of that information is available publicly, and I welcome you or your staff to access that on the AHS website.

Mr. Yao: But that's just things that are under AHS. What about things in the Health ministry like some of these other points in your expenses?

4:20

Ms Hoffman: Service delivery is all done through AHS. I guess if you wanted to refer to physicians as being contractors, because they're not GOA employees but physicians who are paid directly by Alberta Health, that piece could be considered contractors. In terms of service delivery of health care, like providing that front-line health care through contracted agencies or otherwise, that's done through AHS and is posted on their website.

Mr. Yao: All right, then. Yeah. I have to admit, I'm trying to understand the concept of public health care. Is it fair to say that based on what is going on with Alberta Health and whatnot, it's not about who's providing the service; public health care is more about who pays for it? Is that fair to say?

Ms Hoffman: Well, I would love to have – maybe we can have a cup of coffee and talk about the Canada Health Act and the origin of public health care in the country of Canada. Definitely, one of the principles is around single payer . . .

The Chair: Thank you.

I would now like to invite for the next 10 minutes Dr. Starke from the third-party opposition and the minister to speak. Dr. Starke, are you wanting to combine your time?

Dr. Starke: Yes, please.

The Chair: Go ahead.

Dr. Starke: Thank you, Chair, and thank you once again, Minister. I'm going to return our discussion once again back to the business plan. We discussed briefly yesterday, Minister, the roughly quarter of a billion dollars that is allocated in the budget toward PCNs and talked a little bit about PCN accountability. I note under performance measures on page 81, performance measure 1(c), access through primary care networks, the percentage of Albertans enrolled in a primary care network. I want to compliment you that this is actually one of the few areas where there's a current measurement plus a target for the three out-years. Unfortunately, we don't have a lot of targets in some of the other areas. And I note, you know, a steady increase from 78 to 81 per cent.

Minister, has there been consideration given to asking a second question, and that is asking how many Albertans are actually aware that they're enrolled in a PCN? My concern is that that number is actually a whole lot lower than 81 or 78 or 79 per cent. That I think speaks to the accountability of PCN funding, on the number of Albertans that, in fact, are being rostered and being counted as PCN-rostered patients. The PCNs are receiving the $62 per year payment for those patients, but in fact the patient is unaware that that's even happening. Do we have any idea of what that number is, and if not, is there any intention to try to get a feel for what that number is?

Ms Hoffman: I don't believe province-wide that it's one of the measures we have. Some PCNs have started surveying their own patients. I would say that my biggest goal is to ensure that PCNs provide comprehensive services and inform their patients of what those comprehensive services are. I would love for everyone to know that they're part of a PCN because they're actually accessing the pharmacy supports, the nutrition supports, the OT supports and so forth. So we are definitely continuing to work with PCNs. Many of them have been in existence for 10 years. Having the logo on the door is great; having the expanded services is better.

Dr. Starke: Well, you know, being aware of those services, as you mentioned, but also being aware of the fact that somebody is getting paid for the access to those services that they may not even be aware that they have the opportunity to access. I agree one hundred per cent that in terms of primary care through the PCNs, it's critical that they provide a broad basis in terms of hours of service and in terms of a spectrum of services because without that I don't think they're fulfilling their mandate.

I'd like to move on now to page 82 in the business plan, under key strategy 2.1. I want to just sort of go through some of the bullets

here. The second bullet is collaboration with Agriculture and Forestry and engaging with stakeholders to develop and implement a provincial strategy on antimicrobial resistance. As you can appreciate, I'm very interested in this topic. I'm curious to know: what progress is being made on that, how has that particular strategy changed the way we're delivering health care in Alberta, and are we improving our overall profile in terms of antimicrobial resistance for humans? I know the veterinary profession is very involved in terms of trying to reduce our use of antimicrobials in veterinary practice and seeing where that is all going.

Ms Hoffman: Yeah. This is one of these initiatives where we're working in partnership with other orders of government, including the federal government.

Dr. Starke: Right.

Ms Hoffman: They are taking the lead on this, and we are happy to support them in those efforts. You're right that we need to make sure that we are using these responsibly and not creating a bigger problem for ourselves in the future.

Dr. Starke: Okay. I would certainly encourage that because it is something that I think is a concern. I think that Dr. Swann has mentioned it as well in past years, the whole spectrum of antimicrobial resistance.

The next bullet point is somewhat related, and that's with regard to food safety and the food safety reporting mechanisms. I know one of the complaints that I get in rural Alberta quite a bit is from a group of folks within Alberta Health called the pie police or the perogy patrol. These are folks that we a get a lot of complaints about that come to church bake sales and come to country fairs and in some places shut them down because of food safety concerns. Now, don't get me wrong. I don't want anybody to go home with food poisoning – I get it – but, you know, the line I always get is: look, we've been having church bake sales and country fairs for decades, and nobody ever died. I'm not sure they know that for sure, but they say that, that nobody ever died. So I'm curious to know: have there been changes to how that group of Alberta Health inspectors are carrying out their duties? I still get complaints about that group of government officials working on your behalf, Minister.

Ms Hoffman: Thank you for the question. Sometimes there are also – I know one of the lodges that I visited has brought in their own policies around not having bake sales and those types of things, and it's easiest to point the finger at public health than it is to say: we made the decision not to do this.

Dr. Starke: Sure.

Ms Hoffman: I'm going to ask that Jessica Ellison, who is one of our executive directors in the department, come and elaborate a little bit more on some of the work that public health, through inspections, is doing to ensure safety.

The Chair: Can you just make sure to introduce yourself?

Ms Ellison: Jessica Ellison, executive director, health and wellness promotion. Our food safety regulation is being reviewed currently, and we do have a food safety modernization initiative that is done through Alberta Health, Alberta Health Services, and Alberta Agriculture and Forestry. They are addressing the review of the food regulation, which is expected within the next two years.

Dr. Starke: I applaud that. I hope that it brings about what I would consider to be a balance. I mean, it's very clear that we need food safety. Nobody is arguing with that. I think that at times, though, there was this perception, at the very least, that it was a little bit on the heavy-handed side, you know, geared more towards eliminating every last possible risk. In some cases and in any factor of health that's not always possible. So I thank you for that. Thanks for that. I appreciate that.

Minister, the fourth bullet under 2.1 – your colleague the Member for Calgary-East talked a little bit about this, and you and I have had this conversation in the last couple of years – is on increased immunization rates. Again, you know, it's probably no great secret to you that I'm all in favour of doing everything we can to increase herd immunity and to try to get a higher percentage of Albertans vaccinated for flu. But I guess I'm really quite dismayed at the ongoing low levels of vaccination under 2(b) for childhood immunization for MMR and also for diphtheria, tetanus, pertussis. Of course, we had a mumps outbreak not too long ago here that also involved some university students and had people under 50 years of age going and getting vaccinated.

I'm just wondering: what are the strategies to try to make sure that we can also dispel some of the unfounded myths and rumours about vaccination? I think, sadly, there was a survey here not too long ago that said that 25 per cent of Albertans still believe the largely discredited study that linked childhood vaccination to autism. I mean, that's been clearly discredited on a number of occasions, yet we have two or three movie stars that still believe it, so it seems that's all the authority that is needed to still make this a very popular myth.

Ms Hoffman: Really, my heart does go out to any family that learns about their child having a disability or a struggle in life. I think everyone wants to be able to rationalize why that might happen. I understand why some people may have gone to draw those conclusions, but the science doesn't support that; it doesn't validate it. It's important for us to talk about that. It's not anybody's fault when a child has a disability or a different way of communicating or functioning in society, but it is our responsibility to step up and support those parents, those children, and those partners.

I have to say that talking about this is obviously very important. So is making sure that public health is doing that outreach and that engagement with families because some may forget to immunize, busy lives. Some may still be believing the misinformation that's been spread. That's one of the reasons why I was so proud of all of us when we supported the public health amendments that we brought forward last year to ensure that we do have public health doing that targeted outreach, talking to parents about the truth. We've seen that general advertising campaigns don't reach those targeted populations, so having those conversations, I think, is going to go a long way.

4:30

Dr. Starke: Is it too early to know whether that's had any positive effect, that piece of legislation?

Ms Hoffman: The piece comes into effect September 1, with the school enrolment happening. Right now it's all about lining everything up so that in the fall we're able to have full implementation.

Dr. Starke: Minister, we have a very short period left in this, but I want to sort of just prime the pump for the next segment that we'll have. I want to talk about 2.3 and 2.4 in the business plan with the associate minister as well, the whole topics about maternal, infant, and child health and early childhood development, which I know is a topic of interest right now. I also want to talk about prenatal health and the whole concern about, you know, making sure that we do

everything we can to reduce things like fetal alcohol syndrome and that sort of thing.

Thank you.

The Chair: Thank you.

For the next 10 minutes I would like to invite Dr. Swann, leader of the Liberal Party, and the minister to speak. Dr. Swann, are you wanting to combine your time?

Dr. Swann: Yes. Thank you. Thanks very much for joining us again. I want to focus a little more attention on the mental health plan for the next year and would quote the fiscal plan, which indicated "the ministry has committed a $45 million increase overall for addiction and mental health support, including funding to support the implementation of the recommendations in the Valuing Mental Health Report." Could the deputy minister comment on what the full funding is? How much is federal? How much is provincial?

Ms Payne: Yeah. I'll kick it off, and then my colleague can add in anything that he feels I missed. For the implementation of Valuing Mental Health there's a total for mental health and addiction. We've got a $45 million increase in the fiscal plan, which combines $31 million under the addiction and mental health line item – that's element 5.2 on page 153 of the estimates – which is targeted particularly around some of the implementation of the Valuing Mental Health report. Additionally, there's $31 million that is under that same item. Of that, there's $15 million specifically for the recommendations of the Valuing Mental Health report and continuing the work that was started as well as $16 million of that $31 million that goes towards the opioid response in particular.

Dr. Swann: Okay. Where does the federal funding fit into all of this?

Ms Payne: The federal funding, which was also matched with $6 million from our provincial government, was in the 2016-2017 fiscal year because of when it arrived. We will be rolling that money forward through a grant, and it will be particularly targeted around ensuring an increase in access to treatments such as opioid replacement therapies as well as expanding access to opioid replacement around the province. We'll have some more fulsome details on that in the coming weeks.

Dr. Swann: It's not clear to me because I thought the federal funding was announced after the budget.

Ms Payne: No. It was announced on March 10.

Dr. Swann: It was included in the budget?

Ms Payne: Yeah. It was added to the '16-17 efforts, so it appears outside of the estimates that we're currently discussing, but it will be added into the funding that will be basically hitting the round in the coming year.

Dr. Swann: Will we see a progress report on the Valuing Mental Health report?

Ms Hoffman: Yesterday I said: stay tuned.

Ms Payne: Yes. Yes, indeed. We will have much more to say about the status of the implementation of the Valuing Mental Health report as well as the recommendations as well as the work that's been done to date. Over the course of the last year a lot of the work has been a little internally focused on making sure that we've got a fulsome sense of the work that was being done. As the members of the panel such as yourself were well aware, the delivery of mental health in our province has been very fragmented, very siloed. There have been quite a number of agencies, both government and nongovernment, that have been working on this issue and oftentimes don't necessarily know what the others are up to. It's having that collaboration and being able to move forward to ensure the best mental health system for Albertans that we possibly can.

Dr. Swann: I just want to thank you for that. I would say that I get calls regularly from organizations and individuals who are feeling somewhat disappointed that there's been no public statement even about it. I think it would do well to encourage all those front-line workers and organizations that are complementing the health care system, and I'm speaking of the nongovernment side. That would go a long way to assuage some of their somewhat cynicism over several years of reports that didn't get implemented, so I'd encourage you to do that in a timely way if you can.

The fiscal plan says, "The ministry has committed a $45 million increase for addictions and mental health and support." However, line 5 has a total of almost $81 million, which is an increase of $31 million. Where's the other $13 million?

Ms Payne: Yeah. There's also included in there $14 million that would be for the opioid response, particularly around methadone, Suboxone treatment, and that is under the population and public health line item within community-based services. This is, of course, one of our challenges. Sometimes in these documents the dollars appear in a couple of places, and you have to add them all up and figure where exactly they're going to go. Certainly, our government really believes that, you know, the addiction concerns that we're seeing and substance use concerns that we're seeing are indeed a public health issue, and we want to make sure that they're addressed as such.

Dr. Swann: Thank you.

In QP yesterday you indicated that the government would spend up to $56 million on mental health and addictions services. What are you referring to there? That's a different number.

Ms Payne: Yeah. That includes the funds that are allocated in this year between both the fiscal plan and the broader budget estimates as well as the $12 million that we noted from a combination of the $6 million from the federal government and the matching grant from the province that was from March 2017. Of course, based on the timing of those announcements, a lot of that money hasn't made its way out to the front lines as of this conversation. That means that with the combined $44 million that is in the '17-18 budget as well as that $12 million from last year, there will be $56 million being spent over the course of the '17-18 fiscal year.

Dr. Swann: That's a substantial increase. I think it's much needed. Obviously, it's appreciated if it's spent well.

I know that the big questions around mental health and addictions, as in the rest of the health care system, are: how are we monitoring its impact, and how are we evaluating that we're getting the best value? How are you evaluating?

Ms Payne: Thanks. That's a great question. You know, a big piece of how we're able to see how things are doing is the numbers around emergency department visits, the number of opioid reversals as well as the number of people being able to access treatment and to continue with treatment. Certainly, I think that everyone in this room would agree that the numbers that we're seeing with respect to emergency room visits for opioid overdoses as well as the

number of Albertans that have lost their lives to these drugs are much higher than any of us would like to see. We are continuing to evaluate and monitor those numbers as well as communicate with front-line staff around it, both in terms of front-line staff at emergency rooms but then also in regular conversations with first responders across the province. One of the things that . . .

Dr. Swann: Is there a reason why we can't report on emergency room visits when we report on the deaths?

Ms Payne: The emergency room visit information is included in the quarterly reports that have been released by Alberta Health and the chief medical officer of health. The interim report that was released last week focused mainly on fentanyl death numbers. Certainly, as we move forward we may continue to expand the amount of information that is in the reports.

Dr. Swann: I hope so. I hope so. That's very important for people on the front lines, to know what's working, what's not working.

I guess the other question is: do you feel that naloxone dosage, the number of naloxone doses given, is a helpful indicator for how we're doing in the province?

Ms Payne: That is something that's being monitored through the chief medical officer of health, which is where our response to the opioid crisis is being managed. Keeping track of . . .

4:40

Dr. Swann: But they're not reporting it.

Ms Payne: The number is being tracked, making sure that we're monitoring as well what the appropriate dosage is. As members may be well aware, with the emergence of carfentanil in Alberta, of course, carfentanil being substantively more potent than fentanyl, we need to be monitoring the number of doses that are required to reverse an overdose. Within the emergency department . . .

Dr. Swann: I've just got a few seconds left.

Ms Payne: Sorry. That is being monitored within the emergency department.

Dr. Swann: But could we not start reporting on it? If it's a good evaluation tool, surely it would be helpful to the public.

Ms Payne: Yeah. The ER visits by location as well as some of the information released through the chief medical officer of health do include some of that information. We are continuing to have the chief medical officer of health and the medical examiner's office work together on this to improve the information that is being . . .

Dr. Swann: So we are going to see some public reporting?

The Chair: Thank you. The time has expired for this portion of the rotation.

I would now like to invite Mr. Hinkley from government caucus and the minister to speak for the next 10 minutes. Mr. Hinkley, would you like to combine your time with the minister?

Mr. Hinkley: Yes, please. First of all, I'd like to thank the minister for her recent visit to the Wetaskiwin general hospital. It was greatly appreciated, and I know that the staff were not only surprised, because there was not much planning for it, but very delighted that it happened and they had a chance to reach out to you. Thank you very much.

The first couple of questions I have pertain to the business plan, page 91. As you know, our government is making efforts to reconcile with First Nations of Canada in Alberta. This government has made a strong public commitment to work with indigenous people in order to achieve greater equality. However, when we look at the First Nations health outcomes, they still lag behind those of nonindigenous Albertans. When we look at the performance indicator 1(a) on page 91, this has to do with life expectancy at birth. Why have First Nations life expectancies started dropping again, and what are we doing to bring them back up?

Ms Hoffman: I'll just start by saying thank you very much for the question and for introducing it by talking about the visit that we did have. Certainly, the staff there are amazing and deal with a number of complex challenges, and it was great to have a chance there.

I'll ask my associate minister to respond to the content of your question. Thank you.

Ms Payne: Thank you for the question. In general, life expectancy has less to do with the health system and more to do with social determinants of health, including safe and affordable housing, income, education, and early childhood development. In addition, First Nations people are more likely to have higher rates of diabetes, substance use, and poverty, all of which contribute to poor health outcomes.

This performance measure really confirms the importance of our government's commitment to address and resolve inequities facing indigenous people, especially when it comes to health. Our government is working closely with our First Nations partners both on- and off-reserve with the intention of providing stronger supports for both health care delivery as well as those other areas, those social determinants of health that contribute to healthy communities, particularly issues around housing and education.

Some specific examples of the work being undertaken include Alberta Health's ongoing work with AHS and indigenous communities to identify and develop opportunities to support comprehensive health services, including culturally safe and appropriate primary and community care as well as substance use and mental health services. This includes AHS's population, public, and indigenous health strategy, our strategic clinical network, and the work that that clinical network is doing on developing and piloting a comprehensive indigenous cancer prevention and screening approach.

Certainly, you know, continuing that work with First Nations communities and having that nation-to-nation conversation about ways that we can support indigenous peoples both on- and off-reserve are quite critical.

Mr. Hinkley: Still on page 91, now looking at performance indicator 1(b), which is about the infant mortality rate, again we see that the infant mortality rate is higher among First Nations. What are we doing to bring that rate more in line with non First Nations? You know, how can we do better to support their health care both on- and off-reserve?

Ms Payne: Yeah, absolutely. You know, as with the life expectancy comparisons, we also know that First Nations women face more challenges than non First Nations women during pregnancy, which can negatively affect birth outcomes. In addition to the infant mortality rate we also see concerns around birth weight, which can lead to lifelong health complications and challenges. We continue to work on maternal and infant health initiatives to support healthy birth outcomes. Alberta Health provides grants to community organizations that support vulnerable and street-involved pregnant and parenting women and to organizations that tend to include a higher proportion of First Nations clients, which includes the pregnancy pathways program and its support for homeless and

pregnant indigenous women, providing housing, food, prenatal support as well as substance use and mental health counselling and mentoring.

I visited Streetworks not long ago, and they offer a program like this there. You know, one of the things they noted was just the impact of women being able to come and listen to their baby's heart rate on a heart rate monitor. One of the front-line staff there was telling me how they regularly have women come to the clinic who are feeling vulnerable and feeling like they want to use substances, and they say: I just need to hear my baby's heart; I'm tempted, and I just need to hear my baby's heart. Sometimes it's little things like that that can make all the difference in addition to a lot of the larger work that we're undertaking.

Additionally, the Maternal Newborn Child & Youth Strategic Clinical Network is exploring other ways to improve prenatal and obstetric services in rural, remote, and First Nations communities, including supporting initiatives aimed at improving health outcomes, particularly for indigenous mothers and their children.

Mr. Hinkley: Okay. On that line of health care support on-reserve is it within our jurisdiction to build hospitals on First Nations reserves? Are there any hospitals on any First Nations reserves?

Ms Payne: A few of the First Nations communities have health centres that are available on-reserve, and those tend to fall under more of the First Nations, Métis, and Inuit health branch of the federal government. Certainly, there is a lot of partnership.

Additionally, we know that while many First Nations people seek health support on-reserve, there are also many that come to surrounding communities. We know, for example, that in the community of Cardston and other communities that are adjacent to reserves, the communities find that a great number of indigenous people will come to seek services in those. One area, you know, that I'm particularly proud of the work that's been done is around the opioid replacement therapy clinic in Cardston, which is neighbouring the Blood reserve. We've seen quite a lot of members from that community coming to the Cardston clinic to receive treatment for their substance use.

Mr. Hinkley: Well, you've touched on a whole bunch of other things, too. I just want to lobby for a moment that if in future budgets you're looking at hospitals on First Nations, Maskwacis would be happy to have one.

You mentioned partnerships and talked about Cardston, but are there any other reserve partnerships to address opioids other than the Cardston one, or is that just the beginning of possible plans?

Ms Payne: There's been a great amount of work that's been done supporting the work of indigenous communities, you know, again, always wanting to respect the right of self-determination and approaching with a nation-to-nation view of it. A big piece of the work has been really focusing on those community collaborations.

One of the other pieces where I'm particularly proud of the work that's been done is around ensuring access to the take-home naloxone program on-reserve, particularly through reserves that have the health clinics on-reserve, so ensuring that the staff there have the supports that they need to be able to provide naloxone kits to their community as well as, really, making sure that we have the ongoing dialogue to ensure that there's support that is culturally appropriate and that recognizes First Nations and indigenous cultural practices.

4:50

Mr. Hinkley: In the business plan preamble it refers to indigenous and nonindigenous Albertans, but performance indicators 2(a) and 2(b), again, are listed as First Nations and non First Nations. They exclude the Métis. I know that the Métis Nation of Alberta has developed sophisticated ways of tracking health outcomes and providing health supports to its members. This seems like a natural partnership for the Ministry of Health. Why are the Métis excluded from these particular indicators, or will they be included in the future?

Ms Payne: Yeah. Thank you for that. The current performance indicators are based on data available from the Alberta health care insurance plan population registries, and these registries do not and have not historically specified Métis people. You know, during the period when health premiums were collected, up to 2009, the health care insurance plan collected information on the First Nations and Inuit population for the purpose of billing . . .

The Chair: I hesitate to interrupt. However, the time allotted for this portion of the rotation has expired.

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

Mr. Smith: Yes, please, if that's good with the minister.

The Chair: Go ahead, please.

Mr. Smith: Okay. Thank you for being here. It's nice to have both of you in one place. I don't imagine that that happens too often, so it's nice to have both of you here to answer our questions. Now, on page 80 of the government business plan – and we're not going to be focusing on that, so you don't need to turn to it – I read that mental health issues affect 1 in 5 Albertans. You know, that's a pretty scary figure. It obviously tells us that it impacts just about everybody in Alberta at one point in time or another. I don't know about you, but I think that probably every one of us can say that we've known somebody that has been impacted by a mental health issue at some point in time. So I think that it's a really, really important part of the conversation that we're going to have over the next little while.

I want to focus on something that I know as a teacher broke my heart. There were several times when former students committed suicide, and I want to focus on that for just a little bit. We've been told that more than 500 people will die in any given year by suicide, and it really does just about break my heart. Where in the budget would we find, you know, money set aside for suicide and suicide prevention, those kinds of issues?

Ms Hoffman: I'm just going to start. This is when I pull my trump card. I wanted to say that we did a site visit together over a year ago, actually, when we were at the Stollery hospital. I believe one of your constituents, who had been a successful student, was there in a course that worked on chronic pain. Chronic pain and mental health and depression are so closely intertwined. People who are waking up in pain every day very regularly suffer mental health challenges in terms of depression. So having opportunities to do co-collaboration with the Department of Education around courses that can directly impact that and making sure that we bring it to kids, especially early in life, is so valuable.

Please, hon. colleague, continue with the suicide prevention and the line items where that will fit.

Ms Payne: Yeah. Absolutely. The work around suicide prevention is captured under the mental health line items. Let me just grab those particulars. Those are the ones that are mentioned earlier in the fiscal plan. There are several millions in one spot. I would also note that the Valuing Mental Health report spoke quite strongly about the need to improve on suicide prevention as well as ensuring that those community-based supports are there for people. Oftentimes young people with suicidal ideation will wind up in a hospital in a crisis setting, and we really want to make sure that not only is that person able to get the help that they need that day but also that once they're discharged, there's a support plan for them. Oftentimes in the amount of time that someone is in the emergency room or in hospital, you know, the crisis that they're having and the mental health issues they have are continuing, and we really want to make sure that we've got that bridge existing for them. It partially falls under the work that we're doing around implementing some of the recommendations of the Valuing Mental Health report.

Mr. Smith: Okay. So if we took a look at the budget here, what percentage of the budget goes to various supports, and what are those specific supports? You know, if I was an average Alberta citizen, what would be some of the supports that I could access, and what percentage is it of that budget? I mean, obviously, it's a big number here, $76 million.

Ms Payne: Unfortunately, a lot of that isn't categorized in the budget in that level of detail, of course.

Mr. Smith: Yeah, I know.

Ms Payne: I can understand how that can sometimes be challenging in order to, like, you know, evaluate how we're doing.

A lot of the supports that are provided through Alberta Health and Alberta Health Services, you know, particularly for suicide prevention, are within some of the broader services available in hospital. Additionally, there are a variety of support groups and the like that are supported through addiction and mental health and delivered in the community. A big piece of the work that's done is also done through grants to community organizations, and some of them are able to deliver programs in the community. For example, in the city of Calgary the Canadian Mental Health Association has a home that they operate where they have a psychologist on staff. As well, a number of people live there and are receiving treatment and supports. Some of the funding for that is provided through a grant from Alberta Health. It is, really, one of the pieces that we're working to expand that continuity of care as well as the range of services.

Mr. Smith: I realize that it would be a very difficult thing to be trying to figure out what the percentages are and what the supports are specifically and how they break out, but I guess one of the questions I've got is this. We understand that prevention is absolutely huge and that the monies that we spend on prevention are going to be really important in the lives of Albertans and especially young kids. It's my understanding from conversation with stakeholders that Alberta Health Services is no longer going to contract the Centre for Suicide Prevention to provide services around the issue of suicide. That's what I've heard. I'm wondering: is that in fact true?

Ms Hoffman: Sorry. Can you just clarify: was it an AHS contract?

Mr. Smith: Well, we understand that AHS is no longer going to contract . . .

Ms Hoffman: AHS.

Mr. Smith: Yeah.

Ms Hoffman: Okay.

Mr. Smith: . . . the Centre for Suicide Prevention. Obviously, it's a key part of that whole equation of prevention, okay? Again, it's our understanding that the centre has requested about $400,000 a year or so to provide training to all those who need access, to address suicide outside of the hospitals, to community, you know. So are you going to fund the centre specifically to provide the kinds of supports that Albertans will need to address their depression and the things that move them towards suicide, or where is the funding for this centre going to come from? It's been a pretty important key piece of this equation over the last few years.

Ms Payne: Yeah. Absolutely. The work that the Centre for Suicide Prevention does is incredible work. They offer kind of like a mental health first-aid or a suicide prevention first-aid kind of course. It's a two-day training course just like, you know, you'd get for your CPR or your first-aid training. There is some funding directly through Alberta Health of about a million dollars to support the work of the Centre for Suicide Prevention. A great number of not-for-profit agencies and community-based groups do work with them in terms of having that first-aid program delivered to their front-line care providers. The Alberta Health Services budget, of course, is determined by Alberta Health Services, so I can only speak kind of generally to that. But I am aware of the issue that you raise. Part of it is that Alberta Health Services is also evaluating what are the best levels of suicide prevention training for their personnel and front-line workers. That is an ongoing conversation about exactly which programs and services will be available to which front-line workers.

5:00

Mr. Smith: Is that million dollars for this coming year coming out of this budget going to AHS, that's then going to the centre? Or would that be . . .

Ms Payne: That's a grant through Alberta Health to support the work of the Centre for Suicide Prevention.

Mr. Smith: Okay. And that's for the 2017-2018 year. Okay. Thank you. Well, that's good news because that's not what we were hearing. It's always nice to get it from the people that are actually handing the money out, so thank you.

Will you be including community organizations other than the Centre for Suicide Prevention in the preparation of the suicide strategy for children and youth? Who else is involved in that?

Ms Payne: Absolutely. You know, as I mentioned earlier, one of the challenges facing mental health service delivery in our province has certainly been that there's some work done through Alberta Health, some through Alberta Health Services, and a great deal through community groups, and not everyone is aware of the work that everyone else is doing. In addition, there's a great amount of work being done through other departments within government, for example Education and Advanced Ed.

The Chair: Thank you.

At this point I would like to call our five-minute break. We will be setting the timer for five minutes, and we'll reconvene once the timer goes off.

Thank you.

[The committee adjourned from 5:02 p.m. to 5:07 p.m.]

The Chair: I would like to call the meeting back to order. I would ask everybody to please take their seats and stop talking. Thank you.

I would now like to invite Dr. Starke from the third-party opposition and the minister to speak for the next 10 minutes. Dr. Starke, are you wanting to combine your time with the minister?

Dr. Starke: If possible, yes. That would be great.

The Chair: Thank you.

Dr. Starke: Thanks, Chair, and thank you once again. I'm going to return to the topic that we left off with, and that's key strategy 2.3 on page 82 of the business plan. That's maternal, infant, and child health by supporting initiatives that foster maternal-infant health and early childhood development, critically, critically important work. I mean, if there was ever an area where I think there could be huge payoffs in the long term, and not just monetary payoffs but payoff in terms of an overall improvement of the health of our society, I think that certainly is in this area. I guess I'm wondering what specific initiatives have been supported by the government. Are there some examples that you could give? I have one example, and I'm curious to know whether it has been supported as well. You go ahead first.

Ms Payne: Yeah. So the work around the maternal and infant health strategy is ongoing work of the government and Alberta Health. As I mentioned in response to an earlier question, we're also doing work with First Nations, Inuit, and Métis communities around targeting particularly the outcomes for indigenous mothers and their babies. That's an example of a particular one.

As well, a key piece, of course, is ensuring that there is access to prenatal care available to all expectant mothers in Alberta. Certainly, there are some challenges that arise with that, particularly for vulnerable populations.

Additionally, there are fetal alcohol spectrum disorder related grants available across the province in an attempt to reduce the number of infants that suffer from that condition.

Dr. Starke: That's great, and I'm glad to hear those things are ongoing.

I guess one question I would have is that we have actually a world-leading, world-class initiative, the Alberta family wellness initiative, that's undertaken by the Palix Foundation. I'm just wondering. Is there support from Alberta Health? Is there any sort of co-ordinated working together with Alberta Health with the Alberta family wellness initiative? In my view, the work that they have done absolutely could hold the key to a lot of issues, including the addictions issues that we've discussed quite a bit, because a lot of the basis for the addictions that we're struggling with are – in fact, that groundwork is laid through adverse childhood events, that are tracked through some of the work that's been done by the Alberta family wellness initiative.

Ms Payne: Yeah, absolutely. You know, your comment about adverse childhood events is really a key one. The level which that factors into social determinants of health is a really important one. There is work and research funding that we've allocated for that. There's a lot of really fascinating research going on right now that can have, I think, a really huge impact on outcomes in the long range.

You know, one of the interesting findings was through a partnership with the – there's a research chair that's, I believe, cohosted between the University of Alberta and the University of Calgary, particularly around maternal health and perinatal mental health, with findings that for expectant moms with untreated prenatal depression, the impacts for those children extend well into their childhood and even to a number of youth that are having health concerns.

Dr. Starke: No. You're quite right. I mean, some similar findings, for example, on premature births and that sort of thing.

I want to completely now shift gears for the remainder of this segment and talk a little bit about the rural health review. Minister, you and I have had many conversations about this. I continue to get confronted by some of the people from the communities that presented to our committee a couple of years ago, and I have to confess that I'm hearing a lot of frustration that they're not seeing a lot of the measures being implemented. You know, I do applaud you. There are some things that are progress. I think the 811 line is a positive thing. Certainly, the improvements in Lac La Biche and to the dialysis unit I think are also a sign. But there are still some other areas.

Let me start with rural ambulance and the use of non emergency transfer vans. Has the use of non emergency transfer vans been expanded? How many non emergency transfer vans are now being employed in the system province-wide?

Ms Hoffman: Yeah. I think we did have a similar discussion around this same item last year. The non emergency transfer vans are contracted usually through AHS and through a subsidiary, so I will be happy to ask that question and report back. I don't believe that we have that number top of hand given that it's an AHS budget piece. I do know that the number has gone up in the last year. We'll be happy to share information with you on that.

Dr. Starke: Okay. What about rural ambulance and the dispatch and some of the rules regarding rural ambulances and their return to home base? Again, this is something that I'm sure you're hearing because I've heard a lot of it as well, the concern about the borderless system and rural ambulances being pulled into larger urban centres and then being sort of trapped in an urban vortex, and they never get back to home base.

Ms Hoffman: Well, definitely our goal is to make sure that we have ambulances available where they're most needed in Alberta. I will tell you that my goal is to get them out of the emergency room as quickly as possible because I think that whether you're in a downtown Edmonton emergency room, a Calgary emergency room, or waiting in your local community hospital, no matter what, you sign up for that career because you want to get out there, you want to help people, and you want to get them to where they need to go. I think that sometimes the frustration people feel with being stuck in an emergency room becomes conflated with being away from home. No matter what, we know that we need to get trucks back on the streets faster. We're working with AHS on ways that we can continue to move that benchmark, but that is our ultimate goal.

Dr. Starke: Okay. Then another area that is a long-time concern – and I know some adjustments have been made, and I know that there was a review done of RPAP and that that was extended. But the mandate for RPAP has been expanded, which was one of the recommendations of our committee, to a rural practitioner action plan. I think that's very positive. I think it's critically important that we recognize that doctors aren't the only caregivers that can deliver services, especially in areas where it's been challenging to provide services.

5:15

One of the initiatives that was recommended in the rural health study – and I'd love to hear what's been done on this – is what I call a grow-your-own program. [interjection] It has nothing to do with what you're thinking about, Mr. Clark. The grow-your-own program is about identifying high school and junior high school students who have an aptitude for the healing arts. [interjection] Sorry; it's not as interesting as you thought it would be.

My argument for a long time has been that if we spend a fraction of the amount of time identifying our next generation of nurses and doctors as we do identifying the next generation of hockey stars, we will have no trouble whatsoever staffing all of our needs in health care. So a long preamble, but what's being done about developing a homegrown program so that Alberta students become Alberta doctors, nurses, and health care professionals?

Ms Hoffman: Yeah. Thank you for the question and for the focus on other green shoots, which includes investing in these communities . . .

Dr. Starke: We'll get to that.

Ms Hoffman: . . . not the type of green shoots that some members might be referring to. [interjections]

Dr. Starke: We're five hours in, Minister. Keep plugging away.

Ms Hoffman: Definitely, this piece around ensuring that students feel attracted and excited about opportunities for a variety of career pathways in health. When you talk to students, they don't always know about the expanded opportunities that there are. They really only think about doctors and nurses. They don't always think about all of the lab technologists, all of the X-ray technologists, all of the people working in medical device reprocessing, who often can get training on the job. Those are absolutely fundamental for making sure that we have proper infection control in our local communities.

I do want to also highlight that partnerships with the universities and with colleges to ensure that we have the right number of students coming into our programs and that they're being attracted to areas of focus where there will be opportunities in the province of Alberta is an ongoing struggle. Sometimes universities are training students in programs where we don't necessarily need that specific specialization – we might need more in other areas – so we continue to work with them on that, but it is not going to happen overnight.

Dr. Starke: Yeah, but that's a moving target, right?

I guess that on that topic, funding for the rural medical education programs at U of C and U of A: is that still being channelled through RPAP, or is it now going directly to the faculties in the two universities?

Ms Hoffman: We've decided to move it directly.

Dr. Starke: Good. Good. I think that's a very positive move, and I think it recognizes that both of those medical faculties have had significant progress in terms of improving the number of (a) general practitioners as opposed to specialists and (b) general practitioners who are choosing rural communities to start practising in. I think those are two positive developments. I think we have to continue along those lines, and I think it'll be very effective.

That's, I think, the end of that segment. Thank you, Chair.

Ms Hoffman: Thank you for your support on that. I really do appreciate it.

The Chair: Thank you.

At this point I would like to call on Mr. Clark, the leader of the Alberta Party, and the minister to speak for the next 10 minutes. Mr. Clark, did you want to combine your time?

Mr. Clark: I will combine my time if that's all right with the minister. Thank you very much.

I would like to start with the opioid crisis in this province. I'm just curious if you can tell us how much money is spent on opioid replacement therapy and what focus that takes within the overall strategy to deal with the opioid crisis.

Ms Payne: Thank you for that. In 2016-17 there was $7.75 million that was allocated for Suboxone and methadone treatment, so opioid replacement therapies, and that included the dispensing fees for pharmacists. To be frank, you know, it's kind of the unsung hero part of the opioid strategy of our government. Opioid dependency treatment is considered best practice for people with an opioid dependency, so it's finding ways that we are able to expand access to that program, not just within the centres available within Calgary and Edmonton but to also expand that access across the province.

Certainly, you know, when you look at the reports on overdoses, overdose stats and emergency department visits and the like, we see that this is a problem that touches all corners of our province. We certainly need to make sure that we're able to expand access to treatment. A good sum of the money from the upcoming year's budget will be looking at ways that we can expand access to those programs not just in terms of the geographic reach, which is a huge component, but also expanding hours of clinics so that they're able to reach more people.

Mr. Clark: Let's talk about wait times because that's really important. Do you track wait times for people waiting for opioid replacement therapies, and do you have a goal for what the ideal wait time would be?

Ms Payne: Yeah. There are two streams for the opioid treatment, opioid replacement therapies. The one that we're able to most accurately track wait times on and most directly influence is around the AHS clinics that are available in communities across the province. That includes, for example, the Cardston clinic that I referenced earlier as well as clinics in Edmonton and Calgary. We're also expanding to Grande Prairie and working on additional sites across the provinces. Particularly within Calgary and Edmonton there is not currently a wait-list. There are particular intake times, and that's another piece that we are working with Alberta Health Services on around how we can address that to have increased access and more ready access for people.

Additionally, there are private clinics that are operating across the province to provide opioid replacement therapies. Because those ones are managed with more of a fee-for-service arrangement with us, we don't have the wait time information. That is something that those individual clinics would have.

Mr. Clark: Has that improved? I mean, I guess my concern or, I suppose, my question is that people reach out in whatever form that is. They go to emerg, they talk to their GP, or they talk to addiction services. The goal, in my mind, ought to be that when they reach out and say, "I need help; I want to kick this habit," an opioid replacement therapy, being best practice, as you say – and we know

that especially with this particular addiction, as with most addictions, just straight abstinence from the outset is very difficult and especially difficult here, which is part of the really insidious nature of this particular disease, not to mention the prevalence of relapse, which is a particular problem. Given all of that, do you feel that the access to opioid replacement therapies is consistent irrespective of how people try to access that, or is there work to be done in one area or more than one area?

Ms Payne: I'm not sure I will ever feel like we have done enough to address this crisis. I think there will always be more work to be done, and I think the key as we move forward is to ensure that we're able to target each of the populations that are impacted by the fentanyl crisis and provide services that are appropriate. Absolutely, I think that, as I mentioned, expanding access at clinics is critical, continuing to expand physician awareness of it. You know, we want to make sure that doctors in Alberta are aware that opioid replacement therapy is considered best practice for someone with an opioid dependency and to have those referrals from community physicians. We're also working quite closely with the College of Physicians & Surgeons to expand the number of general practitioners in Alberta who are trained in opioid replacement therapies and are able to start their patients on those protocols and make those referrals to the stand-alone clinics where appropriate. That's really a key piece of dealing with the addictions piece.

Additionally, just to kind of dovetail with what you had mentioned, you know, if someone goes through detox for opioids, they are at the highest risk of an overdose death because they have lost some of the tolerance to it. So we certainly want to make sure that people have not only access to treatment – some people choose to do detox, and we want to be able to have detox beds available for them – but we also want the ongoing recovery supports there and the wraparound services to help people address some of the root causes of why they turned to substances in the first place. So that's continuing to work with primary care providers both in terms of prescribing practices for opioids as well as support for prescriptions and Suboxone and methadone treatment.

5:25

Mr. Clark: Okay. Good.

There is a lot of talk today and there has been in your ministry, I know, and in the House and in our province about the fentanyl crisis in particular and addictions more broadly. But when I look at the key outcomes and when I look at the performance measures in your business plan, there are no specific KPIs related to addiction. There's a single KPI related to mental health, patients with unplanned readmissions within 30 days of leaving hospital. I look at your performance measures, and it occurs to me, you know, that there are 14 performance measures where we have numbers in the business plan for the Ministry of Health. I looked at other ministries just to compare because it occurs to me that this seems like a low number relative to other ministries in the other estimates that I've been a part of. Culture and Tourism has 15, which is one more than Health. Education has 25 performance measures. The Ministry of Status of Women has 16 performance measures in a budget of less than $8 million.

Now, the numbers of performance measures in and of themselves are not the only thing that matters, but surely we should expect to see more performance measures around things like addictions. We talk about it here a lot because, of course, this drives what your entire ministry is going to work on, and if you don't measure it, you can't manage it. I'm just curious if you can speak to why we don't see more performance measures with quantifiable data that we track over time to know that we're being successful in areas like addiction, more details around mental health. I can think of probably half a dozen or more areas where I'd like to see more detail. Is that something that as a minister you feel is a priority and that you'd like to see added in in the future?

Ms Hoffman: Thank you very much for the question. We definitely are constantly evaluating performance measures, looking at what neighbouring jurisdictions are doing and other parts of Canada as well, and working as well with CIHI to make sure that we're reporting. They do a great deal of measuring, as does the HQCA, on a number of initiatives that relate to the health outcomes for Albertans.

If you have specific measures that you would like to bring forward for our consideration for subsequent business plans, we'd be more than happy to receive those recommendations and take them into consideration as well.

Mr. Clark: Sure. My last minute here I'll pick up on what Dr. Starke had asked earlier about immunization rates. Like the good doctor, I'm very interested in improving immunization rates around the province. We look on page 83 at 2(b). The rates here are certainly below herd immunity. I guess I'm curious. Can you just speak briefly to what is best practice in how we bring these things up? I mean, is it purely education? Is it being quite forceful with folks in terms of the choices they need to make and understanding the impact not just to their own children but to society? Is it forcing someone to sign something if they choose to opt out? Is it requiring immunization to participate in public schools? I'm curious what the evidence shows as the best tool to improve immunization rates.

Ms Hoffman: Definitely, all those questions were asked while we did the review in consideration of how we were going to move forward with the amendments that we did bring forward to the House last year and saw unanimous support for. There are many jurisdictions that have tried to forcibly require people to have immunizations, and a lot of it . . .

The Chair: Thank you.

For the next portion I would like to invite Ms Luff from government caucus and the minister to speak for the next 10 minutes. Ms Luff, are you wanting to combine your time with the minister?

Ms Luff: Yes, please.

The Chair: Go ahead, please.

Ms Luff: Thank you. I might jump around a little bit this round, but I just want to follow up on one of the questions I had regarding addictions and mental health funding from the previous line of questioning. I did notice that the increase for addiction and mental health is noted at $31 million in the estimates, which is element 5 on page 153, but when reading through the fiscal plan, it notes an increase of $45 million for addiction and mental health. I'm just wondering why there's the discrepancy there.

Ms Payne: The $45 million increase in the fiscal plan combines the $31 million that's under the addiction and mental health line item, which is element 5.2 on page 153 of the estimates, as well as $14 million for the opioid response, which includes Suboxone and methadone treatment, under the population and public health line item under community-based health services, which is element 7.3 on page 153.

Additionally, the $31 million under the addiction and mental health line item breaks down into $15 million to implement recommendations from the Valuing Mental Health report and $16 million for the opioid response.

Ms Luff: That makes sense. Thank you.

All right. I was paying attention to the previous line of questioning, and I'm just curious if there was anything you wanted to add in terms of EMS or ambulances. There might be more that you would like to add.

Ms Hoffman: Thank you very much for that opportunity. We were able to gather some information in response to the question asked by Dr. Starke earlier. Rather than having to table a written response, I'd like to provide it now, so thank you for the opening to be able to do so.

AHS does have 393 ambulances that are AHS ambulances. There are also 132 that are contracted. There are 71 support vehicles, so not the typical ambulances. Usually EMS SUVs have defibrillators and other resources on hand to be able to provide additional support. This year there are now a total of 21 nonambulance vans in the fleet, that are primarily used for interfacility transfer. That was asked about. That's a 40 per cent increase over the year before. We're definitely moving on the right track and trying to make sure that ambulances are available for emergencies and that other vehicles are used whenever they possibly can be.

I want to thank you for the opportunity to put that onto the record to avoid the department having to do a formal written response and to provide the information as quickly as possible. Thank you very much, colleague.

Ms Luff: Yeah. No problem. I'd like to thank the department for finding that information as quickly as possible. Good work.

I do just want to ask about one of the areas in terms of health that I hear a lot about from constituents and the public in general, just the attempt to really try and bring costs down. I know that you've been working really hard in order to bend that cost curve to reduce the increases that we have seen year over year under past governments. Whenever this subject comes up, inevitably AHS comes up. There seems to be an increase in AHS funding again this year. Given that AHS has seen an increase, what evidence is there that they're still trying to find savings within their budget?

Ms Hoffman: Yeah. Thank you for the question. It's completely fair. Typically in years prior to our government coming into office, we looked at what the increases were to AHS, and typically they were in around the 6 per cent range. The fact that we're looking at 2 and a half per cent this year instead of 6 is definitely a smaller increase. Some might refer to that as bending the curve, which was quite steep in the past. We're working to make sure that it's done in a way that protects patients and protects the front lines. We all know that when you call 911 or you show up at a hospital or you're struggling with an addiction, it's important that those resources are available.

We've also looked at other jurisdictions. Some believe that they've gotten their costs for direct hospital operations and acute care, primarily the services that AHS has large items for in the budget, down to abut 2 per cent for a few years. It's really hard to maintain that level. We know that we have an aging population here in Canada. Alberta is no exception. We know that we have increases in the co-conditions that individuals have, and we know that we're being more effective in terms of keeping people healthy longer. That's good news, but we can't do that without acknowledging that there are going to be increased costs as well. We have been working with AHS to optimize best practices, looking at other jurisdictions across Canada and within Alberta, making sure that those best practices from Alberta Children's hospital or from the Stollery are interchangeable so that they're finding ways to best serve patients and maximize the returns on those investments. That certainly is important.

We need a strong, sustainable public health care system for future generations, and that's one of the reasons why we are providing modest increases at about 2.5 per cent this year to AHS. They believe and we believe that this is an achievable target, but it is far less than it has been an increase in years past.

5:35

Ms Luff: Thanks.

I was encouraged to see in the business plan that there is a focus on women's health. Certainly, hearing from the Minister of Status of Women about the GBA plus analysis that's been applied across government to all departments was encouraging. However, I did notice that there aren't any specific key strategies or performance measures that are identified surrounding the area of women's health. I think you've spoken a little bit in terms of prenatal care, but can you elaborate on other work that your ministry might be doing to support women's health?

Ms Payne: Yes. Thank you for the opportunity to comment on this. Government is investing in women's health in a number of areas. That includes, again, dovetailing with prenatal health, increased support for midwives through adding additional courses of care and co-ordinating those across the province so that there is access not just in our major centres but also for rural populations as well as the work being done around maternal and infant health.

With the gender-based analysis plus, or GBA plus, approach, Alberta Health is working on the crossministerial committee on gender equality to ensure that we are taking into account the issues around gender equality and embedding that in policies and decision-making. Within the ministry specifically we've established a GBA plus centre of responsibility and are developing that framework for how to apply that lens across departments.

You know, there are many areas in which women are particularly impacted when it comes to issues of health. Often, you know, particularly as mothers, women are kind of the gatekeepers for a lot of the health appointments of their children and, if they have husbands, sometimes their husbands as well.

Ms Hoffman: Or wives.

Ms Payne: Or wives, as the case may be.

You know, women seem to be the appointment keepers in the family. Ensuring that as we move forward with some of the work being done around the electronic health record, allowing patients to take a more active role in their own health care and the management of their health care is really a key part to bringing patients in as partners in their own health care.

Ms Luff: Yeah. Fantastic. I consider myself very lucky that I have a husband who makes appointments. I'm not great at it.

I do just have a quick last question about an area of concern for many of my constituents, which is dental fees. You know, you hear from people all the time that it's inconsistent. I've also actually talked to dentists who have issues in terms of dealing with things like refugee clients in my riding who are unable to pay, and they don't want to deny a service to people. I was glad to hear about the work your ministry is doing to make these costs more transparent for Albertans, but they are still, you know, sometimes inconsistent and can be very high. I'm just curious: could dental fees for services change after the Alberta Dental Association and College completes

its final dental fee guide and strategies to increase public confidence in this profession?

Ms Payne: Thank you for the question. You know, I think it's definitely a piece that many of us in our role as MLAs hear about from constituents, and certainly as users of the health care system, too, we can find that sometimes with dentists. One of the ways that we've been working on addressing Albertans' concerns about the cost of dental fees is by providing information that Albertans need when accessing dental services.

The Chair: Thank you.

At this time I would like to invite Mr. Strankman from the Official Opposition and the minister to speak for the next 10 minutes. Mr. Strankman, are you wanting to combine your time?

Mr. Strankman: Yes, ma'am.

The Chair: Go ahead, please.

Mr. Strankman: Thank you, Minister. I appreciate that. One of your key strategies from page 83 of the business plan was to improve access to health care providers across the province and develop sustainable strategies that ensure the appropriate education, scope of practice, support, and distribution of health care providers. As you know, we've had a discussion recently in another facility regarding the inequity of health care delivery and the resource funding in the central region. I was wondering if you could explain to me what your thoughts are on that and what the go-forward plan might be about that inequity, stemming back some 10 years. Even though it's beyond your jurisdiction of that time frame, I'd appreciate, you know, if you have a plan, going forward, to potentially address that.

Ms Hoffman: Yeah. Thank you very much for the question. I believe the focus of our previous conversation was around capital funding in particular. You're talking about operating funding in general?

Mr. Strankman: Yes, the regional plan, ma'am. It goes back some 10 years that there's been an inequity of the funding for that central region on a per capita basis.

Ms Hoffman: Yeah. The numbers that I think were first brought forward were around some of the capital concerns, but I'm happy to talk about that in other areas. Typically the comparator is being done between the central region and Calgary and Edmonton. Calgary and Edmonton do have a number of very specialized, focused areas; for example, the work at the Calgary cancer centre, currently the Tom Baker, the work at the Cross Cancer Institute. We're not going to have the same level, but we do absolutely need to expand cancer services in other parts of the province. That's one of the reasons why Red Deer, having its cancer hub – and we're working on expanding those services in Grande Prairie as well to have that regional corridor.

AHS continually works with different zone leadership throughout the province to make sure that they're developing the right sort of 10-year, 15-year, and 20-year framework. Capital regularly drives a lot of the discussions around operations. In health care it's not uncommon for 50 per cent of the capital cost to be seen as operating costs on an annual, go-forward basis. If you're building expensive buildings, you've got a lot of expensive staff working in those buildings.

Mr. Strankman: But that should still relate to a per capita expense other than the cancer direction that you're talking about.

Ms Hoffman: Well, per capita is one of the arguments that's been given. We need to make sure that we have resources throughout the province, and not everyone is going to be able to have specific – obviously, there's Alberta Hospital Edmonton and Alberta Hospital Ponoka as well. We're not going to have one in every single zone, and it's not going to be based on per capita. It's going to be based on needs, on ability to be able to navigate the province, on community partnerships. I appreciate your desire to have as many services as close to home as possible for your constituents.

Mr. Strankman: Well, it's not just my constituents, Minister. For the city of Red Deer there are actually seven MLAs that are included in the central zone. I'm simply asking you about the metrics that you're going to maybe use to consider the situation and to do that in a public fashion.

Ms Hoffman: Well, what I'm trying to say is that it isn't always a dollar amount that equates to the best use of health resources in different parts of the province. I think that it's important to make sure that everyone has access to the care they need. I know that there are specific areas of interest that specifically central Alberta is interested in, cardiac catheterization equipment, for example, being one area. AHS has responsibility to do a focus plan for all zones and to make sure that there is a co-ordinated integration of services for all parts of the province.

Mr. Strankman: So we'll be able to see that going forward?

Ms Hoffman: They do have regional plans that they do. Edmonton's was called the 2030 plan.

Perhaps the deputy might want to expand a little bit, if you wouldn't mind, Dr. Amrhein, on the capital planning processes as well as the operational processes for the different parts of the province.

Dr. Amrhein: The government of Alberta expects and requires Alberta Health Services to periodically create plans for all of the five zones.

Mr. Strankman: Well, if I might, sir, I would suggest that Albertans demand that the accountability of taxpayer dollars come forward, not necessarily the government.

Dr. Amrhein: I take the point that we see the government of Alberta as the elected representatives of the people of Alberta, so I think we're sort of synonymous on who we're working for.

Mr. Strankman: Continue on, then, please.

Dr. Amrhein: Alberta Health Services has been looking at the planning requirements over the next little while in the various parts of Alberta, including a number of focus groups that have taken place in various parts of southern Alberta. We look forward to Alberta Health Services concluding their analysis. They will then bring that analysis forward to the ministry. The ministry will do its own work on the analysis, as we are, for example, on the Edmonton 2030 plan. Then the ministry will see how all five zonal plans will knit together into the provincial health system.

There are some very, very specialized services, like cancer hospitals and quaternary hospitals that do multiple organ transplants, that will not be distributed across the province. One of the challenges we face in a health system that is increasingly specialized is that we need to aggregate enough activity for the specialists to maintain their training levels and their accreditation and for us to be able to recruit the very best specialists to facilities.

Recruiting the very best specialists requires something of an aggregation of activity in a smaller number of regions, a smaller number of cities than would be the case for the whole province.

5:45

Mr. Strankman: Yeah. I appreciate that.

Further to my question – and the minister is well aware of this, that I had approached her and her department regarding the facts of suicides in the constituency of Drumheller-Stettler. In the last four years in Hanna and within 20 Ks of the centre of that town there have been nine adult suicides in that community. I've spoken to the minister directly about this. She gave me some referrals, and I appreciate that. But it turns out, Madam Minister, that they were, unfortunately, completely inadequate. Could you tell me if this may be a result of the funding shortfall in the central region?

Ms Hoffman: I want to start by again expressing my sympathies and the fact that any time anyone takes their life prematurely, it's devastating to the immediate family and the broader community. One of my closest friends lost her stepson over Christmas, and I know that that family is going to be dealing with that for a very long time.

It's important that we have suicide prevention programs throughout the province. The associate minister did touch on some of those programs through Alberta Health, and we're also partnering with Children's Services. There were programs, I think, prior to 2010 that were around peer mentoring, and they were very effective. We want to find as many ways as we can to support communities in being strong and resilient, and we will continue to pursue these discussions further with you.

Mr. Strankman: Well, I appreciate that, but that doesn't give us a metric for performance of the taxpayer dollars allowed or potentially distributed to the system or the area or the region. What I'm asking is: is there a metric for the taxpayer dollars that are being brought forward?

Ms Hoffman: In terms of suicide prevention programs?

Mr. Strankman: Absolutely.

Ms Hoffman: You know, I think that that is a useful point. Obviously, the goal is to help people find access and opportunity in as many programs, wherever best available. One of the challenging measures with this is that it's hard to say how many people would have felt that they didn't have another opportunity and therefore how many lives were actually saved. Of course, that's ultimately the goal every day, to make sure that people find hope and opportunity.

Mr. Strankman: Well, the potential economic uncertainty going forward in the town: as you know, the government's climate action in regard to the coal plant shutdown is certainly creating a lot of uncertainty in the community. That's the reason for my question. We need to be proactive to try and eliminate these types of incidents. So I'm asking for a metric for the taxpayer dollars. There's no malice to anyone here in this, you know. I mean, you talk about suicide preventions that are allocations of funding to other jurisdictions, but there's no mention of a metric on a performance of that.

Ms Payne: If I may add to dovetail with what the minister said, it is challenging to quantify prevention efforts. That said, we do know that there is a need for more targeted suicide prevention within communities, particularly outside of our large urban centres, to ensure that there are those early intervention and mental health supports available to Albertans regardless of where in the province they live. Under the auspices of the implementation of the mental health review as well as the supports for addiction and mental health being delivered throughout the communities, we are evaluating ways that we can ensure that we have appropriate and targeted suicide prevention supports.

Mr. Strankman: Thank you.

The Chair: At this time I would like to invite Dr. Starke from the third-party opposition and the minister to speak for the next 10 minutes. Dr. Starke, are you wanting to combine your time?

Dr. Starke: No reason to change now. Thanks, Chair. Thank you, Minister. I want to just sort of bounce around a little bit. I think this will likely be our last segment to work together. My first question just goes back to the performance objective that we were discussing about early childhood development and supporting initiatives that foster maternal, infant health. Is Alberta Health providing funding assistance to the Alberta family wellness initiative?

Ms Payne: I would have to confirm the rate of funding for that for you and get back to you about that specific grant.

Dr. Starke: Okay. Fair enough.

My second question, on a different topic. A couple of years ago the government instituted an insulin pump program for diabetes. I have a son who is a type 1 diabetic, so certainly this is something that we've been sort of very supportive of. One of the things that we talked about was decreasing the number of emergency admissions for unregulated diabetic patients. Have we seen that yet? That's my first question.

My second question: is the government looking to expand the coverage specifically for glucose testing supplies? I know that for some diabetics, unfortunately, that becomes a barrier. These test strips are expensive. Of course, if they're not testing as often as they should be, the risk of developing complications goes up because they aren't as well regulated. Their blood glucose is just simply not as well monitored.

Ms Hoffman: Yeah. I'll start. First, because I didn't get to share an anecdote last time . . .

Dr. Starke: Sure. Fire away.

Ms Hoffman: . . . I'm going to do it this time.

Dr. Starke: It's my 10 minutes. Go ahead. Chew it up.

Ms Hoffman: Thank you. Not that long ago I was in the United States, and it was right after the bill to repeal and replace Obamacare had been stayed by other elected officials.

Dr. Starke: They chickened out.

Ms Hoffman: That, too.

The server at the restaurant I was at was telling me about how he was a type 1 diabetic. When he was on his parents' coverage, he had an insulin pump. When he went away to university and was no longer covered by his parents' plan, he didn't have a pump. He was taking the best guess he could, but he didn't have health insurance, and he was just hopeful that his sugars were within reason. Based on how he was feeling, he might try to eat an orange, which to me is so devastating. He did end up getting health coverage just a few years ago and proudly showed me his pump on his torso and said: you know, I was really worried last week that I wouldn't have it

anymore. These are the kinds of stories that I think make Canadians so proud of the system that we do have.

Dr. Starke: Minister, on the one hand, no argument from me on that. On the flip side, though, my son has been on a pump for about the last 14 years. The supplies are really expensive, and they aren't covered under a lot of health plans. He's not on the pump program yet; he's working towards getting into the pump program. We're not there yet. I mean, we're working in that direction. But both the cannulas and the supplies that are required for pump patients as well as the testing supplies run to hundreds of dollars per month. So it is something that's still a concern.

Ms Hoffman: Yeah. I know that this is something that your government was grappling with in the lead-up to the last election and that there were some calls to see further reductions in access. Certainly, this is something that we want to make sure – in terms of wellness, I think it expands into this area as well. We obviously are in a difficult financial situation, as my colleagues in the Chamber on the opposite side remind me regularly. We need to find ways to find savings. I know there are other important areas for expanding investment. Sometimes maintaining the status quo is challenging enough when people are calling on you for deep cuts, so it's difficult.

Dr. Starke: No, I hear where you're coming from. That's the joy of being in government, Minister. That's why you knocked on all those doors.

Ms Hoffman: Yeah.

Dr. Starke: Just moving on but staying on the topic of diabetes, if you're like me, if you're an Albertan and you're proud of the research that's being done, you're familiar with the work of Dr. Shapiro and the Edmonton protocol and the fact that Dr. Shapiro feels he's actually very close to actually determining a cure for diabetes within the next five years. I'm just wondering: is there government funding either flowing through to DRIFCan, the Diabetes Research Institute Foundation Canada, or to other supports that are being provided? If we target the 100th anniversary of the discovery of insulin, which was by another Canadian doctor in 1921, in 2021, if we target the next four years to discover a cure for diabetes and have both of those developments happen within Canada, I think that'd be an incredible achievement.

Ms Hoffman: Do you want to start?

Ms Payne: I'll just say that I would agree. That would be incredible.

Ms Hoffman: Maybe Dr. Amrhein might want to respond.

Dr. Amrhein: Michele Evans is our assistant deputy minister that's responsible for a lot of this activity. If my answer is inadequate, we can call Michele to the microphone. My understanding of the islet cell transplant program is that the government of Alberta does cover the transplantation costs. The challenge that Dr. Shapiro seems to be having – and we're doing what we can to help him alleviate this challenge – is that he's looking for reciprocity across Canada. Each province gets to decide on their own whether it's experimental or routine. There are some provinces that decline to list this, and until we have all provinces listed, it's a financial copayment thing. I think that's his struggle. Otherwise, he receives funding from a number of sources, including foundations but the health system as well.

5:55

Dr. Starke: Yeah. If we could find out what funding his specific research is receiving or if it's receiving any funding through the Heritage Foundation for Medical Research, I'd just appreciate that. I think the work that he's doing is incredibly exciting and has incredible potential not just for Alberta but world-wide.

Dr. Amrhein: We will report back on the sources of his funding.

Dr. Starke: Perfect. Thank you.

Minister, if we now look to page 121 in the government's fiscal plan – that's the page that has the breakdown of all the full-time equivalents – I note there's been no change in the number of full-time equivalents in the Health department itself. I congratulate you for holding sort of the line there. There is an increase in 1,500 full-time equivalents in AHS. You know, you need people to deliver services. I absolutely acknowledge that. There's a big number, 1,500, and then it says, "Home care/Continuing care/Primary Care Network," but there's no breakdown whatsoever. Would it be possible to get a breakdown from AHS? I'd sure like to know how that 1,500 breaks down. I guess I'm a little puzzled by primary care networks being there. Primary care networks, I thought, were funded through the capitation formula, and I didn't think that they were actually employees of AHS.

Ms Hoffman: In terms of supporting subsidiaries, primary care networks, and foundations – there are 100 that are aligned through that line item; it's through some partnership work that's being done there – the change in full-time equivalents was required to address the health system priorities, as you've mentioned, including community-based care, with the expansion in areas, including home care. The new FTEs will be 900 clinical staff and 600 clinical support staff. Those would be other types of people working in the health care system to support those clinical staff.

Dr. Starke: Okay. When you have an opportunity, Minister, maybe you could get me the breakdown between home care, continuing care because that breakdown you've just given me is a little bit different from the reasons that are listed here on page 121.

Ms Hoffman: Yep. The one thing I'd just like to add is that 450 of those FTEs under clinical staff and clinical support staff are around the new continuing care beds, that are going to be coming online as well. Supporting home-care activity: 650 full-time equivalents. Then I mentioned the 100 for PCNs.

Dr. Starke: Okay. Great.

Minister, a topic that you're certainly familiar with and is a close-to-home topic for me is with regard to extended care in Lloydminster, the Dr. Cooke extended care centre. We had a brief exchange in question period about this a couple of weeks ago. Where are things with the consultation with the community? I know Dr. Amrhein was in Lloydminster last October and met with some officials, but I know that there is still an expectation and that people are still awaiting an opportunity to have that conversation with regard to the future of the existing Dr. Cooke nursing home.

Ms Hoffman: In one of our trio meetings, I think we called them, between AHS, the department, and myself – actually, quartet because the board chair for AHS is there as well – we were discussing my expectation around there being consultation and some type of engagement with the community. I asked that both the department and AHS work on developing a strategy and bring it back so that we can consider that. It's in the works, and we'll be happy to involve you in those discussions because it's important.

Dr. Starke: I'm was just going to say: loop me into it, and you can save yourself a lot of grief.

Ms Hoffman: We want to loop you into it, and I agree.

Dr. Starke: That'll help.

Minister, thank you very much. I think we're pretty much done. [A timer sounded]

Ms Hoffman: Slick.

The Chair: Well done.

For the next 10 minutes I would like to invite Dr. Swann, leader of the Alberta Liberal Party, and the minister to speak. Dr. Swann, are you wanting to combine your time with the minister?

Dr. Swann: I'd like to read my questions into the record if I could. In whatever time is available, they could respond to what they wish and then follow up, hopefully.

Ms Hoffman: So we'll split it so that five minutes . . .

The Chair: We'll set the timer for five minutes.

Ms Hoffman: Okay.

The Chair: Thank you.

Go ahead.

Dr. Swann: Thanks. First, relating to the opioid issues, what were the total opioid-related deaths for 2016, including fentanyl? I don't believe the last quarter was reported. All opioid deaths, including fentanyl.

Two, is the government planning to expand the 211 number all across Alberta, the distress line? The rural areas are very anxious to have access to the 211 number, and I hope that will be part of the mental health and addictions funding.

Three, the government is increasing home-care funding by about $200 million, I believe I heard you say. I'd like to know what the level of caregiver qualifications is for a home-care aide. What are the standards of training, in other words, for home-care aides? Is there a standard? How many home-care clients are there currently in Alberta and budgeted for, and what is the average cost per home-care client?

Fourth question. What is the average cost per bed per year for the following bed types: ICU, ward bed, long-term care, DAL, and supportive living 3?

Question 5. The Alberta health advocates' office budget is $1.89 million. Last year, in the 2015-16 annual report, the Mental Health Patient Advocate said that the caseload increased, and she was only able to do a single formal investigation. However, the office only used $1.34 million of the budget, so only two-thirds of her budget was used. My questions. If she was so stretched as a mental health advocate, why didn't she use her whole budget? Spending the budget and making new hires requires approval. Did the government refuse to allow her to spend her full budget? Was there a hiring freeze? Yes or no?

Sixth question: are there any plans to increase funding to the Metta clinic in Calgary, the transgendered counselling centre and clinic? If so, when would that funding be planned for, and how much?

Line 3.4 in the budget, physician development, is quite substantial, $179 million. What does this include? What does physician development include?

And the following one, physician benefits, is $435 million. What do those numbers include, and have they been impacted by the new amending agreement with the AMA?

Final question: have you, Minister, been in talks about a national pharmacare program with your other counterparts? What progress, if any, is being made on a national basis for a pharmacare program?

Thank you.

Ms Hoffman: Thank you very much for your questions. What I will try to do is answer as many of them as I can right now, and then we will respond to the others in writing.

Dr. Swann: Thank you.

Ms Hoffman: I'll take this time to put a few things on the record as well.

In terms of physician development and benefits I believe we did address those questions yesterday, but if we didn't, we will make sure that they are included in the response in writing.

In terms of the pharmacare program we have had conversations at the FPT table. We are bringing forward to the next FPT discussions this fall, with Ontario as one of the leads on this topic, a children's drug plan proposal so that at least the information will be costed, it will be available, and then the federal government can, hopefully, be partners in making decisions with us. I think that that's an area where it's hard to argue why you shouldn't be making sure that children who need cancer drugs can have access to them no matter what.

I also wanted to add that in terms of home-care qualifications there's a mix. There are often health care aides, but also LPNs and RNs are often engaged in home care as well as respite workers. So there are a number of different types of categories of home-care workers.

Dr. Swann: Is there a minimum? That is really what I was asking.

Ms Hoffman: The last thing I wanted to add is that in the questions around the suicide network I wanted to clarify that it was AHS, not AH, that has done funding in the past. We misspoke. The amount put on record, I believe, was incorrect. We said about a million dollars. I think that the application is in hand now and is currently being considered. I wanted to clarify that I misspoke at that moment.

Associate minister.

6:05

Ms Payne: I will jump in with trying to answer some of the other questions. With respect to the total number of opioid deaths in 2016, unfortunately, identifying opioid deaths is a complex process that can take several months. As nonfentanyl types of opioids are more widely used therapeutically and tend to be less toxic in small doses, it is often more difficult to determine whether that was the cause of death. On average, the office of the Chief Medical Examiner investigates 20,000 deaths each year, and we are working with their office around the feasibility of including other opioid data in upcoming quarterly reports because we do know that is a measure that people are concerned about.

With respect to the Metta clinic we have asked Alberta Health Services to provide a review and some other information, which we hope will be forthcoming, to determine ways to help increase access to the services provided by the Metta clinic because we know that it is quite beneficial for the clients that it serves.

With respect to the Mental Health Patient Advocate, you know, we really value the work done by the advocate's office. Most complaints brought to the attention of the Mental Health Patient

Advocate tend to be resolved through informal investigation, so generally a discussion between the patient, the advocate, and often members of that patient's interdisciplinary team. The advocate has discretion to determine how much time and effort should be devoted to each investigation, and we respect that discretion.

Over the course of the last five years there have been between zero and three formal investigations launched in any given year, and as I mentioned, that is done at the discretion of the advocate's office. As far as the informal investigations over that same time period, it's ranged from nearly 550 investigations to just over 400 informal investigations that were done in the '15-16 year. Certainly, we are seeing that that can fluctuate.

To be frank, I think that the work being done around addressing some of the concerns with the mental health system will help to support the work done by the advocate. We are really looking forward to continuing to work with the advocate's office and to hear recommendations around things the government can do in better ways, where we can help to improve the system to support mental health service delivery for Albertans across our province.

With respect to expansion for 211, that is something that we are mulling through the process. Certainly, we have heard the support for how 211 is able to connect Albertans with services, and definitely we've seen success with having the one province-wide number for Health Link.

The Chair: Thank you.

At this point I would like to invite Mr. Hinkley from government caucus and the minister to speak for the next 10 minutes. Mr. Hinkley, are you wanting to combine your time with the minister?

Mr. Hinkley: Yes, please.

The Chair: Go ahead.

Mr. Hinkley: Okay. Looking at page 153 of the estimates, and that is element 14.1, continuing care beds, the number that was given there was $122 million. What does this figure represent in terms of access to care? How many continuing care beds is this bringing to Alberta? Also, when do you expect them to be completed and open for people?

Ms Hoffman: Thank you very much for the question. More than a thousand continuing care spaces will be opening in a number of communities, which I've highlighted a couple of times so far, through this current year as projects are currently under construction and are nearing the completion point, so that's great news. Budget 2017 commits $122 million to continue the development of these beds, and our government plans to add more than a thousand continuing care beds in the '17-18 fiscal year. We're working towards making sure that everyone has the opportunity to age in community, as close to home and family as possible. We have a significant backlog that we are needing to address, but we're on track.

Mr. Hinkley: I guess also on page 154, the very next page, element 14. You know, we've made a commitment to building and investing in public infrastructure, that that's an effective strategy in a time of economic downturn. I see that smaller capital projects under element 14, infrastructure support, on page 154, received a funding increase of $113.8 million, almost tripling the budget amount. What projects is that money going towards?

Ms Hoffman: Of this total, $100 million is earmarked for the clinical information system that will enable AHS to have a single health record for every Albertan. Yesterday we mentioned that AHS currently has, they believe, more than 1,300 different programs in play. This system will upgrade outdated technology in Alberta's hospitals and health facilities that has reached the projected lifespan. Paper-based facilities will become automated and will replace most of those more than 1,300 existing systems that aren't connected and do not share information and don't meet those current needs. This is the first of four years of the $100 million annual injections. But this is an important investment to ensure that the right information follows patients and that no matter where you are in the province, your health care providers can make informed decisions with the right information.

Mr. Hinkley: Very good. We know that we've had an infrastructure deficit. What is the total amount of deferred maintenance for Alberta Health Services? I'm sure there must be a huge wish list.

Ms Hoffman: There absolutely is. Alberta Infrastructure has identified the deferred maintenance amount to be $930 million as of March 31, 2016. That compares with the year before, where it seemed to be approximately $783 million. That was a rounding number as well. The amount for the next year we still don't know at this point. We are continuing to invest and address that infrastructure maintenance plan money that has far-reaching impacts.

For example, when I was in Boyle recently, they were saying that it's the first injection of money into their hospital that they've seen for the capital side in many years. One million dollars can go a really long way when you're looking at smaller community facilities. They're usually hiring people in the local communities, creating jobs. The community knows that when you're investing in a new roof, they don't have to worry about the future of their facility.

The budget includes $600 million over four years for that capital maintenance. The annual average is about $150 million, and that compares to $760 million over five years that we had in the last budget. So we're maintaining the high level of funding that we believe is required to address the deferred maintenance that's been backlogged since the deep cuts of the '90s.

Mr. Hinkley: So there's definitely a plan to continue to keep up with the investment in maintenance and . . .

Ms Hoffman: Absolutely. For far too many years I think we've pretended that our buildings weren't aging, and absolutely they were. If you had a house that was 50 years old or 100 years old with the original heat system and roof, people would think that you were a little bit crazy, but there – and I get it. They aren't always the sexiest announcements, you know, new shingles on the roof, but that's a real investment. It puts people to work in local communities, supporting their local hospitals, other health care facilities. Those facilities deserve to have well-maintained bones, bricks and mortar, so that they can be there for future generations.

We do absolutely have a plan. We're working in partnership to – and this is one area where I have to tell you that sometimes it's frustrating to me that health care money, when allocated, can't be spent quickly, on the capital side in particular. I'll tell you this. Infrastructure maintenance money has no problem being spent because there are lots of people available usually for these smaller contracts. We're not looking at putting out, you know, massive RFPs for a brand new build in a community; we're looking at doing things like putting in new windows, putting in new light fixtures, addressing old electrical systems and heating systems. Those are important to make sure that patients and staff are in climate-appropriate environments and to make work productivity as well as

health outcomes better. This is good money, it's a good investment, and we're going to keep on this track.

Mr. Hinkley: That maintenance budget, the deferred maintenance: is that under capital or is that under your operations?

Ms Hoffman: The IMR money is, I believe, under capital. Yeah. The deputy just confirmed. Thank you.

Mr. Hinkley: Okay. I was just wondering how this investment, even though I completely agree with it, is affecting your cost curve that you're trying to keep under control, to the 2 per cent?

6:15

Ms Hoffman: Yeah. This is capital money. It isn't the same operating expense line item. Nonetheless, a tax dollar is a tax dollar is a tax dollar, so we want to make sure that we're spending responsibly, but this does fit in line with the investments that we've wanted to make to ensure that we have safe buildings. I've heard members from a number of parts of the province talk about concerns around the long-term viability of the hospitals in their communities. People shouldn't have to worry about what the future looks like. They should know that they're going to have a boiler system that's reliable, doors and windows that are safe and effective and as energy efficient as possible, too, obviously. We want to address utility costs for Alberta families and utility costs for the Alberta central services, including health care that so many of us really rely on. This has the ability to help us reduce some of our costs not just over the long term but immediately with some of that up-front capital investment. It potentially can help us with some of the operating costs when you're making smart, energy-efficient decisions.

Mr. Hinkley: Budget 2017 brought some very big announcements for your ministry, including the work on the Edmonton hospitals, including the first new hospital in almost 30 years. What are some of the top capital projects that will be funded in Budget 2017, and when will they begin working on them? When will we start to see things happening?

Ms Hoffman: Fantastic. For example, we have Calgary at Bridgeland, the new complex long-term care facility there. We have $130 million over four years, and $2.6 million of that will be in the '17-18 year because, obviously, that upfront planning work needs to be done. We probably won't see people working heavy equipment, but we will definitely have people drawing blueprints and doing all of that important work. That will begin this year. That's going to result in 200 new long-term care beds, and these are complex long-term care beds.

The Calgary cancer centre has an ongoing project. This summer the RFP on that should be completed, and we expect that construction will begin later this year. That's a project that the people of Calgary and southern Alberta have been waiting far too long for.

Edmonton, for example, the CapitalCare Norwood redevelopment: this is a $363 million project over four years; $15 million of that is in this fiscal year, and that's because we want to make sure we have the right plans in place. That is going to help with the expanded net growth there of 145 beds.

The Misericordia community hospital modernization: the capital plan includes $65 million, in that area, and this is a project that, again, has been long lobbied for by the people of Edmonton, and it fits directly with Covenant Health's submission for phase 1 of their redevelopment.

The Chair: Thank you.

At this time I would like to invite Mr. Smith from the Official Opposition and the minister to speak for the next 10 minutes. Mr. Smith, are you wanting to combine your time with the minister?

Mr. Smith: No. What I'd like to do is just simply read my questions. Then the minister can respond after I'm done. Okay?

The Chair: We'll set the timer for five minutes.

Mr. Smith: Thank you very much. Thank you, Minister. I am going to try to go as quickly as I can because I've got a lot of questions here. I'm going to start by looking at line item 2.2 in the budget. That deals with community and home care. Specifically, I want to be talking about self-managed care. Is there any funding budgeted in the 2017-18 provincial budget for self-managed care? I'd like to know what the dollar figures are, and I'd like to know if it's an increase or a decrease over the 2016-17 year. Then what I'd like to know is: have you done a cost-benefit analysis of the impact of self-managed care?

Are the standards for continuing care facilities the same for private and public facilities? We've had some concerns addressed to us out of the Red Deer Community Care Cottages that self-managed funds allowed for the families that are living there are being denied even when the assessed health care needs are on record. Families report that they're hearing things such as that funding does not exist or is frozen. They are being told not to apply because they do not qualify or would not qualify because Community Care Cottages is not a designated facility and is a for-profit and private company. They are told that they will not qualify because the residents are not living in their own homes. These are the stories that we're getting from there. Could you tell us: will you be committing to maintaining self-managed care in the 2017-2018 budget? Will you be committing to publicly supporting private continuing care facilities? What is your ministry doing to implement the home-care regulations to include provisions for self-managed care being consistently applied?

I'd like to jump over now to children's mental health. How much of the $80 million for addictions and mental health will be used to address specifically children's mental health? We know that in the Alberta Health Services Q2 year-to-date performance measures update the Edmonton zone is by far the worst of all the zones, meeting a target of mental health services within 30 days only 40 per cent of the time. Why have the Calgary, the Edmonton, and the north zone not met the 2016-17 targets? In some cases they appear to be a continuing slide further away from meeting those targets. If you could try to explain that to us, please.

We know that you are going to be building a new children's clinic in Rutherford and expanding the number of school-based therapists in high schools and enhancing mental health teams in the Stollery emergency department in the Edmonton area. Those are all good things. How much money has been allocated to each of these projects in the 2017-2018 budget and moving forward, and what are the timelines for the completion of each of these projects? How will you assess the impact of these projects as they move forward?

I'd like to skip to some rural mental health questions now. The Canadian Mental Health Association recently hosted a round-table discussion with more than 20 organizations focusing on rural mental health. They came up with three concrete plans: $300,000 for each of the next three years to develop rural mental health community action plans; they've got some ideas for microfunding

the projects to another $300,000 a year; and then training for rural front-line workers, about $200,000 in the first year and growing as needed. Will you be able to reflect the plans in your 2017-2018 budget? Will your ministry consider funding these proposals? Will you provide leadership to move these proposals forward? And will you provide leadership to the crossministry initiatives to ensure that projects do move forward?

The Valuing Mental Health report – I'd like to talk about that just for a second – released last year, identified the need for a single point of entry for mental health and mental illness being made available across the province and suggested the 211 line. Now that's not available to all Albertans. I guess the questions we have are: will your ministry cover the costs for a 211 line in the 2017-2018 budget? Will you work with other ministries to cover these costs? In other words, if you can't fund it strictly out of your budget, will you be working with other ministries to fund the costs, to cover the costs for this?

Finally, let's take a look just for a second – let's do the Alberta Health Advocate here.

The Chair: Thank you.

I would now like to invite the minister to respond. Minister Payne, go ahead.

Ms Payne: Yes. Thank you. You know, with respect to the questions around children's mental health I think that in some ways those targets have really pointed to an example of how increased conversations around children's mental health and increased awareness about how early children can develop mental health concerns and the decrease of some of the stigma around seeking help have led to an increase in the level of demand for supports for children.

Certainly, that's something that, you know, as the Department of Health we really grapple with, how to make sure that we're best able to address those needs of young Albertans. If someone has a mental health issue, oftentimes – the majority of Albertans who have mental health concerns experience their first symptoms in childhood. If we're unable to connect those Albertans with the services that they need, those early interventions and some of that preventative work, it can grow and balloon and become a lifetime of challenges for that individual. It's really critical for us to be working to make life better for those Albertans by making sure that they've got access to those supports that they need when they need them, starting at a young age.

6:25

For us it's been very key to continue that work that's been done within each department, so working with Children's Services, working with Education, working with Advanced Education, and working with Community and Social Services to ensure that there are those supports available for Albertans and to address some of those social determinants of health for folks that have had adverse childhood events that can really have an enormous impact on that individual's long-term mental health throughout their life. It really in a lot of ways comes down to how we're addressing these concerns within the system.

The Valuing Mental Health report talked about a single point of entry across the province. What we talk about in our department is how we want every door to be the right door so that wherever it is that an Albertan reaches out for help, they're able to be connected, not that every single social worker in a community or teacher or anyone at all is going to be able to provide that same level of service but that we've got a system that has those referral mechanisms and that integration so that when an Albertan reaches out for help on mental health or substance use, there's a hand reaching back to help them out. You know, as we work to evaluate what are some of the best ways to deliver that, in the interim there is Health Link. It is the same number across the province: 811. If you call Health Link and explain that you have mental health concerns, they will connect you with the mental health help line. There is help available to Albertans 24 hours a day to connect them with services that are available within their communities.

Certainly, we are looking to find ways that we can address some of the equity concerns across the province with respect to mental health services and substance use services to ensure that regardless of what age an Albertan is, regardless of what community they live in, they're able to access the help that they need in a timely manner. Certainly, some of the investments being made that you highlighted will help to address those concerns. We have found that in communities we've been able to expand access by adding additional beds. For example, in Calgary and in other communities we've been able to reduce the wait times for youth. That is absolutely work that we want to continue because losing any Albertan to mental illness or to death by suicide is a tragedy. Losing a young Albertan is even more so.

Certainly, the crossministerial work with respect to mental health and addressing the specific needs of particular populations is really critical. You know, a child who is in foster care has different needs for mental health supports than a child who lives at home with their parents and whose family is maybe well off and not having those stresses in their lives. Certainly, there's a lot of incredible work being done within the community, whether that's through organizations like the Sheldon Kennedy centre in Calgary or Zebra here in Edmonton. It's been incredible to see some of the work being done across the province to collaborate and support expansion of those services across the province as well as to meet the youth where they are.

The Chair: Thank you.

We have about one minute left on the clock. Dr. Starke, if you would like, I would like to invite you and the minister to speak for the remainder.

Dr. Starke: Sure. Why not?

Ms Hoffman: Tell the Tommy Douglas story.

Dr. Starke: Oh, no. It's much longer than a minute, but it is a good one.

Minister, the budget you had approved last year represented about a 1.8 per cent increase over the actual for 2015-16, but as we know there's been nearly $400 million of additional expenditure in your department. This year you're forecasting a modest increase at 3.3 per cent. I guess my question, to wrap up, is: how confident are you that you're going to be able to meet the $21.4 billion budget objective that you've set for this year?

Ms Hoffman: Thank you very much for the question. I think that this year's target is within reach. I think that last year we were incredibly aggressive, and we did need to have supplementary supply.

The Chair: Thank you.

At this time I would like to advise the committee that the time allotted for this item of business has concluded.

I would like to remind the committee members that we are scheduled to meet tomorrow, April 12, 2017, from 9 a.m. to 11 a.m.

in the Parkland Room to consider the estimates of the Ministry of Service Alberta.

Thank you, everyone. This meeting is adjourned.

I would just like to mention that we would also appreciate the co-operation of attendees in clearing the committee room for this evening via the elevators in the main entrance to the floor so that the staff can direct their energies to accommodating a maximum-capacity function happening shortly.

Thank you.

[The committee adjourned at 6:30 p.m.]

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