Legislative Assembly of Alberta

The 30th Legislature
Third Session

Standing Committee
on
Families and Communities

Ministry of Health
Consideration of Main Estimates

Tuesday, March 15, 2022
9 a.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

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Ministry of Health
- Hon. Jason C. Copping, Minister
- Hon. Mike Ellis, Associate Minister of Mental Health and Addictions
- Chad Mitchell, Assistant Deputy Minister, Pharmaceutical and Supplementary Benefits
- Kim Wieringa, Assistant Deputy Minister, Health Information Systems

9 a.m. **Tuesday, March 15, 2022**

[Ms Lovely in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: I would like to call the meeting to order and welcome everyone in attendance. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2023.

I'd ask that we go around the table and have members introduce themselves for the record. Minister, please introduce the officials who are joining you at the table.

Mr. Copping: Great. Well, thank you very much, Chair. Thanks for being here. At the table I have Mike Ellis, Associate Minister of Mental Health and Addictions; Paul Wynnyk, deputy minister; Aaron Neumeyer, assistant deputy minister of financial and corporate services; and Evan Romanow, ADM of health service delivery.

The Chair: My name is Jackie Lovely. I am the MLA for the Camrose constituency and the chair of the committee. We will begin, starting to my right, with introductions.

Mr. Hunter: Good morning. Grant Hunter, Taber-Warner.

Mrs. Frey: Good morning. Michaela Frey, MLA, Brooks-Medicine Hat.

Mr. Smith: Good morning. Mark Smith, MLA, Drayton Valley-Devon.

Mr. Reid: Good morning. Roger Reid, MLA for Livingstone-Macleod.

Mr. Gotfried: Good morning. Richard Gotfried, MLA, Calgary-Fish Creek.

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

The Chair: And members across the table.

Member Irwin: Good morning. Janis Irwin, Edmonton-Highlands-Norwood.

Mr. Shepherd: Good morning. David Shepherd, MLA for Edmonton-City Centre.

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

The Chair: We do not have anyone participating remotely today.

I'd like to note the following substitution for the record: Member Irwin is substituting as deputy chair for Ms Sigurdson.

A few housekeeping items to address before we turn to the business at hand. Please note that the microphones are operated by *Hansard*. Committee proceedings are being live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of the meeting can be accessed via the Legislative Assembly website. Members participating remotely are encouraged to have your camera on while speaking and your microphone muted when not speaking, should anyone choose to join us at some point remotely.

Remote participants who wish to be placed on the speaking list are asked to e-mail or send a message in the group chat to the committee clerk, and members in the room are asked to please signal to the chair. Please set your cellphones and other devices to silent for the duration of the meeting.

Hon. members, the standing orders set out the process for consideration of the main estimates. A total of six hours have been scheduled for consideration of the estimates for the Ministry of Health. Standing Order 59.01(6) establishes the speaking rotation and speaking times.

In brief, the minister or a member of Executive Council acting on the minister's behalf will have 10 minutes to address the committee. At the conclusion of the minister's comments a 60-minute speaking block for the Official Opposition begins, followed by a 20-minute speaking block for independent members, if any, then a 20-minute speaking block for the government caucus.

Individuals may only speak for up to 10 minutes at a time, but time may be combined between the member and minister. After this rotation of speaking time, we'll then follow the same rotation of the Official Opposition, independent members, and the government caucus. The member and the minister may each speak once for a maximum of five minutes, or these times may be combined, making it a 10-minute block. If members have any questions regarding speaking times or the rotation, please feel free to send an e-mail or a message to 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 a break? Okay.

Ministry officials may be present and at the direction of the minister may address the committee. Ministry officials seated in the gallery, if called upon, have access to a microphone in the gallery area and are asked to please introduce themselves for the record prior to commenting.

Pages are available to deliver notes or other materials between the gallery and the table. Attendees in the gallery may not approach the table. Space permitting, opposition caucus staff may sit at the table to assist their members; however, members have priority to sit at the table at all times.

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

Points of order will be dealt with as they arrive, and individual speaking times will be paused; however, the speaking block time and the three-hour meeting clock will continue to run.

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

The vote on estimates and any amendments will occur in Committee of Supply on March 21, 2022. Amendments must be in writing and approved by Parliamentary Counsel prior to the meeting at which they are to be moved. The original amendment is to be deposited with the committee clerk with 20 hard copies. An electronic version of the signed original should be provided to the committee clerk for distribution to the committee members.

Finally, the committee should have the opportunity to hear both questions and answers without interruption during estimates debates. Debate flows through the chair. Members, I want to make sure that everyone hears this. Debate flows through the chair at all times, including instances when speaking time is shared between a member and the minister.

I would now invite the Minister of Health to begin his opening remarks. Minister, you have 10 minutes.

Mr. Copping: Thank you, Chair, and good morning, everyone. I'm pleased to be here to present the Health estimates for 2022-23. I already introduced my colleagues at the table. In the gallery we're

also joined by Bryce Stewart, associate deputy minister; Dr. Deena Hinshaw, chief medical officer of health; and other members of the Department of Health executive team.

Budget '22 provides another record investment in health care for Alberta. It provides the resources to build a stronger, more flexible, and innovative health system for patients and families with better access to care and shorter wait times. Budget 2022 supports key priorities: building health system capacity to make sure we have the right beds, resources, and staff in the right places; boosting access to surgeries and improving the entire surgical system; enhancing community and continuing care, emergency medical services, and supports for people struggling with mental health and addiction.

Health's total expense is budgeted at $23.6 billion in '22-23; $22 billion is invested in Health's operating budget, a $600 million increase from Budget 2021. An additional $750 million is budgeted separately to address COVID-19 moving forward and any resulting pressures on the health care system as we recover from the pandemic. This year's COVID funding will allow Alberta Health Services and chartered surgical facilities to eliminate the surgical backlog created by the pandemic by providing tens of thousands more surgeries this fiscal year.

New in this year's budget is $300 million over three years to build the capacity of the health system through an innovative action plan. This includes $100 million this year to add up to 50 new, permanent, fully staffed ICU beds across Alberta. The investment will make our health system more flexible to effectively meet the needs of Albertans today and tomorrow should we face future COVID-19 waves and any other health challenges.

The top areas of health spending continue to be AHS, physician compensation, and drugs and supplemental health benefits. The largest component of Health's budget is allocated to Alberta Health Services. The AHS operating budget is over $15 billion in '22-23, $476 million, or 3.3 per cent, higher than the '21-22 forecast, excluding COVID-related costs. This will support AHS to meet the needs of a growing aging population and to provide advanced treatments such as CAR T-cell therapy, that uses a patient's immune system to fight cancer. The budget will also enable AHS to move forward with key initiatives, including the Alberta surgical initiative, reducing wait times for CT and MRI scans, building access to community and continuing care, and increasing capacity in emergency medical services, or EMS.

AHS continues to move forward in a measured way with recommendations from the AHS performance review, keeping patients at the centre of everything that they do. These initiatives will achieve efficiencies, improve patient outcomes, and help AHS focus on its core services. Every dollar saved will be reinvested into health care.

In terms of supporting front-line health care workers, Budget '22 supports new negotiated contracts with registered nurses. Over the next three years a new rural capacity investment fund will provide $15 million to recruit and retain nurses in rural and remote areas of the province, with another $7.5 million providing relocation assistance.

A significant component of the AHS budget supports care in the community. Budget 2022 provides a combined $3.7 billion in operating funding for community care, continuing care, and home care. This is an increase of $219 million, or 6.3 per cent, from '21-22, which will allow us to open 1,515 new continuing care spaces across Alberta this year. The Budget '22 capital plan includes a further $204 million over three years for the continuing care capital program to modernize existing continuing care spaces across the province and to build new spaces in priority communities. The capital plan also provides $91 million to finish Bridgeland Riverside continuing care centre in Calgary and $142 million to complete the Gene Zwozdesky centre in Edmonton.

9:10

Alberta must transform its continuing care system to be more responsive and sustainable for Albertans. We're working on an action plan, and we'll be introducing new, streamlined continuing care legislation this spring to enable system-wide change.

We also remain committed to the Alberta surgical initiative and our promise to provide the surgeries that Albertans need within the recommended time frames. Budget 2022 provides support from the COVID-19 contingency to eliminate the surgical backlog from the pandemic and sets us on track to offer even more surgeries and to reduce wait times. We are committed to public accountability on our surgery plan so that everyone can track our progress.

Turning to physician spending, about 25 per cent of my ministry's operating budget goes towards physician compensation and development. Budget '22 maintains this funding at $5.5 billion in '22-23. It ensures that Alberta doctors continue to be among the highest paid in the country.

Over the last months I've been working closely with the Alberta Medical Association on a range of priorities to provide the best care to Albertans and strengthen our relationship. We're in discussions using an interest-based facilitation process with defined shared interests, including quality of care, a sustainable health care system, and stability for physician practices. This process is intended to provide the foundation for a future agreement. Because we don't have an agreement with doctors, we cannot forecast beyond what we know now.

However, Budget '22 does provide $6 million to the new RESIDE program. The rural education supplement and integrated doctor experience will support 16 new doctors to start their practices in rural or remote communities in need. We have also adjusted how physicians can bill the province for virtual medical visits to make virtual health care more readily available to Albertans.

Another significant component of Health's budget is funding for drugs and supplemental health benefits. Budget '22 allocates $2 billion in operating funding for drugs and supplemental health benefits, an increase of $110 million from '21-22. In part, this is driven by higher enrolment such as in the seniors' drug plan, where enrolment grows about 5 per cent each year due to an aging population. We also face higher drug costs each year, including new therapies like Zolgensma, a gene therapy for spinal muscular atrophy.

We continue to expand our use of biosimilar drugs in place of biologic drugs. About 38,000 Albertans living with diabetes have switched or will be switching to biosimilar insulins, which are up to 30 per cent less expensive than the original biologic and are safe and just as effective. As more patients transition to biosimilars, we'll continue to ensure that patient safety and quality care are maintained. Overall, we expect to save about $30 million annually with the biosimilar initiative. We are also providing expanded coverage for diabetes test strips and other diabetes supplies at a cost of about $16 million annually.

Alberta spends about $1 billion a year on mental health and addiction programs, services, and supports. We're investing another $20 million in ongoing annual funding to develop a recovery-oriented system of care for people struggling with addiction and mental health issues. This is on top of the $140 million we committed over four years to support this work. The new $20 million allocated to this fiscal year will enhance access to vital supports and services, including for young Albertans and children with complex needs, continue to provide mental health supports

related to the pandemic, and continue to address the high number of opioid-related overdose deaths. Further, this government is investing $29 million in ’22-23 for the child and youth health services initiative to expand mental health, addiction, and rehabilitation services for children and youth.

The Budget ’22 capital plan includes $3.5 billion over three years for health-related facilities, equipment, and IT systems. This includes $2.2 billion for new and ongoing projects, $474 million for maintenance and renewal of existing health facilities, $87 million for health-related IT projects, and $758 million for AHS capital initiatives such as ambulances, parkades, and other capital requirements funded through internally generated revenue and borrowing. The capital plan supports all announced and ongoing health projects, including the new hospital in southwest Edmonton and the Calgary cancer centre. Other highlights include $193 million over three years to support the $1.8 billion redevelopment and expansion of the Red Deer regional hospital, $133 million to expand surgical capacity in AHS-owned facilities, $45 million for the rural health facilities revitalization program, and another $36 million to build additional spaces in recovery communities.

To conclude, Budget ’22 sets our health system on a path to recover from the pandemic and to do much more, building capacity, a strong, publicly funded health system with better access to care than before COVID, from EMS to emergency care, diagnostic imaging, and continuing care.

Thank you. I’m happy to take your questions.

The Chair: Thank you so much, Minister.

Just an update on the coffee break. We will take that after our independent member, Mr. Barnes, finishes with his questions.

For the next 60 minutes members of the Official Opposition and the minister may speak. Hon. members, you’ll be able to see the timer for the speaking block. It’ll come up in red here on both of these screens. Jody will set that up for us.

Members, would you like to combine your time with the minister?

Mr. Shepherd: Yes. I would like to go back and forth with the minister as well.

The Chair: Minister, what’s your choice?

Mr. Copping: I’d be willing to start out that way.

The Chair: Okay. Very good.

Please proceed.

Mr. Shepherd: Thank you, Chair, and, through you to the minister, thank you for that quick breakdown of the budget. I’d like to begin with some questions about the EMS system. I’m hopeful that we can make best use of our time, through you to the minister. I think we’re both familiar with the programs, how they operate, and we have a good understanding of that, so if we can focus mainly, I guess, on some of the substance as opposed to rehashing press releases or anything of that sort.

Through you to the minister, I’d like to start with looking at the EMS budget line, line 2.5, and, of course, under outcome 1 in your business plan, page 53, initiatives supporting key objectives, where you speak of the $603 million budgeted for the EMS system. You announced last Thursday that – through you to the minister, the minister announced that $28 million of the $64 million increase in EMS funding partly listed in line 2.5 was promised for ground ambulances, crews, sustainable funding for helicopter air ambulance services. Could the minister break down how much of that $28 million is specifically to hire paramedics, how much is for actual ambulances, and how much is for air ambulance services?

Mr. Copping: Well, thank you for the question. I’m just digging up the specific numbers as we speak. As you know, there are challenges with our EMS system. We’ve talked about this in the House before. We announced a 10-point plan. I won’t get into all the details of that. We talked about that earlier. AHS announced a 10-point plan. This budget includes $64 million to increase capacity in EMS and partly through the entire system. Twenty-eight million dollars of that is for additional ground ambulance and crews, for helicopter and air ambulance services. Twenty-two million dollars is for increasing capacity in priority projects, including the extension of ground ambulance contracts, supporting integrated operating centres and interfacility transport projects, and another $14 million is for the hours-of-work initiative, addressing crew fatigue, boosting access to surgeries, continuing care and home care, mental health and addictions supports, and emergency medical services.

In regard to the $28 million, that includes roughly $12 million for dealing with air ambulance. And then, as indicated, when we start breaking down the numbers, there’s $14 million for the hours-of-work project, which is actually going directly to increased resources from a human resource standpoint and also paying different times. The hours-of-work project is looking at fatigue management, and there’s an understanding that we actually need to hire additional EMS crews to be able to manage that and then set up different schedules so we can actually deal with those particular issues.

Mr. Shepherd: If I may, Chair. To the minister, of course, I’m aware of that $14 million, but that is outside of the $28 million. You have identified $12 million of the $28 million that is going towards air ambulance, so I guess that would leave about $16 million that’s going towards actual ground ambulances and crews. Can you clarify how much of that, then, is for that specific hiring and how much of that is for actual physical ambulances?

Mr. Copping: Yeah. Of the $28 million, there is $16 million which is for additional ambulances. Now, part of that is for an additional five new ambulances in Edmonton, five in Calgary in the next two fiscal years, so that’s a total of 10. The costs include wages, fuel, vehicle maintenance, supplies, you know, all rolled in. It also includes contract costs for Red Deer and Lethbridge, an increase of 12 ambulance hours per day in each of two new fiscal years. Again, that’s blended both in terms of the costs for labour and the cost for equipment.

The Chair: Thank you so much, Minister.

9:20

Mr. Shepherd: Thank you, Chair, and thank you, through you to the minister, for that clarification. Can the minister clarify, then – I appreciate that breakdown – how many new paramedics, expressed as full-time employees and ambulances, this funding is intended, then, to put on the streets? I guess we have five in Edmonton, five in Calgary, and there was an announcement of one in Airdrie. Can the minister clarify if there are any additional ambulances intended with this funding and how many paramedics expressed as full-time employees?

The Chair: Thank you, Member.

Mr. Copping: You’re correct. It’s five per year, so that’s 10 total over two years in Calgary, 10 in Edmonton. You’re correct; one additional in Airdrie. We’re also adding contract costs for Red Deer and Lethbridge, which is 12 ambulance hours per day in each of the next two fiscal years.

In terms of the staffing, the number of staff that will be required to be able to support all those, we'll get back to you. We're getting that right now, but it'll include the staffing for that, so there will be an increase in terms of the number of paramedics.

The Chair: Thank you, Minister.
Member.

Mr. Shepherd: Thank you, Chair, and thank you to the minister for that. If it's possible with that breakdown, then, of the number of paramedics – if there could be clarification on how many of those would be EMRs versus EMTs versus advanced care paramedics. Thank you.

My next question to the minister, then, is: what specific efforts are you making to increase hiring and recruitment? I had the opportunity to reach out to the Alberta College of Paramedics, and they pointed me to some of their annual reports, which break down their registrations for the year. What's notable is, you know, from 2019 till today, every year, we have a pretty much even if not slightly more number of folks dropping their registration as we do registered. In other words, we are not seeing any net growth. Indeed, occasionally in the past year it seems we have seen a net loss of paramedics actually registering. Certainly, additional funding is helpful, but we also need to have actual paramedics to be hired into the work. Can the minister just clarify what specific efforts are being made to hire and recruit and indeed train paramedics?

The Chair: Thank you, Member.

Mr. Copping: Thank you for the question. Just from baseline setting, we have increased the number of paramedics working for AHS. You know, over the last two years there's been an increase of 9 per cent that AHS has hired, from 2,659 in 2019 to 2,891 in 2021. EMS has brought on additional staff in ambulances and created and filled 30 full-time and 70 part-time paramedic positions across the province over the last year.

We do recognize, however, that in terms of recruitment and retention of health care staff, including paramedics, it is an issue. That's one of the reasons why we appointed an advisory committee, and the advisory committee is a broad scope of individuals, including our postsecondary institutions and the colleges, and this is under the guidance of two MLAs. They have set up a subtable to be able to address this issue in terms of workforce planning, recognizing that, you know, paramedic is a challenging job, recognizing that there is a relatively high turnover, and this has been exacerbated by the pandemic. We understand that this is a challenge. We've asked them to come to us with solutions, both a report this spring and a report in the fall, but if they actually identify something earlier in terms of particular initiatives that we can undertake to increase our pool of supply of workers, then I've asked them to do so. We recognize that with paramedics, just like other health care professionals, there are challenges in recruitment.

Now, just to be clear, the numbers are continuing to go up in terms of the people that we are hiring, but we know we need greater supply, and we know we need to look at the workplace issues. One prime example is the fatigue initiative, that has been undertaken by AHS as part of their 10-point plan, which we're funding as part of this budget to be able to address the challenges of the job, like fatigue relating to the model of service that's being provided, particularly in rural areas. Once we address that, we hope to be able to address retention issues, but I'm looking forward to the report from the advisory committee and, particularly, the table on workforce planning.

The Chair: Thank you, Minister.
Member.

Mr. Shepherd: Thank you, Chair, and I appreciate that answer, to the minister. But also to the minister, then, recognizing, as he said, that there are workplace issues – indeed, there are high levels of burnout amongst paramedics and certainly many frustrations with the work, which is leading, I think, to some of the high burnout rates and indeed loss of paramedics – one of the things that I would note is that, of course, in the recent proposal that's been brought forward by AHS to HSAA, they are proposing to roll back the wages of paramedics in the province of Alberta.

Now, checking into the numbers and having a chance to look at it, we're talking about the wage rollback of just about .3 per cent along with a 60 per cent reduction of the flexible spending account, changes in their shift differential, eligibility reductions, reductions in the compensation for statutory holiday pay. You know, that works out roughly, I think, to an average of about $2,000 per year total cut for paramedics, a realistic cut probably closer to about 3 per cent annual cut in compensation for paramedics.

So given that we're trying to recruit and trying to address workplace issues, does the minister think that cutting the wages of paramedics indeed is going to be helpful in terms of recruitment? Indeed, he talks about a $64 million investment, but what they are proposing here works out, given a workforce of approximately 6,000 paramedics working for AHS and other contractors in the province, to a reduction of about $30 million in compensation. So of the $64 million that he's proposing to invest, about $30 million of that appears to be on the backs of the very paramedics that he is claiming to help. Does he think this will help with staffing and recruitment?

The Chair: Thank you, Member.

Mr. Copping: Well, thank you for the question. There's a lot to unpack there, so I'll just actually start off with, you know, that the assertion that we're tying the $64 million to what the overall budget number is and tying that back in terms of sort of doing the math with what's bargaining is quite simply understandable, but it's an incorrect approach.

This budget, as you know and as I indicated earlier, includes dollars associated with the UNA agreement. That UNA agreement actually was an increase over a number of years, but as you may recall, if we go back a year previously, we hadn't put that in the budget, quite frankly, because we didn't know what the dollars would be when their agreement was reached at the end of the day when we actually forecast it out over a number of years. That's the same approach, quite frankly, we've taken with the AMA. We haven't touched their budget because we don't know, at the end of the day, what the negotiated settlement will be, so we've maintained it for the period.

The reason why I provide this to the hon. member, quite frankly, is that, you know, to draw conclusions about the $64 million to fund if there's an increase in labour costs – we don't know. However, whatever we agree to at the table, at the end of the day, as negotiations: we will live up to those commitments.

The second point I'd like to make. The hon. member, when we had this conversation in the House briefly – I'd much rather do it here, as opposed to in 45-second increments, which is much better. The reality is that, you know, we are in bargaining with the HSAA at this point in time.

This bargaining has been ongoing for a while. It was postponed given COVID. Parties got back to the table, but really last week was the first time that the parties put their initial offers of financial

compensation on the table. This is the first offer. Bargaining is just that, bargaining. Parties put their issues on the table.

You know, one of the issues, I think, that I understand that AHS is trying to address is that for certain professions, they are over market, so looking for correction and then addressing other issues. Quite frankly, the union, on behalf of their members, is trying to address their issues, and they're asking for, my understanding is, over a four-year period a 15 per cent wage increase.

So to draw a conclusion that, you know, we do not value the work that our health care workers are providing is simply incorrect. We trust that AHS is going to ensure that our rates are competitive from a market standpoint, and indeed my understanding is that that's the objective that they're putting on the table.

I also am quite optimistic that the parties, you know, will be able to work through the negotiation process and reach an agreement, just like they have with UNA, and then we will honour that agreement in terms of whatever that looks like in our budgets. To draw a line between this negotiation process, which actually isn't finished, in terms of impacting the ability to attract and retain, I think is, quite frankly, premature, but that is top of mind in terms of our ability to attract and retain health care workers while at the same time ensuring that we have fiscal sustainability for our overall system.

9:30

I guess the only other comment that I'll make in that regard is that once we set the payment schedule, you know, we will continue to work with all of the partners in terms of: how do we improve the job? Again, as indicated earlier, in terms of fatigue management we've allocated budget for that, and then once an agreement is made, then we'll allocate budget accordingly, but we can't do anything more because we don't know what the final outcome is going to be.

The Chair: Thank you, Minister.
Hon. member.

Mr. Shepherd: Thank you, Chair. To the minister, then, just again on the ambulances that you are promising for Airdrie and then the five for Edmonton, five for Calgary in the next year. Through you, Chair, to the minister. Just to clarify, what I've heard you say is that these ambulances will be 12-hour shifts. Can you clarify if that's, in fact, the case for all 11 ambulances you're speaking of? Indeed, will these ambulances be assigned to handle transfers, or will they, in fact, be full emergency units?

Mr. Copping: Just for clarification, you know, in terms of what shifts they will run: I do not know. For certain ambulances outside of the big cities that I mentioned, we're providing funding to contractors to be able to add an additional 12 hours of service. Now, how those shifts are actually scheduled: I think that's going to be up to the contractor to do that. How the shifts are scheduled on the actual ambulances in Calgary and Edmonton: again, that's going to be up to AHS to schedule. But it's really full ambulances to provide 24-hour services, seven days a week. Let's separate the funding and the service from the actual "how they're scheduled" because those are two different questions. In that regard, I can't tell you the number of employees and what the shifts will look like at this point in time. This is the funding arrangement that we're putting in place to be able to provide the services.

The Chair: Thank you, Minister.
Hon. member.

Mr. Shepherd: All right. Thank you. I'm going to move on, then, to discuss, I guess, some of the investments being made towards the surgical backlog in the Alberta surgical initiative. Of course, it's referenced in outcome 1, talking about an accessible, co-ordinated health care system, as well as objective 1.1 under that, increasing the health system capacity and reducing wait times, and, of course, the performance indicator on surgical procedures and national wait time outcomes.

Through you to the minister. He has been quite clear, as has his government, that their intent is to model the Alberta surgical initiative on the Saskatchewan surgical initiative. They have been very clear about that, and what we do know about the model that they are building on is that between 2010 and 2015 the SSI received about $200 million to reduce wait-lists, and it was successful to a point, but essentially as soon as that money ran out, we saw that the wait times in Saskatchewan indeed began to grow again. Without needing to get into all the specific numbers, we saw a very sharp increase running from 2015 up through about 2022, Saskatchewan going from being a leader in these wait times to being behind almost every jurisdiction in Canada.

It seems pretty clear from the data that the SSI was not a sustainable long-term solution. It achieved a short-term fix – some might say a short-term political win – but certainly did not address the actual system in the long term in a sustainable way in Saskatchewan. So, through you to the minister: in planning the ASI, did he and his department do any analysis, any research, into why the SSI has ultimately failed to be a sustainable solution?

The Chair: Thank you, hon. member.
Minister.

Mr. Copping: Thank you, Chair. Our focus with the ASI is to build capacity within the system. It's not only, as the hon. member suggests, additional funding, which it is, to perform surgeries, but it's also looking at the entire patient journey, from the time that they actually meet the family physician and they need to actually go through the diagnostic to getting the surgery and then going home and getting picked up again by their family physician in terms of aftercare after the surgery. So our initiative looks at all aspects of the patient journey, and it's not just about funding additional dollars. It is about finding process improvements within the entire system, and we have a number of initiatives under way to be able to do that.

I can say, you know, that when we made the commitment to bring all surgeries within the recommended times, as you can see in our policy platform, we looked at what Saskatchewan was doing, but we also looked at what we're doing and how we can improve on that. We have leveraged chartered surgical facilities for years in this province both under our government – we're expanding that – but even, as the hon. member knows, under the previous government. Chartered surgical facilities were used.

Now, part of our journey in terms of being able to get wait times down – quite frankly, they were unacceptable when we came into office, and the pandemic didn't help. You know, just before the pandemic the waiting list was roughly 68,000 Albertans waiting for procedures, and that increased over the first three waves. However, we put in place a plan. Part of that was actually leveraging and adding capacity in chartered surgical facilities to get caught up, and we were able to get that number back down by August of last year, of 2021, to 68,000. Unfortunately, wave 4 hit us. We had to move resources from performing surgeries to looking after Albertans with COVID, and our numbers climbed back up. It sort of peaked at roughly 82,000, but numbers have been coming back down even through the fifth wave, and right now we're at about roughly 76,000 in terms of the wait-list. Now, don't get me wrong. This is far too long, and those numbers are likely going to go back up. There is a

care deficit, so we're probably going to have more demand for surgeries.

Part of our mission in terms of the Alberta surgical initiative is to be able to not only fund additional surgeries but to build capacity and actually streamline our processes. When we talk about building capacity, it is not only with . . .

Mr. Shepherd: Chair, if I may, through you to the minister, I appreciate the background. The question was simply about what research you had done on the SSI and how to adapt it to Alberta, but I appreciate the additional information provided. I think that through my additional questions you'll have a chance, perhaps, to dig a bit more into some of the material that you're mentioning here.

Mr. Copping: If I could just finish the thought. I appreciate that. It's actually investing in both our hospitals and increasing – we have funding in this budget to be able to increase operating rooms. For example, at the Foothills hospital in Calgary we're building 11 new operating rooms to be able to perform more surgeries there. Plus, on the CSF side – I'll talk more about that later. I'm sure we'll get into it. I guess my comment is, to step back in terms of the original comment in terms of Saskatchewan, you know, that we are looking at it in an Alberta context in terms of not only additional funding but also process improvements across the entire patient journey to ensure that not only can we get caught up but that we can actually sustain the lower time frames for Albertans to get to surgeries.

Mr. Shepherd: Thank you, Minister. I would note, though, that you are particularly focusing a large amount on doubling the surgical capacity in CSFs over the next few years. We do know that in Saskatchewan, for example, surgical wait times dropped just as quickly in Saskatoon as they did in Regina even though in Saskatoon there was no private medical care available at the time. We did see improvement on both the public and the private side. Through you to the minister: did he or his predecessor at any time consider whether it was possible to simply develop enough capacity to address this backlog within the public system? If so, what evidence or concrete information did they find that convinced them that doubling surgeries in private facilities would be the most cost-effective and efficient solution?

9:40

The Chair: Thank you so much, hon. member.
Minister.

Mr. Copping: Thank you, Chair. When we take a look at the CSFs, you know, our objective of using them is to be able to provide the service and increase capacity in the system overall while at the same time reducing our costs. We have done two RFPs to date, one on ophthalmology, one on orthopaedics. We will be making an announcement in the near future on the ophthalmology in terms of finalizing the contracts. I can tell you that we are seeing a reduction in the cost per unit by using this methodology, which is part of our objective. But it's not just about cost; it's about maintaining service, and quite frankly it's about capacity.

You know, what I can say is that we have leveraged – and what we've learned through COVID is that when we looked at our need to respond, and quite correctly to respond to what COVID hit us with, by increasing our capacity within CSF, which we did over the last fiscal year by roughly, I think, 15 per cent, we were able to not only get more surgeries done even though there was an impact on our public system in terms of having to respond to COVID, but as we got through the fourth wave, we were able to maintain that capacity from CSF, quite frankly, at a hundred per cent while our capacity within hospitals had to drop to be able to move resources over to manage COVID, which actually helped all of us because we didn't fall as much behind in terms of the surgeries that we needed to perform. So having a robust system where we leverage both CSFs, which we have, quite frankly, for years under previous governments, and we leverage our public system, our hospitals, is critically important as we build our overall capacity.

I'd just like to point out that, you know, using CSFs: that still is part of our public system. It's publicly funded, publicly administered. We're just leveraging chartered surgical facilities, building more capacity with them through our RFPs, and actually reducing costs while at the same time building capacity within our public system. Quite frankly, we need it all to be able to catch up and stay caught up going forward.

The Chair: Thank you, Minister.
Member.

Mr. Shepherd: Thank you, Chair. I appreciate that. Minister, I'd certainly look forward to seeing some reports on those costs to see, I guess, some concrete evidence of those savings coming forward, because what we do know from history here in the province of Alberta – for example, with the Health Resource Centre in Calgary we found that despite the fact that they were being given only the least complicated cases and surgeries, every single procedure that they performed indeed ended up costing more on the public by a considerable amount in some cases, procedures costing about $500 more all the way up to $1,800 more to deliver through the Health Resource Centre than through Alberta Health Services.

I just want to clarify, then: what protections are you building into these contracts, through these RFPs, to guarantee that Albertans will not end up paying more for surgeries in private facilities than those in public operating rooms and to protect against any potential liabilities should any private facility prove unable to follow through?

Mr. Copping: Thank you for the question. I appreciate, you know, the concern that the hon. member has. In terms of going through the RFP process, and we're finalizing the contracts for the ophthalmology, those contracts will include not only "These are the costs" – they'll have access to the surgeries through our publicly funded system – but at the same time there are reporting transparency clauses in regard to performance. Then there are also requirements in regard to the quality of care that is provided as part of the overall contract because, as the hon. member mentions, it's important that we improve the cost but that we also maintain the outcomes and the service. We are mindful of that as we finalize these contracts.

The Chair: Thank you so much, Minister.
Hon. member.

Mr. Shepherd: Thank you. A couple of questions to the minister. Will these contracts be publicly available for review, and do these contracts include payments for liability insurance for the CSFs?

Mr. Copping: I'll have to get back to you in terms of the specifics in regard to the contract in regard to liability in that regard and also in terms of if there is any commercial confidentiality, which I'm not aware of at this point in time, and whether or not they can be shared.

The Chair: Thank you, Minister.
Member.

Mr. Shepherd: Thank you. Through you to the minister, in the Alberta Health System Sustainability and Resilience Action Plan, regarding surgeries through the ASI and the surgical resumption plan, it's talking about planning 40,000 procedures a year through CSFs before COVID-19, yet there is a listed number of actions here that also includes, in the third bullet, strategies for increasing surgical volumes, including increasing use of CSFs, expansion of AHS hours in consideration of out-of-province surgeries. Through you to the minister, in the funding that is set aside in this budget for catching up on the surgical backlog, are there currently any plans in place to pay for Albertans to receive surgeries outside of our province or for health professionals from Alberta to provide those services in a facility to Albertans out of province?

The Chair: Thank you, hon. member.

Mr. Copping: At this point in time this is an option that we are assessing, whether it be out of province or not. Our preference is actually to keep the surgeries in province in terms of the Alberta taxpayer dollars being sent here, but at the end of the day we need to get caught up on surgeries and use every option that we can to be able to do that.

In terms of the budgeted numbers we are anticipating the additional funding, that it will happen within province, right? This is what the numbers are based on, but we are still assessing the options for out of province at this point in time because at the end of the day we've got far too many people, as I indicated, you know, roughly 76,000 on the wait-list. We need to get that wait-list down. We have people who are waiting, quite frankly, for years for surgery. That's unacceptable, so we need to look at all the tools that we have at our disposal to be able to get caught up.

Now, from a budgeting standpoint, that's not what's in there at this point in time, but we're still looking at the options because if we can't get it all happening here, we need to get it done because people can't wait.

The Chair: Thank you, Minister.
Hon. member.

Mr. Shepherd: Thank you. I appreciate that, Minister. I think, as you noted, certainly, the situation has been badly exacerbated by the COVID-19 pandemic. Certainly, I recognize that we'll be of differing opinions, how much culpability this government wears for the severity of some of these waves, I guess, in particular the fourth wave, which had such a significant impact on the surgical backlog.

But what we do know is that it has had a significant impact on our public ORs and their ability to be able to continue to provide. I know, speaking with surgeons and others in the community, that we have a number of public ORs that are still not operating at their capacity. The Red Deer regional hospital: I understand about three ORs are sitting empty every day due to a lack of staff. The Royal Alex hospital: one main OR and one ortho OR sitting idle daily, again due to lack of staff. Reports from the South Health Campus that six of the nine suites are often running late and below capacity due to a lack of staff, nurses, and even folks to help clean the rooms or bring in additional patients. There are reports of nurses that are struggling to be able to take breaks, already working 20, 30, 40 hours overtime. What steps is the minister taking specifically in this budget to ensure that we have the staffing that's needed to be able to keep our public ORs functioning?

Mr. Copping: Thanks for the question. There are a couple of items, like, key assumptions that you put in there that I just wanted to address. First of all is, you know, the comment that it was government action that led to the severity of the fourth wave. Quite frankly, I would beg to differ. I recognize that, as the Premier has indicated, during the summer we moved to an endemic phase too soon, but then we recognized that and then acted in September to be able to bring in measures to be able to manage that. Quite frankly, we built the capacity that was necessary to be able to respond to the fourth wave within our ICUs. I'd just like to take exception to that.

The other comment that I would just like to comment on to help reframe our conversation on staff. I appreciate, quite frankly, that there is a challenge for health care professionals in certain areas and in certain professions across the province, right? Part of that challenge is associated with, particularly, acuity. Like, you look at doctors in rural areas, which is challenging. You look at nurses in certain areas. Anaesthetists: again, that's another, you know, area of shortage that we've identified and we put plans in place to be able to address. When we take a look at, "Okay; what are we doing in this budget to address these issues?" we're funding a number of initiatives in this budget to be able to address all of these issues.

9:50

I guess my last comment, just in terms of context, is that this not an item that is unique to Alberta. This is happening across the country in terms of challenges of health care professionals. You know, how do we get the right people with the right skill sets in the right places? We have a number of initiatives that we are pursuing to address that.

I'll start off, and maybe I'll just talk about physicians. Part of this budget continues the $90 million for rural physicians. We recognize that there's a challenge for that. You know, for example, the . . .

Mr. Shepherd: If I may, Chair? Just through you to the minister, I appreciate it, and we'll have the opportunity to talk about some of the, I think, rural physicians and other areas right now.

Right now I'm talking specifically about those that are required for ORs. Perhaps I can clarify a little bit, and I can move on to discussing, I guess, the issue, as you mentioned, of anaesthesiologists. Indeed, those are absolutely essential and part of achieving outcome 1 in the business plan, page 25. Perhaps, Minister, let's break this down a little bit more. Can you tell me: how many anaesthesiologists do we currently have operating or practising in the province of Alberta, and how many specifically are we short in order to have our public operating rooms operating at full capacity?

The Chair: Thank you, hon. member.

Mr. Copping: We'll have get back to you in terms of the exact numbers. In terms of chatting with AHS in terms of that okay; there are both short-term, medium-term, and long-term solutions to dealing with anaesthetists or – okay. Now I can't say it.

Mr. Shepherd: We hold that in common.

Mr. Copping: I've got it: anaesthesiologists. Short term what we're working for with the college and AHS is leveraging, because part of it's a level of training, right? There are a number of family docs that have a certain level of training to be able to provide the services that are needed for certain types of surgeries. Some of them can do that under the guidance of an anaesthetist, which is a specialist. We're working with them at this point in time. How can we have some of the family docs work under the guidance of anaesthesiologists to be able to provide those services and be able to expand capacity? That is some of the work that we're doing short term.

Medium term AHS is looking to bring in and then actually is sponsoring a number – and I'll have to get the exact number – of international medical grads with that level of specialty, to be able to bring more anaesthesiologists into the province and then get certified so we can actually expand that capacity.

Long term we're having conversations right now with my colleague the Minister of Advanced Education. How do we do targeted funding for our postsecondary institutions? This is an anaesthesiologist – or I'm also told that it's an anaesthetist. I don't know whether they're interchangeable, but we can, you know, clear that up another day. But the reality is that this is not only a problem in Canada. Quite frankly, this is a challenge across Europe as well in terms of overall shortages.

The last thing I just want to talk to – and this is specific to Red Deer, which you raised. You know, AHS is looking because, particularly in Red Deer, where there are gaps in anaesthesiology in the operating room – we have four successful recruits in the past year for the seven vacancies, and AHS is continuing to proactively recruit individuals and look at: is there even a different way that we can provide pay incentives for Red Deer because we have a higher shortage in rural areas than we do have in Calgary and in Edmonton?

Mr. Shepherd: Thank you, Minister. Thank you, through you, Chair, to the minister. I am familiar with the recruitment efforts there. I've had the opportunity to review a slide deck from AHS, their Alberta surgical initiative presentation to the Specialty Care Alliance, so I'm familiar that they are working to recruit, I believe, three to five new anaesthesiologists for the Red Deer region from some international locations.

But I can also tell you that I have spoken with, you know, some of the folks working at the Red Deer hospital, and contrary to comments that you have made, most recently, I think, at the announcement of the ICU capacity increase, they have said that the lack of a contract in this province indeed has caused them to lose recruits, that they have had folks that have chosen to pick up and move elsewhere, primarily to B.C., is my understanding. So there are other issues that still remain out there, but certainly I would appreciate if you could follow up with the number of anaesthesiologists currently operating in Alberta, how many we are short to have our operating rooms operating at full capacity.

Additionally, if you could follow up with numbers, then, on how many will be needed to staff the 11 new operating rooms that are planned for the Foothills hospital to be able to make full use of their capacity and indeed how many more will be needed if you truly want to be able to achieve your goal of doubling surgeries performed in private surgeries. Now, the reason I ask that is because there are real concerns that with increasing opportunities for anaesthesiologists to work in private facilities, where they'll have the opportunity, as noted, to focus on simpler, less complex surgeries, as per again slide 25 of the AHS slide deck on that, this would draw them away from working in public operating rooms, where they'd be handling more complex cases. Now, I know that other jurisdictions have implemented ratios requiring anaesthesiologists to work a certain percentage of their hours in public operating rooms versus private. So will you be taking this approach, or what other provisions would you be putting in place to ensure that the chartered surgical facilities don't negatively impact the staffing for our public operating rooms?

The Chair: Thank you, hon. member.

Mr. Copping: Thank you for the question. I just wanted to start out just in terms of – you know, one of the things, when we look at going into the future: how many anaesthesiologists do we need, right? One of the things that we're actually focused on is: how do we improve the number of surgeries that are done through efficiencies, as part of looking at that, so that, quite frankly, you don't need as many anaesthesiologists?

This is the same issue in terms of, like, EMS. One of the things that I tasked the EMS committee to look at is the wait time of vans that we have at the hospitals, which is far beyond the 90-minute target. Sometimes you have three, four hours that they're waiting there. Because they're waiting there and it's an inefficient use of time, if we can address that issue, we actually may have more than enough resources to respond to all the additional calls. We're just not using them well enough.

This is the same approach in terms of when we start looking at: okay; what do we need in terms of the number of doctors to be able to manage through the system as we improve the efficiencies of the surgeries that are done while maintaining still the high levels of services? You can actually get more done with fewer people. The reason why I just wanted to share that is that when you start talking about, "Well, how many people are we missing?" the answer is that, quite frankly, it depends. It depends on how quickly we can get the surgeries done and how efficiently we use the current people, and then part of our approach is doing that. So I just wanted to provide that context. It's not a one-to-one because part of our initiative is actually to be able to drive that.

In regard to your question and the concern you're raising in saying, "Look, if we're using chartered surgical facilities, is that going to draw away the resources and we won't be able to provide protection within our public system?" that, in essence, is the core of your question. You know, I'll take a step back. We have been using chartered surgical facilities for years. Like, this is not new in terms of this. Our focus has been to ensure that we have coverage both for doing surgeries at CSFs and for being able to cover at the public hospitals, and this approach is not going to change. We need to be able to have the resources to do both. Our focuses ensure that you have the coverage in the hospitals and the coverage in the CSFs. We will continue to recruit individuals, especially where and when we need them, and we're going to continue to focus on ensuring that as we improve our efficiencies within doing this, we may need fewer of them. We can actually get through that.

I appreciate where the question is coming from, but I can tell you that CSFs have been around for a long time, right? We are increasing the percentage of doing that, and we are also mindful of the fact that, you know, even if you're doing – like, for example, the same thing goes for orthopaedic surgeons. They're doing orthopaedic surgeries. Some of those orthopaedic surgeons work both for CSFs and in the hospital system, and going to the future they'll continue to work both for CSFs and in the hospital system, and we need to ensure that they do so and we're mindful of that so we can continue to support both.

The Chair: Thank you so much, Minister.
Hon. member.

10:00

Mr. Shepherd: Thank you, Chair. What I'm hearing from the minister, then, is that they are not taking any steps to put in a ratio or any other measures to ensure that we are going to continue to protect the public system. You're going to leave it open, then, simply for the anaesthesiologist to decide between them.

Mr. Copping: Sorry. Maybe I was a little more opaque. We are going to ensure that there will be coverage for our systems both within our CSS and within our hospitals.

Mr. Shepherd: Can the minister clarify what those steps are going to be? Is there something actually concrete, or is this simply a vague assertion?

Mr. Copping: As we work through our processes with contracting with chartered surgical facilities, we are going to ensure that there are going to be measures to have physicians be able to work both within our public system, in our hospitals, and in our publicly contracted systems, our CSFs.

The Chair: Thank you so much, Minister.
Hon. member.

Mr. Shepherd: Thank you, Chair. I appreciate that. I guess that's as concrete an answer as we're going to get on that front at the moment.

Just to respond to some of the minister's other comments, I hear what he's talking about when he says that he can't say specifically, that they're looking at systemic improvements, but the fact is that this government has committed to doubling the number of surgeries that can be done in CSFs in a very short term. They have committed to drastically ramping up the number of surgeries in a very short term. The fact is that there are going to be impacts from doing so when we are already in a position where we are understaffed, chronically so, within the public system.

If the government is not actually sitting down and calculating numbers – I appreciate that systemic changes may improve the number of professionals that are needed in the mid to long term. But in the short term I can't think that the government has not sat down and actually looked at these numbers – I certainly hope they have – and calculated what staffing is needed to be able to achieve the objectives they're setting out and to ensure that they would not have detrimental impacts on the public system that we currently have in place.

That said on the surgical initiatives, perhaps a bit of a friendlier question. Chair, through you to the minister, one of the things that I've heard is that some of the recruitment challenges that have been happening, particularly in central Alberta, around anaesthesiologists are that we have some stricter licensing rules in Alberta compared to B.C., so they've had situations where international grads have chosen to go to B.C. over Alberta simply because they face a less arduous process. Has any thought been given or any discussions had on improving that situation here in Alberta?

Mr. Copping: We haven't had discussions, or it hasn't been brought to my attention that discussions are ongoing at this time, but I'd be happy to enter into them.

The Chair: Member.

Mr. Shepherd: Thank you. In the slide deck I referenced one of the solutions that's being put forward, offering a shift premium for anaesthesiologists within the public sector. Chair, through you to the minister, is there an amount that's been considered for that shift premium? Has there been any calculation on how much that would add, then, to the budget for surgical procedures?

Mr. Copping: My understanding is that that's still being worked out with AHS. AHS is the one that's driving this particular item to be able to attract an anaesthesiologist to Red Deer. But in terms of the exact amount, I'd have to get back to you and on whether or not that's been settled at this point in time.

The Chair: Thank you, Minister.
Member.

Mr. Shepherd: Thank you, Chair, and thank you, through you, to the minister.

We have, I guess, about 12 minutes remaining, so maybe we'll delve into another set of questions here. Let me just take a look.

Let's just talk, then, I guess, about the broader question of health care staffing again, looking at outcome 1 in the business plan on page 53. The minister has spoken at recent press conferences about having more nurses and doctors working in Alberta than two years ago. Speaking of how the EY report means we need more beds, more workforce development, indeed at present we're still averaging about 20 to 25 hospitals, health centres a day where there are bed closures or reductions in services due to a shortage of health care staff: physicians, nurses, et cetera. Some of those have been going on for quite a while. I note that with the Galahad continuing care centre 20 seniors have been displaced from their home there for nearly a year.

To the minister: how does he reconcile this with his claims? Is he counting the number of registrations, so potential health care workers increasing, to sort of make these claims, or is this the actual number of doctors, nurses, paramedics who are actually working, billing, and taking shifts?

Mr. Copping: My understanding in terms of the increase is that the increase – like, doctors have had an increase year over year, and it continues to rise. I think that is based on the CIHI data.

We also take a look at it in terms of the number of employees working for AHS, which we actually track. The numbers of AHS employees also are increasing. When we look at registered nurses, for example, you know, some of the data that we refer to – we looked at the number of licences and nurses in Alberta as well, and those numbers continue to increase. So it's a combination of those three factors in terms of when we look at the data. Generally speaking, we have more nurses today working in Alberta than we did two years ago, a significant number. AHS also continues to hire more staff, and we're continuing to do so.

As indicated before – and this was, you know, part of our approach to dealing with the shortage of anaesthesiologists – it's a similar approach across the health care sector. Again, short term we're dealing with, like, for example, family physicians. Can we use other practitioners to be able to provide services, nurse practitioners, for example? Then medium term leveraging our immigration stream: I was pleased that our government announced the new rural renewal immigration stream, to be able to attract newcomers into rural areas where there are shortages and key area shortages. As indicated, that is in regard to health care.

Then targeted funding for certain health care professions within our postsecondary – that includes nurses; that includes health care aides – and looking at other ways to be able to go after doctors. We recognize, you know, that this is a key challenge for our government, quite frankly, and not only for our government but for all governments across the country in terms of attracting and retaining the resources in the health care professions and maintaining them.

But I can tell you that we are hiring. There actually are more health care professionals in the provinces and the province today than there were two years ago, significantly more, and we're going to continue to actually grow that, continue to grow those numbers, using all these strategies, short, medium, and long term.

The Chair: Thank you so much, Minister.
Hon. member.

Mr. Shepherd: Thank you, Chair. Through you to the minister, I'm just looking at line 4.2, physician services. We see in this line a cut of about 1 per cent. Through you, Chair, to the minister, we know

that we're coming out of five waves of COVID-19, and as we do, we have significant levels of deferred care, meaning that we have patients that will be facing much more complex health challenges in need of support, in many cases, from their family physicians to manage and get referrals for chronic health conditions, yet we have a cut of about 1 per cent. Given the significant level of deferred care we have, does the minister really anticipate that costs on that front are going to be lower?

Mr. Copping: Can I just ask you: what line specifically are you referring to?

Mr. Shepherd: Line 4.2, physician services.

Mr. Copping: This is the same budget as it was for previous years. Part of it, it is my understanding, is that this is a timing issue. So if we look at the budget – you're talking about 4.2, physician services, correct?

Mr. Shepherd: Mm-hmm.

Mr. Copping: In '21-22 it was just under $4.6 billion. We're increasing our budget to $4.7 billion. We had a slight increase in our forecast at just over $4.76 billion. Now, as part of that, there was an increase, you know, of billings as a result of Albertans catching up on deferred physician visits.

10:10

You know, the estimate: we actually did make that higher than we did in Budget '21-22 and then increased it over the actual of '20-21. Our estimate on that will be sufficient to be able to cover that cost. But, again, this is our best estimate in looking at what we think volumes are going to be coming at us, recognizing that there were, you know, more people who actually attended family physicians – and all services, because this is not just family physicians; it's all services – so there was some catch-up. Some of that has happened, but we're still having a higher amount than the $4.711 billion that we had in '21-22 or '20-21.

The Chair: Thank you, Minister.
Hon. member.

Mr. Shepherd: Thank you, Chair. Through you to the minister, then looking at line 4.3, education and recruitment. Now, I think the minister is, of course, aware that we have multiple communities across the province that are still short on family doctors. Indeed, in Lethbridge and area about 46,000 residents do not have a family doctor. On top of that, over the last year we've had, as I noted earlier, rolling closures of hospital beds, emergency departments, obstetrical services due to a lack of physicians, and that is continuing today. Through you to the minister, given that there's clearly a significant need for recruitment and training, can you clarify why on line 4.3 we see that the actual spend for last year was $60 million below what was budgeted? In a year when we obviously needed significantly more education and recruitment, why did the department end up spending less than they had put in?

Mr. Copping: The short answer is that there was less demand in that particular area for the services. But I want to come back to your comment. I fully appreciate that, particularly in rural Alberta, there is a shortage of family physicians. This budget, you know, carries over that we made a $90 million commitment in Budget '21-22 to be able to attract, retain, get programs in place to get family physicians to rural Alberta. We continued that $90 million in this budget to be able to attract and retain.

There's a significant amount of work that is ongoing, again, as I indicated, short, medium, and long term; you know, leveraging nurse practitioners, leveraging our virtual care or telemedicine for people who don't have access in the short term. In the medium term it's our immigration strategy, and AHS has sponsored doctors across the province to be able to work in rural areas. Then, as I indicated before, it's targeted training programs. So in regard to this particular line item the demand was not there for the training that came in this year.

You know, I'd just like to point out that we have continued $365 million for physician education and training, and we will actually continue to look at it going forward. If that's the best path, more money into those types of programs, we will do it. We recognize it's an issue, and I can tell you that our budget includes, like, the $90 million for rural health and family physicians.

I guess the last comment is that I also appreciate that, you know, with the $90 million, even though that is having an impact, some of it will take a little bit longer to be able to do that because part of it goes straight to compensation for rural docs. There is a committee, as part of the family physicians, looking at, particularly in the rural sector, how effective these programs are and at what else we can do to address this. At the end of this month, March 31, they're going to be providing a report. I'm looking forward to that report. Then we'll take a look at what adjustments we need to do to be able to drive more family physicians into rural areas where they're needed.

Mr. Shepherd: Thank you, Chair, to the minister for that. I would hope that that report, then, will be shared publicly so that all Albertans have the opportunity to review that.

Speaking of the $90 million that you've spoken of there, of course that's going to the rural, remote, northern program, the rural health professions action plan, the rural medical education programs, the physician locum services program, the rural on-call programs. That number gets bandied around quite a bit. Is it possible to get a breakdown of, in that $90 million, how much was spent on each of those specific program areas?

Mr. Copping: In terms of the breakdown: rural, remote, northern program, $57 million; rural medical education, $6 million; rural integrated community clerkship program, $4 million; Rural Health Professions Action Plan, $9 million; the locum program, $3 million; and the rural physician on-call program was $12 million.

The Chair: Member.

Mr. Shepherd: Thank you very much. Minister, you've also made reference on a number of occasions to the $2 million that is being put into the RESIDE funding. Speaking of $2 million, I guess each year for three years.

Mr. Copping: That's correct.

Mr. Shepherd: That's, in effect, I guess, a reannouncement of the previous amount that had been committed to by your predecessor earlier last year when he spoke of $6 million in funding earmarked to help pay for medical school for students. What I am just wondering is that you're saying that funding is intended to provide incentive supports for 20 new family doctors, and I'm certain those will be welcome, but by your calculations how many rural physicians are currently needed . . .

The Chair: That concludes the portion of questions for the Official Opposition.

We will now move on to the independent member for 20 minutes of questions. Would you like to combine your time with the minister?

Mr. Barnes: Please. Minister, is that okay to continue this way?

Mr. Copping: Yep. We'll start out that way, sure.

Mr. Barnes: Okay.

The Chair: Please proceed.

Mr. Barnes: Thank you, Madam Chair. Thank you, Minister and to your entire department and staff that's here today. Thanks for all the work you do for us and Albertans, especially these last two years. I can only imagine. Thank you.

Electronic health records is where I want to start. Your key objective 1.3, use digital technology to enable new models of care and reduce manual and paper-based processes: I kind of want to throw three things out there and ask your opinion.

Minister, I'm not sure if you're familiar with the video *Falling through the Cracks: Greg's Story*, an incredible, sad story of a 31-year-old Albertan who passed away because of cracks in information technology and AHS cracks in our service and the inability to liaise properly between specialists and GPs and the patient. It's an incredible story and a very sad story. What's also sad is that the previous government spent over $1.5 billion on information technology, and I don't know that we had the measurements in place to make sure that we were getting patient electronic interface. I talked to an administrator of a hospital – of six hospitals, rather – outside of Canada who had an elaborate information network system that allowed doctors to look at their success ratios on operations in different styles and compare notes to give better patient service.

Minister, on page 55, information technology, this year you're asking the taxpayers of Alberta to contribute $829 million at a time – in your own key objective to reduce manual and paper-based processes. Anecdotally, I hear about doctors using fax machines still. I guess: what measurements do you have in place to make sure that we're going to minimize people falling through the cracks and taxpayers are going to get value for almost a billion dollars?

The Chair: Thank you so much, hon. member.
Over to the minister.

Mr. Copping: Thanks so much for the question. I'll start off with the answer in terms of: what are we spending? What are the key initiatives that we're spending on? Then I might ask Kim Wieringa to actually comment further in terms of your specific question.

You're quite right. You know, we have invested as a government millions of dollars into systems, and quite frankly we need to do so. Our paper-based systems are outdated. There's a potential for loss of information associated with that, and it's also not co-ordinated. There are three things that I just want to talk to, and one of the big initiatives that we're driving forward is connect care. The goal of the connect care is really having a clinical information system that reduces the number of systems in use in our AHS, because we have multiple systems right now, stabilizes our information technology infrastructure within the organization, and has all of the AHS actors [inaudible] the information for patients sort of in one place.

Now, the total system will cost approximately $1.45 billion, and a grant agreement is in place for the department to support the program with $400 million in capital funding from 2017-18 to '21-22. This is included in the . . . [interjection] Yeah. So we are driving through that right now and starting to roll out to deal with that particular issue.

10:20

In addition, the other one I just want to talk to at a high level is in regard to the ENMOC initiative, which is enabling new models of care. This is an initiative to redesign or replace our nine core business applications on the mainframe that support the administration of our health care insurance program, right? This is on the health care side, the insurance side in terms of the billing side and people getting access to that. We have an outdated system, so we're actually contributing to that. Again, $17 million over the course of – that was approved in 2019. We're continuing to do that.

Then the last thing I'll just want to comment on at a very high level is MyHealth records. You may be aware that over the last year we made investments to be able to enable – Albertans should be able to see their own health records online and on-site, so this actually improves transparency. They can also see real time. Like, when they're getting, you know, tests that are being done, they can see this online. Now, this is all part of a move towards getting our records digitized, easier access, and also ownership of individuals to be able to see that.

But with that, Kim, if you can provide comment in terms of any other key initiatives that I missed and then the focus so that we can actually provide greater transparency and improve the health outcomes for Albertans.

Ms Wieringa: Good morning, Chair. My name is Kim Wieringa. I'm the assistant deputy minister in Alberta Health, health information systems, and the chief information officer. To the member, we are looking at modernizing a number of our systems, as the minister has said, being our health care insurance plan, the payment of physicians, eligibility of Albertans, and the ability to put expiry dates on cards. But our electronic health record is a real fundamental component of our system. It's been around for about 20 years, and it is in need for some modernization. As part of the modernization we are looking at our current e-referral. You talk about Greg Price. I am very aware of that story, and it really spotlights how our siloed health system needs to really – where IT can bring a siloed health system together to appear as one even though it's not.

We do have an e-referral process. We have a number of professions already using e-referral that's digitally from the GP into a number of specialties. We are adding surgical specialties to align with the Alberta surgical initiative. That work is ongoing, but with each specialty we need to work with the GPs as well as the specialists to understand their needs, what the specialist needs from the GP. What are the criteria for referral? What is their criteria for testing as well as the criteria for assessment of surgery? Those workflows and those processes are ongoing. They have been for a number of years, starting with Greg Price and moving across the many specialties we have in the surgical and other chronic disease realms.

Mr. Barnes: Excuse me. That is fine. Thank you very much. My time is limited. I appreciate it. Very, very glad to hear that there are so many things under way and happening. I'm surprised that we haven't had better value over the years, so good luck with that. It's essential. Thank you very much.

Ms Wieringa: You're welcome.

Mr. Barnes: Okay. Keeping in mind with value, the previous government, the NDP government, spent $21.9 billion their last year in Health. You are going to take us to $24.8 billion, Minister, and that doesn't count $3.3 billion that was spent on COVID pandemic response: $1.5 billion in 2020-21, $1.8 billion forecast

for this year. With that in mind, administration in your expense column: your forecast for this year is $478 million, increasing – increasing – administration to $523 million for your estimate for this year. We all know that there are all kinds of anecdotal stories about the size and the cost of management in health care. We all know that hard-working, caring Albertans want the best service for their families and their neighbours as possible. Can you talk a little bit about why this increase in your administration budget, and can you talk about your measurement for making sure that administration and management in health services is rightsized and competitively priced?

Mr. Copping: I just want to provide a little bit of context. I thank you for the question. First, I'd like to start off, the needs of Albertans are continually growing, right? We have an aging population. Typically, as with an aging population, most people use their health care services towards the end of their lives. As a percentage that is growing, so we need to actually meet that demand. Quite frankly, as you know, people pay in. They pay their taxes throughout their lifetime, and generally speaking, when do they use health care? Well, the odd time that they're sick, you know, but for the most part it's when they're very, very young. They're kids, and then you're going to the doctor with your kids at that time. You're working, paying in taxes, and then it needs to be there for you when you're ready, right?

The numbers are continuing to increase, so our focus – and I'd like to draw your attention to our business plan. You know, our focus is that, yes, we need to expand our capacity, and this is what we're doing with this budget, the additional $600 million and over $1.8 billion, but at the same time we need to manage costs.

When you ask about, "What measure are you looking at?" if you go to our performance metrics in our business plan, you know, we are focused on not only meeting the needs of Albertans in terms of the increased health demands but also doing it in a way, driving, finding ways to do it so that it's less expensive so we keep below our population increase and our CPI increase, right? You can see our targets associated with that. A big part of that is finding more efficient ways to perform surgeries, more efficient ways to provide the service and reduce our costs while at the same time increasing the service offering to meet the greater demands that we have within the population. That is the target.

Mr. Barnes: Excuse me.

Mr. Copping: I want to get to the admin.

Mr. Barnes: Yeah.

Mr. Copping: In terms of the administration costs if you look at the increases, when we talk about administration generally, of that $30.8 million, you know, there is an increase of $19 million related to reallocation of AHS review savings, realigning the budget with the most current savings forecast. There's an increase for union step increases that are just general wages. There are increases in regard to the Calgary cancer centre, you know, start-up and training, continuing care capacity plan, increasing demands. There is a decrease in regard to some of our other initiatives, but I just put this in context.

When we look at AHS on the administration side, as a total of the budget AHS is 3 per cent of the overall cost, which is the lowest in Canada. We continue to watch that particular number in terms of that. So while I appreciate the number is going up, you know, some of that is related to just general wage inflation and then other realignment of costs, but our overall focus – right? – is on driving costs down in the system, maintaining administration at a very competitive level, and it is right now at 3 per cent. As you may recall, after the EY review there was a reduction in management within AHS, and we're continuing to watch that as a percentage of overall cost to make sure that it's competitive.

Mr. Barnes: Thank you, Mr. Minister, but you're increasing administration costs. Anecdotally, when I walk into coffee shops and people tell me about the high cost of management and managers managing managers, I ask you: do you not get the same questions? What is your answer to people that want more of our hard-earned tax dollars to the front lines? What's your answer to them?

Mr. Copping: I appreciate the stories. To the extent that we can further improve delivery of service and driving dollars to the front lines, you know, that's something that we have to continually look at in terms of process improvements. Again, when we look at the high number, what percentage of cost is going to administration versus the front line, AHS still is very competitive at 3 per cent. Really, the number I look at is: how do we drive our costs down so that we're more comparable? While expanding our capacity over the last three years to be able to improve services for Albertans, our cost per Albertan in comparison to other provinces, the gap – because, as you know with the MacKinnon report, we were significantly higher than other provinces, especially the major provinces. We are narrowing the gap right now, and part of that is actually through cost control.

10:30

Mr. Barnes: Okay. Well, thank you for the answer, Minister Copping.

I want to move to HALO. Of course, southeastern Albertans, southern Alberta, the only area without 24-hour emergency air ambulance with government support – thank goodness for our local donors; our local volunteers for 16 years now have provided so much safety – has easily been my number one question in my 10 years as an MLA. But they've made the case to me that, you know, they can provide a base for about 2 and a half million dollars with a 24/7 helicopter, that STARS seems to provide for $10 million. They go a big distance to provide safety and do the interfacility transfers.

I heard you say earlier that approximately $12 million extra is going to air ambulance in this budget. I'm grateful for that for the safety of Albertans, but again when southern and southeastern Alberta especially is the only area without this air ambulance – and I look at the budget of the government, and I'm looking on page 101, a bullet on the side: total revenue in 2021-22 is forecast at $61.7 billion, $18 billion higher than Budget 2021; $18 billion. Minister Copping, our resource revenue from bitumen is going from $2 billion to $10.3 billion. Other resource revenue is going from $1 billion to 3 and a half billion dollars. Southern Alberta for years was the number one royalty payer because of natural gas. What's it going to take to get consistent, fair support for HALO in southeastern Alberta?

The Chair: Thank you so much, hon. member.

Minister.

Mr. Copping: Thank you, Chair, and thanks to the hon. member for the question. I fully appreciate the value that, you know, all of the services that provide air ambulance services do – STARS, HALO – within our province. Often these were born through local initiatives; HALO, for example, with lots of funding to be able to say: here's a need, and let's address this need. HALO, for example – and I thank the organization for the work that it's doing – has

provided services on a fee-for-service basis for air ambulance services for AHS and for Albertans.

Now, as I indicated earlier, we recognize – and this is sort of indicated in the HEMS report that was completed over a year ago. We recognized that we needed to be able to provide fiscal sustainability for our air ambulance system. That's what this $12 million is for. We're looking at how best to do that at this point in time. Just so you know, as part of the EMS ministerial advisory committee there is a subtable set up on air ambulance services and how to ensure that not only do we have fiscal sustainability but the parties work together to be able to deliver that. That's ongoing. I can say that there is $12 million. We recognize that there needs to be financial stability, and we haven't made any final decisions in terms of how best to do that, but quite frankly we've budgeted for it because we know it needs to be done.

Mr. Barnes: Good. Well, thank you. I appreciate that. It's unfair. It's life-saving. A statistic just came out that our region has not increased in population at all in the five years, and I wonder if the lack of air ambulance support is part of that.

Minister, I'm a bit confused; ICU beds, $300 million, and it's only going to get us 50 beds. A headline in the *Medicine Hat News*, when you visited Medicine Hat or talked to the news at least a week or so ago, said that $100 million was going to get us 50 beds. But ICU beds were the bottleneck for so much of the lockdowns during the COVID crisis and so much of why we had to shut down communities and businesses and those kinds of things.

You stated earlier that our population is aging. Are we not going to need more ICU beds anyway, never mind a pandemic, never mind COVID, as our population ages? And, of course, the talk for many, many years about more continuing care has been based on, unfortunately, too many Albertans in need of care being in the wrong spot in our health care system at the time. Minister, I'll be frank. Over the next three years 50 ICU beds is very underwhelming. It's going to leave us very much at the mercy of another situation like COVID. Please tell me that you can do better than this, or please tell me why I'm wrong.

Thank you.

The Chair: Thank you so much, hon. member.

Minister.

Mr. Copping: Thanks. Thanks for the question. The 50 ICU beds, just so we're clear: it's a $100 million a year, per year, to be able to fund the 50 ICU beds on a permanent basis. We did an analysis, and we asked EY to come in and help us think through this, looking at other provinces, what they have. What makes sense for Alberta? How do we bring ourselves in line from a population standpoint? We landed on 50, that brings us more in line with B.C., just slightly higher but in the same ballpark. But the reality is that, you know, we have been able to operate pre-COVID at about 173. Yeah, we fluctuate over that a little bit from time to time, but for the most part we've actually been able to function quite well. The challenge is that we know we need more capacity, so we're adding the 50 beds in terms of base capacity. We're going to run out of time. We also have a plan to actually spike up much further than that, which we have done in the previous waves, and we're . . .

The Chair: Thank you so much, Minister.

With that, we will have our five-minute coffee break. Thank you, everyone.

[The committee adjourned from 10:36 a.m. to 10:43 a.m.]

The Chair: We will now move to the government caucus for 20 minutes of questions from the members. Would you like to combine your time with the minister's?

Mr. Hunter: Yes, if we could, please.

The Chair: All right.

Minister, combined time? Are you fine with that?

Mr. Copping: Happy to do so.

The Chair: Fantastic.

Mr. Hunter: All right. First of all, Madam Chair, through you to the minister: I wanted to congratulate your department on a very important achievement that you made, and that is helping us to be able to get to balance. I know that our health care system is incredibly important for me and for my parents, who are now seniors, but it's also important for our children and grandchildren. A sustainable health care system has to be a priority for us as legislators.

I want to thank you for – as I took a look at page 107 of the estimates, last year the actual was $22.9 billion; this year the estimate is $22.4 billion. I know that in years past, as I've been a legislator for seven years now, we've seen a growth that was unsustainable, and I wanted to thank you for your team. I know that it's a team effort, especially in health care. This is so absolutely critical that health care gets it right, and you guys have. So I wanted to do a shout-out to you for that.

I wanted to start off by: Alberta continues to be a growing province both in urban and rural areas. You have spoken about increasing the capacity of the health care system both to deal with strains during waves of the pandemic but also to reduce wait times and increase access to health care. Increasing capacity does not necessarily mean building more hospitals. The Butterdome field hospital was never actually used during the pandemic despite being made ready to deal with anticipated surges but also having more nurses and doctors available to prevent hospitals from being overwhelmed. One of the initiatives to support objectives 1.1 to 1.4 is the allocation of $100 million per year to provide additional health care capacity on a permanent basis, including adding ICU beds under the health care system capacity action plan. What else is the ministry planning as part of the health system capacity action plan?

Mr. Copping: Thanks to the hon. member for the question. As you know, the action plan outlines Alberta's approach over the next year and beyond to ensure resiliency and sustainability of the Alberta health care system, with a focus on expanding intensive care unit capacity and surge capacity. It includes recommendations to ensure the health system has the appropriate capacity to respond to potential future waves of COVID as well as other potential system-wide pressures such as influenza or natural disasters.

There are 21 actions across the following six work streams: workforce; acute care, critical care, and surgery; primary and community care; governance and decision-making; public health; and modelling. Specific examples of some of these actions include the following: a surgical resumption plan to develop a patient-first surgical recovery plan with clear targets and public reporting of objectives in progress; an operational surge plan for ICU and non-ICU capacity, which I was mentioning to our colleague MLA Barnes earlier; immediate and longer term workforce capacity strategies to address urgent workforce needs – medium- to long-term workforce needs I talked about a little bit in terms of short-, medium-, and long-term strategies to be able to respond to the

workforce needs – improving data sharing between Alberta and AHS.

Really, fundamentally, you know, even though we talk about the $100 million per year for the next three years for ICU to ensure that we have that baseload of 50, what we also asked AHS to do is that when it's not required, when those resources are not required, to be able to have flexibility to move those resources, particularly to deal with some of our other initiatives like increasing surgical capacity, so to actually have the flexibility to move them back and forth and then to move them off if we have to respond to another COVID.

We also appreciate that we're going to need some of that capacity because the influx in ICU isn't the same throughout the year, right? At certain times you're running significantly lower capacity, like 80 per cent, and other times we're pushing close to a hundred per cent, particularly during flu season, COVID aside. It's ensuring that we have the flexibility to move the resources as need be throughout all of this so that we can actually hit not only our objective of having a baseline to be able to respond to COVID and other issues but also to be able to catch up on surgeries and continue to have surgical capacity to reduce wait times.

Mr. Hunter: Thank you, Minister.

Through you, Madam Chair, to the minister, is there actually a nimbleness – I'm not sure exactly what word to use there – of measurement throughout the provinces or throughout Canada? I guess that with COVID-19 being able to surge up and then being able to come back down again, to meet those waves may be something that we see in perpetuity. Is there a nimbleness measure that they use throughout the country to be able to say which jurisdictions are ready and which aren't?

Mr. Copping: I haven't seen one. I do know that there is, you know, a measure that's commonly used – we use it, and it's used across other jurisdictions – which is percentage of capacity, where you're sitting at. My understanding is that you generally, like, want to be around 80 per cent so that you can flex up as required. That's the ballpark.

I can tell you, you know, about some of the work that EY did when we were looking at: what is the right building and contingency plan for the future, and what is the right number for increasing our ICU capacity? They did a jurisdictional scan and talked to a number of other provinces, particularly B.C. and Ontario, and also about how we and other provinces responded to the pandemic, particularly through the fourth wave and other waves, whether their fourth wave or their third wave. What they found is that one advantage of having a single system – you look at B.C., which is a regionalized system, and you look at Ontario, which has a hospital-based system, right? They don't even have regions. They spent significant resources putting in place processes between the various hospitals or various regions to be able to load level, right? When they looked at, you know, if their ICUs were increasing or their non-ICU hospital beds were increasing, at what point in time do they actually have to start moving patients and how do they move patients, where do they move patients, they had to set up entire infrastructures to be able to manage that throughout COVID.

10:50

One of the advantages we have with AHS is that we have that infrastructure already in place. We did that, and we were able to respond, which helped us be able to get through the fourth wave by load levelling and then even to some regard during the fifth wave. That is one of the tools that we can use to be able to respond to COVID, and that's a tool that we're going to keep in our tool box, you know, for down the road. Hopefully, we won't have to go there, and this increase in capacity will reduce the need for that, but that is something that we'll be able to depend on. Quite frankly, in comparison to other provinces we did quite well because we had a single system.

The Chair: Thank you so much, Minister.
Hon. member.

Mr. Hunter: Thank you, Madam Chair. I wanted to just talk about worker shortages, and I've talked to you about this before. Every jurisdiction around the world dealt with worker shortages during the pandemic, and every industry is going through the same form of worker shortages because of burnout, among other problems. Alberta is certainly not immune to these global worker shortages. How is the minister planning on attracting health professionals to the system to build and maintain the enduring capacity we need while every other jurisdiction is doing the same?

The Chair: Thank you so much, hon. member.
Minister.

Mr. Copping: Thanks. That's a great question, and as we spoke about earlier in this room, this is a challenge that's not only facing Alberta but, as you mentioned, other jurisdictions in Canada and, quite frankly, around the world. You know, we have a series of plans – short, medium, and long term – to address that. The short term, quite frankly, is using all health care professionals to provide service to the greatest extent possible.

You know, I had mentioned one example earlier in regard to nurse practitioners. Nurse practitioners can do not a hundred per cent but close to what a family physician can do in terms of providing the services. We have actually, through PCNs, assisted nurse practitioners. A PCN has hired a nurse practitioner who is providing services in clinics, and this is, you know, in rural Alberta. There are a number of municipalities who have been involved in this to be able to do two days a week in one small rural municipality, two days a week in another one, and one day a week in a third to provide services. We are actually looking at expanding the use of nurse practitioners, so the funding through PCNs is going up in this budget.

In addition, we've actually protected an envelope of funding to enable nurse practitioners to be able to do independent practice, then to be able to get out more into the community and provide the services. That's one example.

Another good example – and this is the work that we continued in this government – is in regard to pharmacists, right? They have a broad scope of practice. For example, for certain medications, if you need to get that renewed, they have the ability to do that and also to offer a number of other services. Their expanded scope is, quite frankly, one of the greatest in the country.

Then third on the short term is, you know: where there is a shortage, can we use telemedicine, telehealth, so virtual care? That is appropriate for some items, again, contacting through telemedicine and being able to address certain services. I think that when we take a look at the short term, these are the strategies that we are using. It's not just focusing on one profession but focusing on multiple professions and making sure people know to do that and using virtual care to maximize the people that we already have in the system. That's the first strategy.

The second strategy is really about leveraging our immigration system, right? Typically Alberta has used, you know, when we talk about family physicians, for example, international medical grads. Roughly 40 per cent of all the applications in the country come here

to Alberta, which is positive. We are leveraging that system significantly. Across the entire province AHS is sponsoring a number of IMGs to get through the process. We talked about a couple of examples already today, but we can just go around the province, to multiple locations – Cold Lake, Lethbridge, Red Deer – and we're using our immigration streams to be able to attract foreign-trained doctors.

Now, we do appreciate that accreditation takes longer than we would like, so one of the initiatives that we're driving also this year is working with the college of surgeons and then also looking at our immigration stream, so a rural renewal stream, and at: how do we leverage that so that when we reach through our rural renewal stream into our express entry stream, which is the federal stream, we're selecting the person that is the closest to accreditation that we can get, number one, who wants to come in, and then how do we, while maintaining safety, streamline the process for accreditation? In an ideal world the person that you're going to select who wants to come to rural Alberta, quite frankly, could actually start their accreditation process before they even get here so that they can hit the ground running in terms of doing that. We know we need to improve on that, and that's one of the initiatives that we'll be undertaking over the course of this year.

I'm actually very pleased with our colleagues. The Minister of Labour and Immigration rolled out the new rural renewal program, which also involves the local municipalities identifying where the challenges are in terms of the professions but also welcoming the people who come there. Because we're focusing on a rural renewal program, it's individuals who want to come to Canada to be in a rural area – right? – and who want to stay in a rural area, so that will actually help with retention.

The other one that we're doing sort of medium and long term is addressing our postsecondary and training here in Alberta. Part of that is, you know, a number of programs we already mentioned as part of the $90 million for the recruitment and retention of doctors in rural Alberta, targeting those individuals who are coming out of not only our great postsecondary institutions but those across the country, so the RESIDE program to get 20 docs per year into those locations which are designated as a significant shortage, which will change over time. Part of the payment issues under that program is trying to keep the docs that we already have there. Actually, I should have put that in the short-term bucket. But then also there are the programs in regard to training of docs – and this is sort of the third bucket, the longer term – working with Minister Nicolaides and Advanced Education on targeted funding to put dollars into training, whether it be for docs, nurses, health care aides.

We also did targeted funding, for example, after we finished the most recent UNA agreement, for nurses and to be able to provide funding, relocation assistance, and then funding for retention and attraction on nurses as well. All of this is ongoing in regard to being able to build the workforce that we need, so leveraging.

Again, to sort of sum up, it is to retain those that we have to the extent possible – some of the funding for the doctors and rural health care, or that $90 million, is to do that, which we continued this year – so retention, using individuals to the greatest scope possible and making sure people are aware of that, using our immigration strategy to be able to get people on the ground, and then a targeted investment in our postsecondary so that we can train Albertans from rural Alberta in certain programs to go back to rural Alberta and be able to practise there.

Now, again, this is a tremendous amount of work we're doing. This is not a simple problem. This is an issue that's being faced by governments across the country. But we continue to see an increase in doctors; we continue to hire nurses and health care professionals. That's growing – we see that in the numbers – and we want to accelerate that so that we can meet the needs of Albertans.

The Chair: Thank you so much, Minister.
Hon. member.

Mr. Hunter: Great. Thank you, Minister.

Interesting. I didn't know that 40 per cent of all the applications coming into the country were coming right here to Alberta. Obviously, we're doing something right here, so that's good to know. I imagine that's because we pay better; I'm sure that helps.

But in terms of my riding Milk River is constantly struggling with being able to find physicians to stay there. One of the questions I wanted to know is: when a foreign doctor comes to Alberta and has a contract, is it a three-year contract that they have to be in that area? Is it longer than that? If it is only three years, is there any way of being able to do it longer, say 10 years, so that they can actually get a feel of that area?

11:00

Then the other question that I have is that – because Milk River is always struggling to have a doctor, they've really struggled to get locums in there as well. Understanding the locum program so that it's specifically working with, you know, these remote areas that really need doctors – I know that the locums get paid quite well, and that's the incentive. But if that's not working, if they feel burnt out, are there other areas where we can also help them to make sure that we have those locums so that those emergency units don't get shut down?

Mr. Copping: Yeah. Thanks for your questions. In regard to the actual term of the contracts, I'm going to have to get back to you on that one. We might be able to do that later today. I do know that, you know, we talked about the RESIDE program. That's the typical length when we're talking about doctors moving out there.

In regard to the locum program, this is a challenge, right? You are correct that the locum program pays additional monies to be able to have staff move out to areas where there's a particular shortage. You know, once you get to, like, a level of shortage and then people are burned out, then it gets harder and harder to leverage that.

That's why we're focusing, quite frankly, on supply as the answer to that. Once you actually increase the supply, that will get easier to use, and you'll get more uptake on it. I think that part of the answer is just continuing to focus on building supply. But again to your point, the longer term solution is having people want to move, live, and raise a family in these areas and stay. That's the longer term solution. Quite frankly, when we look at the amount of money, like the $90 million we're putting into it, a significant portion of that is associated with paying rural physicians higher amounts.

The question is: is this a money issue, or is it a lifestyle issue? When we start digging into that, it's attracting people who want to be in rural Alberta and want to stay in rural Alberta. You know, are the programs that we have like RESIDE, which is focused on people who want to do that and then programs that we have like our rural renewal in terms of immigration – people want to move to rural Alberta. I had an opportunity when I was Minister of Labour and Immigration to spend lots of time with new immigrants in rural Alberta. They came from rural areas, and they wanted to stay in rural areas. That's why they came here. So that's what that program targets. It's really about attraction and retention, and then we'll be able to deal with this issue.

The Chair: Thank you so much, Minister.

That concludes the government members' first block of questions. Now we move to five minutes of questions from the Official Opposition, followed by five minutes of response from the minister. As mentioned, members are asked to advise the chair at the beginning of their rotation if they wish to combine their time with the minister's time.

Do you want to continue?

Mr. Shepherd: Yes, if the minister is amenable.

The Chair: Please proceed, hon. member.

Mr. Shepherd: Thank you to the minister, and thank you to you, Chair. I've got a few questions that I'd like to ask, I guess, under outcome 2, key objective 2.3, improving the measuring, monitoring, reporting of health system performance to drive health care improvements. Through you, Chair, to the minister, I recognize that this pandemic has put unprecedented challenges on our system. Indeed, I think I've heard from the minister several times that we need to learn from this pandemic. That's been emphasized, I think, in the facility-based care review that addressed continuing care and now the Alberta Health System Sustainability and Resilience Action Plan, which the minister released during a recent budget announcement. That laid out, I think, a number of streams or areas in the health care system that really do need to be analyzed. I'm appreciating that there is that internal analysis and review. I recognize that that will likely be shaping our budgets for years to come.

But I do want to ask the minister if he believes it may be valuable to conduct a public inquiry into how this has proceeded and the government's handling of the pandemic, just noting that one of the areas the sustainability and resiliency action plan looks at is governance. It provides, I think, some insight, some very broad description of the challenges between the department, AHS, and the minister's office. I think a public inquiry would be a good way to have a clear, transparent process to address how this was handled across all of the ministries, provide some useful and necessary information to shape the future of our government policy and truly learn from the pandemic. Again, my question for the minister is: what does he have planned to ensure, I guess, that the government's performance on the pandemic is reviewed in a fulsome, transparent way, get that information to Albertans? Would he support a public inquiry into their handling, and if so, when might that be done?

Mr. Copping: Thanks to the hon. member for the question. As indicated by the Premier when a similar question was posed last fall, we will conduct an independent, comprehensive review of government's handling of the pandemic, you know, the impact of the measures. We haven't nailed down a timeline in terms of when that's going to happen – we're still coming out of the fifth wave – but this is something that we're actually thinking about at this point in time in terms of: when do we want to do this, and how are we going to proceed with this? But we haven't finalized the time.

I would like to just take, if the hon. member would allow me, an answer to a previous question that we did actually get. This is in regard to chartered surgical facility contracts and whether or not they're available to the public. My understanding is that the contracts with CSFs are posted online. There's some redaction, given commercial sensitivities, associated with that, but they are up and online. Then in regard to the liability, there are a number of clauses in the contract, including indemnity, liability insurance, WCB requirements, and physician insurance as well.

The Chair: Thank you so much, Minister.

Hon. member.

Mr. Shepherd: Well, thank you, Chair, and I appreciate the minister's response on that. I am still very interested in the question of timing. The minister noted that we are still coming out of the fifth wave. I would note that this government is taking a number of measures which indicate that they feel this fifth wave is done, indeed that they feel COVID itself is done. Indeed, they're going so far as to implement legislation that prevents anyone else from taking measures, including municipal governments, because they have declared that the danger from COVID-19 is done.

So I would say that if that is the case on so many other fronts, certainly I think this government could be starting to undertake this review. There is no reason for further delay, particularly given, I think, that we have seen the need for this. I think Albertans deserve some information about the handling of the outbreaks in continuing care and the meat-packing plants, analysis of why Alberta saw a so much more severe delta wave than other provinces, a better understanding of what happened precisely during the omicron wave. I recognize again that the Minister of Health is doing internal reviews on health, but this is a pandemic health issue; this health issue impacted all ministries. So what is the minister's plan – and when is it going to happen? – to review how it impacted schools, postsecondary institutions, the Justice ministry? How is he going to be working with his colleagues to get that work done, and when can we expect that work to begin?

The Chair: Thank you so much, hon. member.

Minister.

Mr. Copping: Thank you, Chair. As I previously indicated, we have committed to an independent, comprehensive review not only in terms of government actions but, quite frankly, the broader impacts that measures have had not only on society, on the economy. As I indicated, we are starting to turn our minds to the timing and the scope of this review, but we haven't nailed down any details yet. I do appreciate the comments that, you know, as we're moving into an endemic phase, that would be an appropriate time to actually sort of think through: okay; how can we make this happen? We are moving to an endemic phase. We haven't hit stage 3 yet, but we're getting closer, and generally speaking, the numbers are heading in the correct direction.

Again, we are starting to think through this. Our government has made a commitment. Quite frankly, we need to learn from this for future waves because even though we're moving to an endemic phase, COVID is not done. There will be another wave. The question is: what's the level of severity, and then how may it impact our system? We are continuing to monitor that. But I appreciate the member's comments about moving forward on this as we move into an endemic phase, and I fully understand that. Again, we're turning our minds to it, but we're not there yet because we're still climbing down in terms of, you know, removing the measures that we had from the last wave.

The Chair: Thank you so much, Minister.

Hon. member.

11:10

Mr. Shepherd: Well, thank you. I guess what I'm hearing the minister say is that there are indeed still impacts from COVID-19, which seems at loggerheads with perhaps some of the communication that has been from the government.

That said, I'd like to move on. I appreciate that the Associate Minister of Mental Health and Addictions has joined us today, and I do have a question that I'd like to pose to him. In the area of my constituency I have the city centre mall. They have been facing a number of serious challenges related to the opioid crisis, the

overdose situation. Just to give a brief summary, you know, since last year: in the total year they had about 71 overdoses on the premises where they had to call EMS; this year alone, since January 1, they had 60 confirmed ODs where EMS was called. On 44 of those 60 their team administered Narcan, and they are accessing the Narcan through the nasal naloxone pilot that was put in place through the George Spady Centre, where their security service, Paladin Security, has been accessing the naloxone to provide. Now, that program ends at the end of March. If they are not able to access it, they will not be able to provide it, because it is a significant cost, about $500 per day, for them if they have to pay out of pocket for this. If the minister could clarify: what is the intent with this program? I understand it was a pilot. Is it going to be extended beyond March 31?

Mr. Ellis: Yeah. Thank you very much, Member, for the question. You know, the impact of the opioid crisis and overdoses is affecting not just the folks in Edmonton-City Centre but, of course, folks throughout the province. To answer your question quite simply: yes, we're going to continue with that. That nasal naloxone project has been quite successful, and we're very excited about not only continuing with that program in Edmonton but seeing where else we can do it in the province.

The Chair: Thank you so much, Associate Minister.
Hon. member.

Mr. Shepherd: Thank you, Chair. In the brief time we have left, to the minister: will there be an announcement to that effect, then? Have the Spady Centre and the others participating been informed of the extension of that program? I assume, then, that the funding for that program is in this budget.

Mr. Ellis: Yeah. Thank you, Member, for the question. They're completing the wind-down for the review of that particular project. According to staff at the table the summer, I think, is when we're going to actually be able to do some sort of extension of that particular program, so we're very, very excited about that.

Mr. Shepherd: Chair, just to clarify, does that mean, then, there will be a gap? If you're reviewing and you're renewing this summer, will there be an extension until such time as the review is completed?

Mr. Ellis: Yeah. Sorry. Thank you very much. There will not be a gap. The program is going to continue.

Mr. Shepherd: Excellent. Well, I guess we've got about 30 seconds left here. I was previously asking a question of, I guess, the Minister of Health, and perhaps I'll just put that on the record. You know what? At this point I will simply cede the remaining time, and we will come back in the next 10-minute block.

The Chair: Well, that's fantastic. Thank you so much.
Now we will move over to the independent member. Please proceed.

Mr. Barnes: Thank you, Madam Chair. Minister, okay to continue going back and forth?

Mr. Copping: That's fine.

Mr. Barnes: Thank you. Primary care networks: to me, they're very, very interesting; tremendous potential for really, you know, promoting healthy lifestyles and things before we need people in the health care system. I remember a number from a couple of years ago. I think it was $180 million a year the taxpayer of Alberta was contributing to primary care networks. So much good work can be happening there, but, Minister, I also want to be honest. I talk to a lot of Albertans. I say: do you know that you're in a primary care network? Most of them say no. Tell me about: how much money are we spending on primary care networks? Where is it, and what are the success measurements?

Mr. Copping: Thanks to the hon. member for the question. If you look in terms of the line item 7.2, primary health care, you can actually see the amount we're spending on primary health care. In '22-23 the estimate is $250 million, up $10 million from the forecast and up $100 million from the budget. As you know, the purpose of primary care networks, quite frankly, is to be able to provide wraparound services for individuals. It doesn't surprise me that, you know, you say that people aren't aware of what primary care networks are, because, quite frankly, that's the beauty of them. They're almost seamless, right?

Using my own personal example, I have a family physician who is part of a primary care network. They make a reference to another service, you know, that will be able to be provided to that. I didn't know it was part of the primary care network. You get the reference to the service, the service happens, you're able to do that, and it's seamless. That's the beauty of primary care networks, that they can provide better services to Albertans, particularly on the allied health services, and it's all integrated in sharing of information.

We have had an increase in PCNs over the last number of years. Presently we have 40 PCNs and roughly 85 per cent of Albertans are actually covered by a PCN, but they may not know that. That's partly the beauty of it, because it works seamlessly to be able to provide services, and it allows the family physician not only to be able to get advice from the allied health professionals, to be able to provide that type of care when it's appropriate, but at the same time ensure that there's no – to your comment earlier, where sometimes if there's a lack of information, it drops through the cracks: well, they're all working together so you don't have the information falling through the cracks, and you have continuous care to be able to provide it.

Part of that, the increase in the dollars, is $3 million for, you know, population growth, because the way the PCN works, it works on the panel that the doctors have and then we provide the funding so they can work on programs that actually provide the best benefit for that local area. But another $7 million is for nurse practitioners. Part of this is the way that we're actually dealing with a shortage of family physicians. The nurse practitioners, as I indicated earlier, provide almost all the services a family physician can do. So nurse practitioners will be able to do that. They are hired, in essence, through the funding provided through Alberta Health and the PCNs. In addition, part of this funding we're going to be using for stand-alone – and, hopefully, announcing this year because we're doing that work right now – in regard to independent practices for nurse practitioners so they can go out.

I think this is an important aspect to be able to support primary care because, quite frankly, that's the cornerstone of our health care system. We need to support that, and PCNs do improve the outcomes in primary care and actually reduce the potential for dropped balls as you're going from a primary care physician to some of the allied health services that you would otherwise need.

Mr. Barnes: Okay. Great. Thank you for that. So glad to hear that, the extra support for nurse practitioners. That's good.

You mentioned something called RESIDE. I think it was $60 million to get more doctors in rural Alberta. I'm sorry if the numbers were wrong, but I want to tell you my experience. Every

year I have three or four young Albertans from Cypress-Medicine Hat come to me who can't get in to medical school; kids with 4.0 grade averages, kids with volunteer resumés a mile long, and kids that, you know, are Albertans who would stay in Alberta to practise and provide a tremendous service. I think I could say exactly the same sentences for nurse practitioners. I also recall from a few years ago that the actual number of medical spots was reduced at the University of Calgary and the University of Alberta for all students but particularly for Alberta students compared to international students. Minister, do we have any money in this budget to . . .

The Chair: Hon. member, please direct questions through the chair.

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

Is there any money in this budget to ensure that qualified Alberta kids have the opportunity to service Albertans as doctors and nurse practitioners?

Mr. Copping: We're talking about this budget. If we use that term very broadly, the short answer – is there money targeted for health care professionals in this budget? The answer is yes. You know, when we take a look at the overall budget – actually, this is a better question to pose directly to my colleague in Advanced Education because that's where the money actually resides, but I'm working with Minister Nicolaides in regard to: where do we target the funding that's been allocated to be able to deal with shortages in health care professions? Some of it's already been allocated in terms of the health care aides and nurses. The other issue is doctors.

11:20

There are a couple of different approaches that we can actually take to this, right? Some of the things we're looking at are, you know, when we talk about international medical grads – this is what I would call the medium term – some of them come in and they actually need to do one more year of residency, right? You have the story of Alberta kids who don't get into the U of C or U of A; they go to the U.K., they get their training, they want to come back and do their residency. So how do we actually increase the spots for that to be able to streamline in terms of rural Alberta? Those are conversations that are ongoing right now.

Additionally, we'd look at nurses. Right now we have 600 nurses that are waiting to get into the MRU bridging program, which is a six-month bridging program, and then they become fully qualified nurses. There are only 30 spots in that. Again, we're having ongoing conversations about how we increase that or, even better yet, how we get that program accredited to colleges in rural Alberta, because you bring them to right where they want to go and then where you want them to stay, so we are looking at that.

There is a pot of funding that is not necessarily in my budget per se but another budget, so I would suggest, you know, to have a greater conversation there. We're still working through that in terms of where the best use of those dollars is. In addition, the other thing that was highlighted, to your point, saying: okay; well, how do we ensure we get Alberta kids from rural areas into the programs and back out again? That's the conversation that I'm having with Advanced Ed on our med schools to be able to do that.

Again, we do provide some funding for that, that flows through as part of our education budget, but there's another pot there as well. We're still working out which is the best way to do that, but we understand some of the challenges.

I guess my last comment, and I mentioned this earlier to MLA Shepherd, is that, you know, the family physicians rural section in the committee – in terms of: how do we actually attract and retain more? – there'll be a report by March 31, and I'm interested to see what comes out of it. I wouldn't be surprised that there'd be other ideas, like you're saying here, in terms of protecting more spots or adding more residency. Then part of the conversation is: how do we do this in a fiscally responsible manner? We want to increase capacity but also manage our costs and use our dollars as efficiently as possible.

Mr. Barnes: Great. Thank you.

The Chair: Thank you, Minister. Minister, would you please direct the conversation through the chair.

Mr. Copping: My apologies.

The Chair: All right. Hon. member.

Mr. Barnes: Thank you, Madam Chair. The cost of COVID vaccination centres. I mean, looking at the money spent on COVID-19 pandemic response, $1.5 billion in '20-21, $1.8 billion forecast for '21-22. I've driven by a few for days and days where it seems like there's no activity. I've heard stories of, you know, a day's work being one or two vaccinations. Minister, do you have any idea how much the taxpayer contributed to vaccination centres?

Mr. Copping: I'll start my answer, and the officials are looking in terms of the exact number. You know, it's . . .

The Chair: Thank you so much, Minister.

That now moves us over to the government caucus. Please proceed, Mrs. Frey.

Mrs. Frey: Thank you very much, Minister. Minister Copping, I'm going to give you a break, through the chair, of course, and I'm going to ask some questions of the Associate Minister of Mental Health and Addictions. I think there's still, like, four hours of estimates left, so I'm sure the Minister of Health will get a lot more questions.

Associate Minister, on mental health and addictions support for youth, we know that the last two years have been incredibly difficult for young people, especially those who were taken out of school because of online learning and then forced to go back and forth. I know for a lot of students, especially in rural Alberta, they were disconnected from a lot of their friends there. You know, school was really that central piece that held everything together. Associate Minister, could you please talk about the additional funding of $100 million that is – sorry. I see an increase on page 120 of the estimates statement of operations for population and public health. That's an increase of nearly a hundred million dollars, and we've heard a lot about the issues of youth mental health and specifically suicide prevention. Associate Minister, could you please elaborate: is any of that money being allocated towards youth suicide prevention?

Mr. Ellis: Of course, the short answer is yes, but I think you pointed out quite eloquently, you know, that the COVID-19 pandemic has just had an impact on, well, all Albertans, but certainly young people. There have been significant challenges to their day-to-day lives.

From 2009 to 2019, I believe, Alberta had a youth suicide rate of – looking at the numbers here – 11.37 per 100,000, which is 1.4 times the national average, 8.26 per 100,000. Suicide numbers in 2020 remained similar to those seen in 2019. Investigations by the Chief Medical Examiner can take months, of course, to complete, which is always a concern, but you know we're certainly trying to ensure that the medical examiner has the resources to do what they need to do.

Despite these numbers the Alberta government, of course, is aware of the stresses caused by the pandemic. They monitor, they identify, and, of course, they respond to the emerging needs. You know, we continue to monitor this very closely even in '21 and, of course, in 2022. We're committed to undertaking the work to ensure that children and youth have access to the supports that they need.

So we have a number of programs in place. You know, I think you were there at one of my announcements, MLA Frey, which is the youth mental health hubs. We had $7.3 million over three years to support the expansion of youth mental health hubs, $3.5 million in 2022 and 2023. We've seen many of these youth mental health hubs, which are in rural Alberta, and they are in various stages, but from what I have seen, there's been a lot of great work that's being done. I believe that we have young people all the way up until the age of 24 that can go in and engage. You know, what I love about these youth mental health hubs is that they help with a very complex system, right? It's a complex system that the people that work there can help these young people navigate and get the necessary help, whether it be addictions supports or mental health supports.

We're very excited about the work that we've done. We also committed and have over $7 million for the Kids Help Phone, which is another project that has been very, very successful; $2.4 million in 2022-23, in element 6.2. I also just want to note $3.3 million to support youth community support programs, which provide residential and community supports to youth with complex mental health and addiction needs. You know, it's a very complex problem, but we're certainly doing what we can to help those who are vulnerable.

Thank you.

The Chair: Associate Minister, I'll kindly remind you that you need to direct your comments through the chair.

Mr. Ellis: Okay.

The Chair: Please proceed, Member.

Mrs. Frey: Thank you, Chair. I really appreciate those answers. Of course, I remember when the minister was down in Medicine Hat and we announced the youth mental health hubs. That was a really good day.

I'm also going to talk about the addiction and mental health recovery-oriented system of care. You know, the previous minister spoke about this lots, and you have as well. Of course, through the chair, the minister has spoken about the need to enhance the recovery-oriented system of care, and we know that civil society plays a large role in that recovery-oriented system of care, and I am curious. On page 52 the second paragraph talks about early prevention, intervention, managing chronic health conditions, supporting Albertans in optimizing their health. It also talks about the network of community-based services, which we know are so important, when you have people that you can relate to that have gone through the same things as you, those peer-to-peer support groups as well as other organizations that we know are so important.

Through the chair, I'm wondering if the minister could elaborate on those community partners that we are working with and how this will contribute to the recovery-oriented system of care that we have in the province.

11:30

Mr. Ellis: Yeah. Thank you. Certainly, those – I think it's well over 200; don't quote me on the exact number – community partners, not-for-profit organizations are, you know, delivering on this recovery-oriented system of care. There are so many avenues here. You touched a little bit on those folks with lived experience, as an example, right? That's why we're able to provide supports to our recovery coach program. The recovery coach program is folks with lived experience that head out into the communities and engage with the vulnerable people in order to help them in, really, any capacity, helping them to the nearest supervised consumption site, helping them to a pathway from their illness into detox or treatment or recovery, or even just engaging with them to let them know that they're not alone.

What people need to understand about the illness of addiction is that it leaves people very vulnerable in that they become very isolated. They think that they're the only ones experiencing this illness. Certainly, to have all of these folks that engage in the community, that head out there – you know, there are so many not-for-profit organizations throughout Alberta that just do such a fantastic job with engaging with the communities to ensure that the vulnerable people are engaged in order for them to get on a pathway to recovery.

The Chair: Thank you so much, Associate Minister.

Hon. member.

Mrs. Frey: Thank you. I'm really glad that we have time to ask this question as well. Early on in the pandemic I had written to the former minister about the issues that I saw with – of course, we were limiting in-person interaction. Part of the 12-step programs like AA, Narcotics Anonymous, and so forth rely on in-person meetings. I was very grateful that the minister and Dr. Hinshaw granted an exemption for those groups to meet in person. That meant the world to so many people in my community as well as people across the province. So from the bottom of my heart, I just want to say thank you because I know that Dr. Hinshaw is in the audience today. That was critical in ensuring that the continuity of services could continue.

For those people who were living with mental health and substance abuse disorders during COVID, we know that they were disproportionately impacted because a lot of their ties to the supports that they needed were severed just because of things like limiting in-person interaction, which we know is important to curb the spread of COVID but also had other impacts. Associate Minister, I'm wondering. With the added pressures on the mental health and addictions system in Alberta can you comment on how the funding is broken down and, when it comes to funding for treatment services, where that will come from as far as – oh, shoot. You only have 40 seconds left, so I'll get back to you.

Mr. Ellis: Sure. I mean, if you're just talking about funding, I can try and do that in about 30 or so seconds. You know, we have $32 million for services that reduce harm, $10 million for prevention, $23 million for early intervention, $117 million for treatment and recovery for addiction and mental health. When we talk about the recovery-oriented system of care – we can substitute the word "recovery" with wellness or human or holistic, as an example – really what we're trying to do is ensure that the whole person is taken care of, whether it be their mental health or their addiction. Ensuring that we have the funding for that, I think, is vitally important.

The Chair: Thank you so much, Associate Minister.

With that, we will turn over to the Official Opposition. Please proceed, Member.

Member Irwin: Thank you, Chair. Nice to be here with everybody today. I'm learning a lot. I would like to address the government estimates document, pages 108 to 111, and outcome 3 of the business plan, which states, "the health and well-being of all

Albertans is protected, supported and improved, and health inequities among population groups are reduced." The Health critic, David, and I have heard from countless Albertans who are struggling right now, and one of the groups that we've heard a lot from are trans Albertans. Their challenges are many: long wait-lists, a lack of physicians who can provide gender-affirming care, particularly in rural areas but even in urban ones, a lack of mental health supports, and the list goes on. I'll expand upon a few of those in a moment. You know, why this is so concerning is that when care is delayed for trans folks, it can be deadly. It's not an exaggeration. It's a fact that's supported by the evidence.

The member beside me has asked a number of questions about the lack of physicians in this province, and I know some of the other members have as well. We've seen that across the province. One of the biggest challenges that trans folks report is that they're often unable to find a doctor. I'd like to quote, with her permission, someone who works directly with the trans community. Her name is Lindsay Peace, and she's with the Skipping Stone foundation in Calgary. She notes that because so few doctors feel comfortable, confident in caring for members of the trans community, just treating their common colds and sprained ankles, let alone providing a diagnosis or a referral for surgery, you know, is not on the table. She notes that there's actually only one physician in all of Lethbridge who works with the population, and she can't think of any even south of Calgary.

My first question, I think, is just: is this government aware of this crisis that we see in trans health, and do they have any plans to address it and perhaps add additional funding?

Mr. Copping: Thanks so much, through you to the hon. member, for the question. You know, I can say that from a budgeting standpoint we've maintained the same amount of budget for reassignment surgery, and our approach to that hasn't changed this year over last year, nor has it changed for a number of years, even, as the hon. member knows, in terms of the previous government.

We fully recognize that there is, generally speaking, a shortage of physicians. As I spoke to earlier, these are all kinds of physicians to be able to provide the services. I've explained that, you know, our approach is to be able to increase through a number of approaches – short term, medium term, and long term – to be able to have the physicians to provide the services, quite frankly, to all Albertans regardless of background, right? We continue to focus on that, but I can confirm that sort of from the budgeting standpoint we've maintained the same budgeting for gender reassignment surgery. I haven't had any specific details in regard to: is there a backlog in that particular item in front of me? But, you know, that's something that we actually may be able to address.

I think my colleague wants to speak a little bit in terms of mental health supports in this particular area. Maybe I'll pass it over to Associate Minister Ellis.

Mr. Ellis: Chair, are you okay?

The Chair: Proceed.

Mr. Ellis: Thank you very much, and thank you to the member for the question. If you don't mind, I'm just going to read here because there are some specific programs that Alberta Health actually funds. Specific for the LGBTQ2S-plus community, Alberta Health has funded two programs through the COVID-19 community grant program, one being the Outland Foundation for LGBTQ Community Supports and Services. They serve a population in and around St. Albert, just as an example. They also provide online group meetings for youth. We also have the Canadian Native Friendship Centre. They provide support groups for the LGBTQ2-plus community in the Indigenous population in the Edmonton area, just as an example.

You know, of course, we have some fantastic folks at 211 that are specifically trained for folks that are facing mental health concerns, and certainly I'm proud of the work that they do for the mental health support community.

Thank you.

Mr. Copping: Chair, if I could just comment to the hon. member. You know, in terms of some of the details in regard to transgender surgery, we have some of that right here, but I can ask Chad Mitchell if . . .

Member Irwin: I've got additional questions on the surgery piece, so maybe I'll ask those. Would that work?

Mr. Copping: Okay. All right. We can do that. Sure.

Member Irwin: Yeah. Perfect. That leads into my next line.

The Chair: Hon. members, please direct your conversation through the chair.

Mr. Copping: With the chair's permission.

Member Irwin: Through the chair, thank you. I appreciate the mention of the mental health supports, but you know we know – we talk a lot with folks from the trans community – that the best mental health care is actually addressing their physical health care needs because trans-affirming health care is life saving. I just wanted to ask – we can come back to this, but you said that the budget has remained the same. I can't see the exact line item because it's not named specifically. I'm curious what the budget is, just for my own knowledge.

11:40

Trans-affirming health care is, of course, life saving, and I just want to talk about some of the services that are struggling right now as well. The Wellness Centre in Edmonton opened up in 2020. It's actually very low on funding, and they're having to stop their services. One of the doctors there is leaving notes that there is a huge need for transgender assessment and transition care, with long wait-lists.

Another big piece is just, you know, that trans-affirming health care should be something that all physicians are able to do. But it seems like many trans folks are struggling, as I mentioned, to find physicians to do referrals, and there aren't a lot of psychiatrists either that are working with AHS. It sounds like, from reports, there's only something like six psychiatrists with whom AHS works. I wonder about this government expanding the scope of the professionals with whom it works because this would actually be less costly in the long term, as the cost of delayed health care for trans folks is quite high when we talk about the physical and mental health care costs.

Then I just wanted to touch on the surgery piece because that is one of the biggest concerns we're hearing from folks in the community, that access is a problem. There are very few surgeons doing top surgery and none doing bottom surgery although Alberta Health pays for that in Montreal. Actually, I just learned from somebody that one of the surgeons who performs gender-affirming surgery is actually leaving Alberta in July, which, they tell me, will leave only one surgeon for all of Alberta. Again, I'm learning a lot about this, but this person let me know that it's literally, basically, a double mastectomy, that most surgeons can do, but because there is so little awareness about transgender health needs, a lot of medical practitioners are hesitant. They want to help, but they feel

like they don't have the expertise. I think a big part of it as well is education.

So a couple of questions in there, but the last one would just be sort of: what plans does this government have to support surgeons, physicians generally so that more of them can provide gender-affirming health care?

Mr. Copping: Well, thanks for the questions. Maybe I'll start, and then my colleague can follow up. First, in regard to the – the amount of money that is budgeted for '22-23 is $2 million in the budget, and that is buried. You won't see a specific reference to it in the high-level numbers. I appreciate your comments in regard to, you know, having more practitioners be able to provide these types of services. I know that AHS has created a gender health strategy and is working towards developing a broader plan to enhance physician and provider competencies, quite frankly, leading them to broader access so that basically our current workforce can provide and have greater comfort providing those types of surgeries.

Lastly, I just want to chat in terms of the surgeries, you know. Just reviewing the information here, there has been a backlog of surgeries for bottom surgery, largely due to the impact in Montreal of the – we are actually, in my understanding, in ongoing conversations with them to be able to learn: how do we get caught up in the backlog there?

To that extent, you know, maybe I'll just pass it over to Chad Mitchell if you have any further detail on that. Thanks, Chad.

The Chair: Forty-five seconds.

Mr. Mitchell: Good morning, Chair. I'm Chad Mitchell. I'm the assistant deputy minister for the pharmaceutical and supplementary benefits division here at Alberta Health. The minister is correct. This year we are allocating, under element 12.2, $2 million for top and bottom surgery, which is delivered out of the clinic in Montreal. During COVID we've seen reduced out-of-province medical travel, and in terms of cases for gender reassignment surgery a similar type of impact. We're anticipating about $1.5 million in this fiscal year, but once again . . .

The Chair: Thank you so much to the ministers and their teams.

Member Irwin: Is it possible to request just getting some of that information?

The Chair: I'm sorry. The timing is firm. It now moves over to the independent member.

Please proceed.

Mr. Loewen: Okay. Thank you very much. Thank you very much, Minister and the Health staff there, for being here today for questions and to the associate minister, too. I appreciate it. I'll get right into the questions here, just starting with some comments, I guess. The NDP left us with a health care budget of about $21.9 billion, which has now ballooned to $24.4 billion according to the fiscal plan. Now, while it may be tempting to blame COVID for this growth, page 120 of the government estimates shows that we also spent $3.3 billion specifically earmarked for the COVID pandemic response on top of that annual spending growth. I think that many Albertans are wondering where the money went because it seems it did not make it to building acute-care capacity.

I just want to recap some of the history of these ever-shifting numbers of the acute-care capacity. On April 1, 2020, the Premier said that we currently had 295 ICU beds, hoping to expand that to 1,200. On April 2, 2020, the Health minister clarified that that number was actually going to be expanded to 1,290 in addition to over 2,200 other hospital beds. On November 25, 2020, the Premier said that we had set aside 2,300 acute-care beds, including 650 ICU beds. On December 3, 2020, the Premier once again claimed that we had set aside 2,400 hospital beds, including 650 ICU. On January 8, 2021, the Premier said that we would have to cancel surgeries at 2,000 COVID hospitalizations, a number we never reached, which didn't keep us from cancelling surgeries anyways. Statements made in March and April of 2021 were similar: approximately 600 ICU were available. By late April 2021 the Premier said that we have 240 to 250 ICU usually but that we had added 425. On May 11 the Premier claimed we could handle 250 ICU patients with great difficulty, noting that we would have mass cancellations of surgeries at 300 ICU.

Of course, in the 2020-21 AHS annual report they claimed that they had planned surge capacity for 425 ICU plus 2,250 other acute-care beds. I guess the question kind of comes down to – with the wait times in the ministry's business plan failing so badly, the question is: why did we cancel so many surgeries well before any of these triggers were met?

Mr. Copping: I want to thank the hon. member for the question. Part of this budget and our focus is on building capacity within our system, permanent capacity. You know, I do want to take a step back and talk a little bit about the government response to COVID.

As you know, we have been able, although with challenges – and this is not only in Alberta; this is in governments world-wide and provinces across the country – to flex our capacity up to be able to manage the demands of COVID. In the fourth wave the demands were primarily on the ICU; the fifth wave was primarily on the non-ICU. You know, in the fourth wave we had to flex up to just under 400 ICU beds, and we were able to do that, and then the system was able to respond, but it came at a cost. It came at a cost in terms of postponing surgeries, which had an impact. I just wanted to point out to the hon. member that this is not any different than any other jurisdictions. We've seen it in Manitoba. We saw it in Saskatchewan. We saw it in Ontario. The need to respond to the COVID outbreak and ensure that we had the capacity: we can do it, but it comes at a cost.

There are a number of levers that we can pull to actually make this happen. Some of the levers that we pulled were in regard to trying to flatten the curve, and prior to vaccines we had to pull those levers in terms of interactions, both economic and social, to be able to manage within our capacity. But with the availability of vaccines we didn't need to use those types of measures very much, but we did recognize, as noted by the Premier, that we need more permanent capacity available, and that's what this budget does. It invests $100 million over the next three years, $100 million a year, to add 50 more ICU beds to our system. But there still is – and I mentioned this earlier in our conversations – a system to be able to have a contingency plan that deflects that up even higher. You know, we want to mitigate the impact on our postponement of surgeries to the greatest extent possible. Fortunately, we have other tools available right now. We have not only vaccines; we have treatments as well and now this additional capacity. So we will minimize the impact going forward.

The other comment that I'll simply make is that, you know, when we look at wave 1, we didn't know then what we know now about what the impact of the original variant would be. We were concerned at that time, particularly with what we were seeing in countries around the world such as Italy, that we needed to make sure that our system would be prepared for that, and that original assessment was based on field hospitals, a very low level of care, and since the wave 1 we've had impacts on our workforce.

11:50

You know, when dealing with five waves, this is the equivalent of five incredibly bad flu seasons. Just a frame of reference: even with the omicron wave, which is less severe, we still had 1,500 Albertans with omicron in our hospitals where typically our worst flu season at the peak – that was at the peak – had 500. So we're going through five of them, which has had an impact on our workforce and, quite frankly, you know, made it challenging to be able to do staffing.

But, you know, we have responded. The system has responded. AHS has hired a large number of nurses over the past two years. We have more nurses today, more doctors today, more health care professionals today. Even look at the budget. Our total number for AHS is going up to be able to respond, and we're going to continue to invest in this capacity so we can actually respond more easily without the impact on surgeries going forward. While that capacity is not being used, we are actually going to, as I indicated earlier, use those resources to catch up on surgeries.

The Chair: Thank you so much, Minister.
Hon. member.

Mr. Loewen: Okay. Thank you very much. You just mentioned more nurses than ever, but you know we just had the Fairview hospital close nine beds because there are not enough nurses there. Again, we have $3.3 billion in additional spending to increase capacity, yet we couldn't manage the situation.

In fact, the closest we ever got to 2,000 COVID hospitalizations, which was the trigger the Premier talked about in January 2021, was about a month ago, like you mentioned, when the omicron variant caused us to peak at roughly 1,500. But at that time the Premier was already talking about opening the province up. By just this past March 1, when this government dropped the bulk of its restrictions, we were sitting at a total hospitalization figure of nearly 1,200, a figure that exceeded any point we had ever seen for the entirety of 2020 and 2021. So suddenly we remembered that we had all this additional capacity? Now we can handle these hospitalizations with ease where we couldn't before? I think that just doesn't make sense, some of those figures.

We had peak COVID ICU that was approximately 250 last fall, keeping in mind that this is well short of the 425 additional ICU and more than 600 total ICU made available. So it's strange that we were locking down, closing businesses, cancelling school years, mandating masks, bringing in vaccine passports at 100 or 300 or 800 hospitalizations and now we're dropping mandates at 1,000-plus. I'm just kind of wondering: where's the consistency here, and where has that additional $3.3 billion gone? Has it gone into capacity or not? And if it did go into capacity, why have we been suffering with all this for the last two years?

Mr. Copping: Well, a couple of items I'd like to address, and thank you to the hon. member for the questions. First of all, the $3.3 billion is, quite frankly, the response to the system, right? When we talk about, "What are we spending it on?" we're spending it on PCR testing, we're spending it on staff for testing, we're spending it on the rollout of immunization, we're spending it on the additional costs associated with managing COVID patients because, as the hon. member knows, you can't have two patients in a room unless they're both COVID, so you have an impact on that. It's PPE. It's gowns. You know, the $3.3 billion was a response, our response, to COVID. We needed to spend that money to be able to address, quite frankly, a historic event in this province.

I would like to talk to you about – because the member is sort of asking some questions. You know, why did we manage it differently today in terms of omicron versus delta? Quite frankly, COVID has changed over time. The variants have changed the nature of the how the disease . . .

The Chair: Thank you so much, Minister.

With that, we'll move back over to the government caucus. I believe that Member Frey is going to take this question.

Mrs. Frey: Yes, I am. I'm going to continue my line of questioning with the Associate Minister of Mental Health and Addictions if that's all right with him. I see that we have a large amount in this budget allocated towards increasing capacity in our health care system but especially in our recovery system as well. Of course, if people are to recover, we need to make sure that we have the spaces for them to do so. In the addiction and mental health recovery-oriented system of care on page 9 it states that the government is building on "existing commitments to transform the mental health and addictions system to ensure Albertans [will] have a continuum of high quality mental health and addictions care and supports."

I'm wondering, Associate Minister. If our government is incorporating innovative strategies focused on moving individuals in the direction of recovery, I know that it shows the importance that you and your staff and the government as a whole are placing on recovery. We know that recovery works. We know that recovery is important. Of course, we have all of these organizations that come as kind of part and parcel to the larger picture, but of course there is no substitute for recovery.

I also see that you are building a recovery-oriented system of care that connects all service providers, establishing a high bar for server provisions that will be evidenced by the transformed lives and promise of sustained recovery for Albertans. Through the chair, I was wondering if the minister could elaborate on what has been the result of the initiatives that you've had in place so far, and can you comment on whether or not they will be expanded in the future?

Mr. Ellis: Well, thank you, Member. Thank you, through the chair, to the member. Thank you for the question. Capacity really is key, and yes, we're looking at any opportunity to expand the system. You know, really it's about truly understanding the illness of addiction. As many of you do know, I spent over 10 years actually working on the streets of Calgary as a law enforcement officer, dealing with people who had not only severe mental illness but certainly people that had addiction problems. One thing that I learned is that you, unfortunately, can't negotiate with somebody who's high or trying to get high.

I also realized, too, that with every person with the illness of addiction there's always that one moment. There's a moment in their life where they say: I've had enough. Sometimes it's when the justice system comes into play, as I spent my time as a judicial interim release hearing officer for several years, but sometimes there's just that time where you've done that one fix and you're just like: I'm done with this.

You have to have the capacity. You have to have the space available for them, which is why we eliminated the user fees, just as one example. You know, prior to this government coming into being, you pretty much had to be rich in order to get any help in this province. In fact, I would argue that some of the people that were probably getting help weren't even from this province because it was more private beds for, again, really, the wealthy. That playing field has been eliminated. Basically, if you're somebody who wants help, we're going to make sure help is available for you.

As I indicated, too, understanding the illness of addiction, you can't ask an addict to come back tomorrow. You can't ask an addict to come back next week or two weeks from now. That's why it's so important that when they need the help, that help is there for them right away. That's why we've put enormous amounts of funding into detox beds, to ensure that we have treatment facilities, to ensure that we have recovery facilities. That's why we're building five world-class therapeutic communities.

You know, that's why – and I'm happy to get into this. I know we're somewhat running out of time, but during my time on the Alberta Secretariat for Action on Homelessness, as an example, disproportionately our friends in the Indigenous communities have been affected. They had been primarily the vulnerable people. I've made a commitment, along with my good friend the hon. Rick Wilson, to ensure that we have supports for our friends in the Indigenous communities. We were proud to announce in our budget that we have the funding to build on the Blood reserve a 75-bed therapeutic community. I mean, that's phenomenal. Working with the folks in Lethbridge and surrounding communities there, our friends . . .

The Chair: I apologize for the interruption, Associate Minister, but I must advise the committee that the first portion of time allotted for consideration of the ministry's estimates has concluded. I'd like to remind committee members that we're scheduled to meet again this afternoon at 3:30 to continue our consideration of the estimates of the Ministry of Health.

Thank you, everyone. This meeting is adjourned.

[The committee adjourned at 12 p.m.]

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