Legislative Assembly of Alberta

The 30th Legislature
First Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

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3:30 p.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

Ministry of Health
- Hon. Tyler Shandro, Minister
- Hon. Jason Luan, Associate Minister of Mental Health and Addictions
- John Cabral, Assistant Deputy Minister, Health Service Delivery
- Deena Hinshaw, Chief Medical Officer
- Lorna Rosen, Deputy Minister
- Graham Statt, Assistant Deputy Minister, Pharmaceutical and Supplementary Benefits
- Leann Wagner, Assistant Deputy Minister, Health Workforce Planning and Accountability

3:30 p.m. Tuesday, November 5, 2019

[Mr. Ellis in the chair]

Ministry of Health
Consideration of Main Estimates

The Acting Chair: All right. Ladies and gentlemen, I'd like to call the meeting to order and welcome everyone. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2020.

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 am Mike Ellis, MLA for Calgary-West, and I am substituting for Ms Goodridge as chair of this meeting. We will continue, starting to my right.

Mr. Neudorf: Thank you. Nathan Neudorf, MLA, Lethbridge-East.

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

Ms Glasgo: Michaela Glasgo, Brooks-Medicine Hat.

Mr. Amery: Good afternoon. Mickey Amery, Calgary-Cross.

Mr. Walker: Jordan Walker, Sherwood Park.

Mr. Jeremy Nixon: Jeremy Nixon, Calgary-Klein.

Mr. Rutherford: Brad Rutherford, Leduc-Beaumont.

Mr. Long: Martin Long, West Yellowhead.

Mr. Shandro: Thank you, Mr. Chair. The same folks who joined us this morning: I'll introduce them again. To my far left is Assistant Deputy Minister John Cabral, then hon. Minister Jason Luan, and Assistant Deputy Minister Aaron Neumeyer. To my right is Deputy Minister Lorna Rosen, and I am Tyler Shandro, Minister of Health.

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

Member Loyola: Rod Loyola, Edmonton-Ellerslie.

Ms Sweet: Heather Sweet, Edmonton-Manning.

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora.

Mr. Eggen: Good afternoon. My name is David Eggen. I'm the MLA for Edmonton-North West.

The Acting Chair: Wonderful. Thank you very much.

I'd like to note the following official substitutions for the record: Member Loyola for Mr. Carson, Member Hoffman for Ms Ganley, Member Sweet for Member Pancholi, and Mr. Gotfried for Mr. Neudorf for a portion of the meeting later on this afternoon.

Please note that the microphones are operated by *Hansard* and that the committee proceedings are being live streamed on the Internet and broadcast on Alberta Assembly TV. Please set your cellphones and other devices to silent for the duration of the meeting.

We'll now continue to the process review, speaking orders and the time. A total of six hours has been scheduled to consider the estimates of the Ministry of Health. For the record I'd like to note that the Standing Committee on Families and Communities has 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 speaking time is combined.

If members have any questions regarding speaking times or the rotation, please feel free to send a note or e-mail to the chair 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. Does anyone oppose having the break? Hearing none, we will have that break.

When we adjourned our meeting this morning, we were at one minute and 34 seconds into the exchange between Mr. Neudorf and the minister. I will now invite Mr. Neudorf or another member of the government caucus to complete the remaining time in the rotation. You have eight minutes and 26 seconds, sir. Go ahead.

Mr. Neudorf: Thank you, Mr. Chair. I would just like to pick up where we left off, and I will review the question for the ministers. In line with outcome 4, key objective 4.2, on page 88 of the business plan, earlier this year the government announced funding for CMHA Calgary with a grant of $3 million to support the Recovery College. I am encouraged to hear that the government is funding this initiative. The Recovery College teaches people from all walks of life courses on recovery where they can learn skills such as setting boundaries and empowerment. To the minister: how does the funding help those struggling with mental illness specifically?

Mr. Shandro: Thank you, and thank you, Mr. Chair. I will ask Associate Minister Luan to answer that question on our behalf.

Mr. Luan: Thank you, Minister, and thank you, hon. member, for the great question. As I mentioned earlier, before the break, this is one of the best practices that Alberta has adopted. I was involved three years ago to first introduce that and test it in Calgary. I was very pleased to see that pilot turn into a full program and have the Recovery College in Calgary and expand it throughout the province. What the Recovery College is doing is that it's adopted a peer-support model that empowers people who have lived experience, and they become the coaches, become the connectors. They become the one that is easily accessible for people who are struggling with this. You can imagine that when they speak to a person with lived experiences, it's totally changed the dynamic. Not only is this one very effective but also cost saving because they are delivered by volunteers who are trained to do so.

The Recovery College offers courses to help people with mental illness or addiction recognize and develop their own resourcefulness and awareness in order to support their recovery journey. Courses oftentimes are codesigned and developed by the peers and the people who are interested in this, so it's pretty much a community-driven, grassroots kind of approach. Let me tell you that I was more than delighted to see this program being welcomed by Albertans as going beyond Calgary, Edmonton, Fort McMurray, and other places, so we're very proud to support this program.

Mr. Neudorf: Thank you very much. I appreciate that, Minister.

I would like now to cede my time.

The Acting Chair: Okay. Thank you.

Is there another member of the government caucus? All right. Mr. Walker, go ahead, please.

Mr. Walker: Well, thank you so much, Chair. Through you to the minister and the associate minister I just want to say welcome. Thank you for being here and thank you to your colleagues as well for being here. This is a very exciting time and a very important portfolio. I just want to say initially that I am so pleased: another promise made, promise kept with this agenda item, where we're not only maintaining health care funding, but we're increasing, particularly in the area of mental health addiction. I think that's incredibly important, so I'm just very excited about that as well.

In my own community of Strathcona county we have the Strathcona community hospital. Let me tell you, Minister and Associate Minister, it was one heck of a battle to get that hospital built. Going back to a former MLA, Iris Evans, MLA for Sherwood Park from 1997 to 2012, there was a lot of lobbying and advocacy that went on at the political level to get that very important community hospital built in my community, serving not only Strathcona county but also the greater regional area east of Edmonton, but Edmontonians get service there as well.

Currently, from the last figures I saw, about 80 per cent of patients who get service at Strathcona community hospital are Sherwood Park residents, so it's very much a community hospital. It's very important to our community, and I look forward to both of you at some point going out to tour. Myself and the Minister of Service Alberta went out for a tour of Strathcona community hospital about a month ago. It was just absolutely amazing to learn about all the innovation, including drug addiction and mental health services that are uniquely there to serve Strathcona county as well as the Edmonton area, and just how well things are run there and how they're doing such a great job of serving the people of Strathcona county.

In fact, I had my own experiential experience with Strathcona community hospital recently, and I think it's important for an MLA to always directly experience these services that government provides and that are so important to the people. About three weeks ago a family member of mine had an emergency room visit – they're okay; everything is okay – but it took us two and a half hours from the time we checked in to getting out. You know, I was satisfied with that, because I know the average stay for triage patients at Strathcona community hospital is just a bit over three hours, so I felt we were probably adequately served.

Again, I'm just so pleased that we have a hospital in Strathcona county. It was so difficult to get it built, but it got built. A lot of times we're seen as an extension of Edmonton. We love our neighbour to the west, the city of Edmonton, but we're our own unique municipality and we have been since the creation of our specialized municipality in 1995.

Also, Associate Minister, I'm so happy with the increases we're seeing in drug addiction and mental health supports under your initiative. I also know that you and I are both deeply connected to the Mandarin Chinese community. I can tell you that they continue to be very upset that so many of the drug treatment facilities were concentrated in Chinatown. In no other community would government impose that or would that be allowable, and they were really frustrated that the previous government did not speak out on that issue strongly enough. They're so excited to have one of their own in such an important portfolio to also be an advocate for them. So thank you for that. I just know that my friends are so excited about you in the portfolio.

3:40

Something else I wanted to point out: really believing in our government's agenda to harness the power of civil society to provide better outcomes. Only government isn't always the solution. You know, we have a robust civil society that needs to be a partner with government collaboratively, including in health services as well as in the field of mental health and addictions.

In Sherwood Park we have a great civil society group that I've met with called Parents Empowering Parents. I talk to you, Associate Minister, through the chair, about this great community and what they do. I think I've passed the five minutes.

The Acting Chair: You have about 25 seconds.

Mr. Walker: You're so charitable. Thank you. He's such a nice guy.

I just want to say that what I like about Parents Empowering Parents is that they provide civil society supports for parents struggling with adult children who have a drug addiction. They don't know where to send them. They've worked collaboratively with government and also the Strathcona county family and community services over the last 10 years. I just wanted to . . .

The Acting Chair: Thank you, Member. We will get to your question during the next rotation.

We'll now go to the Official Opposition. Mr. Shepherd, go ahead, sir.

Mr. Shepherd: Thank you, Chair – and welcome back, Minister – for the opportunity to continue our conversation this afternoon. I thought we'd start by taking an opportunity to clarify, I guess, an issue of some debate that we've had today both here and in the House. If we can return for a moment to the child and adolescent mental health centre. There has been some dispute about the number of beds that are involved in the project. I thought that maybe we could just take a moment to clear the air on that question. Earlier this morning you acknowledged that the facility would include a total of 101 beds, but during question period today you also wanted to emphasize that that would be a total of five net new beds. Could you just clarify for me where the additional 96 beds currently exist in the community?

Mr. Shandro: Yeah. Very happy to answer that because I think I was interrupted this morning and not able to finish that. I was pointing out that it was not 110, as one member of your caucus had mentioned. It was 101. But, really, it is, yeah, five net new beds. There are 96 right now that are in the community. Then the plan was to amalgamate those beds into what we would call CAMH, I suppose, if I can use that abbreviation, Mr. Chair.

Those 96 beds. More specifically – do you mind answering that, then, John?

Mr. Cabral: The beds that are currently in place exist . . .

The Acting Chair: Sir, would you mind identifying yourself to the committee just for the record?

Mr. Cabral: Absolutely. John Cabral, assistant deputy minister, health service delivery. The 96 beds, as part of the CAMH project, would be consolidated from across the city, primarily over at the Stollery at the University hospital, into the CAMH site.

Mr. Shepherd: Okay. So primarily from the University hospital and the other sites. Any beds for the Royal Alex, for the Yellowhead Youth Centre?

Mr. Cabral: There are some throughout. I don't have the exact counts. We can get that for you.

Mr. Shepherd: Okay.

Mr. Cabral: But they're currently in the system now.

Mr. Shepherd: Are we aware, I guess, of the current age and quality of those bed spaces?

Mr. Shandro: No. We don't have that answer, it would appear.

Mr. Shepherd: Okay.

Mr. Shandro: But we'll endeavour to provide that at this meeting.

Mr. Shepherd: No problem. If we could get that in writing, just a breakdown, then, of where those beds are and, I guess, the age of those builds and those facilities, that would be helpful. Thank you, Minister, for clarifying that question. That's helpful.

If we could, I'd like to just return to our conversation, then, that we were having around LPNs and RNs and sort of talking about, I guess, how that was going to be implemented in the community and in terms of some of the savings that you're hoping to realize there. Looking back at our discussion, am I correct in recalling that part of the savings that you were anticipating there was from the 1 per cent reduction to the employer's contribution to the LAPP? Or was that not in the RNs? I know that was in some of the other professions.

Mr. Shandro: This is on page 118? The line items there?

Mr. Shepherd: Yes, exactly, sort of returning to talking about that funding, then. Let's see here: the fiscal plan, page 84. That is where you talk about expanding the scope of practice for LPNs.

Mr. Shandro: Yeah. I mean, the LAPP employer contribution conversation I think revolved around when we were discussing some of the efficiencies we were able to find on page 118. If we're talking about enhancing the scope of LPNs, what was the question, then, about the LPNs?

Mr. Shepherd: Just asking: do any of the amounts that you were anticipating saving in terms of the reduction of hours for RNs – so that was part of it – within that, was there any anticipated saving from any changes to pensions for RNs?

Mr. Shandro: No, there wasn't.

Mr. Shepherd: Okay. Not in that area. I apologize. I'm confusing my items. Not a problem.

Within that, then, basically we're looking at – you did mention something there, the enhanced vacancy management program, I recall. Could you clarify for me a bit about what that program is and how that operates?

Mr. Shandro: Do you mind if I ask you to answer that?

Ms Rosen: I can answer.

The Acting Chair: Just identify yourself for the record.

Ms Rosen: Lorna Rosen, Deputy Minister of Health. The enhanced vacancy management program is a program for Alberta Health Services where they have actually incorporated some hiring restraint, particularly into their management cadre. As positions become vacant, they're examined more carefully to determine whether or not they actually need to be filled at this moment in time. What that does is that it actually then increases the vacancy that you have over time, which saves money. It doesn't mean that they never get filled, but it stretches out the time that it takes to fill those positions, which then saves you some money.

Mr. Shepherd: Okay. Is that connected, then, with any of the savings within the reductions around RNs and that $100 million there?

Ms Rosen: The $100 million in savings around LPNs has to do with the expansion of their scope of practice and the fact that as opportunity arises, as registered nurses leave their positions, we can actually on occasion fill those roles with LPNs. LPNs make quite a bit less on an hourly basis than do RNs, so we anticipate that that will save $34 million a year, so $100 million over the three-year period of time.

Mr. Shepherd: So there's not a specific targeted reduction; it's what you're predicting and anticipating is going to be the shift as RNs may age out?

Ms Rosen: Yes. On an opportunistic basis.

Mr. Shepherd: Okay. Excellent. Thank you for that clarification.

I'd like to just move back, then, and talk about the $30 million that's set aside for new nurse practitioners. There was the announcement that was made and, again, I believe, referenced here within the fiscal plan, the business plan, that you've set aside $3 million for 30 new nurse practitioners that will be posted in rural, remote areas across the province, again something that at the time I said that I certainly support, that opportunity to improve access in the rural areas at a cost-effective rate. My question on that. You've set aside this $3 million. Is that $3 million intended solely to cover the salaries for those NPs?

Mr. Shandro: Oh, yeah. The announcement we had earlier, in October?

Mr. Shepherd: Yes.

Mr. Shandro: That is for the salaries of those nurse practitioners. That's correct.

Mr. Shepherd: Okay. Excellent.

Mr. Shandro: To be paid to the PCNs and for them to have the opportunity to hire those nurse practitioners.

Mr. Shepherd: Okay. That's for the salaries. In all of these cases, then, these new nurse practitioners will be going to operate in existing PCNs?

Mr. Shandro: Yes. The PCNs had an opportunity, then, to apply for the funding, and I think I've said that we've now found four nurse practitioners who've been hired through this initiative, and we're working with the remaining PCNs who had that funding to make sure that they're filling those spaces.

Mr. Shepherd: The intent of this program, in my understanding, is that you intentionally are wanting to post them at rural, remote areas to increase access to care in those communities. Are there enough PCNs already existing in those communities for these NPs to be able to move in to support that?

Mr. Shandro: Yes, there are in those rural and remote areas.

Mr. Shepherd: Okay. Would those NPs, then, be working alongside existing professionals, or in any cases would they be replacing doctors or other professionals currently working there?

Mr. Shandro: Oh, I don't think anybody is replacing. You said the word "replace"?

Mr. Shepherd: Yes.

Mr. Shandro: I don't think anybody is replacing. No. This is about enhancing. This is about working with others.

Mr. Shepherd: Increasing capacity in all cases. Okay. Thank you, Minister.

Will that include any amounts, then, I guess, for incentives for these nurse practitioners, any amounts in terms of moving and travel costs, or is the $3 million from your ministry simply for wages and it would be up to the PCNs to determine if they wanted to offer additional incentives?

Mr. Shandro: Yeah. That would be up to the PCN.

3:50

Mr. Shepherd: Okay. Thank you. I appreciate that.

What metrics would you be putting in place, then, Minister, to try to track the benefit that these would be bringing to the community? We're committing this $3 million. What would you consider to be, I guess, your measurement, your metric, especially since, at least within the business plan, we're no longer tracking the number of Albertans that are in fact enrolled in these PCNs?

Mr. Shandro: I guess I could say that generally some of the metrics we'll be using are just accessibility to primary care for folks in rural and remote and northern areas as well as improved health outcomes. Those would be our metrics in being able to determine whether this initiative has been successful.

Mr. Shepherd: Okay. So there are going to be a variety of measurements that you're currently already undertaking; you're just going to be watching to see what the impacts of those might be.

Mr. Shandro: Yeah. I mean, accessibility and health outcomes are always being measured anyways in this system, so we'll be looking to those measurements to be able to determine whether this initiative has been successful.

Mr. Shepherd: All right. Can you just clarify for me: how are you defining rural and remote for this program?

Mr. Shandro: Well, rural – maybe I should just . . .

The Acting Chair: All right. Thank you, Minister. I hesitate to interrupt.

We're going to go to the government caucus side. We had concluded with Mr. Walker. Would you like to continue, sir? Go ahead.

Mr. Walker: Thank you so much, Chair. Just continuing on my point, to finish off on the great civil society group Parents Empowering Parents, what most moved me about this group, which was first established in 2005, was that it was established by a group of people, in this case particularly parents, who didn't know where to turn for their adult children who were struggling with drug abuse and addiction. I've been really touched by getting to know them and working with them, and it's also a great example of where municipalities are working hand in hand with civil society groups but also collaborating with the provincial government to provide better health and mental health outcomes. In Strathcona county, for example, with Parents Empowering Parents, they have supported through their family and community services branch a grant which allows Parents Empowering Parents to have an office there, which allows them, then, to serve their clientele much more effectively. That money is put up by Strathcona county at the municipal level.

Another great example of that is our amazing firefighter and ambulance services that we have in Strathcona county. Minister, I'm very excited at some point, as is the Minister of Service Alberta, to let you know about – and maybe you already do know – the cutting-edge, innovative, leading technology and services that the Strathcona county firefighters' service provides in terms of ambulance. I think it's unique in Alberta. I know most services don't offer this, including in Edmonton. We have three people, I think two paramedics or maybe three, in the ambulance, where generally you have two people in an ambulance in Alberta. Also, Strathcona county, as is normal, also provides coverage into the Edmonton area, as does Edmonton for us. We're able to have three paramedics in our ambulance service because Strathcona county at the municipal level saw it as a good investment for quality of life and safe, effective living. They've invested, and they are subsidizing for that third person in the ambulance. This is another great example of how municipalities can get involved, in collaboration with the provincial government, to provide excellent outcomes and support civil society groups that can help us so well deliver these important health and mental health and addiction supports.

Also on the civil society angle of health policy and mental health policy, we have another leading template that I think would be great to take across Alberta. It's called the county social framework. This is where Strathcona county provides a meeting space for civil society groups from the mental health arena, the health arena itself, and everything in between to talk about how, from a civil society perspective, we can work with, assist, and close gaps where maybe government isn't providing the service or they're stretched thin. You have faith-based groups, you have secular groups, and you have nonprofits getting together and really doing amazing things in the areas of health and mental health policy. I'm just really excited about that and would love to put it on your radar.

Finally, from the faith-based perspective, in Strathcona county we have, through some large churches, primarily led by the Sherwood Park Alliance church, a civil society health initiative called bridging the gap. This is led by Pastor Jeremy Cook, who is a fourth-generation pastor, and he's doing just an amazing job of delivering this civil society health policy. I just wanted to put that on your radar as well.

My first question. This budget ends nonsenior dependant coverage for Alberta seniors' drug plans. Now, as I understand it, few provinces provided this to begin with, so my question to you, Minister, is: how common is coverage for nonsenior dependants across Canada? I'm referring, in this case, to the fiscal plan, page 84.

Mr. Shandro: Sure. Well, it doesn't exist in any other jurisdiction. There is no other senior-specific government drug plan in another province which provides coverage to nonsenior spouses or dependants. Now, there are two provinces, B.C. and Manitoba, who provide coverage for dependants as part of their universal plans; however, their drug plans are not senior specific. They treat seniors' families the same way as they would treat nonseniors' families.

Mr. Walker: Thank you very much, Minister.

My second question. The budget makes reference to exploring income testing for the seniors' drug plan. The estimates indicate on line 4.4 of page 118 that seniors drug benefits are increasing from $564,348,000 to $572,362,000. I understand that most other

provinces utilize some kind of mechanism in order to control costs in their drug spending. Can you give us an overview on the jurisdictional comparisons that were used to inform this decision?

Mr. Shandro: Sure. Well, first, I will note that it's incredibly difficult to compare drug coverage plans for seniors across Canadian jurisdictions as plan designs vary widely. Some jurisdictions have deductibles. For example, B.C. and Manitoba apply deductibles to their universal plans. B.C. sets its deductibles as fixed dollar amounts based on income, with zero deductibles for families with incomes up to $30,000. Manitoba sets its deductibles as a percentage of annual income, with rates increasing with income. Other jurisdictions have plans with premiums, which can vary depending on incomes. For example, New Brunswick's drug plan has six premium levels. It ranges from $200 per year to $2,000 per year, depending on income. Then other jurisdictions like Quebec apply both premiums and deductibles. Most jurisdictions' plans also require copayments above and beyond the deductible and the premium.

Mr. Walker: Thank you very much, Minister.

On to my next question. Now, you recently announced an LPN scope-of-practice increase, as indicated by performance indicator 3(c) of the business plan, on page 88. Can you please elaborate on the change and explain the impact on the budget? I'd appreciate that.

Mr. Shandro: Sure. Well, just to start with our announcement, when we did announce this expansion of scope. By allowing the LPNs to work to their full professional capacity, registered nurses, or RNs, will be able to focus on applying their expertise to where it's needed most. This will lower the number of RN funded hours per weighted resident day for long-term care, with no impact on care. As a result, the mix of funded hours will change. The current funding model for long-term care provides for .64 paid RN hours per weighted resident day. This can be reduced to as low as .3 with these hours being shifted to an LPN.

4:00

The modification of the funding model will generate savings which are system-wide since LPNs are paid at a lower rate of pay, as the deputy minister said not long ago, than RNs. As an example, LPNs, I think – well, I won't throw those numbers out there just in case I get them wrong. Alberta has the highest RN full-time equivalent per resident day in Canada. We were talking about CIHI before with Member Yao. Per CIHI Alberta is .64 compared to Ontario, which is .37, and British Columbia is at .42. The savings are a result of amending regulations to allow the LPNs to work to their full professional capacity. The LPNs' expanded scope of practice will come into effect February 1, 2020. Over three years it's expected to save $100 million. That's the expected impact to the budget.

Mr. Walker: Well, thank you so much, Minister, and as well the associate minister for your time. I appreciate your comments and answers to my questions.

Chair, I will cede my time now.

The Acting Chair: Okay.

Who else in the government caucus would like to go? Okay. Ms Glasgo.

Ms Glasgo: Thank you. I would like to, obviously, split my time with the minister. Minister Shandro, if it's okay with you, I'd like to also ask questions to Associate Minister Luan.

The Acting Chair: Thank you. We'll have to pause that for a moment here.

We're going to go to the Official Opposition. We concluded with Mr. Shepherd. Okay. Member Sweet, go ahead.

Ms Sweet: Thank you, Mr. Chair. I will go back and forth with whichever minister is going to respond.

The Acting Chair: Thank you.

Ms Sweet: I'd like us to go to page 89, please, for your performance measures in your business plan. If we're looking at the performance measures of 4(a), we have unplanned mental health readmissions to hospitals. Right now, in 2018-19, 9.8 per cent of mental health patients had unplanned readmissions within 30 days of leaving the hospital. I'm just wondering if you're able to give us a breakdown of how many of those readmissions were within the first 24 hours or 48 hours and how many of them were children and youth.

Mr. Shandro: If we could get back to you with those numbers.

Ms Sweet: If you'll be able to provide it in writing, please.

Mr. Shandro: Sure or later on this afternoon but one of the two. We'll get back to you.

Ms Sweet: Okay.

If we go to 4(b), emergency department visits where a mental health issue was identified for the first time in the past two years, again focusing on children and youth, I'm just wondering. If we're looking at this performance indicator, the desired result is to decrease the number of emergency department visits where a mental health issue was identified for the first time in the past two years. Can you maybe inform us of what strategies you're putting in place to help identify this performance indicator?

Mr. Cabral: John Cabral, ADM, health service delivery. The performance measures that are identified here have been drawn from the recommendations from the MacKinnon panel.

Ms Sweet: Okay. So at this time there are no policies or anything that have been developed out of that because you just received the recommendations, then, I would assume.

Mr. Cabral: The ones that are identified in there: that's where they came from.

Ms Sweet: Okay. Thank you.

Just going back to the CAMH facility, I recognize that the minister clarified the treatment beds. I'm just wondering if you could also speak to the outpatient services as well as the child and youth emergency department that was supposed to be part of that infrastructure as well. If we're recognizing that there are performance measures in place that are supposed to address mental health unplanned readmissions as well as emergency department visits, would it not be important to then build this emergency department as well as provide these outpatient services? It would help address your performance indicators.

Mr. Shandro: You're talking about the outpatient services that are right now being provided at the Stollery and then were going to be moved over to the CAMH facility?

Ms Sweet: If that was the strategy that was to happen, sure.

Mr. Shandro: I think that's the answer, then. I think that was the plan, to move the outpatient services that are at the Stollery right now to that CAMH.

Ms Sweet: Okay. Looking at the Stollery specifically, I've actually heard from many experts in the area, and coming from my background working with high-risk youth on Whyte Ave and Boyle Street, the Stollery is extremely busy with adolescent and youth mental health to the point where there are actual youths that aren't able to be admitted due to shortages of beds. I'm just curious if the plan was to move supports from the Stollery to downtown, to the new centre that's now not being built . . .

Mr. Shandro: That's not correct. Just to clarify that that's not the verdict.

Ms Sweet: Okay. It's on hold. Is there a plan over the next few years or in the next 12 months to expand those supports at the Stollery or existing facilities?

Mr. Shandro: Well, I think as I said this morning, our plan is to make sure that we're taking a moment and as well with the new council that was appointed by the associate minister to be able to make sure that the $100 million more that we're going to be spending on mental health and addiction, the amount that we spend and how we direct it to supports that are going to be in hospitals but also in the community, is going to fit with our government priorities. At the moment I don't think we know the answer, I suppose, and we're going to make sure that we're going to come up with a strategy that's going to try to maximize the effect that we're going to have for the children and the adolescents who are suffering from mental health issues.

Ms Sweet: Okay. Because the report's not going to be done for a year, are there interim measures that are going to be put in place? I recognize you're going to wait for the big strategy, but are there, like, interim strategies that are being created that this money is going to be used for?

Mr. Shandro: I don't think it has to wait until that full report has to be done. I don't think that's the case. I think it's just a matter of us saying that we needed to defer the project to be able to make sure we're looking, and if we're going to spend that $200 million, we're going to do it in a way that's going to maximize the effect on children and adolescents in northern Alberta.

Ms Sweet: Okay. Then just the last performance indicator, which is 4(c): 935 emergency department visits due to alcohol were occurring for every 100,000 population. I notice that you're measuring alcohol. Are you not measuring any of the opiate components? There's no performance measure around anything outside of the alcohol emergencies. And is there a reason that we're focusing so much on alcohol?

Mr. Shandro: The answer would be that, of course, we are measuring all, but the reason that alcohol is specifically mentioned as a performance indicator in the business plan is because alcohol and tobacco are the leading concerns for us in the health care system.

Ms Sweet: Okay. I guess in speaking to that – you might not be able to answer that, and that's fair – are you working with the Minister of Finance and with the AGLC around, you know, liquor store regulations? I know you're doing something on the tobacco strategy. I appreciate that, but are there other strategies in place around not just the reaction to emergency departments but maybe another, like, social determinants of health discussion around alcohol in general?

Mr. Shandro: Well, not in alcohol, admittedly, but we are doing a review, which is being chaired – oh; he's left now – by Member Nixon regarding the Tobacco and Smoking Reduction Act and making sure that we're taking a look at the extent to which we include vaping and vaping-related products in that act.

Ms Sweet: Okay. I'll cede my time to my colleague for now. Thank you.

The Acting Chair: Okay. Thank you very much.
Member Hoffman?

Ms Hoffman: Yes, please.

The Acting Chair: Go ahead.

Ms Hoffman: Yeah, and thank you very much to the ministers and the entire team. I know it must take a village to prepare for today, and I really appreciate your time and your commitment to this work. I want to say that I know that the time goes very quickly, too, so if I interject, it's not because I don't appreciate what you're saying. It's because I want to ask more questions. Please forgive me if that is the case.

I will take a few minutes on the fiscal plan in this rotation to talk about drug and supplemental health benefits. I'd like to begin there.

Mr. Shandro: Sorry. Could you repeat that?

4:10

Ms Hoffman: Yeah. On page 84 of the fiscal plan, drug and supplemental health benefits. I think I'll start with the biosimilars section. I was just wondering if you, Minister, or your designate have met with any of the folks in the GI community who are deeply concerned about being pushed off their existing medication, medication that's working for them in terms of gut health, and being put on biosimilars.

Mr. Shandro: Yes. I'm advised that ADM Graham Statt and members of his staff have met with those folks.

Ms Hoffman: That's great. I would recommend that if your schedule permits, I think this is a really important demographic to have an opportunity to connect with. They are living in extreme pain and have a number of concerns that I think warrant a political conversation as well. I really appreciate all the work that Graham and his team have done in that area, but I would encourage you to take some time to get to know them and their concerns about that. I know that it can be tempting – I think it's estimated through biosimilars and MAC pricing to save about $23 million a year. I think they have some stats from other jurisdictions around readmissions and other types of complications for their conditions, so that might be helpful.

Mr. Shandro: Thank you.

Ms Hoffman: Can you confirm that it is $23 million per year that is the number of dollars that is attempting to be saved by those initiatives, biosimilars and the MAC pricing?

Mr. Shandro: I can confirm that $23 million is for the MAC pricing policy. It would be an additional $30 million for the biosimilars initiative.

Ms Hoffman: Okay. Thank you very much.

I'll touch on the seniors' drug benefits, which I know have already been touched on. I appreciate that Alberta is the only jurisdiction that had dependants on the program. I just want to paint a bit of a picture because most of these . . . [Ms Hoffman's speaking time expired] In my next round.

The Acting Chair: Thank you, Member. We'll have to return to that.

We concluded with Mr. Walker on the government caucus side.

Mr. Shandro: No. Member Glasgo.

The Acting Chair: Member Glasgo. Okay. Go ahead, please.

Ms Glasgo: Thank you, Mr. Chair. I was asking Minister Shandro if he's okay if I also ask questions through him to Associate Minister Luan. Is that okay with you?

Mr. Shandro: Yes.

Ms Glasgo: Okay. Perfect. I'm going to first start with you, Minister Shandro. I'm on page 118 of the government estimates, line items 4.4 and 4.5. There's been a lot of fearmongering around seniors' supports in Alberta. I know as somebody right now who has a grandma in the Medicine Hat hospital who is receiving exceptional care and really benefiting from our world-class health system here in Alberta that you're overseeing – I was just wondering if you could comment. I'm seeing some increase in seniors' drug benefits, dental, optical, and supplemental health benefits from the previous government, but there's still ongoing criticism of you. I'm just wondering if you could tell us how your ministry is standing up for seniors and how those numbers reflect your commitment to that.

Mr. Shandro: Well, thank you. Our government is committed to providing seniors with the supports that they need. Given the fiscal situation we've been left in by the previous government, we need to make some changes to ensure that the benefits that we provide are sustainable. The line item that you mention is showing the overall cost forecast for each benefit program. It's determined by a range of offsetting factors, including enrolment or coverage, volume of benefits provided, and price.

To take the example of the seniors' drug program, this is the largest drug benefit in the province. It costs approximately $600 million per year, and the growth rate is about 8 per cent per year. The budget for the program is actually $8 million higher than last year's actual, so I would emphasize that we're not cutting back on the program. In fact, we're planning to spend slightly more on it than was spent on it last year. That small net increase reflects several different factors. The biggest single factor is a very large increase in costs as more seniors join the program. This is a good reminder that we have the youngest population in Canada, but aging is still a major factor in our budget. In fact, our seniors population is increasing faster than it is in other programs because of the baby boom generation plus large groups of people who moved here during past economic booms when they were of working age and are now becoming seniors.

Costs are also being driven up by increasing costs per claim as more high-cost drugs are covered by the program. To offset these increases, we'll introduce changes to coverage of biologics to biosimilars. We'll also expand the existing use of MAC pricing, which we talked about this morning. Finally, we'll offset part of the increased enrolment by redesigning the program to stop providing coverage to nonsenior spouses and dependants, but I should emphasize – yeah.

Anyway, we're also increasing the budget for seniors' dental, optical, and supplemental benefits to account for higher enrolment due to population aging.

To sum up, there is no budget cut for seniors' health benefits, but there are some changes to get our costs under control and more in line with other provinces, as the MacKinnon report recommended.

Ms Glasgo: I definitely appreciate that clarification, Minister.

I want to switch gears to mental health and addictions. Page 119, line 5.1, in the government estimates: that is where I'm at right now, so I'll let you get there. With no reductions in funding, that means that millions of dollars are still being spent on harm reduction. That's millions of dollars in needles that are used to reduce the spread of disease, but they end up in our parks and our school playgrounds and around our communities. I know that in Medicine Hat the proposed injection site is causing a lot of concern amongst my constituents as well as the residents and business owners in the area, so this is particularly poignant for me, I guess. While new needles may reduce harm for one group, they're also increasing it for another. Can you comment on how this government is planning to mitigate the impact of needle debris to our communities and children?

Mr. Shandro: Associate Minister Luan.

Mr. Luan: Thank you, Minister, and thank you, MLA Glasgo. I want to give you recognition for your leadership in your communities when you helped me to visit them when I had town halls and group meetings there. I heard it loudly: your communities are seriously concerned about this. Let me assure you that that concern is shared across the province, and that was the reason we commissioned that robust socioeconomic assessment/review of the consumption sites.

As you're aware, currently the review is going very well, and we're in the second phase, consolidating the data and providing the analysis to come up with a report before the year-end. Let me reassure you that this government takes the issue of community safety seriously. In the meantime, while we're waiting for the findings to come out, we continue on with the other support services, whether through police or through some of the service providers, for needle cleanup and management.

Let me put out one more point. As we recognize that the current practice of how needles have been distributed and debris managed is not necessarily in a sustainable fashion, I have asked our ministry to take a look at: what are the ways we can develop a more sustainable approach to manage this? I anticipate that that review will be in concert with the findings from the assessment from the socioeconomic review process. In the end, when we make decisions, setting up directions for the future, this will be part of the solutions coming together with that.

Ms Glasgo: I appreciate that very much, Minister. I know that your presence was very much appreciated in Medicine Hat, especially downtown. The panel that came to Medicine Hat: I know it was really important for my community residents to be able to feel like they were heard as well as different interest groups in the area, including businesses who invest a lot into our downtown core. There's obviously a lot of controversy over that proposed injection site in Medicine Hat, and I really do appreciate you and your team making sure that that was heard and recognized.

Also, when you were in Medicine Hat, we toured a detox facility, and we talked to some people who were involved in that, and I know that that was really a passion project for you, to see more of that coming forward. On page 88, outcome 4 of the business plan I see that $10 million is available to expand the support for treatment and

recovery, especially for those people addicted to opioids. I'm just curious if you could tell us exactly what services people will have access to.

4:20

Mr. Luan: Thank you for that great question. Yes, you are absolutely right. This government takes it very seriously as a priority that we open up the availability so that Albertans who suffer from addictions and mental illness can access the treatment and support when they are ready to do so. You're absolutely right. When you and I toured that treatment centre in Medicine Hat, it was lovely but not enough. We need more. You heard our Premier announce that this government committed to increasing that capacity for 4,000 additional treatment and recovery spots in the next four years. Particularly, specifically for the $10 million in 2019, what we're going to do is upgrade a number of social detox beds into medically supervised environments, like the one you and I toured in Medicine Hat, because that will increase the capacity and can deal with a large variety of needs rather than the lower end of social detox beds.

Also, we're going to increase psychosocial support. To put the term simply, that's the counselling, therapy. As you can appreciate, lots of the fundamental, sort of root issues are that people need to change how they deal with difficulties instead of turning to drugs and alcohol as a solution, so learning new skills to change. That's a life-change process, so that one we're looking to significantly increase.

In addition, we're going to expand the virtual opioid dependency program, which is helping provide immediate treatment services to Albertans, particularly for rural areas. When you don't have access to psychiatrists . . .

The Acting Chair: Okay. Thank you, Minister.

We'll now go back to the Official Opposition. We concluded with Member Hoffman. We'll continue. Thank you very much.

Ms Hoffman: Thanks. I was just starting to talk about the seniors' drug plan and some of the folks who are on it. Obviously, it is folks who are over 65, but of the dependants, I believe the lion's share are between 60 and 64, and most are spouses of a person who's on a program. When I think about my family, certainly my dad turned 65 before my mom, and she was part of his drug coverage during that bridging time as she was a dependant of his. I think it's probably a lot of folks that fit that demographic that we're looking at. I understand it's about 64,000 people. Could it be confirmed that that's the number that are currently on it who are not 65 or older, and could the dollar amount that is anticipated to be saved or cut from this line item because of this change please be put into the record as well?

Mr. Shandro: To confirm the number, first of all, all of the dependants of spouses in total is 60,363. You were asking for the ones between 60 and 64, though, specifically?

Ms Hoffman: Just how many are dependants under the age of 65? They wouldn't be eligible for the program.

Mr. Shandro: So 60,000.

Ms Hoffman: Sixty thousand. Okay. I thought it was 46,000.

Mr. Shandro: And then out of all the dependants who made claims, it was 46,000.

Ms Hoffman: Okay. So 60,000 are eligible; 46,000 actually accessed the program last year. Okay. That's helpful.

Then what's the dollar amount that they claimed for and that we were modelling them claiming for in this year? This policy change: what's the dollar amount that it's anticipated to see savings of?

Mr. Shandro: As we spoke about this morning, the number is $36.6 million.

Ms Hoffman: Okay. Thanks for that.

I just want to say that just because Alberta is the only province that has this in the current formula – many don't have the same kind of seniors' drug plan. You did say, Minister, in our previous round of exchange that other provinces have a universal program. I think you referred to Manitoba as being one of them and B.C. Just because Alberta might be the only one that specifically has a seniors' dependants category doesn't, in my opinion, warrant cutting it. I think that these are programs that we've developed over a number of years for good reason.

I appreciate that we do interjurisdictional comparisons, but I think that the impacts that it will have by forcing these people off the program could be very negative. I believe – and I'd be happy to be corrected by somebody else – that it's about 1 in 5 Canadians who doesn't take their medication as prescribed by a physician currently, and I worry how many more people, specifically these dependants, are going to be pushed into making a decision about whether or not they can afford to take their medication and will follow their health practitioner's recommendations.

Mr. Shandro: Yeah. I would point out, though, that the seniors' drug plan, as we're calling it in this meeting – it's called coverage for seniors, obviously, which we know – is just one out of 22 plans that we have that we cover that are government-sponsored plans. The next most significant one is our nongroup plan, which is also a universal plan that we have here in Alberta. There are other options for folks who aren't seniors to be able to find the coverage that suits them.

Ms Hoffman: Yeah. It is the Alberta seniors' drug benefit program. The reason why they're on this one is because it's a better plan than the other plan. We're moving them from a plan that's more comprehensive, I would say, to a plan where they would have higher copays and less ability to access a broader scope of medications. If that's not the case, then why are we moving them off this plan? Is it simply that we're going to cut $36.6 million but add it to the other line item? I don't think so. I'd be happy to receive further clarification if that is inaccurate. The seniors' drug plan, the Alberta seniors' drug benefit program: does it cost less for users, and does it have greater scope of coverage than the other drug plans that these folks will likely have to rely on instead?

Mr. Shandro: Graham, do you mind just coming to the microphone and maybe just answering that?

Mr. Statt: Sure.

Mr. Shandro: I guess that just generally the question is on the difference between nongroup and the coverage of the seniors' plan.

This is Assistant Deputy Minister Graham Statt.

Mr. Statt: Thank you, Minister. Yeah, I can gladly clarify that. The nongroup plan and the seniors' plan actually use the same formulary, the same drug formulary, so one is not more comprehensive than the other. The chief difference with the seniors' plan is that there are no premiums involved for seniors whereas when we move someone to the nongroup program or they sign up for the nongroup program, it's a premium-based program.

Ms Hoffman: Thanks.

If I could supplement, have we done modelling around the average cost or the range of cost that people would see, how their individual cost would go up because they're being asked to pay a premium now?

Mr. Shandro: The maximum annual premium for nongroup is $762 for an individual. I guess that for a family it would be – what is it for a family?

Mr. Statt: I believe it's $1,416 for a family, the maximum premium under the nongroup program.

Ms Hoffman: Thank you.

Mr. Statt: I'll also say that for lower income individuals and families, a subsidized premium is available under the nongroup program.

Ms Hoffman: So, essentially, $1,416 for the 60,000. It's people, so I imagine not all of them are individual families. But $1,416 times – what would be a reasonable estimate? I'm extrapolating what this actually means for an individual family, this decision to move folks off the seniors' drug plan.

Mr. Shandro: Well, if it was a family of two and one, the oldest member of the family, was a senior and there was a nonsenior dependant in the household who was previously covered and moved over to nongroup, I guess it would depend on their income level.

Maybe talk about the income levels, Graham, and how you get to $762 to max out for that premium.

Mr. Statt: Yeah. It's a good question. Thank you, Minister. Happy to do so. The nongroup premium amounts, the ceilings that are there, have been there for a long time. They haven't changed any time recently. One of the things that I'd just like to clarify – and I think the minister mentioned it earlier – is that we do believe that of the 58,000 to 60,000 individuals that are dependants in the seniors' program, only about 46,000 of them actually make a claim. I think, as you mentioned, Member Hoffman, the lion's share of the dependants would be from 58 to 64, many of them still working, and would be able to access private coverage. Of course, the other option is to be self-insured or, in the alternative, to access the nongroup program as a way to bridge the drug coverage.

Ms Hoffman: Thank you for that clarification.

Mr. Shandro: Very briefly as well . . .

Ms Hoffman: Sure.

Mr. Shandro: . . . we have answers to Member Sweet's previous question. Whenever it works in – I know you have other questions, Member Hoffman.

Ms Hoffman: Yeah. If I could use my last two minutes.

Mr. Shandro: Just to advise your caucus of that.

4:30

Ms Hoffman: Thank you. I appreciate that.

I do want to touch a little bit on scope of practice, because, of course, physician compensation, drug costs, and then acute care are some of the biggest drivers in your budget. I think we're all quite aware of that. To get to basically a 3 to 4 per cent increase, which is what we were operating at previously – we were able to have stability in those areas but certainly not opulence. To get to such a small increase in this year's budget: I'm concerned about what the implications are for acute-care facilities. I'm wondering: have we done modelling of how many beds or wards or facilities will have to be reduced to hit these targets for AHS?

Mr. Shandro: Well, we're expecting these efficiencies to come out of expanding the operational best practices. You would know that previously, when it started – the OBP program to date has only been applied to 16 of the largest facilities. This is a matter of being able to expand the OBP program to be able to find those efficiencies, but also we're expecting to be able to get some direction from the AHS review, which will be reporting to us at the end of the year, to be able to help us understand how we can work with AHS to find more efficiencies in their facilities.

Ms Hoffman: If I could just extend on that, operational best practice was in the 16 largest facilities in part because there are other jobs in and around those 16 largest facilities. If we're reducing registered nurse complements in Brooks, it's certainly a lot further to drive to find another job, and often families would actually have to move. Have we done that modelling around the facilities outside of the largest 16? I worry about the implications for rural communities.

Mr. Shandro: AHS has.

Ms Hoffman: Would you be willing to share that with this committee? I think this makes a decision about how we feel about this budget.

Mr. Shandro: Maybe just more specifically, what is the modelling that you would like us to provide?

Ms Hoffman: Yeah. The OBP: what are going to be the reductions in terms of hours . . .

The Acting Chair: I'm sorry, Member. We'll have to return to that point.

We're going to go back to the government caucus side. We concluded with Member Glasgo. Would you like to continue?

Ms Glasgo: No. I'm going to give my time to Mr. Long.

The Acting Chair: Okay. Member Long, go ahead, sir.

Mr. Long: Thank you. For starters, Minister Shandro and Associate Minister Luan, I just want to thank you for your time today and the energy that you're both bringing and the time and the effort that you guys are spending on such a monumental portfolio. I also want to acknowledge your staff and the work and effort they're putting in as well. Thank you.

With my role representing West Yellowhead, rural health delivery for health and mental health services is obviously vital for my communities. It's been a number of years since my communities have felt that their health care has been a priority. At one point it was mentioned, actually, that the Whitecourt hospital is long overdue for renovations. You know, it's been promised, to have a new hospital. It was at one point indicated that it wasn't that bad for a rural community hospital. That was a bit of a slap in the face to that community, but it does show a bit of a trend from past years. I do want to acknowledge today the conversations that I've had with both ministers to this point. You acknowledge that rural hospitals and rural heath care are important to you and to this government and that it's not something that's going to be just shied away from. Thank you for that.

Now, that said, rural surgeries are very important as well and having access to those. In the fiscal plan on page 83 I was wondering if you can elaborate on the surgical initiative that was promised as part of our campaign commitment. When do you expect to be able to make an announcement concerning that initiative?

Mr. Shandro: Page 83 of the fiscal plan does state that a detailed plan is in development to address surgical wait times for Budget 2020. The Alberta surgical initiative, as it'll be called, is going to be designed to maximize efficiency of the current health system and improve patient experience. The initiative will be comprised of, you know, five strategies, which will take place over three phases of the surgical journey for patients.

Those five strategies would include the following. The first would be to improve the provision of specialist advice to primary care providers before the surgical consultation. The second would be to improve the provision of surgical consultation, including referral and triage. The third part would be to improve provision of surgery, including enhancing the use of what we call the NHSFs – we spoke about that a little bit this morning – the nonhospital surgical facilities. The fourth would be to improve care co-ordination and pathway development, and then the fifth one would be to develop strategies and recommendations to support long-term service viability.

Officials from the department and AHS have developed an implementation plan and have commenced this work. Specific financial considerations will be addressed as part of Budget 2020, as we spoke about this morning, including the capital and the operating impacts, surgical volume increases, and procurement strategies for expanding the procedures in AHS facilities and in the NHSFs.

Mr. Long: Okay. Thank you for that.

Outcome 1.4 of the business plan, on page 84, talks about enhancing the use of information technology to help Albertans. The business plan actually makes reference to amending the Health Care Insurance Act in order to place controls on where physicians practise. Again, it's vital to the communities that I represent to be able to actually get physicians. Believe it or not, not everyone likes moving north in Alberta. Minus 40 isn't always at the top of people's wish list when they move to our province in the first place. That said, how will these changes assist with the recruitment and the retention of physicians in rural Alberta?

Mr. Shandro: Yeah. Bill 21, which is in the House right now, contains changes to, as you said, the Alberta Health Care Insurance Act which would allow a Minister of Health to manage the physician services budget and to align physician supply and distribution with population health needs. Overall, there's currently a sufficient supply of physicians here in this province. However, the evidence shows that physicians are not practising in the areas where they're needed the most.

We spoke a couple of times today about CIHI, the Canadian Institute for Health Information. According to CIHI the number of physicians continues to grow at a much higher rate than the general population here in Alberta. Between 2014 and 2018 the Alberta population increased by 4.8 per cent, but the physician population grew by 13 and a half per cent. In 2018 the total number of physicians in Alberta was at 10,800 and something, equivalent to 249 physicians per 100,000 population.

Shortages of physician services continue in rural and remote. I think it was a question for me earlier: how do we define "rural" and "remote"? I'll just briefly throw that out there. "Rural" within a system we would define as not being one of the major urbans or the mid-size urbans. "Remote" is a matter of distance from health care facilities. In 2018 there were 732 physicians practising in rural Alberta, a 3.6 per cent decrease from 2017. This accounted for 6.8 per cent of physicians in Alberta. Using a needs-based analysis, the north zone, central zone, and south zone are experiencing higher primary care health needs than the available supply of our general practitioners, or GPs.

The Calgary zone, the Calgary urban area in particular, has lower primary health care needs but the highest relative supply of primary care physicians. In the Edmonton zone as well the primary health care need only slightly outweighs the primary care physician supply.

4:40

Existing mechanisms to address distribution of physicians include financial incentives such as what we have now, with the rural, remote, northern program, which I mentioned recently in the House, and the rural medical education programs at both of the medical schools here in Alberta. These programs have been in place for many years, but the proportion of physicians working in rural areas continues to decline. The difficulty in attracting and retaining physicians in rural areas affects the province's ability to provide health care services to rural residents and contributes to burnout, really, of existing rural physicians.

You know, the proposed legislative amendments to the Alberta Health Care Insurance Act will allow a Minister of Health to manage the physician services budget and align supply and distribution of physicians with those population health needs. The proposed framework builds on lessons we've learned from similar initiatives in other provinces, including Prince Edward Island, New Brunswick, Quebec.

I hope that answers the question.

Mr. Long: I thank you for taking on that initiative, because it's not only hard to attract doctors in rural Alberta and northern Alberta; the retention is a major issue as well. I know that we have very bright young doctors in most of my communities, but there's always that lingering question of: how long are they going to stay? So I really applaud you in your efforts to actually address this.

The Acting Chair: Okay. Thank you very much, Member.

We will now go back to the Official Opposition. We concluded with Member Hoffman. Will we continue with Member Hoffman? Oh, Member Sweet.

Ms Sweet: Yes.

The Acting Chair: Okay. Thank you very much. Go ahead.

Ms Sweet: Thank you, Mr. Chair. I just wanted to see if the minister wanted to update us on the numbers.

Mr. Shandro: Yes. There are four locations where there are existing beds to get to the 96 that are currently available. I'll just name the facilities first. There's the Royal Alex, there's the Glenrose rehabilitation hospital, there's the Turning Point in-patient unit, and then there's the Yellowhead Youth Centre. The first one, the Royal Alex, has 30; the second one, Glenrose, has 26; Turning Point has 17; and then the Yellowhead Youth Centre has 23. That takes us to the 96.

Ms Sweet: Then we don't include the Stollery? They've got a few.

Mr. Shandro: Maybe if you don't mind answering that.

Mr. Cabral: When I said the Stollery, I erred. It's not beds; it's physicians. Psychiatrists are going to be moving and centralized. The plan was to centralize them at CAMH so that as we bring those beds together, those services will be centralized.

Ms Sweet: Then what about emerg? The idea was that a child and youth/adolescent emergency centre would be built as part of CAMH. The Stollery currently addresses some of the emerg issues. They have emergency for child and youth/adolescent at the Stollery, but they also have them at the Royal Alex. I guess I'm just curious if the capacity was going to be greater at CAMH with emerg abilities and then keeping the Stollery and the Royal Alex. Or was that all going to be amalgamated?

Mr. Shandro: We're bringing all the services together, but the net beds were five.

I'd also point out that the capital plan does include redevelopment projects, including the redevelopment at the Yellowhead Youth Centre, which I mentioned as well. I can't remember the total distribution to the Yellowhead and the other projects, but I think there was 38 point something million that was included for projects which would help out Alberta's youth and homeless.

Ms Sweet: Minister, have you toured the facility?

Mr. Shandro: Which facility?

Ms Sweet: All of them.

Mr. Shandro: The Stollery?

Ms Sweet: The Royal Alex, the Glenrose, Turning Point, and then, of course, YYC, or Yellowhead Youth Centre.

Mr. Shandro: The Royal Alex, the Glenrose, but not Turning Point or Yellowhead.

Ms Sweet: Okay. I would like to move on, then. If we could go to population and public health, which is part of your government estimates 7.1 and 7, just talking about population and public health programs and services such as the office of the chief medical officer of health. I just wanted to chat a little bit about the role of public health and population and education of Albertans. Could you maybe walk me through the responsibility of educating Albertans around the importance of public health and making sure data is relevant?

Mr. Shandro: Sorry; which line item are we referring to?

Ms Sweet: On page 116 you reference population and public health programs and services such as the office of the chief medical officer of health. It's in your government estimates. I just wanted to see if you could walk us through real quickly the role of the office of the chief medical officer of health in public education and accuracy of data collection and distribution of that information.

Mr. Shandro: Dr. Hinshaw, do you mind coming and speaking?

Is that within scope, Mr. Chair?

The Acting Chair: For one of your staff to come to talk?

Mr. Shandro: Or the question, I suppose.

The Acting Chair: Yeah. She's referred to the line item and page item, so I believe it is in order.

Mr. Shandro: Then, Mr. Chair and colleagues, I'm asking Dr. Deena Hinshaw, the chief medical officer of health for the province of Alberta, to be able to answer the question.

Ms Sweet: Thank you.

Dr. Hinshaw: Thank you. I believe the question was on the role of the chief medical officer of health in educating Albertans. Is that correct? The chief medical officer of health has a legislative mandate to monitor the health of Albertans and to provide recommendations to the minister and to regional health authorities, which in this case would be Alberta Health Services, on measures to protect and promote the health of Albertans and to prevent disease and injury. The act doesn't specify exactly how that works in public education, but one of the roles that I have is to be a spokesperson for public health issues for the ministry and on issues such as the recent acute vaping-related lung illness. That's a role that I have had in making sure the public is aware of those risks. I hope that answers the question.

Ms Sweet: Yeah. I think that's great. Part of the reason why I'm asking the question is that, actually, when we talk about, if you want to go to page 90 of your business plan, safeguarding Albertans from communicable diseases through initiatives aimed at decreasing sexually-transmitted diseases or blood-borne pathogen infections, I believe it would be in the scope of the chief medical officer to be ensuring that that information and public health information is being shared with Albertans correctly. To the minister, I guess my question is: when we talk about needle exchange programs and needle debris, do you believe that it's accurate to say that 48 per cent of needle debris has decreased since the opening of supervised consumption sites?

Mr. Shandro: Do you know that answer, Dr. Hinshaw, if it's 48 per cent?

The question is whether we can validate your number of a 48 per cent decrease?

Ms Sweet: There's a report that was done by the Alberta Community Council on HIV. The question that I'm asking is on how there continues to be discrepancies around whether or not supervised consumption sites support the lack of needle debris in communities, and I would really like clarity for the committee and for all Albertans about whether or not that number has actually decreased since the opening of supervised consumption sites.

Mr. Shandro: Okay. Two things. Will we be done, do you think, questions for Dr. Hinshaw? We can let her sit down.

Ms Sweet: Oh, yeah. Sure. Sorry. I just wanted to clarify. Thank you.

Mr. Shandro: Thank you, Dr. Hinshaw.

Then maybe I'll allow Associate Minister Luan to answer that question for you.

Mr. Luan: Thank you, Minister. You know, early on, when we reported on my visit and some of the numbers provided by our current providers – there are big discrepancies in terms of how they report numbers, how they interpret them. The same is true of that report that you're referring to, if you're talking about that HIV in Alberta report, if that's the one you're referring to. That's one of the reasons we commissioned this review expert to review all those pieces, including the data analysis of what they're doing as we speak, the validity of such and whether or not the way the data is collected is reflecting what needed to be brought to the table.

4:50

Ms Sweet: I appreciate that. I guess what I'm talking about, though, is that when we look at population health initiatives and we're talking about educating Albertans around safeguarding Albertans from STIs as well as blood-borne infections, needle exchange is part of that so that people are using clean needles. I would then assume that the chief medical officer as well as all of our experts within our ministries are collecting data on that information. Do you not believe that it's in the best interests of Albertans to get clear data around needle debris within their communities, and should that data not then be publicly released to Albertans to understand that there has been a decrease in those issues? Like, you must have the information.

Mr. Luan: If I can share, our current understanding on this is that, yes, there is a lot of data being collected. But when you interpret it, what contributed to the effect? There is more than one approach that has contributed to the decrease or increase of the overall impact. So that's precisely one of the reasons why we're asking experts to deliver the findings to us versus each one of us taking a swing at a particular number and having our own interpretations about that. That's exactly why we're relying on the experts.

Ms Sweet: But we should be relying on the chief medical officer because that's the role of the office, to look at Alberta's data. It's not up to you and I as politicians or anybody in the room to decide on the data . . .

Mr. Luan: Correct.

Ms Sweet: . . . which is why I'm asking whether or not that role makes sense and if that data cannot be released to Albertans so they understand. I worked in the chief medical office on secondment for a year. I understand how it works. So I would really like to understand why we're not using the mechanisms within the Health ministry that you're funding, very clearly, to be able to provide public health information to Albertans so that we're not having discrepancies in information.

Mr. Shandro: Would it be helpful to bring Dr. Hinshaw back up to talk about the data that is being collected?

Ms Sweet: It's up to you, Minister. Whatever you're comfortable with.

Mr. Shandro: Dr. Hinshaw, do you mind coming up? Oh, you're at the mic. Perfect. Okay. Maybe explain the data that is collected now and I think . . .

The Acting Chair: I'm sorry, Doctor. We're going to have to return in a bit here.

We're going to go back to the government caucus side. I know we concluded with Member Long, and at the conclusion of this segment we will be taking our five-minute break and then returning with the Official Opposition.

Okay. Member Long, would you like to continue, sir?

Mr. Long: Yeah. I just had one more question, actually. I would hate to have anyone think that I only care about rural Alberta even though that's what I represent.

Page 130 of the fiscal plan: I just wanted to talk about the $2.9 billion commitment that references a number of ongoing projects, which includes the Calgary cancer centre and the Norwood long-term care facility. I was just wondering if you could give us a status update on those projects.

Mr. Shandro: Before I answer that question, I'd just advise the opposition caucus that there was a question from Member Hoffman about whether we could provide the modelling undertaken by AHS. At this time I'm advised that we can't commit to releasing the modelling undertaken by AHS, just so you know. Then when it's your time again, you can ask any follow-up questions.

Questions about ongoing projects: first I'll talk about the Calgary cancer centre. Regarding the Calgary cancer centre itself, just to be very clear, our government is fully committed to the project. Budget 2019 includes over $1 billion over the next four years for this. As is to be expected with major capital projects, especially for one of this size, cash-flow adjustments can and will be made to align with the anticipated construction schedules. Obviously, as you try to scope out projects initially, construction schedules can change as you start to get into the details. The previous cash flows, then, were based on preliminary estimated project delivery schedules. The new cash flows are based on the project delivery contract and the milestones which are in discussion with the project contractor. The Calgary cancer centre remains on time and on budget; I can advise of that. Construction is under way, if you ever have a chance to drive by on 16th Avenue in Calgary, with design complete and concrete being formed and poured up to levels 6 through 8 right now. The connector between the cancer centre and the FMC, the Foothills medical centre, is under construction as well. Construction will be complete in 2022.

The cancer centre is scheduled to open in 2023. Once construction is complete, it takes AHS approximately about a year to commission, which is to move in all of their equipment, the site. The $1.4 billion investment in the Calgary cancer centre will help put patients at the centre of the health care system by ensuring that they have access to comprehensive cancer services in a world-class facility.

I guess I can also speak about the Norwood long-term care centre in Edmonton. We are also committed to this project. The cash flows were adjusted in Budget 2019 to align, again, with anticipated construction progress and project escalation costs. There is $327 million budgeted over four years for this project. This funding will continue support for this complex continuing care project. This is a continuing care project meant for patients with complex needs. This project will add 145 net new beds, and it will also renovate 205 beds, for a total of 350 long-term care beds for complex continuing care patients upon project completion. The facility will also offer postacute in-patient programs for people who have become deconditioned and require goal-oriented, structured rehabilitation following their surgery or following their illness.

Mr. Long: Okay. Thank you, Minister.

I'll give the rest of my time.

The Acting Chair: Okay. Thank you.

The government caucus. All right.

Mr. Guthrie: Well, thanks for being here. I like the moustache. It takes some getting used to here, but I appreciate the support for Movember.

I guess that, continuing on this capital side of things, if you look on page 113 of the estimates, we see the capital investment budget there. It remains the same. However, if you compare the spend year over year from the previous government there, it equates to about a $14.8 million growth, or 199 per cent. Can you explain this spending and inform the committee about the projects, initiatives that are within that funding?

Mr. Shandro: Sure. The capital investment that you're referring to in the budget is for health IT systems development. In Budget 2019

we've estimated a $22 million annual budget for this work although just over $7 million was spent in 2018-2019. The funding supports the enhancement and the maintenance of key IT systems. This is going to ensure the proper functioning of IT systems and support the development of new applications to meet the department business needs as required.

Initiatives funded from Health's IT systems development funding include development of a document management portal to automate the report submission process for PCNs, the enhancement to the Alberta organ and tissue donation registry to support the Northwest Territories donation program, upgrading of the immunization system to support the new regulatory changes for immunization and adverse events reporting, enhancements to the provincial surveillance initiative system to automate the processing of lab data. There's a replacement of end-of-life hardware to ensure that Alberta Health applications run on supported infrastructure. There's also a need to ensure the replication of data between the primary and secondary sites to ensure that Alberta Health is prepared in the event of a disaster. Last, I would note the replacement of end-of-life servers to improve performance and to provide flexibility.

Mr. Guthrie: Okay. Well, thanks. That's pretty detailed.

On page 118 of the estimates, line 3.2, we see the remuneration for physicians has gone up about 4 per cent. Now, last week, October 31, your department had announced action being taken to get physicians where they need to be in the province. Is this increase related to that expense, or is it something else altogether for that increase? Can you maybe just explain a little bit as to what that supply and distribution agreement was?

5:00

Mr. Shandro: Yeah. Just to talk about Bill 21 again, Bill 21 addresses physician distribution by establishing a balancing system so that communities do not continue to experience doctor shortages. Starting in 2022, April 1 of that year, Alberta Health will adjust its billing system so that access to physicians is balanced throughout the province based on the measured health needs of Albertans. This will help ensure that all Albertans have equitable access to physicians no matter where they live in the province.

New doctors will only be able to bill the government for delivering insured services if they practise in the locations which are identified as there being a need. This will include rural and remote areas as well as underserved urban areas. These changes will help to ensure that government spending on physicians in 2019-2020 happens in a way which best serves the health care needs of Albertans.

The increase on page 118, which you note, on line 3.2 is to cover the cost of growth due to population growth and aging. It is not caused by this new balancing system that I've been talking about. The MacKinnon panel highlighted that physician compensation has grown by nearly 300 per cent since 2002, and the average fee-for-service billings in Alberta are significantly higher than in other provinces.

Mr. Guthrie: Yeah. I guess that as an aside, then, I'm seeing there on page 85 that graph of Alberta's growth in physician expenditure. Just to extend this, then, a little bit more, what would you attribute that to? Why would our growth be so much larger than these other major provinces?

Mr. Shandro: Well, the drivers for physician compensation are that people keep moving into the province, so the population is growing. The population is aging. We have more physicians coming and deciding to move to the province, and the volume of billings is increasing.

The Acting Chair: All right. Thank you very much, Minister.

Ladies and gentlemen of the committee, we will take a five-minute break and return. Thank you very much.

[The committee adjourned from 5:03 p.m. to 5:09 p.m.]

The Acting Chair: All right. Ladies and gentlemen, we can continue. I do see that the minister is present. We have members of the government caucus present, and we also have members of the Official Opposition present. Minister, you can certainly try to get some of your staff back in here, but we are going to continue as we are limited on time.

We concluded with the Official Opposition. My understanding is that Member Hoffman is going to continue. I think she indicated that – I apologize.

Ms Hoffman: Dr. Hinshaw.

The Acting Chair: Dr. Hinshaw. Okay. Dr. Hinshaw, if you would like, go to the mic, of course, with the approval of the minister, to conclude answering the question.

Mr. Shandro: Yeah. Maybe if I could hear the question first.

The Acting Chair: Sure. Maybe hear the question again. Thank you.

Ms Hoffman: Yeah. I'll paraphrase what I recall. It was the last question that was asked by my colleague MLA Sweet around needle debris and information or misinformation around the consequences of the sites.

Mr. Shandro: Oh. Please. Yeah. If you don't mind answering that, Dr. Hinshaw.

Ms Hoffman: Thank you.

Dr. Hinshaw: The supervised consumption sites report back on their activities, and one of the things that was included in the grants for those sites was needle debris remediation. That is something that has been done by the sites, but we know that there is a need for a provincial strategy on needle debris. That's something that the department has been tasked with working on, and I'll be involved in creating that strategy.

I don't know if that answers your question.

Ms Hoffman: Yeah. If I could just supplement, drawing back to my colleague's original question, I think that it was around that sometimes we hear accusations that the numbers are going up. Certainly, for anyone finding a needle anywhere, I know that that can be very traumatizing. But I was hoping that we could have some of the data on what's actually happening and the trend line of finding needle debris in communities, particularly communities where there is supervised consumption.

Dr. Hinshaw: Those specific numbers I don't have with me right now, but that's something that, certainly, we could prepare and get back to you if there is that specific information that you'd be looking for.

Ms Hoffman: Yeah. That would be really helpful if the minister . . .

Mr. Shandro: Oh. Yeah, if it's something your office is collecting, sure. Thank you.

Ms Hoffman: Thank you very much.

The Acting Chair: Thank you, Doctor.

Ms Hoffman: Maybe I'll pivot back. We started talking about operational best practices. I just want to clarify that when this model was brought forward for consideration, some of the things that I asked about were: was it going to be through attrition only, or was it going to be through bumping? I put some parameters around it, saying that I wasn't comfortable for us to be going into all facilities and saying, "Here are your pink slips," to nurses and other health care workers on the front lines but that when there was attrition, we were comfortable with there being attrition-based operational best practice realignment with staff. I appreciate that it sounds like the minister isn't comfortable sharing AHS's specific modelling for different sites, and that's fair, but I'm wondering if we can have some clarity, because this is a big portion of the budget, the AHS line item, around what we're looking at. Is it expanding? I know it was expanded beyond the original 16 sites, but is it expanding to non attrition-based realignment, so warranting bumping processes and reduction of services where there aren't currently vacancies, and what is the scope that we're looking at?

Mr. Shandro: I can say that currently there's still an attrition-based model.

Ms Hoffman: Okay. And the budget is based on the assumption of it staying attrition based for the remainder of the year?

Mr. Shandro: Yes.

Ms Hoffman: Okay. That's certainly better news than I expected, having seen those numbers, so that's helpful.

Has there been other modelling? I know that there have been public reports through the *Journal* and other sources around facilities, particularly rural health facilities, that some people think aren't needed in those communities. I know everyone in those communities one hundred per cent believes they're needed. I'm wondering if we've done some modelling in preparation for this budget around . . .

Mr. Shandro: Our department hasn't.

Ms Hoffman: Pardon me?

Mr. Shandro: No, our department hasn't, not for this budget. No.

Ms Hoffman: So for the remainder of the fiscal year every health facility that's open today we can expect to stay open?

Mr. Shandro: We have not done any modelling as a ministry regarding this issue. I can't say whether or not the AHS review and whether Ernst & Young are looking at that. I actually have no idea. But we have not done any of that modelling. That's not something that we have included in this budget.

Ms Hoffman: So looking at hospital closures is part of the scope for the Ernst & Young report?

Mr. Shandro: Well, I'm just making it very clear. The question was: have we done it? We have not. I don't know what Ernst & Young might come up with. I just want to make it very clear that we haven't done that. We haven't directed them to. We haven't asked them to do that.

Ms Hoffman: But it's part of their scope, potentially.

Mr. Shandro: Well, if they're looking at AHS and reviewing AHS, I suppose – I don't know. We haven't had their report yet. But if you're asking whether we have as a ministry or whether it's included in this budget, then the answer is no.

Ms Hoffman: I guess my question is: will there be hospital closures or site closures within this fiscal year? That's my question.

Mr. Shandro: No.

Do you want to answer that more specifically?

Ms. Rosen: Lorna Rosen, Deputy Minister of Health. I just want to make sure that when we answer that no, that allows for the fact that, say, for example, on the Misericordia hospital site, with respect to the emergency room construction there is a clinic on that site that will be taken down to make room for that emergency room expansion. So with the exception of those kinds of clinic closures – and there may be some other clinic programs that might close just as a matter of evolution – there are no hospital closures. There are no what I would call true AHS facility closures planned.

5:15

Ms Hoffman: Or unit closures?

Ms Rosen: Yeah.

Ms Hoffman: Okay. That's helpful. Thank you for that.

I think I will cede the remainder of this time to my colleague Mr. Shepherd.

Mr. Shepherd: Thank you very much.

All right. Minister, just taking a look, then, I'd like to take some time, I guess, to talk about physicians in the province of Alberta. Looking at your business plan, you have a number of metrics that you're looking at, one of them being the percentage of total physician payments that are alternative relationship plan payments. Pardon me; I don't have the exact number here in the business plan. I can locate that.

Ms Hoffman: It's referenced in the fiscal plan, page 85.

Mr. Shepherd: Thank you.

My colleague noted that that is noted on page 85 of the fiscal plan. You talk about that there. Looking at the table that you include there from the government's recent MacKinnon report, Alberta is currently at 13 per cent, so about 7 per cent behind two of the major comparators, that being B.C. and Quebec, who are at 20 per cent, a considerable amount behind Ontario at 36 per cent, but of course Ontario is also well ahead of Quebec and B.C. Is there a particular target that you're aiming for within the next year or that you hope to achieve for Alberta?

Mr. Shandro: For us to be able to move physicians to ARPs.

Mr. Shepherd: That's correct.

You're sort of providing some specific comparisons to other provinces. Noting that Alberta is currently at 13 per cent, do you have a specific number that you hope to achieve? Are you hoping to just simply achieve the levels of B.C. and Quebec, or are you hoping to, I guess, hop over them and sort of catch up with Ontario?

Mr. Shandro: We don't have a specific number for this year.

Mr. Shepherd: Okay. You just know that generally you want to see more plans?

Mr. Shandro: Yeah. We're in the middle of negotiations right now with the Alberta Medical Association. We know – and I'm sure they know as well because it's been spoken about quite a bit by our government publicly – that it's one of the issues that we want to have a conversation with them about at negotiations.

Mr. Shepherd: Okay. That's going to be a part of the negotiations coming up.

Is that your only plan or initiative, then, in terms of trying to increase that, those direct negotiations, or are you going to be considering some sort of incentives or other ways to convince doctors to move to this from fee for service?

Mr. Shandro: Well, we hope that the physicians over time will see the benefits of some kind of, you know, capitation model, whether it's fixed capitation or blended capitation, and want to start changing their relationship with the government to that kind of a model.

Mr. Shepherd: With Bill 21, then, you seem to be setting the direction that you're intending to go in terms of how you want to negotiate with physicians, both in terms of, I guess, where they are able to practise and indeed in terms of how payment agreements would work and go forward. Is that the main mechanism you're using, then, at the table to negotiate with doctors?

Mr. Shandro: No. I don't consider that to be leverage. Sorry; what's the vocabulary you used again?

Mr. Shepherd: That's a fair reading of my question. Is the intent of a bill like Bill 21, where you're taking what some doctors – and certainly I can say, from the correspondence I've received, that it's probably a number of doctors – feel is a significant and possibly unconstitutional overreach into how doctors practise, to create leverage?

Mr. Shandro: No. I guess I would say first of all that every physician in the province who is currently practising would be grandfathered, as it were. This is about any physician that begins their practice after April 1, 2022. Those are the physicians where the prac ID, or the practitioner ID, that's mentioned in the . . .

The Acting Chair: Okay. Thank you, Minister.

We'll return to the Official Opposition. We're going to now go to the government caucus. We concluded with Mr. Guthrie. Okay. We'll continue with Mr. Guthrie. Thank you, sir.

Mr. Guthrie: Thank you. Let's see here. The opposition has been talking about a reduction in the budget with regard to ambulance services. On page 92 of the business plan on the consolidated financial statement we see that the previous government had overspent in that area by about 7 and a half million dollars, but the Department of Health is going to be reducing that budget in that category, at least on the consolidated basis, by $4 million.

Now, in my constituency I'm constantly hearing stories about ambulances and EMS workers that are waiting at hospitals for hours simply to transfer patients. They're leaving communities without coverage or at least coverage that's close by. It appears as though these EMS workers could be better served in the community rather than waiting up to eight hours sitting at a hospital, not to mention the cost that's involved in that. Is this an area where your department is looking at making improvements, and are there other areas and points of focus within ambulance services that you're looking at to improve costs and delivery?

Mr. Shandro: The short answer is yes. I think all of us know from just knocking on doors that this is a significant issue among Albertans. The answer is yes. It is actually a conversation I had last week when I was speaking with the chief paramedic. He was telling me a little bit about how over the last year there have been over 100 projects put in place by AHS to address prolonged EMS wait times, so he was just walking me through samples. I mean, he didn't walk me through all 100 of these initiatives or programs, but there have been a significant number of attempts by AHS to be able to address the prolonged EMS wait times in emergency departments. They haven't to date had any sustained improvement.

The most significant reason for off-load delays world-wide is the aging population and unmet demand for continuing care beds. This is something that our government is committed to addressing, making sure that we're going to increase the number of continuing care beds in this province. By not having enough to keep up with demand, it actually leads to congested acute-care facilities, the hospitals that are owned by AHS and then as well the emergency departments in all these AHS facilities. The situation is also exacerbated by more short-term factors such as flu season during winter, shortages of health care professionals, including family physicians in some areas, the opioid crisis.

Another issue as well is that to date the only place for EMS, a paramedic, to be able to take a patient right now is just to an emergency department. It's going to be important for us to develop a strategy that allows for EMS to be able to take patients to a place in the community as well; as an example, maybe to a PCN. You know, if a PCN in a major urban has a 24-hour clinic, if there's an opportunity for someone not to be taken to an emergency department but instead to somewhere like a PCN, that's an opportunity for us as well.

So our department is working towards resolving the issue with multiple actions, which we're co-ordinating. This includes increasing the availability of continuing care spaces and services such as home care; changes to policy and agreements which allow paramedics to transport patients to facilities that are not acute care; supporting the requirement of increased education and training for paramedics to enable different care models, including community paramedicine; and clinical triage at dispatch. It should be noted as well that there are no reductions being made to the level of ambulance services in Alberta. Ambulance services' funding includes in the province ground ambulance, air ambulance, patient transport to the hospital and between hospitals, and as well the EMS central dispatch. Those areas are going to have no reductions in the level of services in Alberta.

5:25

Mr. Guthrie: So we are looking at some kind of way to have that quicker hand-off rather than having these EMS workers sitting hours and hours and hours at the hospital. Is there a way that they can hand off there at the hospital, have that triage that you were talking about and have the hospital handle that and get the ambulance back into circulation?

Mr. Shandro: We don't have the answer yet, but it is an area that we have been looking at for the last five months. ADM Cabral has been working on that. We've come back and forth a couple of times talking about what is going to be needed for us to reimagine – not even reimagine. That's actually incorrect. But how do we enhance transfers of care at our hospitals? That is something that he and his team are working hard on to be able to develop so that the transfers of care are done in a more efficient way in Alberta.

Mr. Guthrie: Okay. Thanks.

Last week the Leader of the Opposition was out making claims that the government of Alberta was delaying funding to the cancer clinic and claiming cuts to support cancer patients. The Leader of the Opposition was also making claims of cuts to front-line staff and caregivers.

You know, I've been going through these budget estimates pretty thoroughly here, and I don't see this. I see a year-over-year increase in spending in the estimates of $296 million; outpatient cancer therapy drugs spending is up 11 per cent, or $23 million; high-cost drug spending up $13 million year over year; increases to diagnostic and therapy up $10 million; and year-over-year increases to seniors' drug benefits, support programs, equipment for cancer corridor projects. I guess you've addressed that the cancer clinic is going ahead, but do you have any comments on these needed therapy programs and these comments that are being made by the opposition?

Furthermore, what has been the reaction that you've had from the health industry to this budget and the initiatives that are coming out of your department?

Mr. Shandro: Sure. Budget 2019 reflects our commitment to maintain or increase health care spending – I'll just point that out – with a $201 million, or 1 per cent, increase in 2019-2020 compared to the actual spending for '18-19. Our government's commitment is to provide a universally accessible, publicly funded health care system.

I'll talk a little bit about therapy programs. You are correct that we have increased the budget for outpatient cancer therapy drugs by about $23 million over last year's spending. The budget for outpatient specialized high-cost drugs is up $13 million from '18-19. For outpatient cancer therapy drugs, we are seeing increases in the cost of individual cancer drugs. We expect more new drugs to be added to the benefit list in 2019-2020. For specialized high-cost drugs: with the increases for volume growth as more patients are provided treatment as well as for new drugs being added to the program, there are more than 11,000 patients being provided treatment through this program.

I'll also just mention the Calgary cancer centre. As I said earlier, we are committed to this project, and Budget 2019 includes over $1 billion over the next four years of this. The $1.4 billion investment in the centre will help put patients at the centre of the health care system by ensuring that they have access to comprehensive cancer care services in a world-class facility.

What reaction we have had: do you mean from health care professionals?

The Acting Chair: Okay. Thank you, folks. Just hold that thought.

We're going to go now to the Official Opposition. We concluded with Mr. Shepherd, and we will continue with Mr. Shepherd.

Mr. Shepherd: Thank you very much. Minister, just before I continue to my question sort of regarding, I guess, the negotiations with physicians in some of Bill 21, I did just want to clarify on one other project. There was the Bridgeland-Riverside continuing care centre in Calgary. That was a project that we had going. Is that facility going ahead as originally announced and designed?

Mr. Shandro: The answer is yes.

Mr. Shepherd: Okay. So no changes to that project, no anticipated delays?

Mr. Shandro: No. I haven't heard of any delays, none that I know of.

Mr. Shepherd: Okay. Excellent. Thank you, Minister, I appreciate that.

Mr. Shandro: Actually, maybe I should change that answer. Well, there is actually a delay, but it's with the city of Calgary. The city of Calgary, which Member Hoffman probably knows, has been advocating for us to move where the building is currently designed by 30 metres or something like that. I think that if there is a delay, it's not with our department, though.

Mr. Shepherd: Okay. So your intent is then to move forward with the project as originally announced and designed?

Mr. Shandro: Uh-huh.

Mr. Shepherd: Excellent. Thank you, Minister. I appreciate that confirmation.

We were just talking there, I guess, about your negotiations here with physicians, then. You know, as I mentioned, I've received a number of e-mails and contacts from different physicians and folks that are sort of involved in this process expressing concerns, I guess, around some of these steps, in particular the question of how you're approaching these negotiations with doctors. Indeed, Dr. Christine Molnar, head of the Alberta Medical Association, is saying of the bill that's currently before the House that they're viewing it as something that's basically allowing the government to, to quote her, unilaterally rip up the current master pay deal and any future pay deals it reaches with doctors. To quote her specifically: "Government is cynically asking us to work toward agreements when it appears we are the only party to be bound by them."

Now, I recognize that, you know, the position that your government has taken in some respects, whether that's through Bill 9 or some others, has been to, I guess, assert that power of government. Again, just what we were talking about, is that part of how you're approaching these negotiations with the alternative payment plans and other things to assert that power in such a way as to achieve what you want to get?

Mr. Shandro: The answer is no. No. Previously your question was whether – was it the prac IDs? Yeah, it was the prac IDs.

Mr. Shepherd: Yeah. We were talking about that aspect as well.

Mr. Shandro: No. The answer is no. I mean, look, I think this government has for years had an important relationship, an important partnership with the Alberta Medical Association. We look forward to continuing that relationship with them. They are an important partner of ours. We spend $5 billion on their members in any given year, and that amount is only increasing. They are going to be an important part of our surgical initiative as we try to get wait times down in this province in the next four years. We continue to look forward to having a good relationship with the AMA, and we look forward to making sure that the negotiations are in good faith. I think to the extent that Dr. Molnar or any of her members has a concern, I look forward to them having the opportunity to bring up any issue they have at the negotiating table. I have no indication that these negotiations will not be in good faith.

Mr. Shepherd: Respectfully, Minister, you're happy to bring this up at the negotiating table even as you're bringing this legislation into the House. Was this something you discussed with them beforehand as part of this to realize these, I guess, intents of your business plan?

Mr. Shandro: Which amendment to the legislation? Is this the prac IDs?

Mr. Shepherd: Well, in particular, I guess, I'm speaking here of, to quote the doctor, giving the government "the power of pre-approval to cancel any physician services agreement without recourse."

Mr. Shandro: Well, first I'll talk about the prac IDs. My understanding from the AMA is that when we advised them of the legislative amendment, I didn't have any indication that they were opposed to this proposed amendment.

Regarding the legislative change to allow an agreement with the AMA to be amended or terminated by order in council, like, if you go to the AMA agreement, like any well-drafted agreement, it's going to have a termination clause. It can be terminated by mutual agreement of the parties or by operation of law. What we're doing in the legislation is merely providing some clarity about: if it was to be through operation of law, how would that happen? Is it through a legislative change, or would it be by order in council? We're providing some clarity. The current agreement that we have had, which was amended by a previous government, says that it would continue unless it is mutually agreed upon by the parties or by operation of law.

5:35

Mr. Shepherd: Here's where I'm going with this, Minister. You have, to put it lightly, an ambitious agenda as a government and as a minister for the health care system in the province of Alberta. As outlined in this business plan, as outlined in the legislation you've been bringing forward, you're attempting to effect a pretty massive transformation here. The metrics that you set forward in your business plan here: the majority of them are drawn from the MacKinnon report, and the majority of them seem to be fixated on some particular numbers, certainly recognizing that the MacKinnon report was largely looking at finances and looking at where we save money, how we can save money, and not really looking at other effects that it might have within the system.

When you are coming in, I guess, with this sort of approach, this sort of legislation, these sorts of negotiating tactics with physicians, not to mention with front-line workers, we're dealing with things like where you're rolling back the amount that you're going to make for your employer contributions by 1 per cent. You're reducing the amount, as we just found out today, I guess, that you're willing to pay rural physicians that are on call. You are choosing as a government to make several cuts in education. Indeed, we just met with resident physicians yesterday, as I know you did as well, as they're working through that process and others are looking to determine if they want to practise here in the province of Alberta and to ensure that we're going to have the supply of both doctors and other medical workers. But we are driving up their tuition, in particular for doctors, noting that that is a program that is particularly targeted for in-program increases often beyond the amounts of other programs, but also for nurses, health care aides at the same time that we are increasing the costs for their student loans, at the same time as we're removing their educational tax credits. What incentives, Minister, with these kinds of approaches, are we giving to actually create more workers and to keep the workers we have and to motivate them to actually want to work with you to achieve these things?

Mr. Shandro: I think the answer, first of all, is pointing out that they aren't tactics. I think very specifically as well, because the on-call program was mentioned, as I said in the House today, this is a change to the on-call program which was actually negotiated or proceeded through the mechanisms which are contemplated in the agreement. The agreement with the AMA provides for a physician compensation committee. This went through the physician compensation committee. I would totally disagree that this is a tactic at all. This is something that proceeded through the agreement, through the terms that were agreed upon.

Mr. Shepherd: Fair enough. We will concede on that point.

Do you understand the larger issue that I'm addressing here? You are setting out a fairly ambitious scope in this budget and in the business plan that, frankly, you have no way of achieving without the co-operation of physicians and a large spectrum of health care workers within this province, yet you are creating incredible disruption within that system. Certainly, in the view of some of the people involved in these negotiations and in this process with you, it's frankly antagonism. Do you feel that that's going to allow you to actually achieve these incredibly ambitious and transformative goals you have for our health care system?

Mr. Shandro: Well, I suppose I don't concede the premise that this is antagonistic at all. To the extent that physicians, any member of the AMA and those who are at the negotiating table, have concerns, I mean, that's exactly why we're having these good-faith negotiations with the AMA, so that they can be able to bring up the issues that they have at the table, making sure that we can hear the concerns of their members and get to the point where we can have an agreement that's going to work for both the government and their members.

Mr. Shepherd: Well, fair enough, Minister. I think it would seem that both physicians and a number of other health care workers would certainly take issue with your definition of good faith.

The Acting Chair: Thank you, Member.

We will now go to the government caucus side. We concluded with Mr. Guthrie. We'll continue with Mr. Guthrie. Thank you, sir.

Mr. Guthrie: Yeah. Thanks. Just when we left off there, you were just going to continue on, I guess, about what the reaction has been from the health industry to the budget and the initiatives that you're bringing forward.

Mr. Shandro: Yeah. When you say "health industry," you mean health professionals?

Mr. Guthrie: Yeah.

Mr. Shandro: Well, I mean, there are quite a few categories of health professionals that we have spoken to who have been incredibly supportive, for example the LPNs. The College of LPNs has provided us very positive feedback on that initiative, as well as the nurse practitioners. My understanding is that the midwives are very happy to see the increase in courses of care. I mean, the feedback that we're receiving has been positive.

I think that perhaps to tie in with Member Shepherd's comments, you know, we're also in the middle of negotiations with our front-line partners in the system to the extent that individual members might have anxiety about what these negotiations mean and what the outcomes are going to be. We hear that feedback as well, but we're confident that we're going to be able to work with our partners in the system who represent those members.

I don't know if that answers, then, the . . .

Mr. Guthrie: Yeah. I guess this is kind of off my question, but with the Ernst & Young independent look that's going on right now, I know that as a government you're looking for ways and opportunities to be able to find savings to be able to move those to the front lines.

Mr. Shandro: To reinvest in the front lines.

Mr. Guthrie: Right.

Mr. Shandro: I think that most health professionals who are on the front lines see that commitment as well. I think that the health professionals we speak with are very excited to see and understand that there is going to be that reinvestment. Many physicians, knowing that the surgical initiative is soon to be announced, I think are very excited to understand that – you know, I think that a lot of them do see that they have a lot of their patients that are on a waiting list. They want to see those waiting lists come down. They want to have more access to operating rooms. They want to have more OR time, so they're quite excited to be able to understand that this is something that we're going to be working with.

I don't know if that answers this question.

Mr. Guthrie: Thanks. Last question here. In the business plan, page 84, outcome 1, key objective 1.4, evolve the use of information technology to improve person-centred care, including modernizing administration of the Alberta health care insurance plan and Alberta's personal health care cards.

My health care card: as, I think, with most, there's not much left of it. I've been carrying it around since I was about 18. I mean, obviously, it seems like there's plenty of opportunity here, one, for us to make these more secure and maybe eliminate potential abuse and that kind of thing. Can you explain what the plan is?

Mr. Shandro: What we've done so far?

Mr. Guthrie: Yeah.

Mr. Shandro: We haven't made any announcements yet because we actually haven't firmed up what exactly we're going to be doing. It was a campaign commitment of ours to be able to merge our Alberta health care cards with our drivers' licences. This is something we've asked Minister Glubish to go and study and work with his department to be able to come up with: what would it look like? What are our options? How much is it going to cost? Stuff like that. Over the last few months those of us in Health have worked with Service Alberta to be able to scope that out and to understand what exactly is possible and what the consequences are for all the different decisions.

The last time we spoke, it seemed like he and his folks at Service Alberta have actually done quite a bit of work, and I'm hoping that sometime soon we'll be able to make some kind of an announcement about what exactly that's going to mean for our health care cards.

5:45

Mr. Guthrie: Awesome. I look forward to it. Thank you very much.

I will pass the time over to MLA Nixon.

Mr. Jeremy Nixon: For sure. Thank you very much. Thank you to the minister and your team for being here. It must be exhausting to sit here all day and listen to us whip questions at you. I think you've done well and have shown you certainly know your portfolio. We appreciate you doing that.

To echo the comment that was made earlier, this is monumental, and frankly speaking, it's necessary. One of the biggest things that I heard at the door outside of jobs, economy, and the pipeline was concern about health care, mounting costs of health care as well as diminishing returns and results from that investment. The need to get in there and understand what that's about and how we can do better is absolutely crucial. I appreciate you and that vision, the vision that you've presented here for us.

Mr. Shandro: Thank you.

Mr. Jeremy Nixon: It needs to be done. With my background, obviously, being not-for-profit, working closely with people in mental health and addiction, one of the components of this budget that I'm so excited about is that intentional investment in mental health and addiction and a lot of talk about transformational change. I think this is one of the clear examples of what transformational change is. It's not just a buzzword, but it's the need to do things differently.

One of the things I'd say to people at the door is that if we actually cared for people better, it would be most cost-effective in the long run. Again, this is an example. When I was working at the Mustard Seed, we worked with people who were dealing with serious mental illness. They would be in our program until they became a risk to themselves. They'd end up at the hospital. They'd be there and then discharged right back to the street, and we would just see this absolutely vicious cycle. We certainly saw the same thing with people struggling in addiction, from street to detox to treatment back to street, so the need to do these things better is so critical. I appreciate that investment, that focus, and the need to stop that cycle.

One of the programs I worked with was Canadian Mental Health Association. This was just a postdischarge program. It was a group home where we worked with folks with Axis I diagnoses: schizophrenia, major depression, psychosis. What we did is that we would transition them from the hospital, where the cost burden was significantly high, and they would stay with us. We had a full-time, 40-hour per week Alberta Health Services nurse in the home, so this kind of neat partnership between civil society and Alberta Health Services to work towards reducing that cost burden. I think there are lots of opportunities and examples of us to be able to do that.

My first question is in regard to exactly that. Some of the things I've heard from my former colleagues is concern that as we invest more money into mental health and addiction, it's just going to get lost within AHS and it's not going to make its way to the program areas that we need it. I want to know a little bit more about what our process is in regard to ensuring that we're getting the most value for this investment and that it's getting to the programs and services that need it.

Mr. Shandro: Thank you. I'll let Associate Minister Luan answer that question.

Mr. Luan: Thank you, Minister, and thanks, hon. member, for your great question. Also, I want to commend you for your knowledge and your past experience in this field. I know you and I toured Fresh Start, one of the best treatment facilities, right in your constituency. I also know that when you say that you want our government to be transformative in providing different ways of serving Albertans, that is really coming from your heart. I can see that.

Let me assure you that yesterday, when we announced this new council, that's the beginning of how we're going to take a different, new approach to this. Community-based services, particularly when they come to the table leveraging what limited government dollars can offer, are a great value-added component to how we approach the services, particularly in a difficult fiscal time for our government. You can rest assured we're not going to let that idea get lost. In the coming weeks and months the work of this committee will guide how our government is going to . . .

The Acting Chair: Okay. Thank you very much, Minister.

We will now go back to the Official Opposition. Mr. Shepherd, you had the floor last. Go ahead.

Mr. Shepherd: Thank you, Mr. Chair. Minister, I will just take a step back here and take a look again at some of these performance measures that you're setting out, I guess, within section 3 of your business plan. Again, the majority of these are drawn from the MacKinnon report, and from your remarks today it seems to be the major driver for a lot of the decisions that you're making, the direction that you're pursuing, and the elements that you're choosing to measure within that. Taking a look at item 3(e), the average wait time from general practitioner to orthopaedic surgeon consult, you observe what the average wait time was at the beginning of 2019-20. You want to decrease that average wait time between general practitioner to orthopaedic surgeon consults. I'm just wondering why you specifically are targeting orthopaedic surgeon consults here given that the measurement provided in the MacKinnon report is general, sort of just referring to GP referral to treatment in general and not specifically focused on a particular discipline.

Mr. Shandro: Well, I think we hear that anecdotally. I mean, I don't know if you heard this feedback at all when you knocked on doors, but there are a lot of people who are waiting for hip and knee surgery, or if you aren't waiting for hip and knee surgery, there's someone in your family who is. It seems like an issue in particular, along with cataract surgery, where there are significant concerns that Albertans have. My own dad just had one within the last month, actually, so I know it's something that was a particular concern for our family. I suppose that's the reason why we wanted to. We know that for those orthopaedic surgeries in particular the wait times have gone up over the last couple of years.

Mr. Shepherd: We know that statistically or anecdotally?

Mr. Shandro: Well, I guess it is both. It is a concern. It is going up. Cataracts, hip and knee surgeries . . .

Mr. Shepherd: Cataracts are included within orthopaedic?

Mr. Shandro: No, no. I'm just listing some of the ones that we know that are statistical.

Mr. Shepherd: Okay. What my question was, then: given that, as you note, there are other things, like cataracts and things, which we do need to track, why are you specifically for this performance measure within here, rather than keeping in key with the MacKinnon report, which is a general measure, just targeting orthopaedic?

Mr. Shandro: Just to remind folks, these aren't the only performance indicators that we have. Like, these are the ones we included . . .

Mr. Shepherd: I recognize that, Minister, but I have to assume that you're including these in this public document for a particular reason. It's not on a whim.

Mr. Shandro: I don't know how else or what else to supplement the answer with. We do have other performance indicators. We included orthopaedic specifically in the business plan as one of the ones as an example. I don't know how else to supplement the answer.

Mr. Shepherd: Okay. No specific reason. Certainly, I wouldn't want to imply that it was for any particular reason or perhaps that they're, as you noted, anecdotal and what might resonate well in a political sphere. But we'll move on. You don't have a specific reason for why you're focusing on that particular measure.

Looking at some of the other questions here – actually, if I could, I'd like to pivot over just to look at the budget again here, on page 118 if we could, please. Looking at ministry support services and the minister's office, we do see a notable increase here in the budget for the minister's office for this year, from $745,000 to $1,195,000. Can you provide some clarification on where and why those additional dollars are coming in?

Mr. Shandro: Yes. That's an increase that is related to severance and vacation payout for ministry office staff of the previous government.

Mr. Shepherd: Okay. The full amount and extra above that?

Mr. Shandro: This is a one-time increase.

Mr. Shepherd: A one-time increase. If it were not for those increases, you would be remaining at $745,000 or less?

Mr. Shandro: Yes.

Mr. Shepherd: Okay. Thank you, Minister.

Mr. Shandro: We have much – this is also your stuff as well, right? Don't talk about it? All right. I won't go into that.

Mr. Shepherd: Okay. There is some clarification regarding this that you do not wish to put on the record.

Mr. Shandro: We have a lot fewer staff in our office. I'll say that.

5:55

Mr. Shepherd: Okay.

Ms Hoffman: On the same budget.

Mr. Shepherd: On the same budget, though. So you have many fewer staff, but you would still be at the same budget of $745,000. Are you paying those staff considerably more?

Mr. Shandro: No, no. They're not being paid considerably more.

Mr. Shepherd: Then if you have fewer staff but you would be running at the same amount, where would those additional dollars be going?

Mr. Shandro: It went to the severance and vacation payout.

Mr. Shepherd: I recognize that that is the amount above $745,000, but, Minister, you just touted the fact that you have fewer staff in your office.

Mr. Shandro: I was confirming that we wouldn't be more. I don't know how much we would be less, but we would not be more.

Mr. Shepherd: Okay. So at this point you don't know precisely how much would have been allocated, then, in this increased amount for that severance and vacation pay.

Mr. Shandro: No. Oh, that's right.

Mr. Shepherd: Do you have some clarification, Minister?

Mr. Shandro: We don't want to go there, do we? No, we won't go there.

I guess I can confirm that it would be the same amount.

Mr. Shepherd: Your office would remain at $745,000 with a lower staff?

Mr. Shandro: Yes.

Mr. Shepherd: But you cannot give any indication of why with fewer staff your office would be running at the same cost.

Mr. Shandro: Oh, wait. Sorry. We could say that it would be the same amount of staff.

Mr. Shepherd: You have the same amount of staff? You do not in fact have fewer staff than the previous minister?

Mr. Shandro: There were people who were in the minister's office who were not paid out of this budget, and I've just been reminded of that.

Mr. Shepherd: Sorry. There were people . . .

Mr. Shandro: In the previous government who were working in the minister's office that were not paid out of this budget.

Mr. Shepherd: Okay.

Mr. Shandro: I think that that's a question to perhaps have offline with your caucus colleagues.

Mr. Shepherd: Okay. All right.

Well, at this point, then, I will cede my time over to Member Hoffman.

Ms Hoffman: Thank you very much. I want to talk a little bit about page 118 of the estimates. There are a couple of line items. One that I want to talk about is 2.5, ambulance services. First of all, can you clarify: is this page consolidated, or is this page strictly government? I think that it's strictly government, but can you just confirm?

Mr. Shandro: This is strictly government.

Ms Hoffman: Okay. My question from here is: of that ambulance service budget, how is it being distributed in terms of AHS or private operators, and how are we doing that breakdown from the $465 million?

Mr. Shandro: It all goes to AHS is the answer.

Ms Hoffman: Then the contracting out would be from within the AHS budget, I assume. In terms of the actual modelling that's being done around the AHS allocations, the $465 million, how is this actually going to impact the number of folks working on ambulances? I know that there have been announcements earlier in the year about cancelling the HELO program and other things.

Mr. Shandro: Well, the HELO program is one of those hundred initiatives that I mentioned earlier this afternoon that AHS has done to try and make transfers of care more efficient. My understanding from the chief paramedic of the province of Alberta, Darren Sandbeck, is that HELO ended up not showing any improvements in that efficiency, so that's part of the reason why that one has been cancelled. It's a matter of trying to continue to be innovative with these initiatives until we can start to show some improvements in the transfer of care.

Ms Hoffman: So did the minister review the data? Does the minister believe that the HELO initiatives in Edmonton and Calgary didn't result in reduced wait times?

Mr. Shandro: I believe that Darren didn't lie to me.

Ms Hoffman: So did the minister review the data?

Mr. Shandro: John, do you want to maybe answer this?

Mr. Cabral: Yes. John Cabral, assistant deputy minister. We have reviewed the data. We received the data from AHS. There have been, as the minister had indicated earlier, over a hundred initiatives that have been undertaken across the province, primarily in Edmonton and Calgary.

Ms Hoffman: I'm asking about HELO, though, the HELO data from Edmonton and Calgary.

Mr. Cabral: Yeah. They're all similar exercises. They're looking at reducing ED wait times and offload from EMS. None of those resulted in the desired outcomes. They did initially, but what ended up happening was that you'd wind up getting more people circling through. The queues would keep going up, but no results were found, so we are working with AHS to look at other options.

Ms Hoffman: If the minister would be so inclined, I'd really love to have the HELO data so that we can confirm that that indeed did not result in reduced wait times.

The Acting Chair: Okay. Thank you, Member.

Minister, you'll have to hold that thought.

We will now go back to the government caucus side, where we had concluded with Mr. Nixon. Continue, sir.

Mr. Jeremy Nixon: Thank you, Chair. Just to pick up where we left off, we were talking a little bit about the process for ensuring that funds have the most impact and actually make their way to where they're needed. I believe that what I heard from the associate minister is that there's been a strong consultation process, working and trying to connect with front-line service providers, as well as the development of this committee of civil society organizations to make sure that we are getting the best bang for the buck. As the associate minister knows because he has been to my constituency several times, touring addiction-serving agencies within my constituency, including Sunrise and Fresh Start Recovery – we know that their program models are based off best practice, and they've had significant success – as well as from our discussion about my previous experience with CMHA and knowing that they're also based off best practices, one of the things that my dad actually said to me when I was young was not to reinvent the wheel. If something is good out there and they're doing good, instead of trying to replicate it and put all the money and resources into that, go and find what's good and tag along and help build that up. Is there a way to leverage and build on what is currently being done in our communities by our civil society partners, and is it reflected in the budget?

Mr. Shandro: Sorry, Mr. Chair. Just because we ran out of time, the answer to Member Hoffman's question is yes.

I'll allow, maybe, Member Nixon's question to be answered by Associate Minister Luan.

Mr. Luan: Thank you, Minister, and thanks for the hon. member's question. You are right. Alberta currently holds some of the best treatment centres in the whole country. It's like a jewel that has not been shined through previous governments. Fresh Start is an example. They're leading the whole country in their ways of providing community-based treatment services – they have a national licensing standard; they have awards all over the place – and they have empty beds that our previous government didn't, you know, give them to provide service.

You heard me saying early this morning that we currently still have a crisis in our province, an opioid crisis, and people are waiting on wait-lists to get into treatment. As an emergency response, of those 4,000 spaces that we're going to commit, we're going to work with the ministry to fast-track what I call the first-priority groups. They currently have a contract with the government. They currently have capacity. We don't need to invest anything capital, and they're available. We're going to use a portion of the money we have to bring them up to their full capacity right away. The examples you're using – Fresh Start, Sunrise – are all in that sort of rank. They are well recognized. We have track records. We currently contract them. They have open spaces there.

That's one way of ensuring that, yes, we're developing a comprehensive strategy to be transformational, to change how we do business, but in the meantime we can't wait, you know, another year before we do anything. We're going to fast-track this first group, so in the coming weeks and months you can rest assured that we're going to work with the ministry, we're going to work with service providers, we're going to work with the stakeholders to figure out the quickest way to get there. At the end of the day, what we're facing is: on one hand, we have hundreds and hundreds of people that we're putting on wait-lists to get into the treatment places; on the other hand, we have service providers that have the capacity, yet they were not given the recognition or support so that their spots can be available for Albertans.

That, to me, is a totally unacceptable failure by the previous government. I say that strong and say that very firm. You know, how can you do this? If you don't know anything else, this is an area, in my sort of view, that they should have known better. How can you spend all the effort managing the ever-growing addiction population and forget about all those first-class treatment centres in our province that are left empty there for their spots? To any Albertans who have common sense, this is totally unacceptable. As I'm touring the province and discovering this, let me tell you that my sense is that Albertans did the right thing, electing a government that is responsible, electing a government that is being effective. We're going to have to do that and show to Albertans that we're up to that expectation.

6:05

Mr. Jeremy Nixon: Awesome. Thank you to the minister for the answer there and the very thoughtful approach. I can echo what he said in regard to – as I've been reaching out and connecting with treatment centres and addiction-serving agencies, they have been relatively left alone for four years, so I'm thankful that we're taking advantage of that opportunity to make those connections and build those relationships.

I'm just going to dovetail a little bit but kind of still go down this idea of transformational change. One of my mentors at one point said to me – he was on a health committee, and they kind of all went around the circle and were talking about their vision for health. Everybody kind of had the same thing: more beds, enough beds for sick people, kind of along that line. It finally got to him, and he said: well, what about fewer sick people? I don't necessarily think that the measure of success with health is about spending more money. I think that at the end of the day we need to think bigger than that and have a different vision. You know, obviously the work of the Tobacco and Smoking Reduction Act and kind of reviewing that and seeing what we can do for young people – but we also know that there are a lot of young people that are involved in drugs and risky behaviour. Prevention is not new. Saying that doesn't sound transformational, but we've been focusing on prevention for a long time.

I'm curious: what have we learned, and how do we want to approach it differently in regard to helping make sure that we're not losing our youth and our kids to drug addiction?

Mr. Shandro: Associate Minister Luan.

Mr. Luan: Thank you, Minister, and thanks, hon. member, for the question. You're absolutely right. Remember that when we were talking about this new council, we also shared our high-level government direction. We're talking about a recovery focus. We're talking about change for a future that is healthy, constructive, and responsible citizenship. That's kind of the bigger direction we're going into. Within that continuum we clearly talk about prevention as one of the, you know, four big pillars there, particularly for youth. Can you imagine, if we can do lots of preventative work that prevents youth from getting into mental illness and addiction, how much savings and how much better the quality of life they will be experiencing? Under the prevention arm, currently we have lots of programs going in there already, but in this new plan the prevention elements will be absolutely one of the priorities.

If you'll allow me to have a few seconds, I can give you some examples of some of the youth-related programs we currently fund. Many of them I'm very fond of. They are the best practices in our province. I'll give you an example. One of these is PolicyWise for Children & Families. They developed and implemented collaborative and community-based – you'll love this one – youth support services, hubs for youth, so they can easily access primary care, mental health, substance use, and social services. When they do that in such a community hub kind of a concept, it removes the stigma, removes the labelling: you've got some mental problems. The services are carried out in a way that is tailored to youth for their liking. Oftentimes they come in groups. In a way, helping each other, they actually learn all those other skills to get them better.

I have about 20 seconds left. I have a few more to say. Do you want me to carry on?

Mr. Jeremy Nixon: For sure.

Mr. Luan: Another one is: Alberta Health also funds $10 million right now, from 2018 to 2021, for the mental health capacity building in schools initiative.

The Acting Chair: Thank you very much, Minister.

We will now go back to the Official Opposition. We concluded with Member Hoffman. Member Shepherd, go ahead, please.

Mr. Shepherd: Thank you, Mr. Chair.

All right, Minister. I just have a few different things I'd like to touch on with you. Again, returning to the line item for support services within Alberta Health, that being 2.10 on page 118 of your estimates. Within support services we do see a small increase there, but I just wanted to clarify: within this, are you building any anticipated savings, then, from the contracting out of laundry services that you discussed in the House with one of your government colleagues the other day?

Mr. Shandro: No. The answer to that is no. There is an increase from actual in 2018-19. That's actually due to leap year step increases for the unionized staff and some contract inflation as well, and then that's offset just by the reduction in the LAPP employer contributions.

Mr. Shepherd: Okay. Excellent.

Within your business plan you're talking about Albertans having access to health care professionals, the mix of professionals that

best suits their needs. You have several things where you talk about reducing costs so that funds can be better directed towards those front-line services. Within that, I'm assuming you are – at least, in your indication when you've discussed some of these things in the House, it's that you view these opportunities like, say, the contracting of these laundry services as part of realizing those savings. I just wanted to clarify: with this RFP that you're intending to bring forward to privatize those laundry services and to go with an external contractor, how many positions would that affect within AHS's budget?

Mr. Shandro: We don't know the answer to that because the RFP . . .

Mr. Shepherd: Is that information you'd be able to follow up with?

Mr. Shandro: I don't believe, until the RFP has been issued – I don't think we can provide that information until that time.

Mr. Shepherd: Okay. So it's not a question of not having the information. You don't feel that that's information that you would like to or should be released.

Mr. Shandro: Well, until the RFP . . .

Mr. Shepherd: You feel that that would affect the RFP, to know how many positions are involved?

Mr. Shandro: I'll allow the deputy minister to supplement my answers.

Mr. Shepherd: Certainly.

Ms Rosen: The RFP in question is actually both for, potentially, services that are already contracted out that will, where the contract is expiring – and we will be asking for new proposals, and there may in fact be. But that hasn't been actually formally put into an RFP, contracting out of existing services that are provided in-house with respect to laundry. We wouldn't really be able to assess what the implications would be until we actually find out whether or not there are proposals that would come forward.

Mr. Shepherd: Okay. To clarify, you'll make the RFP; the RFP will not prescribe, I guess, the specific things involved, so until you see what the proposals are that come from people that'd be interested in taking on the contracting of these services, you don't know what the impacts on current employees within AHS would be.

Mr. Shandro: No.

Mr. Shepherd: Okay. Thank you. Is it correct, though, that the majority of those positions, well, the majority of these services, in fact, are currently being provided in rural areas outside of the major centres?

Mr. Shandro: We do already have contractors providing services in Edmonton and Calgary, so most of it's actually going to affect those two contracts, to the extent to which – you know, whether we're even going to receive any proposals from a proponent regarding anything outside of Edmonton/Calgary, we don't know yet.

Mr. Shepherd: Right. Okay. So at this point you're not clear, I guess, on how many positions may be lost in rural areas and indeed whether those positions, any jobs with new contractors would remain in those areas as they may instead choose to consolidate in one of the major centres.

Mr. Shandro: I may not have understood the – yeah. To confirm: yes, we don't know.

6:15

Mr. Shepherd: Okay. All right. Thank you, Minister. I appreciate that.

I just wanted to ask, then: sort of within some of these larger pieces that you're looking at, particularly in terms of looking to adjust the percentage of licensed practical nurses relative to registered nurses, as in item 3(c) in your business plan, within that, do you anticipate that you can achieve all of the transition that you hope to achieve and that any changes, I guess, in those ratios, the percentages that are outlined here from the MacKinnon report, are within the current regulations as they stand in the Nursing Homes Act, or do you anticipate that you may need to make any changes to achieve the goals you have?

Mr. Shandro: Well, I don't anticipate changes being required to that extent. You were in my office with the constituents that you brought along who had questions about the personal care homes, and I did mention to you that we do want to do a review of continuing care legislation, which is, I think, six different pieces of legislation. That is one of the pieces of legislation that will end up being reviewed but not for the purpose that was the premise of the question. That's not the purpose of us doing that review. I don't see a need for us to make any amendments to that legislation for these savings, no.

Mr. Shepherd: Right. Okay. So in terms of these regulations, the requirements for operators to have one nurse on duty at all times, the 1.9 paid hours of combined nursing and personal services per resident: you don't anticipate making any changes to those aspects?

Mr. Shandro: I mean, at this time I can say that it's not an item on my agenda to be amending that, I suppose. I don't know how else to say it. But as I mentioned when you came to my office, I wanted to let you know that we will be doing a review of continuing care legislation in the province.

Mr. Shepherd: Thank you, Minister.

I just want to double back. We were talking earlier about the new nurse practitioners and the program that you're setting up, then, with that $3 million to move them into rural and remote areas. I'm not sure that I actually did come back to where I gave you the opportunity to define what you consider to be a rural or remote area for the purposes of that program.

Mr. Shandro: Going back to that answer?

Mr. Shepherd: Yes.

Mr. Shandro: I tried to provide that answer.

Mr. Shepherd: I apologize if I missed that.

Mr. Shandro: Yeah. Sorry. I have some notes here for me. I mean, it's a different definition than it was in my previous life. I guess small communities are defined as those that have fewer than 10,000 people and are up to 200 kilometres from an urban centre. Rural centres are defined as having between 10,000 and 25,000 people. Remote areas are communities which are a greater distance than 200 kilometres from an urban centre.

Mr. Shepherd: Thank you, Minister.

It sounds like within that program there's some discretion as to, I guess, which PCNs apply to be part of a program that may determine where nurse practitioners are placed, but is there any specific thought being given – I'm thinking in particular of indigenous communities. Now, I recognize there's fairly limited mention of indigenous communities within your business plan, but there is some and certainly a measurement of the infant mortality rate compared to non First Nations. Is there anything within this program with the nurse practitioners to try to seek to provide better service for indigenous communities?

Mr. Shandro: Sure. I'm going to ask Assistant Deputy Minister Leann Wagner to come to the microphone to be able to answer that question. If you don't mind, Leann.

Mr. Shepherd: Thank you, Minister.

Ms Wagner: I understand the question is about LPNs and nurse practitioners better serving indigenous communities. Training of people from indigenous communities is an ongoing effort by the two universities in terms of getting people who come from those communities to take up professional training and then return to those communities to work or to work in urban settings with indigenous peoples. The nurse practitioner program that was introduced this year has as one of its intentions to serve indigenous peoples.

You know, this is a journey by both the PCNs and the indigenous communities. As you probably know, health care has a poor history with indigenous communities, so it will take some time for the primary care networks to work with those communities and to identify nurse practitioners that they trust and that they are willing to work with.

We are also doing the same with midwives. Alberta Health Services is working hard to get midwives in place who indigenous communities are comfortable working with. I think we have at least two indigenous midwives in Alberta.

The Acting Chair: Thank you, Assistant Deputy Minister.

We will now go back to the government caucus side. We had concluded with Mr. Nixon. We have eight minutes and 50 seconds. Go ahead.

Mr. Jeremy Nixon: Thank you, Chair. I'm kind of staying on the same line of thinking in regard to: if we can care for Albertans better, we will save in the long run. I know one of our platform promises was to increase palliative care. We see in line 7.5 – and we know that investments in palliative care should actually reduce the costs for the overall health system – that $5 million in funding has been reserved for palliative care; that is, $20 million over the course of the next four years. Has the $20 million in funding for palliative care been allocated to specific programs or services as of yet? If you can tell us a bit about that.

Mr. Shandro: Sure. The government of Alberta has committed a total of $20 million – it's over four years, so it's going to be $5 million per year – to a number of activities related to palliative and end-of-life care. These commitments would include, you know, continuing to shift from hospital to community-based home and hospice care. Another example would be spending the money to raise public awareness of palliative care and how as well as when to access it and developing effective caregiver supports to support Albertans in their home and in the community. Another example would be to establish and implement palliative care education and training and standards to help professionals. Those are examples of the scope of how the $5 million is going to be spent.

The government of Alberta is also working closely with key stakeholders to identify gaps related to these areas, and work is under way to build on existing work related to these areas in addition to identifying new opportunities to achieve our campaign commitments.

Mr. Jeremy Nixon: Thank you.

Chair, I'd like to pass my time on.

The Acting Chair: Sure. Absolutely.

Mr. Rutherford, go ahead, sir.

Mr. Rutherford: Thank you, Chair and Ministers. As we get into the last few minutes here, I just wanted to touch on one of the reasons why I chose to run for public office: to bring more awareness to mental health issues and to really advocate for that. In my 10 years of policing I always say that I went into it quite naive as to how prevalent mental health issues really were until you start to see it first-hand. I'm glad to see that there is an associate minister now for mental health and addiction and that additional funds are being put towards these two pretty predominant issues in society and how many other issues they lead to as a whole and that we're going to start dealing with what I would say is the root cause of many problems.

As we come down to the last few minutes here, I just wanted to highlight from the fiscal plan on page 83 the $100 million commitment for the mental health strategy. I was wondering if you could provide us with a bit more context as to where that $100 million is going to be spent over the next four years.

Mr. Shandro: Assistant Minister Luan.

Mr. Luan: Thank you very much, and thank you so much for . . .

Mr. Shandro: Associate Minister Luan. Sorry. End of the day.

Mr. Luan: It's been a long day. I know.

Thank you for your service to our province. I know your passion when you talk about it is really from your heart, and sometimes it's inspirational to have a colleague like that truly believe in what you're doing. So thank you for that.

6:25

Let me have a few seconds to outline our plan for how we're doing that, how we're allocating that $100 million. Starting from this year, you know, the $10 million increase is already in the budget. Most of that money is dedicated for the opioid crisis part of that. We talk about the detox centre and the psychosocial supports and a few other things there. What we anticipate is that by the beginning of the next budget we're going to be quickly increasing that because by then this new Mental Health and Addictions Advisory Council will have been in motion for some time. You heard me talking about how we're going to be rapidly responding to fill the gap for some of the current treatment and recovery services spots. Following on that, we are taking advice from this advisory council and, through them, reaching out to hundreds and hundreds of other service providers, stakeholders, and various sectors to get them mobilized.

Our thinking is this. We don't believe that government alone can do this. We believe in leveraging. We believe in a shared, common vision so that there's collaboration among all who are interested in this. Despite lots of my dissatisfaction over the previous government, what they were doing, there's one thing that I think we all share in common, that when you have family members, colleagues, and others who struggle with mental health, who

struggle with addictions, it has a huge impact on all of us, not only as family members, as friends, as colleagues, you know, but it sort of draws the whole community into the negative force of that. I acknowledge that we all want to help them, that we all want to get them onto the healthy side of the equation. In doing so, we need everybody to pitch in.

This is where I get very upset when I see certain advocates trying to create divisions among how we should do it versus focusing on what you're good at. You know, if harm reduction is a part of the intervention that you're good at, retain that. We will take you on to lead on that piece of work. But don't come in with an approach that that is the only way you can do business here, that you can help people there, and then at the same time crush the rest of the people not having a say for their part of the contribution to the pie. That is where I'm very sort of concerned and very upset in many ways.

You know, if our heart is in the right place, we should all find ways to maximize our strengths and make our portion of the contribution. That's how this whole council is focused on the recovery-oriented continuum of care, focused on the strength-based rather than the problem-focused one, focused on getting to the healthy side of the equation as to why we're doing it versus: "Who is right? Who is wrong? Which is more important? What money do you get? How much less do I get?"

I spent 21 years, in another part of my social work career, managing families. We have never had a time where you have more available money than the demand. The demand is always higher than what we can have, but the real solution isn't in the money. The real solution is communities working together. When communities work together, the solution rests within them. What we see from our government with the $100 million is our strong commitment to say that we are serious about this. We're putting money on the table. We're naming a ministry – I'm very honoured to be the first one, you know, to have a chance to give a kick at it – solely dedicated to this purpose. We can work with the broader community. We can work across our ministries within the government. We can find the best and most effective ways to get this right and make it impactful.

I mean, Member Nixon talked about transformational change. I think we're up for that. I'm so much looking forward to it. With limited dollars – you know, $100 million is . . .

The Acting Chair: Okay. Thank you very much, Minister.

I apologize for the interruption, but I must advise the committee that the time allotted for this item of business has concluded. I'd like to remind the committee members that we are scheduled to meet tomorrow, November 6, 2019, at 9 a.m. to consider the estimates of the Ministry of Community and Social Services.

Thank you, everyone. This meeting is adjourned. Have a great evening.

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

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