Legislative Assembly of Alberta

The 30th Legislature
Fourth Session

Standing Committee on Families and Communities

Ministry of Health
Consideration of Main Estimates

Wednesday, March 8, 2023
9 a.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

Ministry of Health
Hon. Jason C. Copping, Minister
Paul Smith, Assistant Deputy Minister, Health Workforce Planning and Accountability

9 a.m. Wednesday, March 8, 2023

[Ms Lovely in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: Good morning, everyone. I'd 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, 2024. I ask that we go around the table and have members introduce themselves for the record. Minister, please introduce your officials who are joining at the table. My name is Jackie Lovely, and I'm the MLA for the Camrose constituency and the chair of this committee. We'll start to my right.

Mr. Smith: Good morning. My name is Mark Smith, and I'm the MLA for Drayton Valley-Devon.

Mr. Yaseen: Good morning. Muhammad Yaseen, MLA, Calgary-North.

Ms Armstrong-Homeniuk: Good morning. Jackie Armstrong-Homeniuk, MLA, Fort Saskatchewan-Vegreville.

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

Mr. Long: Martin Long, the MLA for West Yellowhead.

Mr. Copping: Good morning. I'm Jason Copping, MLA for Calgary-Varsity and the Minister of Health. With me at the table I have Mr. Paul Wynnyk, deputy minister; Mr. Aaron Neumeyer, assistant deputy minister, finance and corporate services; Ms Corinne Schalm, assistant deputy minister at continuing care; and Mr. Paul Smith, assistant deputy minister, health workforce planning and accountability.

In the gallery behind me, who may come to the microphone, are Mr. Chad Mitchell, assistant deputy minister, pharmaceutical and supplementary benefits; Ms Kim Wieringa, assistant deputy minister, health information systems; Mr. Andy Ridge, ADM, health standards, quality, and performance; Ms Wanda Aubee, ADM for public health; Dr. Mark Joffe, chief medical officer of health; Mr. Chris Bourdeau, director of communications; Mr. Dan Hemming, executive director, financial planning branch; Ms Pranita Chandra, director of financial planning branch; my chief of staff, Ms Shannon Gill; and policy adviser to the minister, Mr. Mark Feldbusch.

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

Member Ceci: Joe Ceci, MLA for Calgary-Buffalo.

Ms Sigurdson: Happy International Women's Day. I'm Lori Sigurdson. I'm the MLA for Edmonton-Riverview.

The Chair: Thank you, everyone.

A few housekeeping items before we turn to the business at hand – pardon me. I forgot to introduce those people who are participating remotely. Let's start with Tanya Fir.

Ms Fir: Good morning. Tanya Fir, MLA for Calgary-Peigan.

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

The Chair: Thank you so much.

A few housekeeping items to address before we turn to the business at hand. Please note that the microphones are operated by *Hansard* staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of meetings can be accessed via the Legislative Assembly website.

Members participating remotely are encouraged to turn your cameras on while speaking and to mute your microphone when not speaking. Remote participants who wish to be placed on the speakers list are asked to e-mail or message the committee clerk, and members in the room should signal to the chair, please. Please set your cellphones and other devices to silent for the duration of the meeting.

With regard to speaking rotation time limits, hon. members, the standing orders set out the process for consideration of the main estimates. A total of six hours has been scheduled for consideration of the estimates for the Ministry of Health. This meeting is the first three hours for consideration of the ministry's estimates. Standing Order 59.01(6) establishes the speaking rotation and speaking times. In brief, the minister or a member of the 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, and then a 20-minute speaking block for the government caucus. Individuals may speak only for up to 10 minutes at a time, but speaking times may be combined between the member and the minister.

After the speaking times we'll follow the same rotation of the Official Opposition, independent members, and the government caucus. The member and the minister may 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 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 object to having a break today? Okay. Seeing none, we'll have one.

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 commencing. 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 arise, and individual speaking times will be paused; however, the speaking block time and the overall three-hour meeting clock for the first segment of the six allotted hours will continue to run.

Any written materials 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 the estimates and any amendments will occur in Committee of Supply on March 16, 2023. 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 committee members.

Finally, the committee should have the opportunity to hear both questions and answers without interruption during estimates debate. Debate flows through the chair at all times, please, members, including instances when speaking time is shared between a member and the minister.

I would now invite the Minister of Health to begin with your opening remarks. You have 10 minutes, Minister.

Mr. Copping: Thank you, Chair, and good morning, everyone. I'm pleased to be here to present the Health estimates for 2023-2024. Budget 2023 provides another record investment in health care for Alberta. It delivers 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 2023-24 provides $24.5 billion for Health's operating budget, a $965 million, or 4.1 per cent, increase from last year. This is the highest ever budget for health care in the province. With this level of funding we will continue to build capacity and flexibility in the health system and invest in the right resources to provide Albertans with the health care they need.

The largest component of the Ministry of Health's budget is allocated to Alberta Health Services. The AHS operating budget is over $16.7 billion in '23-24, up more than $600 million from last year. AHS will have nearly 3,600 new full-time equivalents this year, which will allow them to make important improvements in the system through the health care action plan.

The plan specifically focuses on four goals: one, improve emergency medical services' response time; two, decrease emergency department wait times; three, reduce wait times for surgeries; and finally, empowering front-line workers to deliver better health care. While actions have already started since the plan was launched in November, Budget 2023 provides more funding to continue this important work.

Let's start with EMS funding. We are investing more money than ever in emergency medical services to improve ambulance response times. There is $194 million in new funding over three years for EMS to strengthen services by hiring more staff and implementing recommendations made by the Alberta EMS Provincial Advisory Committee. This brings the total investment to $740 million this year alone for EMS, and this is an increase of 23 per cent over last year's budget. In addition, $15 million over three years will be invested in a new program to purchase ambulances and related equipment, which supplements AHS's self-financing program for EMS.

We are also making important investments to reduce wait times and boost access to surgeries. Budget 2023 includes $237 million over three years for the Alberta surgical initiative capital program, including $120 million in new funding, which will support projects in 15 communities across the province to upgrade or expand operating rooms in public hospitals. Our goal is to ensure that all surgeries are happening within recommended clinically accepted wait times and being done in more communities across the province.

Moving to another goal of the health care action plan, empowering front-line health care workers starts with having the right number of professionals in the right places. Budget 2023 targets $158 million this year towards workforce planning to grow the number of health care professionals in Alberta. This amount includes $90 million to strengthen programs to attract and retain rural physicians, $29 million to fulfill the government's commitment in the agreement signed with the Alberta Medical Association that specifically focuses on underserviced rural and remote communities, $7 million for the targeted recruitment of internationally trained nurses from the United States and the United Kingdom, and an additional $1 million to fund the provincial nurse navigator program, which supports all nurses immigrating to Alberta.

9:10

Physician support is also a top priority for Alberta's government. Alberta's total spending on physicians is $6.2 billion for '23-24. The budget fully funds the new agreement with the Alberta Medical Association. The agreement goes to 2026 and will ultimately help stabilize the health system, target areas of concern, and support Albertans' health care needs. Under the agreement, more than $250 million over four years will go to addressing rural physician recruitment and retention, helping physicians with business costs, and assisting physicians with information technology supports. In addition to the AMA agreement, Alberta Health Services has a dedicated team in place to support recruitment efforts across our province.

A significant component of my ministry's budget supports care in the community. Budget 2023 provides a combined $4.3 billion in operating funding for community care, continuing care, and home-care programs this year, a 15 per cent increase from last year. Over three years Budget '23 provides $1 billion to support continuing care transformation, which will shift care into the community, enhance workforce capacity, increase choice and innovation, and improve the overall quality of care in our health care system.

The Budget 2023 capital plan also includes $310 million over three years for the continuing care capital plan. This funding will help modernize continuing care facilities, develop innovative small homes, provide culturally appropriate care for Indigenous residents, located both on- and off-reserve, and Métis settlements, and add new spaces in priority communities with the greatest need. Two significant continuing care modernization projects are also included in the capital plan, with a $120 million investment in '24-25. This includes the Bethany Care Society in Calgary and the Good Samaritan Society in Edmonton, which will see the modernization of over 700 spaces.

Budget 2023 also invests more than $2 billion, the highest investment ever, to improve primary health care. This includes funding for primary care networks, payments to family doctors, funding to strengthen and modernize primary health care, and investments to help community-based physicians with information technology systems: $243 million in new funding over three years for the primary care system includes $125 million as an initial investment for implementing recommendations from the modernizing Alberta's primary care system, or MAPS, panels of health care experts; $40 million to support primary care networks, as outlined and committed to in the AMA agreement; and $27 million to primary care networks, PCNs, to provide for an expected increase of patients attached to a primary care provider.

Strengthening health care relies on having modern facilities where they are needed, and the Budget 2023 capital plan includes $4.2 billion over three years to address health capital needs: $2.9 billion for new or ongoing projects, $732 million for AHS self-financed capital, $529 million for capital maintenance and renewal of existing facilities, and finally, $90 million for health-related IT projects.

Other highlights of the capital plan not already mentioned earlier include $634 million over three years for the new south Edmonton hospital; $321 million over three years for the Red Deer regional hospital centre redevelopment; $105 million over three years for medical device reprocessing department upgrades for hospitals in Calgary, Edmonton, Fort McMurray, St. Albert, and Westlock; $105 million over three years for the rural health facilities revitalization

program, with $75 million in additional funding to support new capital projects in rural Alberta; $54 million over three years for a new program to renovate and upgrade 33 pharmacies in AHS facilities to meet new standards for sterile compounding.

It also includes planning money for various capital projects, including the north Calgary-Airdrie regional health centre, a stand-alone Stollery children's hospital in Edmonton, Strathcona community hospital expansion as well as new or expanded facilities in Bassano, Beaverlodge, Cardston and Whitecourt, and finally, $11 million over three years to expand the renal dialysis program at the Chinook regional hospital in Lethbridge.

Another significant component of Health's budget is funding for drugs and supplemental health benefits. Budget '23 allocates $2 billion in operating funding for drugs and supplemental health benefits, an increase of $104 million from last year. 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 for new, more expensive gene therapy drugs. I will note that we have made no policy or program changes to any of our drug or health benefit programs.

To conclude, Budget 2023 sets our health system on a path to do more. It supports our health care action plan to take urgent action to provide Albertans with world-class health care where and when they need it. New and continued investment in all facets of our health care system will improve EMS response times and decrease emergency room wait times. We are also making important investments to reduce wait times and boost access to surgeries. We continue to expand and modernize hospitals and other facilities to protect quality health care, grow system capacity, and support the best health care workers in the world.

Thank you so much for the opportunity to present, and I look forward to questions.

The Chair: Thank you so much, Minister.

For the hour that follows, members of the Official Opposition and the minister may speak. Hon. members, you will be able to see the timer for the speaking block both in the committee room and on Microsoft Teams. Members, would you like to combine your time with the minister?

Mr. Shepherd: If the minister is willing, as we have in previous engagements, I would love to share time.

The Chair: Minister, what's your preference?

Mr. Copping: I would be happy to do so at this time.

The Chair: Perfect. All right.

Please proceed.

Mr. Shepherd: Thank you, Madam Chair, and thank you, Minister. I appreciate the collegial engagement we've been able to have in the past, and I hope that will indeed continue today. Of course, I will endeavour to be respectful in going through you, Madam Chair, to the minister and hopefully then, you know, be able to engage. I may at times speak through you, Madam Chair, to indicate if I feel I've received the information I've needed or that we are straying from the direction we're hoping to go, but again we'll be looking to maintain that respect and collegiality as we do so. Thank you.

Minister, I'd like to begin by looking at outcome 1 in your business plan and key objective 1.1 regarding the reduction of surgical wait times. Now, just a few weeks ago your AHS official administrator, Dr. John Cowell, stated, and I quote: I actually believe that we'll be at zero waiting outside of clinical wait times by March 2024; nobody will be outside of clinically appropriate wait times; my team and I are absolutely confident this is achievable.

Through you, Madam Chair, to the minister, I reached out to a number of contacts throughout the surgical system across Alberta. A response from one surgeon: is Dr. Cowell delusional? I spoke with another contact who ran the numbers and told me that if the Red Deer regional hospital were to stop seeing any new patients today and focus solely on their current wait-list, it would take them three years to simply clear that. Now, Don Braid, in a column today, noted that Dr. Cowell's words sounded more "like a campaign promise", and "he seemed as much a cheerleader as an administrator."

When I look at the numbers from your business plan, to the minister through the chair, we see that we are currently at about 51 per cent on hip replacements, 39 per cent on knee replacements, both lower than where we were in 2017-18, '18-19, though I will acknowledge that you have grown the number of cataract surgeries. So given that's the case, it seems that folks on the ground do not agree with Dr. Cowell. The numbers certainly suggest this would be an incredible commitment.

To the minister, through you, Madam Chair: is this your commitment that Dr. Cowell has brought forward? Do you commit that you will reduce, you will end, I guess, all waiting times outside of the CIHI standards by March 2024?

Mr. Copping: That is our commitment, and that's our objective. You know, as the hon. member knows, as a government we actually made a commitment to try to get this done by this spring, the end of this year. With COVID we were unsuccessful. That impacted our ability to get the number of surgeries, to get all scheduled surgeries within recommended wait times. But we have continued to build capacity in our system, building capacity in expansion of OR rooms. You know, Budget '22 included additional capital to expand the number of OR rooms in the province.

9:20

As I mentioned earlier in my remarks, this budget continues to act on that work. We are also leveraging chartered surgical facilities. We've had a number of announcements both, you know, over the past year, and we continue to drive forward to expand capacity for cataract surgeries, orthopaedic surgeries.

There's also an RFP out in both the south zone and the central zone for additional surgeries. We are expanding capacity, and we're providing funding for that expanding capacity. So it's not only the capital side, you know, within our hospitals and rural ORs; it's on the expense side, both to be able to staff the ORs in our public system as well as pay for the contracted services from our chartered surgical facilities. We are committed to reach that goal. It's going to take us longer than spring of this year, so we're committed to reach that goal in the spring of next year. With the additional resources I believe it is entirely realistic. We've already had some success.

I note in the 90-day plan that we actually have been able to reduce the number of patients on the wait-list in that plan. Let me just pull up the data here for a second. Yeah. You know, between November and January we reduced the people waiting outside of the response time from 39,246 to 35,595. We are going to continue to drive that.

I guess the important thing to realize is that it's – yes, absolute numbers matter, but it's also, you know, when we take a look at the total number on the wait-list, which is 68,000, the important number is actually: who's waiting outside the recommended wait times? We are focusing on those who are outside the recommended wait times,

where our energies are going to be put on the scheduled surgeries, and we're expanding capacity.

Dr. Cowell mentioned that, you know, his target working with the senior executives is to get scheduled surgeries within the recommended wait times by this time next year, and that is our target as well.

Mr. Shepherd: Thank you, Minister, through the chair. Fair enough. That is your commitment. That's the standard you are setting. We have some challenges to get there. Certainly, I recognize the capital investments that you've made, but I think we can agree, to the minister, through the chair, that the significant obstacle at the moment is not capital or space. We are currently underusing even the space that we have.

I have here printouts of a number of e-mails from the scheduler for the University of Alberta hospital that were sent out to a number of mail lists for anaesthesiologists, asking for individuals to cover open shifts, the span from September 2020 up until the end of last month. The most recent, from February 17, lists a number of dates this month alone where the ORs have multiple gaps. On March 1, two anaesthesiologists; March 27 and 28, three anaesthesiologists; March 29, short two; March 30, short four.

Speaking with local anaesthesiologists, I'm told that these e-mails go out every week, with similar numbers of shortages at the Misericordia and Grey Nuns, nearly twice as many at the Royal Alex. I have an e-mail from the Sturgeon hospital showing that as of February 10 they had 15 days out of the 31 in March where they were short on anaesthesia coverage, either in the OR, endoscopy, or on call. Surgeons at the Red Deer regional hospital are hearing that they may see several days of surgeries cancelled in the next few weeks due to a lack of anaesthesia coverage.

So they are quite clear that the obstacle we're seeing here is not currently a lack of OR space; it is a lack of anaesthesiologists. We spoke about this last year at estimates. You told me that we had approximately a ballpark figure of about 460 anaesthesiologists working in the province and that based on the level of productivity at that time, we needed to see an increase of about 5 per cent to meet the goals you've set, which were, at that time, less ambitious than the ones that Dr. Cowell recently set out and that you affirmed today.

I recognize that we also, at that time, talked about efficiency and other alternatives. I want to dig into that, so let's set that aside for now.

What I'm just asking at the moment is: can you provide an update on the approximate number of anaesthesiologists actively practising in the province?

Mr. Copping: I'm going to have to ask my team to actually provide that update. If we don't have that information on hand right now, we can probably get it to you and revisit this over the course of the day.

Mr. Shepherd: Okay.

Mr. Copping: Maybe ADM Paul Smith.

Mr. P. Smith: Thanks, Minister. Now, there are a number of things. The anaesthesiologist shortage is a global shortage, number one, so that makes it a little bit more challenging. It's not just an Alberta experience.

In response to that, a couple of things are happening. Number one, the seat expansion, the physician seat expansion at the med schools, will contemplate training more anaesthesiologists. That's probably a little bit longer term.

Mr. Shepherd: Definitely.

Mr. P. Smith: But in the meantime I know that AHS are pursuing different care models to be able to leverage the anaesthesiologists that they have right now in order to actually perform more surgeries.

Mr. Copping: We understand we got the numbers for you the last time, so we'll pull that. I'll actually get ADM Smith to pull that over the course of it.

You know, as we talked about last time as well, there are different models of care. We've changed from – instead of one anaesthesiologist per operating room, it's one anaesthesiologist for multiple operating rooms, with other health care professionals being able to provide support and monitoring. So that model, that new model of care, has been rolled out and continues to be rolled out and improved, number one.

We do recognize that there is a shortage, which is a risk. That said, when we look at the numbers of surgeries, they continue to actually increase. You know, when we also look at – we talked about last time efficiencies in the system. When leveraging chartered surgical facilities, what we're seeing is that they're getting more surgeries done in a similar period of time, because they don't need to be operating – they're focusing on one type of surgery and then getting that done. So we can actually get more surgeries done with the same people that we have.

I fully appreciate, as we talked about last year, that one of the barriers and the challenges is anaesthesiologists and people. However, by, you know, different approaches in terms of the anaesthesiology team, number one, and, number two, leveraging focused – these ORs are going to be used for this type of surgery, so we're getting more done in a period of time. So then you can actually get more surgeries done with the same level of anaesthesiologists, and we can continue to ramp up the numbers.

I appreciate it's a concern, and maybe we can talk a little more about this.

Mr. Shepherd: Sure.

Mr. Copping: But part of our health human resources piece is, quite frankly, you know, looking to not only train, which ADM Smith also mentioned, which is longer term, but attraction, right? So in terms of internationally trained graduates, attracting them to Alberta, I know that AHS is focused on not only family docs in that regard but also bringing in anaesthesiologists and other specialists to be able to provide the services that we need.

Mr. Shepherd: Madam Chair, through you to the minister, yeah, I'm aware of the recruitment efforts. I've had a chance to speak with some of the folks who work on the recruitment committee with AHS. Certainly, they have indicated there has been some level of success. I do recognize that there have been a few that have been recruited to begin work I believe at the Red Deer regional hospital. Certainly, I recognize and I commend them for that success. But also in speaking to members of that committee, they are not overly optimistic about – certainly not to the level that I'm hearing from yourself and Dr. Cowell in terms of success.

Let's talk about one of the things you were talking about there, the Anaesthesia Care Team. You said that these are in fact beginning to operate, and that is my understanding as well. We talked about that model last year. Basically, we're using specially trained respiratory therapists supervising patients in the OR under the supervision of a single anaesthesiologist. My understanding, though, is that this is currently only allowed in very specific circumstances, that being for basic surgeries with mild sedation, such as cataracts or podiatric procedures, or in hospitals, with

exception of some privately delivered cataract and podiatric surgeries in Calgary. That is not a model that's currently in use or available to CFSs. So not a practice that would be used in general, spinal, or epidural anaesthetic, that would include the kinds of surgeries that you are projecting to make a significant gain on such as hips and knees.

Indeed, even the surgeons and anaesthesiologists I've spoken with indicate that with those parameters, those teams are really only useful in about 5 to 10 per cent of current surgeries. Perhaps you can provide a bit of an update, then, on where things currently stand with increasing use of those teams. Are you in fact proposing to expand the circumstances under which those teams can be used, so beyond just the mild sedation, and are you proposing to use them in facilities other than hospitals such as chartered surgical facilities for things like knees and hips?

Mr. Copping: The ultimate decision about where this is going to be used actually lies with AHS and the medical teams, to make sure that where it's rolled out, it's going to be used and be used safely. So that's the ultimate decision. I understand that they have rolled out the model in certain locations. They're looking at: where else can they use this safely? But in terms of the details of that, I actually don't have that with me.

ADM Smith, do you have anything further to add here?

9:30

Mr. P. Smith: Yeah. Thanks, Minister. We are actually working closely with AHS and the colleges now on a couple of pieces. Right now the compensation schedules for physicians don't clearly contemplate supervisory services versus direct, so we're working actively to define the piece in there to facilitate this model. The second piece: we're also working with the regulatory colleges to make sure that the appropriate team of professionals is authorized to perform those services. So those two pieces certainly are actively being pursued now to be able to expand on.

Mr. Shepherd: Well, thank you to the minister and the deputy minister.

I note that to the best of my understanding – and please do correct me if I'm wrong – there are no other jurisdictions in Canada that are making use of respiratory care teams, respiratory therapists as part of anaesthetic care teams outside of the kinds of circumstances I've outlined. I understand that Ontario is in fact making use of them, but they are not doing so outside of mild sedation. They are not doing so on hips and knees and these sorts of things that are being contemplated.

The folks that I've spoken with – certainly surgeons, certainly anaesthesiologists I've spoken with – have expressed deep concern about the safety involved here. This is what one anaesthesiologist explained to me, that the riskiest times for an individual when they are being sedated is when they are going under and when they're coming out. Then there's the maintenance period in between, but not even then – you know, an individual does not always remain stable. Currently respiratory therapists are being used on these teams in very specific circumstances; for example, where the patient is not being completely put under and in situations then where they are covering for maybe 10 to 15 minutes while an anaesthesiologist is taking a break or while they are called out to, say, perhaps do a quick epidural in the emergency room.

Again, this is something you're contemplating. Are you committed that you will not move forward with this kind of a model if there are serious safety concerns raised by the regulatory colleges and anaesthesiologists themselves?

Mr. Copping: As I indicated beforehand, you know, we are not going to move with a model that's not safe, period, right? We're going to continue to work with the colleges, as indicated by ADM Smith, the anaesthesiologists, the SCNs at AHS to actually put out a model that's safe and that we can actually get more surgeries done. When I was speaking to CSFs and the efficiencies from CSFs, you know, the efficiency is actually to be able to do more surgeries in a period of time than you would typically see in a hospital setting, which is a separate question than whether you're going to use a team-based model. But, at the end of the day, that's a decision to be made not, quite frankly, by government but a decision to be made by AHS, the colleges with safety in mind.

Mr. Shepherd: Through you, Chair, thank you to the minister for that answer. I appreciate the candid response and just recognize, then, that, again, this is an incredibly ambitious goal that the minister has set through his administrator, and this is one of the components that would have to uphold that. So it seems this is not necessarily going to be a piece that will get us there, but fair enough.

I would also note, through you to the minister, that certainly, yes, we are seeing – there may be efficiencies realized through these chartered surgical facilities. They are also realized through publicly operated facilities such as the centre that exists outside the Royal Alex hospital, which is a nonprofit, I guess – pardon me; it's a nonprofit one that's run not as a sort of shareholder entity – and achieves the same kinds of efficiencies, because it really is about the model and not about the ownership or who was operating it. So I acknowledge that, and I would suggest that we could be looking at investments in that in the public system.

In regard, then, to the ASI and further expansion of the CSFs: do you have any sense of what, if any, impact the opening of these new facilities have had on the availability of surgeons, anaesthesiologists, and OR nurses in our public hospitals? Looking back to the Ernst & Young AHS review, on page 49 they said: "Our analysis suggests that surgical wait times can be reduced, in part, by maximizing existing capacity . . . [and] moving some procedures out of hospitals to independent providers and reducing procedures of limited clinical value." Now, I've received reports that the Alberta Surgical Group has in fact drawn OR nurses away from some of our local hospitals, and as they've taken over the WCB surgeries that were formerly done at the Leduc hospital, that has also drawn surgeons, anaesthesiologists, and nurses away from that hospital.

In the words of some of the surgeons and anaesthesiologists I've been speaking with, it doesn't seem that you're necessarily creating as much new capacity as claimed. In some respects you're simply shifting where these surgeries are being done. So what is your sense of those impacts? Are you tracking that at all, Minister?

Mr. Copping: In terms of the sense of impacts – you need to take a step back and look at it, because this is one system. This is all publicly funded, publicly administered health care. The way that it works with chartered surgical facilities is that, you know, whether the surgeon is working at, for example, the Foothills in Calgary or working at a chartered surgical facility in Calgary, they will be assigned by AHS. Similarly with the anaesthesiologist: they'll be assigned.

The advantage that a chartered surgical facility does is that because they're focusing – and I appreciate your comments that it's the model. Whether it's in a chartered surgical facility or a public hospital, it's the model that you're going to focus on one area; that's all you're going to do and do it well. When you use the resources and you have resources for the entire system and use it in that space, because of that model, that is actually more efficient.

We recognize that, you know, we need to continue to hire to be able to expand capacity, and we're doing that. It's not only hiring in terms of doctors, anaesthesiologists; it's hiring in terms of nurses. So that's partly addressing that as part of our health human resource strategy in terms of expanding the seats, capacity in all our universities for training, also attracting internationally trained nurses, internationally trained doctors. What we're seeing when we have the assignment of the doctors and anaesthesiologists to these locations, which are actually more efficient: you get more surgeries done for the same resources that we have in the system. So it's all one system.

Now, I appreciate that people move between different facilities, whether it be a chartered surgical facility or a hospital. That happens all the time. But when you take a zoom out and you look at, "I have this number of resources here now; we want to use them in the most efficient way possible," by having chartered surgical facilities focus on that and be able to churn through more surgeries, that's a more efficient use of the actual human resources that we have while at the same time we continue to hire and train for additional resources in the system overall.

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

Let's talk about that, I guess, in terms of those efficiencies and a single system. One of the other significant factors, I think, in addressing surgical wait times, addressing the quality of life for Albertans that are seeking help with their joint issues is the intake system. Now, again, the EY-AHS review spoke of examples of leading practice where clinical services like oncology, hip and knee replacements moved to a centralized intake model for better wait-list management, better triage for surgery, better movement of patients along the surgical pathway.

Recently I had a chance to speak with the Alberta Bone and Joint Health Institute: as of Q3 last fiscal year about 4,800 referrals directly to surgeons regarding hips and knees. Standards say that they should have been seen within four weeks; they're currently waiting eight to nine months. Of those individuals, according to the ABJHI, only about 20 per cent are likely to actually need surgery, so we've got 80 per cent that, if assessed quickly, could be receiving other support and treatment that would drastically improve their productivity and quality of life.

Now, I'm aware that in Dr. Cowell's report he speaks of the FAST program to connect family doctors in the central team to help them get to a specialist with the shortest wait time. I commend that; that's a good step forward. But I also understand that you have had a proposal on your desk for about a year to create more of a centralized intake model along the lines of what's been recommended by EY about three years ago, that would make use of rapid assessment clinics. Now, I recognize, again, that Dr. Cowell does make reference to adding rapid access clinics for orthopaedics under some of the ongoing actions. That would allow, just for those listening, nonphysician experts – so physiotherapists, et cetera – to assess an individual's need for surgery, get them on the right pathway, whether that's surgery, rehabilitation.

Are there actual dollars in this budget allocated to begin to implement these RACs as part of a centralized and accelerated assessment process? Can you give some clarity on what progress, if any, has been made on that front?

Mr. Copping: Thank you for the question. As you indicated, you know, a number of reports suggested that we need a better use and better scheduling system and booking system so people can have access to assessment, and then once they get through the assessment process, they can get access to surgery.

9:40

You know, I was pleased last year to participate in and actually lead an innovation forum on the orthopaedic side with stakeholders – surgeons, colleges, AHS, Alberta Health – and identified these issues exactly in terms of centralized triage, centralized booking, centralized intake. What was born out of that was the FAST model, right? And we've already started to implement that, as part of Budget 2022, to be able to do the centralized intake and centralized bookings and centralized assessment.

This budget does provide additional funding to be able to expand, you know, this concept not only in orthopaedic but other areas of surgeries. We're starting with orthopaedics first. It does include $31 million for rapid assessment.

Mr. Shepherd: For the FAST program?

Mr. Copping: Yeah, for the FAST program and for rapid assessment. We're continuing to move forward on this because we recognize that, you know, when we talk about getting surgeries done within scheduled wait times – right? – that's once it's determined that the person actually needs the surgery. That's wait time 2. What we're talking about here is wait time 1, how long it takes you to get to the assessment that you actually need a surgery or not need a surgery. And we need to work on both, quite frankly.

So, you know, part of the funding with a centralized triage, centralized assessment is to actually move that faster in terms of the intake system so we can reduce that down, because, quite frankly, the surgical journey starts when someone has a pain and they see their family doctor and they need to be assessed.

Mr. Shepherd: If I may, Minister, through the chair. I appreciate that. I know the figure $31 million. How much of that is specifically for the FAST program? How much of that is to establish a RAC? Again, to be clear, with the FAST system you still have to wait to see a specialist, and there is still a bottleneck in that respect, because the specialists are the actual surgeons who are performing the surgery, so they have multiple things on their plate. If we can move that away and make better use of that specialist time through a RAC system, where we're using specially trained physiotherapists and others, that would seem to be an even better move. So of that $31 million, how much is to just continue the FAST and how much is for investment in setting up a RAC system?

Mr. Copping: I'll get back to you on that in terms of the breakdown.

Mr. Shepherd: Thank you, Minister. I appreciate it.

Let's move on, then. Let's talk about another aspect, then, of your health care action plan. Let's talk about EMS. This would be under outcome 1 and objective 1.1, implementing the action plan to strengthen the EMS system. Let's begin by talking about paramedics. I think we all agree that emergency medical services are not possible without the front-line paramedics, who continue to provide support and deliver care. When we talked about this last year, you indicated that with the new funding you committed, there were dollars for 185 FTEs, broken down as 62 advanced care paramedics, 94 primary care paramedics, nine emergency communication officers, and 20 supervisors.

The 90-day report from Dr. John Cowell indicates that in the last year, in 2022, EMS hired 341 paramedics. Can you tell me: is that 341 full-time equivalents? Can you express that, I guess, in that figure, and is it possible to get a breakdown, then, of the different kinds of paramedics that are included in that?

Mr. Copping: I have a current breakdown of full-time versus part-time, but in terms of whether that 340 – I'd have to get back to you in terms of whether that's a full-time equivalent number. But the current full-time EMS staff consists of 2,095 employees, 1,960 regular full-time and 135 temporary full-time. Current part-time staffing consists of 340 employees, which is 305 regular part-time and 35 temporary part-time.

Mr. Shepherd: Sorry. Part-time, again, was how many?

Mr. Copping: Sorry. The current full-time EMS staff is 2,095 employees, and that's broken down by 1,960 regular full-time and 135 temporary full-time. The current part-time staffing consists of 340 employees, which is 305 regular part-time and 35 temporary part-time. These do not include the 1,184 casual employees employed by EMS. I think, indicated in the 90-day report by Dr. Cowell, AHS is currently posting positions that would convert 70 temporary part-time positions to regular full-time and 80 net new full-time positions to staff new ambulances.

Mr. Shepherd: Excellent. Through you, Chair, thank you to the minister.

In the Legislature on Monday, through you to the minister, he stated that over the last three months EMS has added 39 front-line staff, including paramedics and emergency communications officers, in rural areas. Are you able to provide a breakdown of the type of staff that have been hired for those?

Mr. Copping: That we're going to have to get back to you on, the 39 staff.

Mr. Shepherd: Certainly. I appreciate that. I'll look forward to those as usual. I guess that those will be submitted in writing, I suppose, if they become available later today. We've got time.

All right. Through you, Chair, to the minister: when you're reporting on the number of paramedics hired, are you also taking a look at those who've quit, who've left, or those who are on leave? When you are provided those numbers, are you providing net figures? According to data from a recent Parkland Institute report sick time in 2022 represented a loss of over 22,000 12-hour paramedic shifts; in fact, if you control for the number of full-time equivalent positions, sick leave for paramedics in 2022 increased by 33 per cent.

Ms Armstrong-Homeniuk: Point of order.

The Chair: We have a point of order that's been called.

Go ahead, Member.

Ms Armstrong-Homeniuk: I don't have my reading glasses on. I believe we're getting off the budget here, actually. It's 23:

(b) speaks to matters other than
  (i) the question under discussion,
  (ii) a motion or amendment the Member intends to move,
or
  (iii) a point of order or question of privilege.

We're getting off budget.

The Chair: Okay. Go ahead.

Mr. Shepherd: I can speak to that, Madam Chair. As I indicated, I am speaking to outcome 1, an accessible and effective health care system, and objective 1.1, implementing the health care action plan to strengthen the emergency medical services system. That health care action plan specifically speaks of numbers of individuals that are working within the system and how many people are being hired, how many people are being sought. The questions I am asking are directly in line with that. I'm asking about those numbers, how they are in fact figured and if, in fact, they are net figures, noting the information from the Parkland Institute report about the increasing number of paramedics that are taking sick time.

The Chair: Okay.

Ms Armstrong-Homeniuk: Madam Chair, what line item would that be? I'd just like to be able to find it here.

Mr. Shepherd: Again, to the member: it is budget and business plan. This is from the business plan, outcome 1, objective 1.1. I would appreciate if we stopped wasting time.

Your ruling, Madam Chair?

The Chair: Thank you. Thank you, both members. I don't find this to be a point of order at this time.

Member, please proceed.

Mr. Shepherd: Thank you. The question, then, to the minister.

Mr. Copping: We'll have to get specific. As the hon. member knows, there's always turnover in terms of – so we do a significant amount of hiring. Many of the figures that we're using are net new, but I'd have to actually look at, you know, the exact figure that we're actually talking about to be able to get into the detail in terms of whether that's net new. We are investing as part of this budget to expand, so that is net new positions for EMS and for all of health care services.

I appreciate your comments in regard to the Parkland report. As the hon. member knows – and I commented on this yesterday – the sense that I get when I'm reading that report: it looks like it was actually done a couple of years ago. Now, it just came out, because I recognize also when you're . . .

Mr. Shepherd: That's on record, 2022.

Mr. Copping: Oh. So it was from 2022?

Mr. Shepherd: Yes, Minister.

Mr. Copping: Okay. Actually, as I read through the report, it appeared that a lot of the interviews and some of the data tables were back to 2021 and then previously.

But I appreciate there is, you know, turnover. That's one of the reasons why we gave AEPAC the mandate not only to look at the issues in regard to process and flow but also issues in regard to staffing. That's why we had postsecondary institutions there, and that's why we had representatives from EMS employees, including the HSAA, participate in that, because we do know that there's turnover, people leaving, and absenteeism. So we need to address those issues.

9:50

I was pleased that, as the hon. member knows, the AEPAC report was submitted last fall, accepted. All the recommendations were accepted along with the PWC report looking at dispatching. All those recommendations were accepted in principle. And some of the issues, like especially in regard to core flex scheduling, as part of Budget '22 were invested in to be able to address that, because that model was no longer working, so moving to a more certain model, particularly in rural areas. In addition, we have additional funding in this budget to continue that work, to be able to expand that.

Like, in terms of the specific issues we'd have to actually talk about what number you're talking about so I can actually double-check, but I can, you know, assure you and assure Albertans that there are net new positions being budgeted for and net new positions being hired for. Now, obviously, you're doing way more hiring than just those net new positions because there always is turnover associated with that, but we have expanded our workforce over the last year, and we have plans to expand our workforce next year, which are net new positions.

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

Continuing, I guess, along a similar line of questioning and referencing budget line 15.7, emergency medical services vehicles capital program, as well as the objective I had noted, I saw a recent article from *Alberta Views* which quoted a dispatcher who recalled a shift last summer where they had 94 trucks down. That's 20 per cent of their workforce. It was

> an Edmonton paramedic [who] has been tracking ambulance staffing numbers. For the first 10 months of 2022, he says, 20-30 per cent of [our] city's ambulances regularly were off the road because they were unstaffed.

And recently we've had two Calgary paramedics, in that article from *Alberta Views*, who spoke of being

> told to park their old ambulance at a station and take out a new one. "So on paper, we can say every day the new ambulances were staffed, but they're actively dropping the truck that I was scheduled on off the board."

I appreciate, Minister, that you are dedicating additional funds to new ambulances, but are we really making progress here, or to some extent are we just sort of seeing some juggling of statistics? That certainly seems to be the case with what these two Calgary paramedics have testified in terms of addressing these pressures. Again, I appreciate the investment in line 15.7, but to be clear: are new ambulances really going to be of much use if we are still short the paramedics to operate them?

Mr. Copping: I appreciate that there are some circumstances where we're short of staff, right? That happens, and you can't fill the shift. But are we making progress? The answer is absolutely yes. You know, when we take a step back and what are the broad measures that we – and it's not saying that, like, this didn't happen to an individual that you actually spoke to; that's saying: look, we couldn't fill that shift, and we didn't have as many ambulances out as the plan called for.

But when you actually look at the – and even in the 90-day report, you know, making progress. Metro and rural areas: from 21.8 minutes down to 17 minutes in terms of EMS wait times. Communities over 3,000: 21.5 minutes from November down to 19.2 minutes in January 2023. Similarly, you look at the times in rural under 3,000 and remote communities: you see all the times going down, the response times. At the end of the day, that is the ultimate measure of: can we actually get our response times down and improve the service we're providing to Albertans?

This is part of our human resource health action plan. We appreciate that we need to hire and train more paramedics, and we also need to address the issues with paramedics on the job. So, again, very pleased that we are investing in our new seats in universities for training paramedics, pleased with the work in terms of – I had talked already in terms of changing the model – the core flex model so that we can actually continue to attract and retain paramedics in rural areas, creating more full-time jobs so there's more certainty for paramedics in terms of what their scheduling is, and then, you know, other suggestions in terms of: how do we support the mental health of paramedics and providing supports for them there? Not only AHS is moving forward on that basis, but we've also had other recommendations through AEPAC. So we need to do all of these things.

But when you take a look at the high level – right? – are we having success in driving the times down? The answer is yes. And even if we take a look at the number of red alerts – and this was noted in the 90-day report – the absolute number and, more importantly, the times associated with those numbers have decreased significantly, January '23 to January '22. You know, a significant decrease. So we are making progress. Are there challenges still in the system? Absolutely. But this is part of, you know, our significant investment in EMS, that you can see in the budget line item an increase of more than 20 per cent to be able to address not only the absolute volumes – right? – but also to address the issues to ensure that there's greater certainty for workers and address those issues associated with that.

I appreciate that we still need to buy new equipment, because we have equipment that is actually old and we need to retire, and we need additional equipment to be able to expand the capacity of our service. You know, we need both equipment and people; we are doing both. It doesn't mean that everything is fixed or solved. That's why we're investing more money as part of this budget to continue to work at that.

Mr. Shepherd: Thank you, Madam Chair, to the minister for that answer.

Let's talk about, I guess, one of the initiatives through that health care action plan that, I understand, is funded in this budget and certainly falls under, again, that objective regarding improving and strengthening the EMS system as well as reducing ER wait times. You've announced plans to add additional nursing staff to ERs, specifically to take transfer patients from EMS, AHS stating that the plan is to hire 114 full-time equivalent nurses. I believe the Premier indicated yesterday that hiring is currently under way. I also understand, Minister, that there are currently about 3,400 vacant nursing positions across the province, a vacancy rate of approximately 10 per cent. Indeed, you know, nurses on the ground itself are saying that the staff shortage is very real. Given that's the case, can you provide us some details, I guess, on where are you hiring these off-load nurses from? Are you looking to staffing agencies? Are you looking to move nurses from other areas? And can you clarify precisely how much has been budgeted for the program?

Mr. Copping: Thanks for the question. We don't have the exact number that is budgeted for the – and we can get that to you later if it's required.

Mr. Shepherd: You don't know the value of 114 full-time equivalents?

Mr. Copping: No, no. The 114; I don't have the exact number, but we can get that. It is in the line item 2.4 under acute care for AHS, but that is – you know, I appreciate that's $3.8 billion.

Mr. Shepherd: Sure. I'd welcome that, if you can provide that.

Mr. Copping: It's in the $3.8 billion, but we can get you the 114.

Mr. Shepherd: Thank you.

Mr. Copping: Now, in terms of the 114, where that's coming from, you know, postings, my understanding: they are already gone out, and hiring is already happening. The hiring would be anyone who

wants to, actually, externally and also internally – right? – so that there'll be movement.

We know we have a shortage of nurses, right? We are continuing as – again, this is a challenge, as you are aware and we've discussed many times, that's not only facing Alberta but, quite frankly, facing other provinces and much of the western world. We are continuing to invest. I was very pleased as part of Budget 2022 – you know, my colleague in Advanced Education invested $31 million in terms of expansion of seats for nurses, LPNs, HCAs, and other allied health professionals to be able to train up additional health care workers.

We are also focused heavily on, you know, the attraction and retention of internationally trained nurses and also pleased that we have set up, as part of our budget this year, a nurse navigator to assist nurses in navigating the credential system. We're also working with the colleges to reduce the time it takes for credentialing and make that process easier. We have also added expanded seats at bridging programs so that when nurses come, for example from the Philippines, into Alberta and given the training that they had there, they're accredited as an LPN but not necessarily as a nurse. Then we can quickly upgrade them in a nine- to 12-month program at Mount Royal College, for example, or right here in Edmonton as a nurse.

10:00

We fully appreciate that there are challenges in getting the number of nurses that we need, so we have a whole different plan to work on that and be able to backfill so that we actually have individuals coming in. So if you have someone who's basically coming from, you know, the hospital bed and then coming into the emergency department as part of that 114, then we need to backfill that individual. But, also, the opportunity – some people are working part-time now, and this is a full-time role. We know that we need to take a high-level look at it plus a lower – we're actually doing both. The estimate for the cost of the 114 is $16 million.

Mr. Shepherd: Sixteen million dollars. Thank you, Minister. I appreciate it.

On that as well, then, I guess, as you say, the positions are currently open. Indications have been that the program was to begin as of March 15. Is there specific training that's required for these nurses or anything else that has to be in place before they can begin to offer this? Can you for the record just be clear that AHS will not begin to implement this policy until those nurses are in fact trained and in place?

Mr. Copping: We will not jeopardize the safety of Alberta patients, period. I just want to be crystal clear on that. Again, when we start talking about moving forward in this direction – like, I know it's been framed as a mandate. It is not a mandate. It's a goal – right? – a target to reach that. We will be hiring people – like, this is at the 16 sites. We'll be hiring people at the 16 different sites. They will take time to come on and onboard, and they'll need to – you know, whatever training they require, we'll make sure that they will have that.

Again, this is something we need to do in terms of reducing the amount of time that ambulances are sitting there. We've heard loud and clear, quite frankly, from paramedics.

Mr. Shepherd: No question.

Mr. Copping: I'm very pleased with the work that Parliamentary Secretary Sigurdson has done. You know, he went out, spoke to paramedics across the entire province. We did a survey, received hundreds of responses in that survey. Paramedics do not want to be sitting in the hospitals. That's not what their job is for.

Mr. Shepherd: I don't disagree with that, Minister.

Mr. Copping: We need them to get in and get out. But also that provides more services to Albertans, so we need to do this.

I just want to make crystal clear that this will be done in a way that protects the safety of Alberta patients. My understanding is that there was – you know, given that that issue was raised via an e-mail and that it was raised by yourselves – clarification that was sent out on this. Whether that particular e-mail that was sent out earlier, that your party used in the press conference, was a misunderstanding or – we still don't know where it actually came from, and we're looking for where it came from. The reality is that what was said in that e-mail was absolutely incorrect – right? – but we still need to drive this initiative forward in a safe manner, which is what we're doing.

Mr. Shepherd: I absolutely agree, Madam Chair, through you to the minister. This obviously is an issue that needs to be dealt with. Multiple governments have attempted to deal with this, and some programs not dissimilar to this one, I understand, speaking with paramedics, have been tried. That said, I recognize the need to make this change, and I appreciate the additional detail and clarifications that have been provided.

Now, in regard to this, I guess, AHS has also stated that they're in the process of hiring about 127 full-time equivalent allied health staff, pharmacy and geriatric resources to support patients in getting through emergency departments and back home safely as quickly as possible. I was wondering if you could just clarify: how much has been budgeted towards that program? I assume that is in one of the lines here for AHS. When do you anticipate those staff would be in place, and does that include the 48 that are referenced in Dr. Cowell's report that he refers to hiring between November and January?

Mr. Copping: Yeah. Many of those dollars will actually be in acute care, item 2.4, but again we're going to have to get back to you in terms of the actual dollar amount.

With the permission of the chair, I have the information on the number of anaesthesiologists that we have currently working.

Mr. Shepherd: Please. By all means.

Mr. Copping: I can provide that right now. We have AHS permanent anaesthesiologists, 412; AHS locum anaesthesiologists, 42; for a total of 454 anaesthesiologists across the province.

Mr. Shepherd: Thank you, Minister.

Yeah, I'm happy to follow up, then, I guess, on those numbers regarding the allied health staff.

At this point I'd like to cede the time to my colleague MLA Sigurdson.

Ms Sigurdson: Thank you very much, and thank you, Madam Chair, for the opportunity to speak in Health estimates. Thank you to the minister and his public servants for, you know, putting their minds and focus on this today.

I'd like to refer to the estimates, lines 11, 11.1, 11.2, 11.3 – that is all about continuing care, of course – page 111. I understand that the facility-based continuing care review, that was completed a few years ago, is the guide to transform continuing care by the UCP government, and we see in line 11.2 a significant increase in funding. As the review clearly indicates, staffing is one of the very

most important issues that needs transformation. On page 80 of the fiscal plan you indicate that this increased funding is in part meant to enhance workforce capacity.

You know, I've heard and I'm sure many members of the Legislature have heard from Albertans all across this province about their concerns for their loved ones in continuing care, and staffing is indeed a top issue, Madam Chair. I've heard that staff are not allotted enough time to complete their duties and thus rush through them. In other situations staff are not able to keep up with the demands placed on them. This is due to unrealistic expectations of employers, increased responsibilities due to the pandemic, high rates of staff absenteeism, and, I'm sure, many others.

I've heard reports of seniors being fed too quickly, the food shovelled into their mouths and that they are not able to eat it and that it falls out. It's then scooped up from where it's fallen and shovelled back into their mouths. Residents had little interaction during the pandemic, especially with the public health restrictions, Madam Chair, when they had no contact with loved ones. This caused regressive behaviours in many residents. An example of this is the loss of mobility as they were not supported to walk. I've heard specific examples of this from constituents and people all across this province. Significant hygiene concerns were reported to me. Residents were left for long periods in their own waste, not being toileted on a regular basis, and not being supported to regularly shower.

Today, as I said when we did the introductions, is International Women's Day, an appropriate day to discuss that this work is gendered work. Many immigrant women are employed in the sector. Vulnerable immigrant, racialized women are doing this low-wage work. Despite some acknowledgement for being health care heroes during the pandemic, ongoing concrete supports for these staff are minimal. In fact, research shows that during the pandemic the single-site work policy had severe negative financial consequences for staff. They also experienced physical and mental health challenges and suffered from improper management and co-ordination, Madam Chair.

Another issue in continuing care facilities and certainly one of the key reasons COVID was spread from facility to facility is that most staff work at more than one location. An extremely high percentage of staff are part-time. I know, Madam Chair, that the minister didn't have this information when the budget was created, but the recent Auditor General report, that just came out, indicates that 85 per cent of the staff are part-time. Staff are not given full-time work, so they must cobble together several jobs to make ends meet. This keeps costs low for operators of continuing care but seriously compromises the care provided to residents. Continuity of care is needed, especially with the senior population.

I guess I wanted to have all of this on the record, Madam Chair, so that the minister could speak to these concerns, that I'm sure he's heard directly, and certainly I have. Just would he please elaborate on the workforce strategy that will address these issues, with a very significant increase? I'm just wondering what, through you, Madam Chair, the minister is planning.

Mr. Copping: Great. Well, thank you so much for the question. I'm actually very excited about this budget and the continued investment in the continuing care transformation that's in this budget. As you know, the facility-based continuing care review was done a number of years ago, and we started our transformation last year as part of Budget 2022, expanding the capacity within our continuing care system, so congregate-based care.

10:10

Also, you know, I was very pleased and thankful for the work done by our team in terms of new legislation, to basically take all the disparate pieces of legislation that govern this space and put in the new Continuing Care Act, that would be able to govern that, and we're in the process right now of getting the regulations.

As part of Budget 2022 we added more home-based care because we heard loud and clear that, quite frankly, Albertans want to be looked after in their home as long as possible, so we started that as part of Budget 2022 with a million more hours. We also heard loud and clear that people wanted to be close to home when they have to come into congregate care, you know, associated with that. Then, also, particularly from First Nations and Indigenous peoples, having access to culturally appropriate care was incredibly important. Again, as part of Budget '22, $200 million was focused on increasing the capital spend to the number of spaces, which includes that an RFP was done and a number of awards for Indigenous homes.

I'm very pleased that we are continuing in this regard on part of Budget 2023: a billion dollars over the next three years – and that's an additional billion dollars – to continue the transformation. I just want to talk a little bit about what that means and then also comment on staffing. As you know – and this is highlighted in the facility-based continuing care review – staffing is a challenge. There's high turnover, and this is not only in a congregate care setting but also in a home care based setting, and this is exacerbated right now, where there is a general shortage of staffing.

You know, this investment – I'll start off first, and then I'll maybe ask ADM Schalm to comment with some more details, but this advice is on a number of fronts – first of all, is more funding to home care. We need to continue to increase the hours of home care and change the percentage from the number of people in congregate care into home care, so this actually continues on our journey, that we had an additional million hours in 2022 and will continue to be able to expand that in 2023 and going forward. It also recognizes that we need to address the quality of care. You've mentioned, in terms of the care that's provided, both whether being in a home-care or continuing care setting, that it's sometimes rushed. We heard this loud and clear in the FBCC report, that in some cases it's the bare minimum.

So we know we need to improve the quality of care and the way that it's – you know, that came out in the report, the average hours of care. Now, as you know, that is a strange number. We need the level of care for each individual based on an individual assessment. But I can tell you that we are devoting, as part of this $1 billion transformation, over $300 million associated with improving the amount of care that people in home care and people in continuing care actually receive so that there is more time to provide the services that they need.

But we also recognize that you need the staff to do this, right? So how do we reduce the turnover? In terms of enhancing workforce capacity, you know, we are investing in '23-24 over $84 million, and then over the three years that's increasing by more than $100 million, so it's on top of that, so close to $200 million over three years to be able to enhance workforce supply. That's a combination of things. For example, as you may be aware, on the $2-an-hour top-up that was provided as part of COVID – and we have continued even though we're in the endemic phase – we're going to continue that as part of the continuing care plan.

We also know that we need to look at the compensation levels and the benefits associated with individuals to reduce the high levels of turnover. Part of that funding is actually going to go towards that and working with the industry in terms of, you know: where is the best way to allocate that in terms of wages versus

benefits and providing them – again, it's focused on the employee – some flexibility and be able to do that in a way that is smart and actually reaches the outcomes, which is reducing the level of turnover associated with staff?

The other key point of this is also looking at – I'll use an example in terms of the home care – innovative approaches. You know, one of the challenges you have with staffing is when you are, for example, providing care in the morning and care in the evenings and then that results in split shifts and only needing people for those periods of time. Well, how can we use different approaches – right? – to be able to enable full-time employment and different contracting mechanisms with home-care providers to be able to have full-time employment of individuals so they can provide the care, and how do you organize that care in a way that actually addresses the people's needs? There's additional funding associated with that.

Lastly, you know – and I haven't hit all the high points; I'm just recognizing that in time we may have to get back into this – we also need to improve quality, so there is funding associated with improving quality and measurements, because you manage what you measure. We need to actually – like, the facility-based continuing care review was at one point in time saying: these are the issues associated with it; these are the challenges that we're having, but we also need to be able to track our progress. There's further investment associated with that in terms of improving the quality.

Then I guess the last comment that I'll make is that we still know – despite further investment in home care and people wanting to be in their homes more in a congregate care setting, we also know, given just the sheer numbers that are coming at us over the next 10 years of people who will be eligible for it, that we need to continue to increase our capacity within the congregate care setting, so it also includes additional capital for increasing capacity and different approaches, so small-home approaches. It also includes larger settings like renovating Bethany. Again, I see we're out of time, and I'm happy to talk about this with you more later.

The Chair: Thank you so much, Minister.

Now our time will go over to our independent member. Please proceed.

Mr. Barnes: Okay. Thank you, Madam Chair, and thank you to the minister, first of all, and your entire staff for all the work you do for Cypress-Medicine Hat and Albertans. Greatly appreciated. Minister Copping, is it okay to go back and forth?

Mr. Copping: Please do so.

Mr. Barnes: Okay. Thank you. I appreciate that. My first question. Of course, Alberta Health Services and Alberta Health this year: you're $26.7 billion in the estimates, 40 per cent of what the taxpayer of Alberta spends. It's a big, big number. I want to kind of start with the value we're getting for that, and I want to start with the performance indicators that you have in your business plan on page 64. It's not promising.

I look at hip replacements. The national benchmark is 182 days. In 2017-18 the department, Alberta Health, met 70 and a half per cent of that; last year, 51 per cent. Knee replacement: from 64 per cent down to 39 per cent. Cataract surgery, a slight improvement: 2017 to 2018 was 53 per cent; last year, 2021 to 2022, rather, 64.7. That's still a percentage that's not meeting the national average of 182 days or 112 days in the cataract surgery. I'm concerned that, you know, for billions and billions of dollars we're not meeting the national benchmark average, which sounds excessive already, for a couple of reasons, Minister Copping.

I don't know what it's like in the rest of Alberta, but the fact that Cypress-Medicine Hat is right on the American border – the number of constituents in Cypress-Medicine Hat that go south for those three procedures is tremendous. There's a lot. I hear it anecdotally. I hear it when they come back. I hear it when they call. I wonder if your department has any numbers on how many Albertans just abandon our system and pay for it themselves or pay for themselves to go south, whether that's America or Mexico.

Again, I'm wondering. You know, we're beneath the national average on these. Our numbers are slipping over the last four or five years. I wonder your thoughts on that, and I'm wondering, maybe more importantly: do we have such benchmarks for cancer and heart and stroke and for real life-threatening things?

Thank you.

10:20

Mr. Copping: Well, thank you for the question. As you are no doubt aware, you know, this is a significant issue. It's something that we focused – it was something that was a challenge, the wait times, even before our government took office. We've made significant strides in building capacity within our system, but the capacity that we're building was impacted by COVID. Many of the numbers that you actually see in '19-20, '20-21 – I fully appreciate there has been a slide in '21-22, that you've seen there's been a decrease in the number of surgeries that were done within the recommended wait times. The numbers went down. It is because of COVID.

However, the situation is improving. I give cataract surgeries, which shows you just '21-22. That was where we started. Like, when we talk about the Alberta surgical initiative – and you actually ranked all of the procedures that had the most number of people on wait-lists, right? Cataract surgeries used to be the number one category, with the most number of people on the wait-list. So over the course of the last two years we have leveraged chartered surgical facilities and reached agreements – the use of RFP, particularly in Calgary and Edmonton. Those are actually – we have RFPs out right now in the south zone which includes cataract surgeries, and we've been able to get those wait times down.

The wait times: you know, if we look over the span of two years, two years ago until last year, the median wait times went down from 19 weeks to 10 weeks, and it's continuing to improve, and you can see that reflected in the numbers. We are on the right path to be able to get those wait times down and hit our objective, which is to get all procedures within the recommended wait times by the end of this fiscal year. Part of what we're doing is that we're investing in expanding capacity across the province not only in our operating rooms, in our public hospitals but, as I indicated before, chartered surgical facilities. So we are making progress in that regard.

In regard to the question of people leaving the province and people going out of country, I have heard that anecdotally. That is, quite frankly, our system not living up to the commitment to get it done within a reasonable wait time. As you know, this is not a new problem. It was exacerbated by the pandemic, but it has been a problem for Alberta for some time, and the reality is that it's not only here in Alberta; it's across the entire country. In terms of the exact numbers we do have some assessments of Albertans receiving services outside of Alberta. The total number, and I'll have to just confirm whether or not this is the – because this is all emergency, not just scheduled surgeries. Is that correct? Yeah.

I don't have the – like, we do know that Albertans who received services outside of Alberta within Canada in '21-22 was 126,000. However, that's both emergency and scheduled surgeries. Also, it includes where there's out-of-country assessments, because for some Albertans if we don't cover – like, if there's a specialty

service that is medically necessary but we don't have that service because it's highly specialized and we don't have the service in Alberta, we will pay for people to receive that service out of country. So that number is not a breakdown of the actual number of people who are going outside the country to receive that, but that's a total number.

We do have some data, like specific to hip replacement surgery and knee replacement surgeries in '21-22, that 94 Albertans, 25 for hip replacement surgeries and 25 for knee replacement surgeries that were claimed outside the reciprocal agreement, which can be attributed to service being received – they'd gone to a private clinic, to the question you asked. So we do have some numbers associated with that, but the reality is that our focus needs to be, which we are, expanding capacity within our system to get it within recommended wait times. We are committed to doing that.

This budget, Budget 2023, includes the funding not only from a capital standpoint within our own hospitals, in particular rural hospitals, but also funding in terms of the actual dollars to actually get the surgeries done and get caught up. This is one of the key areas of focus for our official administrator, Dr. Cowell, to get that. You know, as I spoke to earlier with colleagues, we are having success. The surgery wait-list has dropped down between November of '22 and January '23 from 39,246 to 35,595. So we are making a difference, and we're going to continue to drive to get that number down.

I fully appreciate, you know, your constituents talking to you and saying that the wait-list is too long. It is, right? The wait is too long. But with that, with our focus on expanding capacity, we talked earlier – especially when we talk about that the second-highest list was orthopaedic surgeries, which is now the highest because we've actually brought cataract surgeries down. That's the next highest. That's why our area focused on that. They've got the most number of people waiting for hips and knees and replacements. That's why we have chartered surgical facilities, expanding our capacity, and then we're also using centralized triage, centralized booking to be able to speed that process up. We are focused on this, and we will get there.

Mr. Barnes: Okay. Thank you for that answer, and thank you for your work.

This budget shows a significant increase to physician compensation. It's an increase of over a half a billion dollars, $6.2 billion. Minister Copping, that's 9 per cent of our total budget. It's nearly $1 out of every $10 that the taxpayer of Alberta spends goes to a doctor.

We're in crisis. We have a chronic shortage. The south zone is 30 family doctors short. My goodness, I went out for supper with some friends from Edmonton last night. Their family doctor just retired, and all of the friends that they talk to can't get family doctors. We have 11,400 physicians sharing $6.2 billion. I think back to my constituency office, where the number of young Albertans that have come to my office with great resumés and perfect scores can't get into medical school. At the same time we're short of doctors. You know, it's so frustrating. I've talked to – I know that the nurse practitioner situation has expanded, and there has been some work on that, but I also talk to a lot of great nurse practitioners that can't get a billing code or get into the system. At the same time 60,000 Medicine Hatters may be short 30 family doctors. I look at the increase in 2022 over '21, just 300 doctors. Of course, with the population growing, that appears to be nowhere near enough. I presume physicians are like large parts of the rest of the population, where we're looking at a lot of retirements in the next little while.

It's a big budget, and we're in crisis. What can we do to make sure we get more physicians and nurse practitioners?

Mr. Copping: Thanks for the question. I'll come to that in a second. In your preamble you talked about, you know, additional money: what's the value we're getting for that money? I just want to spend a little bit of time on that, and then I'll talk about the specifics in regard to our health human resource strategy and the investment that we're making in our physician compensation.

We as a government are focused on, you know, expanding the capacity of our health care system to be able to serve the needs of Albertans while at the same time doing this in a way that manages costs. One of the things that we're focused on is primary care. It's part of the MAPS initiative: how do we improve access to primary care? One thing that we've seen as part of COVID is that when people didn't go see their family doctors because of the COVID restrictions – instead, they didn't see their family doctors, they got sicker, and then what we saw in our acute-care system was more people showing up with higher levels of acuity, right? So our objective is to look at – and this is what's driving part of our MAPS initiative. How do we focus more on primary care to keep people out of the hospitals, where they're the sickest and the most expensive? Prevention. When we start talking about our investment in health care, it's not only to build capacity, but our investment in health care, as part of the additional billion dollars, is to focus on ways that we can actually reduce the overall cost per person, because we're doing it smarter, right? It's not about less health care; it's about better health care, and it's about improving both health outcomes while managing costs in the same way.

10:30

I'll just give you, like, another example of this. You know, we talk about EMS service, a very small example, in terms of reducing the wait times in the hospitals and moving those resources around. Not only does that provide better service, because we have more ambulances out there reducing the response times, but it's also a more efficient use of resources, right? Overall, our cost per use actually, all else being equal, will go down.

Our investment here is not only about expanding health care, but it's about managing costs. You can actually see that in the performance metrics on the business plan, 2(a). We have brought our costs on per capita spending in line with other provinces, and we're continuing to focus on that. But I just want to be crystal clear. When we're focusing on that, we're focusing on that in the context of better health care outcomes, right? We can do both, but it's how we deliver the service. So I just wanted to spend a little time on that.

Okay. Let's talk about physician compensation and health human resources. On the physician compensation, you know, that is part of an agreement that we reached with the Alberta Medical Association, because we know, like, there's competition in the world for doctors, including family doctors, which make up 50 per cent of all the doctors that we have here in Alberta, and we know we need to be competitive, right? This funding is ensuring that we have some of the highest paid doctors so we can attract doctors here.

But we also know, as part of this agreement – and then it goes back to: how do we actually be more efficient? Looking at different models of pay, for example, one thing that came out of MAPS – and we knew this beforehand because it was also put into the AMA deal which we negotiated last year – was different compensation models for team-based care. It's not just a doctor on fee-for-service seeing you, but it could be a doctor, nurse practitioner, assistant physician paid for a panel. This is a different approach. You're paid by your panel as opposed to pay on an individual basis to do that, which can provide better care and actually manage costs, and by providing better care, we keep you out of the emergency department. Part of the funding there, you know, in the AMA deal

– and part of the deal is to be able to expand the use of these types of approaches.

Again I recognize that, you know – and you were quite right when we were talking about physicians being the largest part or one of the largest parts of our budget. We are expanding the dollars not only to continue to attract and retain doctors, but also part of that agreement is actually looking at different methods of paying that so we actually get more value as a taxpayer. I also note that part of that agreement also has gain sharing in that. We can share the gains with doctors as we actually improve the system.

But I appreciate that, you know, at the end of the day, even though we have a competitive system and compensation mechanism within the market, we still have a doctor shortage, right? As you indicated, we have more than, I think, 250 doctors, Q4 last year versus Q4 of the previous calendar year. We're continuing to expand the number of doctors, but it's still not enough.

We know we need more, so part of our health human resource plan, short term, is different models for team-based care. You can use nurse practitioners, assistant physicians and doctors, and pharmacists – right? – to provide all the primary care, so different models. Part of the AMA idea is driving that team-based care, and that's short term. It is leveraging international medical grads, again streamlining the process. We're working with the CPSA to be able to streamline the process so we recognize grads faster. AHS is actually sponsoring IMGs across the province, and we've had significant success in terms of attracting international doctors, particularly to rural areas.

But longer term we need a solution, which is: train our own. Part of Budget 2023 increases the number of seats both at the U of C and U of A. But what's particularly important, I think, for rural Albertans is that we know that, you know, if you train local, people are more likely to stay local. So part of the expansion of the seats is focused on family doctors, particularly in rural areas. It is doing – as you may know, for med schools typically it's four years: first two years in the classroom, and then the next two years you're still doing classroom work, but it's also clerkship, and then you go into residencies after that.

Very pleased that we announced, with the Minister of Advanced Education, expanding both the clerkship portion of that program and the residency portions outside of Calgary and Edmonton. Actually, we'll be starting in Lethbridge. Medicine Hat is on the list, so stay tuned because we're coming there, too. We're starting first in Grande Prairie and then expanding to, again, Fort Mac in that regard, to do the clerkships and do the residencies there so we can fix this problem. Now, I know that's a longer term solution, but if we haven't started already, when is the best time to start? It's today. Budget 2023 contemplates that.

It also contemplates that we have really talented Alberta kids, and even though we've expanded – like, all else being equal, by expanding the number of seats for U of C and U of A, you know, to get in, the marks that you need will actually drop because that's actually a matter – government is not setting that. The university is not setting that. It's just a matter of supply and demand – right? – in terms of that. That will drop.

But we're also expanding the number of residencies for IMGs. For both Canadians and for foreign-trained non-Canadians, you know, if they need to upgrade because they're not deemed equivalent or they just finished in another school and they want to come back here to do a residency, we have 40 spots right now for IMG residencies. This budget also expands that, the number, so that for . . .

The Chair: Thank you so much, Minister. I appreciate the nice, friendly dialogue.

That concludes our first portion of questions for the independent members. We'll take our break now – five minutes, please, everyone – and when we return, we'll move over to the government caucus.

Thank you.

[The committee adjourned from 10:37 a.m. to 10:43 a.m.]

The Chair: All right, everyone. Thank you so much.

We'll resume and start with our government caucus members. Please proceed.

Mr. Smith: Thank you, Madam Chair. Through you to the minister I want to say: thank you for your hard work. I can say that there have been many times when I have needed to talk with your ministry, to talk with you, and you have always been available for me and my constituents. Just the other day you met with our health care action committee out of Drayton Valley along with the central zone for AHS, and we were able to put some things on the table and get some things moving. I just want to really thank you for all of the hard work you do. I'm sure that Mr. Wynnyk understands my constituency, having been raised there, and some of the unique things that we have to face every day.

I want to get into some questions here with you today, Mr. Minister. AHS has been a hot-button topic, obviously, in the province for many years, and I'm sure that we've all talked about our health care authority at the doorsteps with our constituents over the last weeks or months. On page 79 of the fiscal plan it mentions the $608 million increase for AHS's operating budget in the next fiscal year. Now, we've heard about how AHS needs to modernize and to continue to be more efficient. Minister, could you provide some background on the need for such a substantial increase and how it's going to help us continue to be more efficient at AHS?

Mr. Copping: Well, thanks so much for the question. You know, you're quite right. It's a substantial increase for AHS of over $600 million in terms of their budget. Part of this, as I mentioned earlier, is part of our government's plan. We need to invest to build capacity while at the same time, you know, focus on areas where we can actually manage costs.

You know, the $600 million, recognizing that we still have an aging population and there's an increase in complexity associated with that and an increase in – we have more people coming to Alberta, so there's an increase in services. We know that's part of that, associated with it. Also, we need to do it more smartly in terms of: how do we actually spend these dollars to be able to manage the cost per individual?

When we take a look at, you know, the AHS system, an example I can give you in terms of the better health care outcomes is sort of our Alberta surgical initiative. We spoke earlier today about the FAST program in terms of centralized triage, centralized assessment, leveraging chartered surgical facilities to get those surgeries done. When we actually look at the cost, when we go to chartered surgical facilities, it's – and we've seen this not only play out in the contracts that we've done for cataracts but also in the orthopaedics – a ballpark 20 to 25 per cent cheaper per procedure.

Now, you know, that has to do with the model – right? – associated with it. When you're focused on one thing at one time, you don't need to have the OR with all the equipment for any type of surgery, which our public hospitals need to do and be ready. You're not necessarily bumping surgeries because you have an emergency which needs to be taken care of, which should be getting taken care of at that point in time. It's scheduled. You're just rolling through this time and time again.

Even some of these newer facilities that are set up – whereas instead of where they need to do the autoclaves and all the machinery for cleaning the equipment is easy access. You know, even for the surgery, when you're actually doing it, whether it be a hip or knee – you know, I've had an opportunity to tour some of them – the storage room is actually right in between the surgical suites, right?

So it's not about being public or private; it's about the model that we're setting up. It's all part of our public system, like, you know, publicly administered, publicly delivered. The funding is not only – we do need to expand capacity on the one hand, so you have additional funding associated with that. But we're doing it smartly, right? This is one example, where you have – as part of our Alberta surgical initiative we're actually managing our costs at the same time because, quite frankly, we need to do both.

You know, health care, as indicated earlier, continues to increase as a percentage of our overall government spending. We need to focus on the areas to be able to provide the services in a cost-efficient manner but make sure we measure the health outcomes. As well, more broadly speaking, as I indicated earlier, we're talking about MAPS. It's to the extent that we can actually reduce the amount of people who actually need the surgeries, then we'll actually get better health care outcomes while at the same time further reducing our costs.

Mr. Smith: Now, I don't know. Maybe it's just me becoming a little old with age here, but I'm having a hard time hearing you. Is it possible to turn up the mic a little bit?

Mr. Copping: I can get closer to the mic.

Mr. Smith: Well, you don't have to swallow the mic. Maybe we just need to turn up some volume here, or maybe I need to access some hearing aids.

I want to stay on the topic of AHS, and I'm going to be looking at key objective 2.2. We moved from an AHS board to an administrator in Dr. John Cowell last November. Can the minister explain how this change has improved our health system in delivering real results for Albertans? I can remember when you made the announcement that we were going from the board and we were bringing in Dr. Cowell. How has that improved things? Has it made it more streamlined? Decision-making – how has that improved AHS?

10:50

Mr. Copping: Yeah. Well, thanks for the question. You know, it has improved AHS. Really, the purpose of bringing in Dr. Cowell as an official administrator was really to accelerate change. Work had been done under the old strategic board – thanks to the work that they've done – but it's a strategic, part-time board focused on setting broad targets whereas the official administrator is focused on much more being hands-on involved full-time and supporting the executive lead team in making change happen faster.

We spoke earlier this morning about the 90-day report, and we can actually see the results of those types of changes accelerating initiatives. You know, we talk about EMS wait times, and I'll just mention a couple. Again, metro and urban areas: a reduction from 21.8 minutes in November to 17 minutes in January. Communities over 3,000, which is more your neck of the woods: also from 21.5 minutes to 19.2 minutes. I won't go on. Surgery wait-list, those that are waiting outside the recommended wait times: that decreased. ED wait times to see a doctor: that decreased as well.

But it's really about the actions. These are the outcomes, but it's really about the actions that we're taking. Some of the actions, especially on the EMS side, were moving towards reducing NAT vans, particularly in Calgary and in Edmonton, when people need to be transferred home, where beforehand there would be an ambulance because they either needed – you know, you're being transferred in a wheelchair or in a stretcher, but they didn't need an ambulance to actually do that because they were stable. It wasn't from a medical standpoint; it was from an operational standpoint. Using NAT vans within Calgary and Edmonton and other service providers to get people home freed up the vans that we had. I just use that as one example, and that was driven by Dr. Cowell.

Another example was in regard to – and this is on emergency departments – an announcement that we made in Edmonton, where we had individuals who are homeless coming to the emergency department and then would be staying in a bed because there was no place for them to go home to even though they had been stabilized and it wasn't medically necessary to do that. But, you know, we couldn't kick them out on the street. Then eventually when they left the emergency department, back out and homeless again, again, it's difficult to deal with either medical issues associated with that. They become acute again, and they're back into the hospital.

Another initiative that was driven is: how do we actually address these individuals and expanding capacity with the Jasper lodge, which would enable us to move them once they're stabilized in acute care, homeless people, into the Jasper lodge, which focuses on a not-for-profit, focuses on: how do we get you permanent housing, right? Then we continue wraparound services, whether that be AISH, whether that be services for jobs, whether that be continuing medical services, whether on the mental health side or on the physical side, to be able to get them to that, and they don't come back into the system. That actually does a couple of things. One is that it reduces the demand on the emergency departments, for example, and it improves the flow – right? – through the emergency department while at the same time improving the health outcomes for the individual. Actually, as an aside, it actually reduces the overall cost of the system because you don't have someone continually cycling through the emergency department.

One other example. Like, the move from the 911 to the 811, right? You know, someone calls 911. Again, depending on the location, estimated 10 to 20 per cent calling 911, but they don't actually need an ambulance; they don't need transport. Being able to shift them to 811, again, addresses the issues that they need from a health care perspective while at the same time reducing the need to send an ambulance so it can be due for more higher acuity calls.

These are examples of some of the actions that were helped driven faster by having the official administrator there. And then you actually see these types of actions showing up in the results. I think that, you know, setting up an official administrator to help drive these actions faster is showing up in the results, and we're going to continue to work to get those results down.

Mr. Smith: Thank you. I think that if you live in a rural area, probably anywhere in Alberta but in a rural area especially, we are obviously struggling with finding enough doctors, finding enough nurses, health care aides. You know, I could look at myself. My doctor has just retired, and I'm looking for a doctor in Drayton Valley, okay?

We know that these are issues. We've had lots of talk about them over the last few years. But can you provide us with any assurances that the funding that we've been talking about, that $608 million, is actually going to go towards doctors and the nurses and the health care aides and the people with the boots on the ground and not just, you know, for managers covering managers covering managers within the system? That's really important.

When my constituents come to me or come to the health care action committee or to AHS central zone, you know, they're not talking about managers that they need; they're talking about the doctors and the nurses and the health care aides. So could you give us assurance that this funding will increase and go towards those kinds of services?

Mr. Copping: Thanks so much for the question. As you know – we chatted even recently with the Drayton Valley health committee, which was fantastic – our focus is on front-line staff. We know we need to increase the number of front-line staff to provide the services, particularly in rural areas. This has been, as you know, an issue before COVID, but quite frankly after COVID it's gotten worse – right? – so part of our health human resource plan is to focus particularly on rural areas, where it's particularly challenging to get the staff, so we can provide the services that Albertans need.

You know, AHS – this is an issue that I know that they are constantly watching. When we actually look at the number of managers and senior leaders versus the number of front-line workers, it's about 3 per cent, which is actually the lowest in the country. But we need to continue to drive the resources where they're required, which is actually at the front lines. I can tell you that AHS is cognizant of this fact. They know that the shortages are actually on the front line – so nurses, doctors – and our additional funding associated with this is actually to improve the services, which is actually getting the people on the front lines to make sure that we can do that.

Also, you know, again, there's ongoing work to say: okay; do we actually have the right people in the right places – right? – from an org design standpoint? That is continually ongoing because, at the end of the day, what matters is the results and that we focus on measuring the results. Do we have people to be able to provide the service, and are we providing the service in a timely manner? We'll continue to measure that and make sure we get the resources where and when they're needed.

Mr. Smith: You're absolutely right. When the people come into my office, it's the results, right? You know, they either have a doctor or they don't have a doctor; they either have the capacity to have the service at the hospital or not have the service at the hospital. It's important for us to – we need managers. That's important, but at the same time we need the boots on the ground.

I would maybe do a little bit of a shout-out for you in that – and maybe we'll get to it a little later in some questions. I think the nurse practitioner pilot project that you've had has truly helped my constituency. We can maybe delve into that a little more, but I know that there are communities, like Thorsby and Warburg, that are having health care in their communities, sometimes for the first time in 25 or 30 years, through that program. So good on you. I hope we can talk a little bit more about that a little later.

Lastly on AHS, page 64 of the business plan under objective 2.2 states that your ministry will "assess the effectiveness of health care institutions including the HQCA and AHS to improve health care delivery and health care outcomes while managing costs." Minister, how do you plan on measuring the success in this area? Specifically, is there anything beyond the performance metric 2(a) that will measure success for this objective?

Mr. Copping: Yeah. Thanks for the question. You know, part of the work that we're doing is also work with the HQCA in terms of what needs to be measured and how we actually report that back to Albertans. We started with AHS in terms of our objectives: reducing surgical wait times, reducing EMS response times, reducing emergency department times. We are posting that within AHS, but also HQCA plays a role as a separate body to measure the outcomes of the health care initiatives that we are driving.

So part of our work assessment with HQCA is sort of: how do we ensure that they continue to play? Like, that's always been their role but to be more involved and actually have the right measures associated with measuring the performance.

11:00

At the end of the day, you know, what's critically important is that we take a holistic view of our health care system, maybe look at not only the money we're spending but the health care outcomes as well in terms of measurement and that we take a step back, because it's not just about these measures within our acute-care system but in our primary care system. Then also, from a broader standpoint, we know – and that's why I'm so excited about the continuing care initiative – that we get better health outcomes typically if we have seniors at home longer, right? But as part of that initiative we need to measure those outcomes, look at what we're doing as part of the transformation, understand what's working. The HQCA has a role with that.

The same with primary care. We also know, you know, if we look at other countries, that if we invest more in primary care – and that's part of the work that we're doing with MAPS, to focus on that – we actually keep people out of the most expensive door when they're the sickest, which actually reduces our overall costs. How do we measure the value coming out of primary care from a system standpoint? That's the work that we're doing with the HQCA in terms of getting a better handle on: what would measure success? I'm looking forward to MAPS coming forward with their recommendations and to say, "Okay; how do we measure this?" and then "What is the role of the HQCA in terms of ongoing measurement of that?"

You know, you manage what you measure. It's important that we have all the measurements in terms of how our health system is doing, and then we actually share that with Albertans so that they know how our health system is performing. But, again, this is a combination of both transformation – you know, focusing more on primary care, focusing more on the continuing care, back to the home care – and based on what we see in other countries, which results in better health care outcomes and managing our costs at the same time.

Mr. Smith: When you set health care outcomes – I mean, health care delivery is so different across the province. It's different in the urban areas versus the rural areas. Do you find that your outcomes can measure both equally validly, urban versus rural, or do you need to work on outcomes that will be specifically for rural areas versus urban areas?

Mr. Copping: We're going to have to measure all of it. We actually do measure it differently right now. A prime example: like, even on the EMS metrics the response times are different and the targets are different per location – right? – recognizing that. When we talk about health, you know, that's just one example.

Also, I'll talk a little bit about Indigenous health outcomes. When we look at our health outcomes for Indigenous peoples in the province versus the average Albertan, quite frankly, they're unacceptable. We know that. And it's not only an issue of access to care, which are challenges, you know, that we have in all rural, remote areas for some; it's also wanting to access care, culturally appropriate care.

Again, very pleased, as part of our work in MAPS, to build on the work we've already been doing in terms of: how do we address that issue? The short answer is that, yes, we do need to measure

different populations – right? – in terms of the care and the different areas and different regions as well.

Mr. Smith: Thank you.

The Chair: Thank you so much, Minister.

That concludes the government members' first block of questions.

Now we'll move back over to the Official Opposition. Are you going to continue to combine your time?

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

The Chair: All right. Please proceed. Ten minutes.

Mr. Shepherd: Thank you, Madam Chair. Minister, going back to what we were talking about earlier, about the surgical system in intake clinics, I recognize the implementation of the FAST program, certainly how that can be assistive. We also mentioned, you know, movement towards RACs, where we have folks other than the specialist who can do this. One of the reasons for that, of course, is for those in rural areas. It's still quite a challenge for them to get in to see that specialist. We have a limited number of specialists that are available in rural areas, so we do see too many from rural areas being forced to go into major centres to be able to get that assessment.

I know that at the University of Alberta they have a program that they have been working on, the virtual rapid assessment clinic. I had the chance to visit them and actually try the system out prepandemic, got in the harness and sort of walked on the treadmill and kind of got a sense of how that works. Now, this is a potential solution as part of developing RACs. That could expand that access for folks in rural communities. Now, my understanding is that that's a program that's funded by Alberta Innovates. Their funding is about to run out, so they're looking at having to lay off staff, preparing to potentially mothball that program. So I just wanted to check in again in terms of the direction that you're looking in terms of perhaps supplementing the FAST program with investment in RACs, whether you're looking at the virtual RAC process as a potential solution for rural communities.

Mr. Copping: Yeah. Thanks for the question. There is, you know, an opportunity for using virtual mechanisms to be able to provide care, particularly in rural areas. I know that there are a number of initiatives that are ongoing, especially, like, from the work that's being done in MAPS. There was an innovation forum that was held about: how do we leverage that? So I'm actually looking forward to seeing the recommendations coming out of that in that regard.

In regard to this particular program on RAC, we have asked AHS, you know, as part of their FAST program to include, like, rapid access centres, to be able to do that. So we asked to do that. Now, whether or not they're looking at this particular technology as the way to do it – again, the assessment of the technology versus the efficacy versus costs for each: that's a decision that's going to be made. I don't know whether this particular – I think I've actually had a meeting with the same group that you're talking about although I didn't have a chance to get on the treadmill.

But, then again, it's also an assessment that we actually leave to AHS, whether it's a private endeavour, because I think that's what this would be, you know, to say: "Okay. Is that the best use of resources, and is that the actual best product? Are there other products out there doing that?" But I know that rapid assessment clinics are on the list as one method to improve access to clinical care. Whether this particular item is the answer, I'll let AHS decide that because they need to do the assessment in terms of best cost and approach.

But conceptually, you know, leveraging virtual technologies so that – and I know that some of our hospitals have actually even been wired for an assessment centre. You can go into rural Alberta and be able to travel rural Alberta and individuals can actually speak with a specialist virtually, right? Then not only do they have the connectivity, like the fibre cable there, but also it's private, so you're not dealing with concerns with health information. You know, that technology is out there, and quite frankly that infrastructure is out there as well.

Mr. Shepherd: Thank you, Madam Chair and, through you, to the minister. Yeah, absolutely, I recognize the role that AHS needs to play in terms of determining appropriate procurement, that sort of thing.

One thing I would note. In my conversations, I think, with a number of folks who are involved in sort of health innovation and initiatives, there are challenges at times because AHS tends to approach all these things at large scale, so they implement for the entire province when there are perhaps opportunities for pilot projects or other smaller adaptations. I'm just noting that that's something for consideration.

Mr. Copping: Can I just comment on that?

Mr. Shepherd: Yeah.

Mr. Copping: We appreciate – and I've heard some of the same issues associated with different ideas coming out, different innovative approaches, some on the technology side. Some are not only on the technology side; they're on the process side, right? It's like: if we put in this standard or this level of care and we take a look at it with the larger lens – so it's not just about primary care versus acute care versus continuing care but with the larger lens and in terms of a health economic standpoint – it actually will, again, improve health outcomes and reduce costs.

You know, one of the things that we haven't talked about yet but I want to highlight is that we have a new funding stream as part of Budget 2023 called the health innovation funding program, right? This is additional in the '23-24 estimates, $17 million. And then, if we look at the total over the next number of years, it sort of adds up to just over $80 million associated with that. But, really, what that is about is looking at funding – and, again, this will be through an RFP process, and we will be doing assessments – innovative approaches to providing care. But it's bigger than just the technology piece. This is not just technology; this is technology process. It can include technology or pieces of that but setting the process and looking at: how do we expand this? We did an assessment last year – right? – in regard to the programs that the government of Alberta has made available, and what we found was that we actually didn't have enough focus on this area. Even though we have some through – and you mentioned this particular program . . .

Mr. Shepherd: Alberta Innovates.

11:10

Mr. Copping: Right.

. . . Alberta Innovates, they focus on the tech side, but they don't focus on the broader processes. Often the technology needs to be put into a process. We need to actually validate the process to get people onboard and then say, "Okay; this works," and then we can scale it. So I'm excited about that, and this may be an opportunity on some of the new processes with this particular vendor.

Mr. Shepherd: Through you, Madam Chair, thank you to the minister. I do appreciate you flagging that, and I will look more into that. Certainly, I appreciate that. It sounds like something I would absolutely support.

If I can get one more quick question in in the 10-minute block that we've got. I understand that as part of the ASI the Alberta Bone and Joint Health Institute has been a key partner, and they're involved in the bone and joint SCN, and they are helping to provide some of the quality monitoring. Now, they do have some questions about: with the implementation of more CSFs, are they now going to be utilized in the same way – and it's for the quality monitoring – with these chartered surgical facilities? Will you be giving them, I guess, the same access, empowering them in the same ways to provide the same quality monitoring that they do in terms of the public facility with the new CSFs?

Mr. Copping: That's a decision for AHS to make. I'm not involved in that level of decision-making. Do we actually need oversight? Absolutely. And there is oversight, certainly, from the colleges. Actually, this all started – as I mentioned earlier, we had an innovation workshop. We put everyone at the table and said: "Okay. What's the system working now? How do we make it work better?" You know, coming up with FAST, coming up with rapid access clinics: like, all of this was part of those conversations, and I know that work is actually ongoing.

I'm just going to look to anyone else to add on that piece. ADM Smith.

Mr. P. Smith: Yeah. I mean, that work is ongoing, Minister. You referred before about the patient's journey in ASI, so that's the space where I'm aware a lot of work is ongoing with respect to FAST triaging and whatnot. That also involves primary care physician leads as well, because obviously there's the footprint of primary care, not just AHS. There are defined tables now whereby they're working together collaboratively and representing the interests, obviously, of the referrers to the actual specialists on the AHS side as well.

Mr. Shepherd: Excellent. Thank you to the minister and deputy minister.

I see we've got about a minute and a half. Let me see if I've got something that might fit well in that time frame. Here's one. Line 1.5 in the budget, the Health Advocate's office. We see a significant increase in funding there, about $1.6 million. Can you just give me some details on the reason for that increase?

Mr. Copping: Well, thanks for the question. As you may be aware, you know, last year – and the process started even prior to that – there was an assessment of our complaints process. One of the recommendations that came out of that assessment is that we need better navigation. As you are probably aware, we have a number of colleges; we have AHS as a service provider. If someone has a complaint that there's a concern, often they may need to go to multiple colleges. Sometimes they'll go to AHS, which also has a complaint process. It's a fractured system, difficult for patients to navigate. So, really, what this additional funding is is adding additional staff. The role of the Health Advocate will expand to include navigation of the complaint system.

Really, you know, what's important about this is that it will not only provide easier access for complaints, but the whole reason we have a complaint system is so we can identify what the trends are, understand the underlying causes associated with this so that we can deal with it from a policy standpoint. So that's what it's for, additional staff.

The Chair: Thank you so much, Minister.

We'll turn it back over to the government caucus and begin with MLA Pitt.

Mrs. Pitt: Wonderful. Thank you, Madam Chair. Thank you, Minister, for your time and, I think, for a great budget that's been very positive in many directions. I think you've been doing an excellent job – excuse my bias – in your role as the Minister of Health for the people of this province. I know that many people are saying these same things in our health care system and those that interact with it, so thank you for the work you do and the service that you've been giving us.

My questions today are around the capital plan around the north Calgary-Airdrie regional health care facility and the $3 million that has been allocated to planning over the next three years. I have a number of interested parties from the great city of Airdrie that are joining us online as we eagerly await more details around this much-anticipated project. Firstly, I guess I will say thank you for the $8 million in renovation that will soon start at the urgent care facility. It's an excellent Band-Aid solution to the problems that we face in what is often the fastest growing city in all of Canada and will always face growth pressures, certainly, as Calgary starts inching in on the borders of the city of Airdrie as well.

My questions are – and I seek to share this information with my constituents. Firstly, what are the expected outcomes of the planning for this facility?

Mr. Copping: Well, first of all, thank you for the questions. You know, I'm very pleased to work with you and your colleague MLA Guthrie and Mayor Brown in terms of very positive conversations about: how do we ensure that we provide health care services for the people of Airdrie and, quite frankly, for the people in the entire north zone of Calgary, like, the north area of the Calgary zone? Very pleased as you and I actually have toured the urgent care clinic and the need that we need for renovation. I'm glad that we've been able to drive that forward.

But we also know that that particular building is a constrained site, right? Part of the conversation that we've had with the mayor is: okay; what's the next step? And we need to start planning for it now because we recognize that an urgent care centre is just one type of service. What other services are needed? Quite frankly, how do we actually create, like, a health campus? Part of the work here is – you know, the initial planning was done a number of years ago. It's outdated, right? Like any capital project, we need to update our needs assessment. You indicated that Airdrie is growing. North Calgary is growing as well. So what are the needs for that area?

Then specifically not only on the acute-care front but also across the entire spectrum of health care services – community-based care, home-based care, for example – what's the best way to deliver it? And then you get the question: okay; then what is the infrastructure that we need to actually support that delivery? We put funding in the budget to actually do that work. It is going to take some time. These are not done in months. It's often, you know, more than a year to actually get that done. But what that does is that it sets us up for a long-term plan, which enables not only us as a provincial government to plan but also municipalities – right? – to be able to plan in terms of: okay; this is what's going on.

And having a health hub to provide multiple services: I know that many municipalities and conversations we've had – and hats off to Mayor Brown for thinking a vision out that way as well, particularly for Airdrie. But that's what we need to do. So this is a step in that direction.

You know, the current funding for renovations in the urgent care centre is a stopgap, but we need to spend – while we actually get

that done and allow some expansion, we need to think longer and harder about: what do we need for the citizens of Airdrie and the citizens of north Calgary? We need to do that jointly, together. So I'm pleased that we put this funding in the budget and we can actually do that planning and do that with not only input from service providers but also input from municipalities.

Mrs. Pitt: I can't tell you how exciting it is to see the word "Airdrie" and the word "health" in a line item in a provincial budget. It's been a very long time, so we're pleased to see that. I would be remiss if I didn't mention the work of the members of the Airdrie Health Foundation, whom you've met with and spoke to many times, and we're grateful for that opportunity to hear their stories and the work that they've done in the community. They're just amazing, and they're very well supported by members of our community as we're all eager in the health care needs of our communities. So thank you for the time that you have given to us. It's been very meaningful.

You mentioned and we've talked about the $8 million that is going to the renovations, which is the stopgap, and we're planning for the longer term. Are there any sort of medium-term solutions? Even if this budget were to say, "We're going to give you millions of dollars to build a hospital right now; we're going to break ground tomorrow," you know, this is maybe still seven, 10 years down the road before this facility is up and running. By then Airdrie's population will likely have doubled because those tend to be our growth rates, and of course north Calgary isn't going to stop growing, those types of things. Is there any medium-term planning, or is that something that's going to come from this $3 million plan?

11:20

Mr. Copping: Yeah. I anticipate this coming from the $3 million plan in terms of: what are the overall needs? You're quite right. Like, large health infrastructure projects take a considerable amount of time. You know, even the planning: like, once you even do the needs assessment – yes, we need something – then what exactly do we need? Then there's a business case; then there's functional planning. So that's longer term.

But a part of this plan is saying: okay; what do we need on an interim basis? Like, the acute care may not be part of the answer but not all of the answer, right? This is why the concept of a health community, a health hub, where it's not just acute care – but it would be a combination of things in terms of, you know, community-based care. It can be a combination of having private operators like family physicians, which are privately delivered, all coming together into a similar place to provide different services. So that may be the answer. I'm getting ahead of myself because, quite frankly, we need to do the needs assessment first.

But when you're sort of thinking, "Could that be a medium-term solution?" even a longer term is that if we are going to go to a campus-style approach, well, then what does that look like? And plan that over a period of years. Again, this is something that we need to do: firstly, what are the health needs in the area? But then engage with municipalities because it's not just about AHS. It's about, you know, acute care, continuing care, primary care all coming together to provide the services and with a broader vision. Quite frankly, that's not just us as a provincial government; that's us working with the municipalities in terms of: how do we actually set that up? Again, I'm excited for this work to continue. It'll look at both medium term and long term, but it needs to be a joint approach.

Mrs. Pitt: Absolutely. Thank you so much. I like the word "health hub." Airdrie as a community has talked about many of these things for quite some time. We're innovative and creative, so this is certainly the community to be building a facility and a project such as this.

A few more questions I'm going to hammer off in the next minute and a half. Where is the information coming from for the planning assessment? We do feel failed as a community from the information that's coming from Alberta Health Services in terms of what we need, and in many ways we feel that AHS has gotten us to this point. Government is certainly pushing this, which we're really grateful for. There's a bit of mistrust in the Airdrie community with AHS. So where's the information coming from? How can community participate: the Airdrie Health Foundation, the local doctors, the PCN, the mental health organizations, different private operators that health interests? How can they participate in that? I'm going to let you talk for the next 40 seconds.

Mr. Copping: Well, thanks for the question. My understanding at the highest level is that, you know, AHS will do, like, an initial needs assessment. That's based on: what are they seeing right now? The population, anticipated population growth, age complexity, like, a lot of the demographic information: what are we seeing now in the area? What do we anticipate in the demographic information? My understanding is there's also opportunity as part of that process for input, and I have actually heard from some that say: where did you get this data, and how are you allocating . . . [Mr. Copping's speaking time expired]

We'll talk further.

The Chair: Thank you, Minister.

We'll return to the Official Opposition.

Mr. Shepherd: Thank you, Madam Chair and, through you, to the minister. Just speaking of, again, your health action plan and the implementation of that, under outcome 1 and objective 1.1 in the business plan, and also looking, I guess, at the budget though my question has to do with which line item I should be looking at. The appointment of Dr. John Cowell as your AHS administrator reporting directly to yourself: if Mr. Cowell is reporting directly to the minister – I just wanted to clarify. Mr. Cowell's salary of $360,000 for his six-month contract: is that included under budget for AHS, or is that included under a budget line for Alberta Health as he reports directly to the minister? In that case, then, I just wanted to clarify who would be signing off on the appropriate expenses.

Mr. Copping: The line item is actually in AHS because that's where the costs – and for frame of reference, you know, all the line items associated, like, all the costs associated with the previous strategic board were in the same place, so that isn't a change. It shows up under the administration line as paid by AHS.

Mr. Shepherd: Excellent. In that case, then, Minister, through the chair to the minister, for those expenses, are those signed off through the minister's office, or are those signed off by the CEO at AHS?

Mr. Copping: They're approved by AHS, but I actually do see them.

Mr. Shepherd: Excellent. Thank you.

I will cede some time to my colleague from Calgary-Buffalo.

Member Ceci: Thank you.

Minister, hoping to go back and forth.

Mr. Copping: Pleased to go back and forth.

Member Ceci: Okay.

Mr. Copping: Can I just – I just want to make sure that there's not a misunderstanding on the last question because I was using the word "approval." They are vetted. "Vetted" is a better word. At the end of the day, I sign them, just so we're clear.

Mr. Shepherd: Thank you, Minister.

Member Ceci: With regard to the Calgary cancer centre I've been paying attention, but I don't think I've heard it mentioned yet today, and I just wanted to ask a few questions about it. I presume that some of the costs associated with its capital or fitting out or certainly its staffing will come under this ministry. Can you just give me an update on where we are – I remember the opening of it to be in 2024; I can't remember the quarter – and just maybe an update on where it's at? I know many people are looking forward to, not only on the patient side but on the staffing side, a brand new building to address the needs of people who are going through some challenging, challenging times. So maybe I'll just turn it over to you.

Mr. Copping: The targeting: Q1 of next calendar year. In terms of opening I know that they are hopeful they might be able to get faster, but there's a significant amount of work in terms of moving all the equipment, in terms of certifying the equipment and making sure that it's operating as possible, or operating as appropriately, and then also training the staff, because they're going to be – you know, things are going to be in different places, so the staff will need to be trained and familiarized with that.

As indicated at the handover between Infrastructure and Health at the event, there's a multiphase plan to be able to sort of open up the building. The first phase is actually moving the folks from Tom Baker. The next phase is actually co-locating, because there are a number of sites that we have providing cancer services in Calgary, getting them into the cancer clinic, and then, you know, as the needs increase, increasing the staff to be able to meet those needs. Our budget does contemplate the staffing associated with the Calgary centre, but this is going to take over a period of, like, years to be able to run through all these various different phases. The first phase is actually getting the Tom Baker in and then the co-location, and then you'll actually see some growth over time.

Member Ceci: Okay. Thanks. I can't wait for that. I think many people are excited about that beautiful building, and it is a beautiful building that has been designed. Many people at the Foothills who are part of the committee to kind of understand what the needs of that, not only the building but the function, would be in the future are very pleased and excited about it coming on.

Thank you.

Ms Sigurdson: Okay. Thank you. I'd like to ask the minister about, through the chair, line item 1.4. I'm not positive that this actually falls into that line, so maybe there can be some support around that. In 2018 Bill 30, the Mental Health Services Protection Act, was passed unanimously. Of course, it's 2023 now, and it has still not been proclaimed. The legislation would regulate counselling therapy, addictions counselling, and child and youth care counselling. These professions would be included in the Health Professions Act, which I understand is within the Health ministry. The legislation is for the creation of a college of counselling therapy of Alberta.

11:30

Of course, we're currently in a mental health crisis, an addiction crisis, and many Albertans have to wait long periods of time to receive help. This regulatory body would mean thousands more Albertans could be serving those needing support. I'm just wondering: what's the delay? How come this has not been proclaimed? Can the minister, through you, Madam Chair, please elaborate?

Mr. Copping: Well, thanks so much for the question. As you know, although this is mental health, dealing with mental health, the Health Professions Act continues to fall under my ministry although when I had control with that and we had the associate minister of mental health, my former colleague had point on this particular issue. You know, the reality is that there were concerns raised in regard to the inclusion of all the various – there are three groups: people dealing with the children, on the addiction side, and counsellors as well. There were concerns raised from Indigenous communities, particularly on the addiction side.

We took this back to do more consultation associated with this because we want to make sure that we get this right. We recognize that when you're putting in – the whole purpose of the policy, of having the regulation, is to ensure that we protect individuals, particularly those who are seeing counsellors. Counsellors are working as independent operators, so an Albertan doesn't know: how good is that independent operator? And if there's a complaint, where do they actually go to, from a college standpoint? But we also recognize that, you know, for a large number of certain aspects of this group that wanted to be in the college there, they're also working for an employer, many of which are working for the government of Alberta. So there is some oversight.

Anyways, because some concerns were raised, we're doing further consultation on that. Maybe I can ask ADM Smith to speak more in terms of what the status of that is exactly.

Mr. P. Smith: Thanks, Minister. Yeah. Just to follow from the minister, I mean, we continue to work, actually, very actively and closely not only with our counterparts in Mental Health and Addiction but also with officials from the Alberta counselling therapists association, the group that was stood up to assist us in proceeding to our regulation, basically to focus on, as the minister alluded to, making sure that we take care of those additional consultations before we actually proceed forward. So that's in play currently.

Ms Sigurdson: Okay. Thank you. Thank you, Madam Chair. It sounds like the same answer as last year. Nothing has really been done.

I'd like to refer to line 1.5, the Health Advocate's office. There is no report that's been published this year. Usually there's an annual report that comes out. There's no report. I'm just wondering why there's no report available from the Health Advocate. That's part of their responsibility.

There's a significant increase in the budget, you know, about a 1 and a half million dollar increase. How come? What's happening? What are you doing in that area?

An Hon. Member: He asked some questions already.

Ms Sigurdson: Oh, did you ask about that?

Mr. Shepherd: Yeah.

Ms Sigurdson: Oh, no. Okay. So that was – and I also wanted to specifically talk about seniors' issues because I've been told

repeatedly that the Health Advocate does work with seniors, but that's not been reported, and that's not what I'm hearing from stakeholders. So, Madam Chair, through you to the minister, I'd like him to speak to that. Sorry.

Mr. Copping: The report is coming, so I can tell you that. I can also comment on, you know, that I know that the Health Advocate does work with seniors, because she talks to me about that.

The Chair: Thank you so much, Minister.

We'll return over to the government caucus side.

Mr. Long: Thank you. Thank you, Minister and your department and your staff, for taking the time and putting in the effort to provide some clarity around your budget and your ministry's plans. You know, I want to echo the sentiment of my colleague from Airdrie about the excitement to see the word "Whitecourt" in a health care budget for planning a project for something around their health care facility and, with that, also give a shout-out to the Friends of Whitecourt Society, who – I've actually worked alongside of Repeat Boutique recently, a local shop that they run to help fund different projects within health care in the community. They've provided over, well, a few million dollars now towards health care projects over the years in the Whitecourt community, so thanks to them for their efforts.

I'd like to focus some of my time today with you on concerns that have come from my riding. I've had numerous conversations since I was elected, so this is a long-standing concern, actually, around surgeries. It seems the most common issue is around getting access for hip surgeries, actually. I know a number of constituents have gotten to the point where they've had to go to other jurisdictions to get surgeries, whether it was the pain or them realizing how long they've been on pain medication that drove them to make that final decision. So with that in mind, according to the Health business plan the success rate of hitting the national wait times for hip and knee surgeries has actually declined – and I hope it's okay to say – to atrocious levels. That's what my constituents are saying. Just simply, what monies are being spent on improving wait times for surgeries and how long will it take for Alberta to achieve the national wait time guidelines?

Mr. Copping: Well, thanks so much for the question. I hear this, you know, as the Minister of Health both from my own constituents in terms of the long wait times, and they're unacceptable. The fact that there are some people who are choosing to leave to get – our system is not performing as it should. We understand that this is an issue. We have been working on this issue, and actually, as we indicated before, this was an issue even before we took government, but quite frankly COVID made this matter worse. So even though we have been investing in capacity to get caught up on surgeries, we've been delayed in getting the outcomes that we want, which is getting all surgeries within the recommended wait times.

Under Budget 2023, you know, AHS will spend an additional $310 million. As part of our Alberta surgical initiative there are a number of components. It includes investing in our public hospitals to expand capacity, so there's capital dollars associated with this as well. Part of that is actually to ensure that people don't need to travel as much, so they can get the surgeries closer to home. And then part of this, as well, is reaching agreements with chartered surgical facilities to expand our capacity. When you talk about hips and knees, we're very pleased that we were able to, as part of an RFP process, award a contract for an additional 3,000 surgeries in Calgary. That has been stood up. I actually made an announcement in January, and that's happening today.

Similarly, we reached a contract in Edmonton with the Enoch Cree Nation, who did a joint bid with Canadian Surgery Solutions. They're building that facility right now to be able to provide, again, 3,000 surgeries. That actually is not only going to add a capacity, but I'm also excited about that from an Indigenous standpoint. They're going to use that as one key element of their health hub. They're going to set it up in a culturally appropriate way. Now, it's for not just Indigenous peoples; it's for all Albertans to be able to access those services, but it'll be done in a culturally appropriate way.

Anyone who wants to avail themselves of that approach will be able to do so. It's going to do two things, not only provide more surgeries and reduce the backlog and ensure that we have that over time – because it's not just about investing money right now – get caught up in the backlog and have the capacity to continue this in the future, but also what it'll be able to do is provide better access to care for Indigenous people and have Indigenous people wanting to access care, which is another issue that we're trying to address, obviously, through MAPS, leveraging charges for facilities and then doing it in rural areas, like in your neck of the woods, in terms of the ability to expand to have surgeries done.

We know this is an issue. We're focused on it, and our objective, quite frankly, is to get surgeries within the recommended clinical wait time by the end of next year.

11:40

Mr. Long: Thank you for that, Minister. I did pick up on the joint bid that you mentioned. I hope that wasn't a play on words with hip and knees or anything like that. I assumed it wasn't, but I'm a sick mind like that. Thank you for that.

Like most members in the room, I receive e-mails, messages, and have conversations with constituents frequently about being on a wait-list. Some of them will actually wait months to even hear, get a phone call back from their physician or specialist about even an update. Actually, you did point out in my riding, actually, that your ministry has actually chosen a path forward, which I appreciate and I believe that many of my constituents appreciate, to use some facilities that might be underutilized in rural Alberta.

One of my hospitals is actually doing cataract surgeries now. Another is doing hip and knee now. I love having those conversations with constituents to let them know that they don't have to drive to Edmonton or Calgary, let alone leave the province, to get those surgeries done and that they can have it done in a facility that they're familiar with and be close to home so they don't have a bumpy ride in and out of the city, which puts them through even more pain and unease, discomfort. So thank you for that and for looking at all aspects of what's available in the health system to combat these wait times.

I'm just wondering if you can sort of expand on this a little bit more, on where we're actually at as far as our targets for reducing the wait times for some of the surgeries, including hip, knee, and cataract.

Mr. Copping: Well, thanks for the question. We are having some success, especially when we're talking about cataract surgeries and orthopaedic surgeries. You know, generally speaking, we sort of highlighted this in the 90-day plan. It showed that surgical wait times have decreased by 9.4 per cent since November 29, 2022, and this is between February and November in terms as outlined in the 90-day plan. As of February 28 there are now nearly 8,000 fewer patients waiting outside clinically recommended wait times compared to April 1, 2022. In addition, the number of patients waiting the longest for surgery and more than twice the recommended wait time has decreased by 5,250 during that point

in time. We are focused on, obviously, those waiting the longest and then getting everyone down who is actually on the wait-list. [interjection]

The Chair: Excuse me. Somebody is intruding into the call. If we could please get that addressed.

Sorry, Minister. I don't know what happened there. Please proceed.

Mr. Copping: Okay. Yeah, happy to. Someone just being excited about our improvements in wait times.

The Chair: I think that was it.

Mr. Copping: We've also been able to see a reduction in both hip and knee arthroplasties. It decreased by 4 per cent since December of 2022. Then, you know, we've also seen, and I mentioned earlier, year over year, like two years ago to last year, an improvement on cataract surgeries. As a frame of reference in April 2022 the wait time had decreased four weeks from April 2021. In October 2022, if we look to this fall, that's a further two weeks, so a reduction of six weeks in terms of the wait times. We still know we need to do more, but we are making progress, and Budget 2023 invests money to be able . . .

The Chair: Thank you so much, Minister.

We will return back over to the Official Opposition.

Ms Sigurdson: Thank you very much, Madam Chair. I'd like to, I guess, go back to continuing care a little bit. Certainly, at the end of the comments by the minister he talked about that certainly staffing is a significant issue. I guess I just want to say, in a sort of response to what he said, that making sure that workers are full-time with benefits will absolutely reduce the high turnover rates. So I hope the minister is looking at that. Then that 4.1 hours of care per resident is sort of seen as the minimum, and I'm hoping the minister is looking at that also.

I just want to look at line 2.1 again and the continuing care expenses. Certainly, there are lots of different providers of continuing care in our province. Actually, the recent Auditor General report regarding COVID-19 talks about, does a lot of research about all the different metrics that they looked at. In continuing care facilities cases and deaths were monitored by the Auditor General, and he breaks it up in terms of: AHS operated, contracted for-profit, contracted nonprofit. CapitalCare and Carewest got their own line. We see that the for-profit care providers had far and away significantly more deaths and cases than the other operators, so I'm just wanting the minister to address this. Is there greater scrutiny, because of these pretty challenging findings, that people in for-profit are more vulnerable because of the care provided in those settings? I'd like the minister to respond to that.

Mr. Copping: Thanks for the question. You know, I understand that COVID was a very challenging time. Our government acted, actually, fairly quickly to be able to provide additional funding to the continuing care sector to be able to support workers and support Albertans living in a congregate care setting.

We heard loud and clear in the Auditor General report about the need to look at, you know, not only how we respond in future to outbreaks but also to ensure that we reduce the risk, and we've already taken action on this. There's a high correlation, and the risk was associated, quite frankly, with the age and model of the facility, so higher risk associated with shared rooms and higher risk associated with shared bathrooms. It had more to do with the facility than it did, necessarily, with the delivery model.

We've already taken action. We have invested in additional spaces and new spaces, a significant number of continuing care spaces. These new spaces are not based on that model. It's a better infrastructure, you know, focusing on improved HVAC as well as single rooms with single bathrooms. An additional $200 million in Budget 2022 was put towards that. Also, we closed a number of shared beds. An example right here in Edmonton is at Southgate and then, similarly, in the Bethany care system, but we still know we need to update those facilities. So I'm very pleased as part of this budget, Budget 2023, that there is a commitment to funding to be able to build new facilities, both with Bethany and the Southgate facility, to be able to replace both of those facilities with new, modernized facilities but also ones that, quite frankly, aren't shared rooms or shared bathrooms and then improved HVAC systems to reduce the risk going forward. You know, we are fully aware of the impact that COVID had.

One other comment I'll make in this regard, and this goes back to the great work that's being done by the team in terms of updating our Continuing Care Act. Basically, as you know from your time on the file, five acts, from before, to be able to govern all of the services that are being provided – we're talking in terms of home care, continuing care, and DSLs and the various levels – were put into one single act. We've also improved the act, put in administrative penalties as well, so it's not just a licence on or off, but there are some administrative penalties there so you could have a medium approach to be able to address issues. We are now working through the regulations. Again, just to be crystal clear – even though this has happened before, it will even happen under the new act – the regulatory regime, the requirements for operators, is the same regardless of whether they're private, not-for-profit, or public service providers. Quite frankly, we need all of them to be able to deliver the services that we need.

11:50

Ms Sigurdson: Madam Chair, I think the minister has sufficiently answered my question, so that's all for me. I'll just pass it on to my colleague.

Mr. Shepherd: Thank you. I'll just go with a question, I guess, regarding public health, line 8.1, program support for population and public health. Now, that includes the office of the chief medical officer of health, who I recognize we have here with us today. I appreciate the work Dr. Joffe has been doing. Now, I just wanted to clarify in this line item: what salaries are being included? I know that Dr. Joffe was originally forgoing any salary for this role as he was still bound by his contract with AHS. I just wanted to clarify if that continues to be the case or if there is salary included here for Dr. Joffe. In regard to the deputy medical officers of health we know that we had those resignations in November and December. Have those positions been filled, and therefore are the salaries included in this line?

Mr. Copping: I can say that Dr. Joffe is full-time CMOH and that his salary is included in this budget at this point in time. I don't hear that at this point in time there's going to be a change. It is in the budget, the salary for the CMOH, and he is filling that role.

We are also in the process of recruitment and selection for deputy CMOHs. In the interim there are CMOHs within AHS that provide services for AHS; for example, outbreaks. They are providing support for Dr. Joffe as required. But the funding for the positions for those deputy CMOHs are in the budget while we're continuing to do the recruitment.

Mr. Shepherd: Thank you, Minister. I appreciate that clarification.

To you, through the chair, I'd just note also, then, line 8.2, immunization support. That's for immunization providers outside of AHS, operation of the provincial vaccine depot. There is a significant increase here, probably about double the funding. Certainly, I've had a number of Albertans reaching out to me about, you know, access to another round of the bivalent, but that's not currently available. I don't know if that's related, but if you could give us a bit of detail, I guess, around the reason for doubling the funding for this year.

Mr. Copping: Yeah. You know, up until this point, when we actually looked at COVID costs associated with addressing COVID, those were actually separate line items. What we've been requested by Treasury Board, as we're moving into an endemic phase, is to take the COVID cost and put it, actually, into our budget line items. So you will see increases across the budget, and this is one of them. Oh, my apologies; this has to do with something else. So you will see increases across the budget line items to be able to put in the costs associated with COVID, but this is not one of them.

Mr. Shepherd: That would be line 8.3, perhaps? There's an increase there.

Mr. Copping: This is 8.2. This is an increase to support the impact of syphilis and antivirals, because we do have an outbreak of syphilis. So this is the budgeted amount to be able to address that particular issue. My apologies. I was confusing this item with another item.

Mr. Shepherd: No problem, through the chair to the minister.

The confirmation, then, is that what you were speaking of with the COVID vaccinations, that sort of thing, would be line 8.3. That would be the additional funding that's showing there?

Mr. Copping: Yeah. That's part of it. That's correct.

Mr. Shepherd: Okay. On that, are you anticipating that there will be another round of the bivalent COVID vaccine for those who may be looking for, I guess, another top-up? Would that be included as part of that anticipation?

Mr. Copping: You know, we are making the bivalents available and continue to make them available to Albertans, and we are guided by the advice from the Alberta advisory committee.

The Chair: Thank you so much, Minister.

We'll resume with the government caucus, and that will take us to the end of our time. When we get back this afternoon, we'll resume with the government caucus. Please proceed.

Mr. Long: We'll start off with me again if that's okay, Minister. Obviously, lots of discussion by Premiers, Health ministers around the country about, you know, how we need the federal government to step up a little bit more with their contributions to our provinces. On page 66 of the Health business plan it actually outlines the transfers from the federal government, including the Canada health transfer. Now, my understanding is that there was a new deal in which the federal government promised they'd give $196 billion to the provinces over the next 10 years. I'm just curious if this includes that money. If not, I guess it's possible that the budget would have gone to the printer beforehand. If it's not included, when will we see that reflected?

Mr. Copping: Well, thanks so much for the question. The answer is that it includes it in part. We knew prior to the budget because the federal government had come in and indicated that they're putting something on the table. That was a combination of both a change to the Canada health transfer and funding for specific shared interests in bilateral agreements. The portion of the Canada health transfer, which amounts to roughly $233 million in '23-24 as a one-time Canada health transfer top-up, is included in the budget, as are the anticipated increases to the Canada health transfer. What's not included are the additional dollars associated with a bilateral agreement. We've had initial conversations with the federal government. We've reached an agreement in principle in terms of the bilateral agreement, and I know that officials are continuing to work with them.

As you know – we've talked about this before – we are investing in transforming our system. We are investing more in staff. We are investing more in mental health and addictions, significantly more, significantly more on primary care, and then we talked about the continuing care transformation. These are all items that have been listed by the federal government as potential areas for joint investment. You know, we'll be working through, with them, in terms of the additional funding to go into those areas, which will, quite frankly, help us to drive our changes faster. We're already doing this, but this will actually help drive them faster.

You know, while the dollars that the federal government is putting on the table are not what the province has asked for – quite frankly, we're asking for significantly more of an increase than is here – as the Premier indicated, we will happily take the dollars, but we'll still continue to advocate for the federal government to play a greater role as a funding partner to enable us to be able to do the transformation that we need to do and accelerate that transformation.

We are also continuing to, you know, as part of that, look at information in terms of metrics. But I just want to be crystal clear, because I know there are some concerns about what metrics we may be providing, about the conversations in regard to performance data, not individual health data, number one. Secondly, through CIHI we do this already. You mentioned earlier this morning about comparison of our provinces in terms of not only investment in health care but health care performance metrics through the Canadian Institute for Health Information. I think I have that right; I might have the "I"s mixed up. We already share – and it's high-level system performance data – with them so that they can do comparisons.

We'll be looking, as part of this, to continue to share data. You know, we haven't worked through all the details on that, but much of the data we already share publicly anyways. But, to be crystal clear, this is not sharing any personal or individual health-related data. It's performance data, and quite frankly it's performance data that we already need to actually measure ourselves in terms of the reforms we're doing on things, quite frankly, we're doing already. The addition of the additional funding: what that will help us with is to accelerate the changes that we're going to do, so I'm thankful for it. I wish it was more so we could go faster, but we'll continue to work on it, and I'm looking forward to officials finalizing agreements in the coming weeks.

The Chair: I apologize for the interruption, but I must advise the committee that the allotted time for this portion of consideration of the ministry's estimates has concluded.

I'd like to remind committee members that we're scheduled to meet again today at 3:30 p.m. to continue our consideration of the estimates of the Ministry of Health.

Thank you, everyone. The meeting is adjourned.

[The committee adjourned at 12 p.m.]

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