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
3:30 p.m.

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Standing Committee on Families and Communities

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Sigurdson, Lori, Edmonton-Riverview (NDP), Deputy Chair
Smith, Mark W., Drayton Valley-Devon (UC), Acting Chair
Feehan, Richard, Edmonton-Rutherford (NDP),* Acting Deputy Chair

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Also in Attendance

Pancholi, Rakhi, Edmonton-Whitemud (NDP)
Shepherd, David, Edmonton-City Centre (NDP)

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Standing Committee on Families and Communities

Participants

Ministry of Health
- Hon. Jason C. Copping, Minister
- Chad Mitchell, Assistant Deputy Minister, Pharmaceutical and Supplementary Benefits
- Aaron Neumeyer, Assistant Deputy Minister, Financial and Corporate Services
- Paul Smith, Assistant Deputy Minister, Health Workforce Planning and Accountability

3:30 p.m. Wednesday, March 8, 2023

[Ms Lovely in the chair]

Ministry of Health
Consideration of Main Estimates

The Chair: I would like to call the meeting to order and welcome everyone in attendance. The committee has under consideration the estimates of the Ministry of Health for the fiscal year ending March 31, 2024.

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

Mr. Feehan: Hi. I'm Richard Feehan. I'm the MLA for Edmonton-Rutherford.

Mrs. Allard: Good afternoon. Tracy Allard, MLA for Grande Prairie.

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

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

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

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

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

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

In the gallery, who may come to the microphone, we have Chad Mitchell, ADM for pharmaceutical and supplementary benefits; Kim Wieringa, ADM, health information systems; Andy Ridge, ADM, health standards, quality, and performance; Wanda Aubee, ADM, public health; Dr. Mark Joffe, our chief medical officer of health; Chris Bourdeau, director of comms; Dan Hemming, executive director of financial planning branch; Pranita Chandra, director of financial planning branch; we have Geoff Pradella, senior strategic adviser in my office; and Scott Johnston, press secretary for my office as well.

Mr. Shepherd: Thank you, Madam Chair, and, through you, to the minister. Thank you, Minister and to all of your staff who are here today.

The Chair: Are you doing introductions?

Mr. Shepherd: Oh, introductions. I'm so sorry. I am just eager to get going. I am raring at the bit. David Shepherd, MLA, Edmonton-City Centre.

Ms Pancholi: Good afternoon. Rakhi Pancholi, MLA for Edmonton-Whitemud.

The Chair: Now we'll go to the members participating remotely. I see Member Fir.

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

The Chair: I'd like to note the following substitutions for the record: the hon. Mr. Feehan is substituting as deputy chair for the hon. Ms Sigurdson, the hon. Mrs. Allard is substituting for Mr. Gotfried, and later this afternoon Mr. Smith will be stepping in and substituting for me as chair. Thank you.

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 visual stream and transcripts of meetings can be accessed via the Legislative Assembly website. Members participating remotely are encouraged to turn your camera on while speaking and mute your microphone when not speaking. Remote participants who wish to be placed on a speakers list are asked to e-mail or message the committee clerk, and members in the room should signal to the chair. Please set your cellphones and other devices to silent for the duration of the meeting.

With regard to speaking rotation and 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. For the record I would like to note that the Standing Committee on Families and Communities has already completed three hours of debate in this respect. As we enter our fourth hour of debate, I will remind everyone that the speaking rotation for these meetings is provided under Standing Order 59.01(6), and we are now at the point in the rotation where speaking times are limited to a maximum of five minutes for both the member and the minister. These speaking times may be combined for a maximum of 10 minutes. Please remember to advise the chair at the beginning of your rotation if you wish to combine your time with the minister's.

One final note. Please remember that discussion should flow through the chair at all times regardless of whether or not your speaking times are combined.

If members have any questions regarding speaking times or the rotation, please feel free to send an e-mail or a message to the committee clerk about the process.

With the concurrence of the committee I will call a five-minute break near the midpoint of the meeting; however, the three-hour clock will continue to run. Does anyone oppose having a break today? All right. We'll proceed with the break.

When we adjourned this morning, we were five minutes into the exchange between Mr. Long and the minister. I will now invite Mr. Long or another member from the government caucus, if you choose, to complete the remaining time in this rotation. Member, you have five minutes.

Mr. Long: I'd like to pass on to MLA Yaseen.

Mr. Yaseen: Thank you, Madam Chair, and thank you, Minister. Can I go back and forth, Minister?

Mr. Copping: Pleased to do so.

Mr. Yaseen: Thank you very much, Minister, for your hard work on this very difficult and challenging ministry, which not only has a significant part of our budget, but it affects every resident of this province. Thank you for the people beside you and behind you for the good work they have been doing in this ministry.

My question, I think, before, earlier this morning, when the question was asked with respect to the Calgary health facility up in north Calgary, or Calgary-North – the name goes back and forth. But it is very close to my heart as well. My riding is called Calgary-

North, and it is on the upper northern part of Calgary-North that this facility is contemplated on. I just would like to clarify a couple of things on that. I know that we have $3 million set aside for this: $1 million for this year, $1 million for next, and $1 million the year after. For the planning phase of it, could you please elaborate a little bit on that again as to what you are contemplating to do in this first $1 million this year for that facility?

Mr. Copping: Well, thank you so much for the question, and again I reiterate your thanks to the people beside me, behind me, and all health care professionals for the tremendous work that they're doing in supporting Albertans and their health care needs. You know, very pleased that as part of Budget 2023 the capital plan is planning dollars for both, you know, Airdrie and north Calgary, and I fully appreciate how near and dear that is to your heart.

You know, as indicated this morning, we need to do an updated assessment of the needs for north Calgary and in Airdrie, like, look at the area. That's the first step in any capital planning. You know, they do a needs assessment, then a budget, then a functional plan, and then we actually get to building. The $3 million is actually to be able to take us through that process, so initial funding for that. As indicated to our colleague earlier, MLA Pitt, the assessment for the Calgary zone, particularly the north area of the Calgary zone, is dated, so we need to update that, take a look at the growth that's happening in the area. That assessment includes looking at the amount of pressures that are already on the system right now, the population growth, demographics, because as a population ages, increase in complexity and increase on needs of health care needs. So we'll be taking a look at all of that.

Again, you know, this project will be led by AHS. We did have conversation as well this morning on the importance of including local community in those conversations when we do the assessment, and we also had conversations this morning about: what will that need to look like? There are needs on acute care, but there are also needs on primary care and continuing care. We need to do a better job, quite frankly, of understanding all of those needs, and then how do we actually provide the infrastructure to be able to support that? It may not just be additional beds per se, but it may be urgent care. It may be being able to providing more community-based care but out of an AHS facility or potentially the health hub – right? – which actually blends a lot of these particular areas.

The first step in all of this, however, is to determine: what are the broad needs of the community for the north zone, and what do we see the increase being over the years to come? And then we actually start doing the planning: okay; what does that look like from an infrastructure, and then where does that infrastructure go, and are we looking at two pieces, one piece? You know, those conversations will happen, but the first step is the needs, and I'm pleased that we've started that planning process as part of Budget '23.

Mr. Yaseen: Okay. Thank you very much. So to determine the need and in determining that need – consultation. You talk about public consultation; that's really good, and I thank you very much for putting that in the budget. I look forward to that because people would want that, to be talking again on that.

I will move on to my next question. It's about . . .

The Chair: And that's your time, Member.

We'll go over to the Official Opposition. Please proceed.

Mr. Shepherd: Thank you, Madam Chair. Now that it is actually my turn, allow me to follow the lead of Mr. Yaseen in wishing my sincere thanks to all of the staff and support that are here with the minister today. I appreciate all of the work that you do on behalf of Albertans and that you are here today to provide the support for our questions and our comments.

3:40

Minister, I wanted to shift, if we could, to talk about primary care. Of course, under outcome 1 and objective 1.3, strengthening and modernizing Alberta's primary health care system, and your commitment to funding, I believe, about $243 million over three years for recommendations from the work being done through MAPS. There were a number of recommendations that were put forward in a preliminary report from MAPS. Now, am I correct, Minister? My understanding is that you have accepted all of those recommendations.

Mr. Copping: Yeah. We've accepted all of them in principle at this point in time. You know, some of those recommendations were still high level, so we're actually working through the implementation plan on that, but the general thrust of those recommendations is expanding team-based approach to health care. We actually already have that as part of the AMA deal in terms of – so we're actually working on that. Part of it was looking at different approaches to funding for PCNs, allowing rollover in terms of their budgeting. We're actually making that change immediately.

Mr. Shepherd: Well, if we could, why don't we start there, Minister?

Mr. Copping: Sure.

Mr. Shepherd: I did want to dig into some of these individually, so we can start there with restoring the operational stability fund. Now, my understanding is that the OSF was established through a policy implemented April 2018, as you say, allowing PCNs to roll over dollars to the next year. It was eliminated by your government in the 2020-2023 grant cycle as a cost-cutting measure. So is this an acknowledgement, then, that that was an error to have made that cut? You're restoring it here.

Mr. Copping: Yeah. So that was made, then, at a particular point in time, you know, where we had a different fiscal reality. We actually heard feedback as part of the MAPS process that that actually constrained the ability of PCNs for ongoing planning, so when they came forward with that recommendation to say that we need to maintain the funding or have more flexibility, we accepted it.

We also recognize that both the funding formula and the governance mechanism for PCNs need to change. You know, that's one of the issues that we've highlighted, and I've asked for the committee to give recommendations back to our government in terms of: how do we change the structure that's been in place for years?

I just want to take a step back. You know, we as a province led the country with the establishment of primary care networks and supporting primary care – and this is over 20 years ago – but we need to evolve it to actually improve its effectiveness, so that's what I've asked the MAPS panel to do. They made some preliminary, like, quick hit, which we asked for, say: okay; what can we do right now to actually improve the system so we can act on it more immediately? We're also asking for a long-term plan, right? How do we evolve this over time, including different governance structures and different funding mechanisms to be able to do it? And we're reflecting this – now, it's $125 million in terms of in the budget for the initial funding for the MAPS recommendations. But part of that also includes additional funding for PCNs. We need to do that. Some we've already announced as part of the AMA deal.

Mr. Shepherd: Thank you, Madam Chair, through you, to the minister. I'm happy to get into it a bit more as we go later. I wouldn't mind just touching a bit more on the OSF now. Your government eliminated it. You've consulted now, and I appreciate that you have taken a much more collaborative approach in terms of engaging on primary care than we saw earlier with your government, so I do commend you for the MAPS committees and working with them.

On the OSF. Now, I had a chance to check in with some physicians, and they asked me to check in with you on how this will apply to your commitment of that $40 million for PCNs. Basically, because those amounts are allowed to roll over, if they – here's what they said. PCNs will underbudget to 2 and a half to 5 per cent a year just to make sure that they're not going over. Then you allow them to roll that over now with the OSF. With the $40 million they're asking, you know: if they're not able to make full use of those dollars each year, are those also going to be allowed under the OSF? The OSF has a cap on it, right? It can only be used on 5 per cent of the funding from the budget year. Their concern is that they will get the additional $40 million, and if they're not able to make full use of it – for example, if they're looking to hire team-based staff or other things and it takes some time to achieve that – this money would be clawed back. So can you be clear: is your intent with the OSF that that will not necessarily apply to the new funding that's being given, that PCNs will be allowed to hang on to that money?

Mr. Copping: The intent between the additional $40 million – and that's $20 million lump sum this year, $20 million lump sum next year, just so we're clear – is to be able to enable PCNs to expand the resources that they're providing right now, today, right? While we're getting the report from the MAPS panel to say how we actually reform our funding structure and our governance structure for that, the OSF will not be funded by the $40 million.

Maybe if you could just provide more clarity on that.

Mr. P. Smith: Certainly.

Mr. Copping: I think what that means is that they'll be able to – like, even if they don't fund the whole amount, they will be able to roll it over. But can you just clarify that?

Mr. P. Smith: Yeah. Thanks, Minister. I mean, the OSF is really leveraging the existing funding that's already appropriated each year for PCNs, like you mentioned. It simply allows them to maintain anything that otherwise would have dropped off the table in that fiscal year. The $40 million is for a different purpose, and we've actually stood up a working group that involves primary care leaders, the AMA, et cetera, and a provincial PCN committee as well to inform how we're actually going to spend that money over the two years. They are two separate pieces. One augments the other one.

Mr. Shepherd: Excellent. Thank you. I appreciate that clarification, as will the physicians that I was speaking with. So they'll be able to hang on to those dollars. And I appreciate the clarification, Mr. Smith, that the $40 million is over two years, $20 million per year.

We also have another $27 million to provide for the expected increase in patients attached to a primary care provider. What I'm understanding, then, is that the $27 million is simply to address additional patients that are going to come on under existing terms, and the $20 million per year, then, is to expand teams. That's correct?

Mr. Copping: That's to augment the services, and as indicated by ADM Smith, we're working with the AMA and the PCN networks in terms of what that looks like exactly. But it's basically to expand the services. We do know that we'll want to have more Albertans attached to primary care clinics, and as more Albertans get attached, then the funding and the formula, which is on a per person on the panel basis, will increase the funding to PCNs.

Mr. Shepherd: Excellent. Thank you, Minister. Through the chair, I appreciate that clarification.

We know that right now there are at least three communities in Alberta that have no doctors that are able to take on new patients, so Albertans are not able to access. Now, one of the chief tools they have in seeking a new doctor is the Find a Doctor website, that appears to be a joint venture between AHS, PCNs, and the AMA. Now, I had someone reach out to me recently who reported that that service is currently being run and maintained by two PCN employees, one in Edmonton, one in Calgary, on top of other duties as there's no specific dedicated funding for that service. That seems to be a bit counterproductive. This seems to be a pretty essential part. I just want to clarify, Minister: is that correct? Is there no dedicated funding within, I guess, this budget either for PCNs or another part of this budget specifically for the Find a Doctor service?

Mr. Copping: Well, there is definitely dedicated funding for PCNs. That's crystal clear.

Mr. Shepherd: Okay. Yes, of course.

Mr. Copping: In terms of whether or not there's dedicated funding for Find a Doctor, ADM Smith?

Mr. P. Smith: Yeah. I mean, the only thing I can add there is that if it were funded, it would be out of that global PCN funding block as well. But other than that, I mean, there wouldn't be anything that is targeted specifically for that particular initiative.

Mr. Shepherd: Understood.

We've got about a minute and a bit. I'll make the question quick, and we'll see if we can make the answer quick. Minister, you've spoken several times, in fact just this last fall, about the 17 doctors needing to be recruited in the Lethbridge area and stated that 17 have commenced the first part of their assessment and that the first few were going to start practising in the fall. Can you give us an update? How many of those 17 doctors have begun to operate in the Lethbridge area?

Mr. Copping: We'll see if I have an update here. As of January 9 six physicians have begun practising, and as others work through their CPSA practice readiness, it is anticipated seven will begin between February and April and the final four between May and December of this year.

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

I don't think we're going to get much in the next 13 seconds.

Mr. Copping: I was too brief with that answer.

Mr. Shepherd: No. It's all good. We're working well here. We're getting a good flow. Excellent. I look forward to the next round.

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

We'll go back over to the government caucus. Please proceed.

Mr. Yaseen: Thank you, Madam Chair. My next question, Minister, is with respect to cancer research and prevention. If you look at page 66 of the business plan, the budget is $10.38 million.

It used to be – actually, in the last budget it was $11.3 million. That is a reduction of about $0.9 million. Can you please explain what's happening there?

3:50

Mr. Copping: Yeah. Happy to explain, because even though it looks like a reduction, it isn't. This is because of the joys of and the requirements for presenting a fully consolidated budget. In fact, funding for cancer research is actually increasing.

If we, you know, go to the ministry estimates on page 111, program 14 – this would actually be going into the estimates binder – you can actually see the increase moving from $25 million to $25,850,000. So page 111 of the estimates. The reason why the statement of operations, which is what you referred to earlier in the business plan on page 66, shows a decrease is due to a year-over-year increase in cancer research funding provided by the department to AHS. It's flowing through a different entry, through AHS.

Funding provided to AHS from Alberta Health is eliminated as part of the ministry's consolidation so that the expenses are not overstated. The department is providing a $1.77 million increase in cancer research funding to AHS, bringing the total funding, when we combine everything for this work, to $15.47 million in '23-24. And because AHS reports cancer research and funding from the department in other programs on their line items, then it's difficult to see the flow through on this.

You know, we are committed to continuing to fund cancer research. This is an aspect of health care that we provide. As I know the hon. member is aware, 1 in 2 Albertans will get cancer at some point in time. All of us will be affected by it, either us or a family member, so it's important that we continue the research, continue to fund that. Quite frankly, some of the research and some of the treatments, like the CAR T-cell therapy treatments that we're doing in Edmonton, are groundbreaking, world leading, and resulting in significant benefits without the negative side effects that we have with chemotherapy.

Again, we continue to fund this, and we're actually not dropping funding; we're increasing it. It just doesn't show up there.

Mr. Yaseen: Yeah. Thank you very much for that clarification, Minister.

I will move on to my next question, and that is with regard to continuing care. On page 65 of the business plan, under key objective 3.5, can you please give us an update on the work you're doing to modernize and transform the continuing care system?

Mr. Copping: Well, thanks for the question. As you know, we've had numerous conversations about this and in different roles but just as important because I know the continuing care transformation is important to you and many members in their constituencies. The facility-based continuing care review was completed a number of years ago. As part of Budget 2022 we started on our journey of transforming our system and moving people more from a congregate care system to home care and improving it. You know, part of Budget 2022 was increasing a million hours in home care.

As well, we knew that given the demographics and the sheer numbers that were coming at us – like, even as we move people more to home care, we're still going to need more continuing care spaces, so part of Budget 2022 also committed an additional $200 million to capital to build more continuing care spaces in a number of environments. It's not only small care homes but continuing care spaces on- and off-reserve for Indigenous people and then also continuing care spaces and replacing continuing care spaces that we have today.

Very pleased that as part of Budget 2023 we are investing a billion dollars over three years to continue our journey on transformation now, and part of that, you know, is shifting care to the community. That includes expanding home and community care. We continue to add more hours so that more people can be available to be looked after in their home.

And it's not only about adding hours at home for home care but also adding wraparound supports. What we heard – and I know that we talked about this in the facility-based continuing care review – was that roughly 10 per cent of people who are going into a congregate care setting don't actually need to be there, but the reason they're going there is because they don't have sufficient supports around them at home. So part of our shift to the community and part of Budget 2023 is not only funding more hours at home but also funding navigators to be able to assist people at home and then also providing supports for not-for-profits to provide services like shovelling, like meals, you know, so that people can stay at home longer and don't have to enter into a congregate care setting. So we're continuing that shift to the community. That's part of it.

Another big part of it – and we spoke about it this morning with members of the opposition – is enhancing workforce capacity. We know and we heard loud and clear in the facility-based continuing care review report that there's high turnover and that it's difficult to attract and retain individuals, particularly in the home-care setting but also in the continuing care setting, and quite frankly the current environment is even more challenging, where we have a shortage of health care workers.

Part of this billion-dollar investment is offering, you know, increased workforce supply, so that's additional dollars. As you may recall, we provided a $2-an-hour top-up as part of COVID to a number of health care workers, so we're going to continue that as part of this initiative in terms of supporting our transformation in continuing care but also additional funding in terms of enabling service providers to pay workers more, whether that be in wages or looking at benefits, and looking at the employment contract so that we can continue to attract and retain.

Then, also, we're looking at innovation. We talked earlier this morning on the employment side. How can we enable service providers to be more nimble – it's not necessarily an input-based system but an output-based system – so that, you know, they can create more full-time jobs, more flexibility to provide the care to Albertans when they need it? If you have a bunch of casual employees working split shifts, it's harder to attract and retain, but if we have more people working full-time jobs and not split shifts and you can have flexibility to overlap them while you're providing the services, then we can hold on to them, which actually results in better care.

The last piece of this is improving quality. We know – and we heard from the FBCC – that we need to provide more average hours of care. Now, that's a high-level number that we talk about in this budget; you know, for 2023-24, for example, an additional $100 million to increase the hours of care for people in congregate care in the home-care settings. That means it's not just doing the basics but doing more than the basics. It's improving the quality of life and giving more time to staff to be able to work with individuals who are receiving the care. Now, again, there's still going to be an assessment of each individual in terms of what they need, but this will be able to provide better quality care.

Then, lastly, measuring all this, ensuring that we have measures in place so we can see, you know, how we are improving, not only improving in terms of health care outcomes, because we know that, generally speaking, if you look after people in their homes longer, they're happier and they have better health care outcomes than necessarily being institutionalized.

Now, at a certain point in time they will need to be, so we are also, as part of this plan, continuing to increase our capacity in the continuing care space and the congregate care space, small homes. Again, I'm very pleased – you know, for us in Calgary, we are going to be investing in and replacing Bethany, but we're also doing it here in the Good Samaritan in Edmonton, replacing those facilities, which, quite frankly, are far too old. But the reality is that they also had a lot of shared rooms with shared bathrooms, which, we learned through COVID, put residents at higher risk, so we're replacing those moving forward.

Very pleased about the billion dollars that we're investing in transforming our continuing care system and measuring the progress.

4:00

The Chair: Thank you so much, Minister.

We'll go back to the Official Opposition.

Mr. Shepherd: Thank you, Madam Chair. Minister, continuing the conversation, then, on the MAPS recommendations, one of the recommendations is to enhance access to a virtual care program. I looked back to a letter from the Alberta College of Family Physicians from March 25, 2020, where they indeed stated that "we need to bolster capability to provide virtual care including telephone and telehealth visits and programs provided by physician offices and [PCNs]" in a number of areas. They also noted at that time that "investments in private enterprise such as Telus Babylon need to be redirected to enable those that have been providing care to our communities to continue to do so."

I know that between the two of us we've rehashed that history a number of times. It was something that you inherited as opposed to a decision you personally made, but we do recall that initially family doctors in Alberta were offered $20 for a visit virtually while a contract was signed with Telus Babylon, now known as Telus Health MyCare, at $37.50 per visit. That was corrected not too long after but has been maintained at $37.50 for a virtual call regardless of whether that call is 15 minutes or 45. That's a factor, I'm sure you're aware, that was creating a great deal of financial difficulties for family doctors throughout the pandemic. Thankfully, we are through that period, but I do want to just ask about that now.

I'm guessing, from what you've told me, that this is one of the recommendations where you will be having those higher level discussions because, of course, doctors' fees are determined in your negotiations between yourself and the Alberta Medical Association. Along those lines, I guess I'm just curious. Given the recommendation from the ACFP and sort of the bad blood that's created with doctors, can you provide some clarity, I guess, on how much longer that current contract would be running, then, with Telus for those services? Are there dollars in this budget, whether in physician services or another line, to continue to pay those amounts to Telus my health? And is there an intent to transition those dollars to Alberta family doctors through the recommendation from MAPS?

Mr. Copping: I'll start off, and then I'll maybe ask ADM Smith to comment on it. We recognize that virtual care is an important aspect to be able to provide care to Albertans, particularly in rural areas. Like, we had an innovation forum in January, and one of the key elements coming out of that forum – and I expect this to be reflected in the final MAPS report – was using technology to be able to provide care, particularly in rural areas and where there are shortages, and actually reduce the need for travel – right? – because that actually is a barrier to care.

Now, we also recognized – and this is part of the discussions that we had in the AMA deal – that we need to rethink how we approach physician compensation in this because typically, you know, our fee-for-service model is based on not only seeing the patient and the work for the patient done but also the charge associated with all of the bricks and mortar, which isn't needed in a virtual clinic. There's a recognition that a pure virtual clinic needs to be different than a pure, you know, seeing someone in person, like in terms of the fees associated with that, but then you have the challenge of doing both – right? – and a combination of both. We identified that issue with the AMA to work through that, and we're actually having conversations to actually work through that right now, to be able to say: how do we actually manage this in a fair way, not only to incent the doctors to be able to provide the service and fairly compensate but at the same time protect taxpayers? So those conversations are going right now.

In regard to Telus I'm going to kick that over to ADM Smith because, quite frankly, we haven't been focused on that. You know, that is a way to provide service, but we need to get this other area fixed, and fixed first, before we move forward. I don't know. ADM Smith.

Mr. P. Smith: Thanks, Minister. There are no specific overtures on the Telus contract specifically.

To follow from the minister's comments, under the AMA agreement we had very specific time-defined commitments to actually review some of the virtual care codes that we had not instituted during the pandemic. We actually instituted a number of very important, basic virtual care codes to properly compensate physicians over the pandemic, and we made those permanent. As part of the AMA agreement we committed, together with the AMA, to revisit a lot of the codes that were at play but weren't necessarily instituted at that time. Some examples: pediatrics, psychiatric-type codes, that the AMA felt were very important and I think the society of psychiatrists as well brought to bear. We're actually actively discussing that this week down with AMA about how we're going to further that and ultimately bring those forward for implementation. So that work carries on, and there are some broader tables as well that are looking at the future of virtual care more broadly from a policy perspective.

Mr. Shepherd: Excellent. Thank you to the minister and deputy minister, then, for their response on that. Minister, you brought up, I guess, looking at other forms of payment, and I recognize fee for service may not be the best choice in every case. I appreciate that there is some ongoing dialogue on that going now in a more collaborative form.

I do recall back – this was raised in the MacKinnon report. They talked about the number of physicians in Alberta that were on an alternative payment plan. At that time it was 13 per cent. Their most recent data, from 2020-21, shows it's risen by about 1 per cent to 14. So we haven't seen a lot of movement. I'll be frank, Minister. The approach under your predecessor seemed to be rather aggressive and, from what I saw, looked to take sole control of that process of developing new ARPs, cut out the physicians' elected representatives in the AMA, and looked to force physicians to negotiate directly with Alberta Health and choose from just a handful of one-size-fits-all options. Now, that has not obviously led to much success. Many physicians, certainly family physicians, were at points desperate for stable income, I think, over the last few years yet were not inclined to take up the ministry on the offer. Do you acknowledge, I guess, that some of these previous tactics were not terribly successful, and can you give me a sense, I guess, of the

direction you're going to take on trying to improve these numbers now?

Mr. Copping: This is an issue that we spoke about at the AMA table and we actually have in the AMA agreement. We fully recognize that we need to expand different methods of pay, and it's not one size fits all. You know, there is the fee-for-service model, and to anyone watching: that's going to remain. But the reality is that we need to expand different approaches. The agreement has a joint commitment to expand it to 25 per cent. I'm hopeful we'll go far beyond that, because if you look at other jurisdictions, like Ontario, for example, that's closer to 50 per cent, right? But we also know that we're going to have to do this jointly.

There are a number of models already out there in the province. Some of them – like, these are capitation or blended cap models – are working well. But we're also getting feedback that – you know what? – there are problems with it. We have organized in the next two weeks – next three weeks? Anyways, a workshop with all of the blended cap because there are a number of clinics across the province. This is part of our AMA deal to actually look at: okay; what's working, and what's not working? And then how can we improve this, and what are the options we want to provide? That's right in the agreement. Some of those also, you know, want to provide pay for performance, so it's not only about a base pay – right? – on a blended cap but also where we get improved health outcomes, and there's additional pay for that.

We are working directly with the AMA in terms of further refining the models we have and developing the model so we can actually roll them out with a commitment to get to at least 25 per cent. I'm hopeful that we'll do more, but I also appreciate that even with the current models that we have, it's been identified that there are some problems with them, so let's fix those first and then roll it out and then keep working together. I also know that when you put something out there, you know, getting it a hundred per cent right: it's not going to happen. But that's okay. As long as you're measuring and continue to talk and modify it, then we can move forward on that.

Mr. Shepherd: Thank you, Minister. I do appreciate again and recognize the collaborative process you're bringing to this because, as I noted, at many points over the last few years, when it has come particularly to negotiating with physicians, particularly for family physicians, that has not been the case. Indeed, again, I commend you on the agreement you were able to sign back in September with physicians, but I would note that was largely an agreement that simply rolled back pretty much every proposal that your government insisted was necessary when you tore up the master agreement back in February 2020.

While I do appreciate the possibilities that are available now as you engage in this collaborative process with physicians, with others at the table on things like alternative payment plans and some of these other pieces, I do have to wonder: how much ground could we have gained if that would have been the process to begin with instead of the heavy-handed approach that we saw that was brought in initially and, frankly, the damage that did for, I think, a number of physicians? I know we may disagree on this point, but I think it has certainly led to part of the situation where we have, to some extent, the lack of doctors that we do certainly in family medicine and in some other areas of the province. I recognize there are about 10 seconds left, so I don't want to just sort of throw that to you, I guess, for no opportunity to respond, but I look forward to connecting again in the next round.

Mr. Copping: Thank you.

4:10

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

If we could go back over to the government caucus side, please.

Mr. Yaseen: Thank you, Madam Chair, and thank you, Minister. Based on what I heard from the last question that I had for you with respect to continuing care and modernization and transformation, I think you have a comprehensive plan which looks at a number of aspects to modernize, so that's good. Thank you very much on that.

I'll move on to the same, continuing care. Another question: when you look at the staffing specifically in continuing care, can you please tell us how much is being spent on the continuing care capacity plan and just a general update on how the plan is progressing?

Mr. Copping: Thanks very much for the question. As indicated in our last conversation, you know, even though our focus is on shifting to home care as part of our plan, we know we still need to increase the capacity in our continuing care sector, basically more beds, because of the sheer number of people that are coming at us given the demographics, so AHS plans on spending $60 million per year over the next three years on the continuing care capacity plan. It's estimated this level of funding will support up to 2,300 net new spaces from '23-24 to '25-26. AHS is also targeting to open up 750 community care beds in '23-24. This includes long-term care, designated supportive living, and mental health beds as well as mental health adult day program spaces, community hospice beds, and other community residential wraparound health supports. Implementation is ongoing, and AHS is always reviewing opportunities to increase continuing care spaces.

The ministry is also working to improve continuing care options for all Albertans. This includes expanding the number of continuing care beds across the province, particularly in high-need areas, and improving quality and access to care in both continuing care and home-care settings. Many of these bed increases are possible thanks to the new partnerships with community providers to be able to do that and innovative arrangements for both continuing care homes.

I just wanted to point out that this is in addition to the Budget 2022 $200 million that we committed. Also, previous to that, through an RFEOIQ approximately 1,500 spaces were awarded. That's noncapital, but by committing to fund the operating expense, you know, 1,500, we are significantly expanding our capacity. And then, of course, as I mentioned before, the 700 spaces in Bethany and the Good Samaritan in Calgary and Edmonton. So we are ensuring that we have the capacity in the congregate care setting while at the same time expanding capacity in the home care because we'll need it. This is, quite frankly, what Albertans need and expect.

Mr. Yaseen: Okay. Thank you. Thank you very much for that answer.

I'll move on to the next topic, which is emergency medical services, EMS. You're quite familiar with that and the issues around that and the challenges. In line 2.5 emergency medical services has an additional $47 million in the budget. Now, as everyone knows, there has been a lot of strain on EMS workers coming out of the pandemic, and they are getting burned out. So can you tell me – and I have a number of questions here. Maybe I'll just throw them out up front, and then you can see. How much of the money will be spent on things like EMS staffing, training? How much will be spent on new hires, and what are the current full-time and part-time EMS workers? And what amount of money will be used to try to move part-time EMS workers into full-time workers?

Mr. Copping: Well, thanks so much for the question. You're quite right. This is a key issue for our government. This is part of our health action plan, to get our response times down. To be able to do that, we need to have people to be able to, you know, expand the capacity so we can actually get the times down. When we take a look at your first question in regard to EMS staff training, you know, as part of Budget 2023 for EMS we'll be investing approximately $19 million in workforce and training activities. The workforce and training recommendations for AEPAC and the PWC dispatch report include focusing on initiatives such as staff fatigue management, mental health and wellness, clinical training, leadership development, culture, and training additional staff in ground ambulance and dispatch settings. So that'll go towards those. The workforce and training investments and initiatives are designed to enhance and support EMS across our entire province.

In regard to your question about how much will be spent on new hires, AHS EMS plans on investing an additional $20 million to hire new staff in dispatching ground ambulances in Red Deer, Lethbridge, Calgary, and Edmonton. This represents a net new hiring of staff, an increase of over 100,000 staffed ambulance hours – right? – from an hourly standpoint, and this is in addition to the normal hiring of staff across the province.

Finally, in regard to your last question: what are the current full-time and part-time EMS workers currently, and what amount of money would be used to try to move part-time EMS workers to full-time roles? I think I gave this out earlier this morning, but current full-time EMS staff consists of 2,095 employees. The current part-time staffing consists of 340 employees. Now, these figures do not include the over 1,184 casual employees employed by EMS, and AHS is currently posting positions that would convert 70 temporary part-time to regular full-time and 80 net new full-time positions to staff the new ambulances.

We fully appreciate that we need more human resources to be able to run the ambulances, so this is part of our plan to do that as an overall approach to getting those times down. As we chatted about earlier, in the 90-day plan we're actually showing progress in getting the wait times down, but we have more work to do, and this will help us get there.

Mr. Yaseen: Thank you very much, Minister.

I will now share my remaining time with MLA Armstrong-Homeniuk.

Ms Armstrong-Homeniuk: Thank you, MLA.

Chair, through you to the minister, I've heard from many of my constituents, as I'm sure most others have around this room, about the challenges they've experienced with our province's health care system. I'm happy to see yet another year of record health care spending, but my constituents are going to be asking me how we'll be seeing this new spending improve our system. When looking at page 63 of your business plan, key objective 1.1, about implementing the health care action plan, can you start by giving us an update on how the health care action plan has worked so far to improve the health care system?

Mr. Copping: Well, thanks so much for the question. You know, we are seeing some success with our health care action plan. Don't get me wrong; there's more work to be done here. Budget 2023 provides more funding to not only increase the staff and increase the capacity within our system but also to focus on process improvements so we can get the results that we need to get. As you know, we launched the health care action plan in November, and we were able to report back out a couple of weeks ago, in the 90-day report, with Dr. Cowell, our official administrator, and the Premier, on the key objectives outlined in the health care action plan.

The first is improving EMS response times. We look at the EMS wait times as part of the 90-day report: metro and urban areas, a reduction from 21.8 minutes to 17 minutes; communities over 3,000, 21.5 minutes to 19.2 – that's a little closer to your neck of the woods – also decreases in rural and remote communities. Part of that was driven by the additional resources that have been provided: new ambulances in Red Deer and 19 new ambulances in Calgary and Edmonton and also a number of actions being taken, like the movement to 911, 811, where roughly 10, sometimes, depending on where we are, 20 per cent of the calls don't actually require an ambulance so are routed to 811 and reduce the demand, so we improved the response time. That was one area that was part of the health care action plan where we've seen improvement.

The other area is decreasing the emergency department wait times. We've seen, again, between November and January a reduction from 7.1 hours to 6.4 hours, decreasing emergency department wait times. Again, that was assisted through additional resources in the emergency departments, working through the flow through in the entire part.

I'm happy to talk more about it later.

4:20

The Chair: Minister, thank you so much.

We'll go back to the other side.

Mr. Shepherd: Thank you, Madam Chair. Through you to the minister, I'd like to take a turn back, I guess, follow Mr. Yaseen's lead, and perhaps revisit some things on EMS under objective 1.1, outcome 1, implementing the health care action plan to strengthen the emergency medical services. In his recent report Dr. Cowell claims a number of improvements in wait times for ambulances, which you also referenced in the House this week, stating that they've been reduced by about 10 per cent. Can you just clarify: what are the parameters for that measurement? When is the clock considered to start and stop to calculate the length of that wait? Are those parameters remaining consistent from previous data, so the comparisons being made apples to apples between the previous reports and this new report from Dr. Cowell?

Mr. Copping: Like, the data that we're referring to, first off, is 90th percentile. I just want to be crystal clear. Typically, historically, we actually refer to 50th percentile. The data we're referring to: 90th percentile. The reason that we changed to 90th percentile, quite frankly, is because it captures more of the instances of – you know, at the 50th percentile, that's 50 per cent above and below, of the calls, but the outliers can have a huge impact on that, right? The 90th percentile: you're actually catching more of those outliers in terms of doing that. So that's what the numbers were, associated with that.

In terms of the times for each of those in terms of, you know, EMS wait times – and I may actually need to get back to you to be more precise, but my understanding is that the time that the call has come in and it's determined that we're sending an ambulance to the time that the ambulance arrives: you know, those are the times that we're talking about in terms of higher acuity calls at the 90th percentile. So my understanding is that that is the same that it was, actually, in terms of tracking before. Typically often when we talked about this before, it was the 50 percentile, not the 90th, but we're using the 90th because it captures more of the calls and makes sure that we have fewer outliers.

Mr. Shepherd: All right. There's been a change in that respect in the percentile, but that's been taken into account. So when you're

putting forward the claim that there's been a 10 per cent reduction, that's based on calculating like for like.

Mr. Copping: Yeah, it is like to like. November to January with certainty I can tell you because there are reports in the past, right? But in terms of – we're talking about the reduction from November to January: it is like to like.

Mr. Shepherd: Thank you, Minister. That was really all I needed to hear.

In the report Dr. Cowell also claims a significant reduction in red alerts, from 1,092 in the Edmonton zone in January '22 for a total of 39.7 hours to only 81 for a total of 1.8 hours in January 2023; in Calgary, 328 for a total of 8.1 hours and then 134 and 3.2 as of this year. To clarify again, are these comparisons like for like, using the same criteria from year to year? I ask just because I've had some paramedics reach out to me, and they've sort of said, "Hey, are these new stats including the PRUs?" According to this paramedic, those weren't included before because they're not able to transport a patient. In other words, a PRU being on scene would not necessarily count as ending a red alert. So I just want to clarify, I guess: again, we're comparing like for like in this statement from Dr. Cowell about the change in the number of red alerts.

Mr. Copping: My understanding: it is like to like. But I will verify because I agree wholeheartedly with you. If we're comparing apples and oranges, that doesn't lead to understanding whether we're winning or losing. We need good data, and we need transparent data, so that is the intent behind this. My understanding: it is like to like because otherwise that's a false comparison, and we can't make that. Now, when we talk about the, you know, PRUs – you're talking about interfacility transfer: is that what you're talking about? Yeah. Or you're talking about . . .

Mr. Shepherd: Or, I guess, sending them in the case of a red alert, so they sort of hold place. Or perhaps I'm misunderstanding, Minister. My apologies if that's the case.

Mr. Copping: Yeah. I'm not quite sure where you're getting this. Just remember that the purpose of a red alert – it's actually a management tool. It's a management tool to say: we do not have an ambulance there at this point in time that could receive a call, so we need to get one on deck to be able to do that. That's the purpose of a red alert. It's a management tool to do that. That doesn't necessarily mean that that call got missed. It just means that . . .

Mr. Shepherd: No. I understand. I certainly wasn't meaning to suggest, Minister, in any way that there were calls being missed. It's more a question, I think, where they're saying that ambulances – actually, you know, we're getting into some confusing territory. Maybe we're better to move on to something else. Yeah. I have a chance to follow up on that.

Along similar lines, last year you announced a new ambulance for Airdrie, that began operating, I believe, last April, covering both interfacility transfers and the emergency response. Now, according to some local leaders that I had the chance to speak with over the last week, those Airdrie ambulances were largely out of the area answering calls in Didsbury and Calgary over the last two weekends. So they're concerned – and this is directly from them – that the call times are not reflective of all the call times and suspect that Airdrie may be included in rural numbers for response time and not urban ones. Can you just clarify, I guess, sort of where the Airdrie ambulance falls in terms of them being able to understand those stats?

Mr. Copping: I'm going to have to actually get back to you in terms of where it falls. Just so I'm clear on the question, is the question in terms of, you know, metro and urban areas versus communities over 3,000? Is that, like, where it falls? Is that what you mean by that?

Mr. Shepherd: That's my understanding, I think. Yes. I mean, generally the concern is being raised that what's being reflected in terms of the benefits that Airdrie is seeing from the additional ambulance is not actually reflecting the reality.

Mr. Copping: Well, you know, it's part of our system. I can tell you that part of our system is that we provided more ambulances in Calgary, an additional ambulance in Airdrie. Now, part of our system is that we move ambulances around to be able to provide care, with the highest levels of care where they're needed at that point in time. But there's coverage both ways.

I can tell you, because we actually track this, that there was particular concern raised by the municipalities around the largest cities and Calgary and Edmonton that they're being called into the cities and not getting back out, so we actually changed the dispatch rules. We've had a reduction, you know, a roughly 40 per cent reduction in time for those ambulances being in the cities as opposed to being out in the community. Now, as part of our system works, you still are going to be moving that ambulance around – right? – to be able to provide coverage. But what's really important is – again, it goes back to the response times, because even though we're moving resources around in the area, in the region, what is the ultimate response time?

I can get back to you on whether or not they were in the communities over 3,000 or they are considered in that metro-urban area, which I think they are. But I don't know that for certain, so we'll get back to you on that.

Mr. Shepherd: I understand. Thank you, Minister.

We've got a couple of minutes here, so I'll revert to some of my briefer questions perhaps, and we can come back to some more in-depth ones in the next block.

Let's take a look at one here. The child health benefit, line 5.9: I notice that the forecast is coming in quite a bit lower than what was budgeted, about $12 million. Your estimate for this year is set just above that forecast level, so retaining that sort of lowered figure. I'm just wondering if you could provide a bit of detail for the reason that this came in so much lower than had been budgeted and why you expect that trend to continue.

Mr. Copping: Let me just catch up with you here. Yeah. As seen in the estimates, this number is coming in budgeted at $37 million, forecasted at $25 million, and then the estimate is just slightly under $25 million, at $24.8 million. You know, the Alberta child health benefit applies to lower income families with children. They have essential health benefits associated with this, and there are a number of moving pieces to how we actually do the assessment, and it's hard to get it necessarily bang on, right? That's why you see the variability. It was anticipated lower last year, but it's actually higher. There are three things that are assessed . . .

Mr. Shepherd: Is this about it being difficult to anticipate, I guess, what the need might be?

Mr. Copping: Well, part of the issue – and this is why even where we're saying, "Okay; this year it's the number of people that are on," as the economy improves, you actually have fewer people that are eligible for it. That's one thing. You actually have more kids in

certain areas, but some of them are actually going over 18, so they go from this benefit to the adult benefit.

4:30

The Chair: Thank you so much, Minister.

Mr. Copping: My only comment on this: we continue to fund . . .

The Chair: Thank you so much, Minister. Sorry, Minister; we need to move on.

Mr. Copping: Sorry. My apologies. I just wanted to finish that thought.

The Chair: We will move back over to the government caucus side, and after this 10-minute exchange, then we'll stop for our break. Then, when we resume, I'll have MLA Smith take over my duty here as chair.

Please proceed, Member.

Ms Armstrong-Homeniuk: Thank you, Chair. Through you to the minister, to follow up on reducing surgical wait times, page 79 of the fiscal plan talks about "restoring decision-making to local health care professionals to help incentivize regional innovation." Minister, can you please explain how local decision-making is being restored as part of this process?

Mr. Copping: Well, thanks for the question. As part of Alberta's health action plan, you know, the fourth element of it was actually pushing down decision-making. I had the opportunity to tour the province and speak to over 1,100 individuals involved in health care: continuing care operators, AHS employees, patient advocates, people on advisory committees, and a large number of AHS employees, both managers and people on the front line. One of the messages that they gave to me was, quite frankly, that they felt they were disempowered, that they are unable to make decisions at the local level. We even had instances where the local hospitals had to wait months to get approval to buy two chairs. We heard that loud and clear, and one of the reasons for making this an important issue for Dr. Cowell is to push down operational decision-making.

Now, I fully appreciate there are huge advantages to having a single, you know, health provider like AHS in terms of the ability to procure, whether that be supplies or equipment, in a cost-effective manner, to be able to ensure that the care provided in Vegreville is the same as in Edmonton, is the same as in Fort Mac, is the same as in High Prairie. There are huge advantages to having a single system but disadvantages also if you decentralize operational decision-making, with the inability of people to make decisions on the ground and be able to move quickly. That is why we actually asked Dr. Cowell to work with the executive lead team to push down decision-making, to enable more decisions to be made locally. I know that the first part of that piece is actually having enough people, and I talked about that a little bit already, and there's a separate plan on that.

But I want to talk a little bit about, you know, some of the decisions that have already happened to be able to push down decision-making, and one example is hiring, right? To shorten the process, if you have a person that you need to replace and it's in your budget, then go out and hire. You can actually engage a centralized HR for that but actually go and do that without waiting for it to go up the line, get approval, and then go all the way back down. So that's one piece of it.

The other piece of it is, actually, pushing down decision-making in terms of, you know, some local capital decisions, or how, within the standards of practice, are we going to deliver that? When I take a look at the Alberta surgical initiative, one of the things, as a key part of that, is leveraging local hospitals to perform more surgeries. One example of this is our chair, Camrose, in terms of engaging folks locally, in terms of: what do we need to do to actually get an operating room up and running? There was one small change that needed to be made from capital. We actually had the people already there to actually start doing more surgeries, so they've already started to do that. That's an example, but it didn't have to go all the way up and all the way down in terms of a decision. They can actually move forward and do that.

Now, this is culture change, and it's going to take time. But this is important, what we need to do in terms of pushing down decision-making. That's just one example, but we need to continue to do that, maintain the benefits of a single system while, at the same time, allowing more flexibility locally to be able to make the decisions, to be able to provide the services. That also deals with the whole issue of culture for employees. You know, the place where you want to work is where you think you can make a difference. We have fantastic employees who work incredibly hard, and they want to make a difference, so let's enable them to make a difference. This is one of the key ways we're doing it and one of the changes that we're focused on through the health action plan.

Ms Armstrong-Homeniuk: Thank you, Minister.

Through you, Chair, to you, Minister, page 79 of the fiscal plan states, "ER wait times are being addressed by bringing in additional health professionals to deliver better on-site patient care, improve patient flow and shorten transfer times." Minister, can you give us an update on how this and any other improvements we've introduced have improved ER wait times so far?

Mr. Copping: Yeah. Thanks for the question. This truly is a complex issue because ER wait times is a combination. We need to think of it like a pipeline, you know. You arrive in the ER wait room. You need to get assessed, triaged, admitted into the emergency department. Then, for many, if you're not ready to go home, it's an in-patient service. Then, after that, if you're still not ready to go home and you still need some level of care, then continuing care or, actually, home care can be set up in support of that.

AHS has been focused on all elements of this, because if we increase the flow, we can get more people through faster and decrease the wait times, so there's been a ton of work that's been done in this regard. I'll talk about the end of it. Part of what's been incredibly helpful is our government expanding continuing care spaces, and that means we increase the flow. There are a number of people waiting who have already been cleared to leave the hospital, but we don't have a place for them in an alternate level of care. They have been able to reduce that number from roughly 400 to slightly over 200. Being able to do that actually frees up 200 hospital beds right across the system, so they're focused on actually moving people out quickly when they're ready to be moved out.

That's a combination of not only having additional continuing care spaces but an alternate level of care, and one example of that is – and I mentioned this earlier. We had an announcement in Edmonton about Jasper Place for those who are homeless, to give them a place of care so that they're not re-entering the system and then being able to move out. You know, for some who go through the emergency department and then are put in as in-patients, they can go out to a place sooner when they're stabilized to do that. But it's also in terms of home care, right? We have been making changes to the process to more quickly be able to do the home-care assessment for someone waiting in a hospital to have a home-care

assessment, and then we can support them at home. So that's on that end of the spectrum.

Also, in terms of expanding capacity within our health care system, part of this budget and what we've already done is expanded the number of in-patient beds so that we have more capacity to be able to flow through that. Then, on the front end – and we've been talking about that over the last number of days – it's hiring more triage staff to be able to receive patients and do the assessment, an additional 114 full-time equivalents, which will do two things. One is that we can do faster triage, but also that means that for the drop-off for ambulances they can come in and drop off and get out in our 45-minute target to be able to get back on the streets to be able to serve the next patient.

Then it's also about demand management, right? You know, 911 to 811: that's demand management. As people say, provide the health care they need without necessarily taking them to the hospital, because they actually don't need it. But for some that do, we will get them there, and we'll provide service. Also, allowing paramedics to be able to treat on-site and make that call with more flexibility. All of this together actually impacts the emergency department wait times, that one metric.

There is a ton of work that's involved, and as part of the 90-day plan we actually are making progress in that, but there is no silver bullet. This is affecting not only our systems but systems across the country. It's a lot of little things that will add up that will improve it. We're still not done. We have more work to do, and we're doing it. The great thing that I'm excited about in Budget 2023 is that it provides additional funding to be able to expand the capacity and also focus on process improvements so we can ensure that we can actually make the pipeline flow as easily as possible. Then we can all talk about MAPS and how we try to keep people out of that pipeline altogether, which is focusing on primary care, which this budget also does.

4:40

Ms Armstrong-Homeniuk: Thank you, Minister.

Chair, through you, I'd like to cede my time to my colleague MLA Yao.

Mr. Yao: Well, thank you very much. You know, Minister, I just want to say, with the 30 seconds that I have available to me, that you and your team have done an exceptional job in Health. I have a lot of contacts within our health industry, including family members, and they speak very, very highly about a lot of the initiatives that this government has been doing. I really want to give a lot of credit to you and your entire staff, your entire team for all the hard work that they have been doing as they try to work through a lot of bureaucracy, quite honestly, and then other things to address those issues. Again, thank you, all, so much for your amazing work on this file.

The Chair: Well, thank you so much, everyone. We'll take our five-minute break.

[The committee adjourned from 4:41 p.m. to 4:47 p.m.]

[Mr. Smith in the chair]

The Acting Chair: Thank you, everybody. I think it's time for us to get back at 'er, so if you'd take your seats, please.

I believe our questioning is over to the opposition. Go right ahead.

Ms Pancholi: Thank you, Mr. Chair. Since this is my first opportunity to speak in estimates today for Health, I just want to also express my thanks to all of the staff, the leadership team, and, of course, all the health care professionals who are the underlaying foundation of our health care system and just really express our thanks to the minister as well for being forthcoming and open today in estimates.

I want to ask a little bit about the announcement in December 2022, when the government had announced that it had secured 5 million units of children's acetaminophen and ibuprofen from Atabay pharmaceuticals. Of course, about 250,000 bottles of acetaminophen arrived in January this year, and of course I recently saw an announcement that perhaps another 270,000 bottles were received, actually, just late last week although have not yet hit the shelves. So we're still looking at about 4.5 million bottles that are outstanding. My first question for the minister is: where in the budget line items can we see both the expenditure from 2022 that might have been expended for this contract and the anticipated costs in 2023? Which line item?

Mr. Copping: It actually shows up in three spots on the expense side: acute care, support services distribution, and population and public health.

Just to confirm, that's all AHS?

Mr. Neumeyer: Yes.

Mr. Copping: Yeah. That's all within the AHS side.

Ms Pancholi: Okay. Can the minister tell us: what was the total amount of the contract in order to purchase the 5 million bottles from Atabay?

Mr. Copping: Yeah. This is on the expense side. AHS will spend $64.2 million in '23-24, which will be a one-time expense, and total cost is $80 million, of which $15.8 million is spent in '22-23; $70 million is the cost of medication while $10 million is the cost for shipping, waste disposal, and other administrative costs. Just to be clear, the government doesn't allow us to – we show expense separately, and then we show revenue separately. So the intent is that we actually expect a shipment – sorry; it's actually already arrived. It's being distributed, the 250,000 bottles. We expect two other additional shipments to be coming in over the next little while.

We are working with other provinces. We've had one other province that indicated that they want access to this, and then we're also going to be having conversations with other jurisdictions about access to this. We made a commitment to Albertans that once it hits the shelves, we will be subsidizing it. They're going to be paying about approximately, you know, what the standard cost would be, which is, give or take, $7 or $8 per bottle. We'll have to subsidize that as well about $7. We've shown the entire expense in the budget. Then we'll actually be off-setting that with revenue – right? – because it's not going to be given to cost to pharmacies. And on the total of the 5 million we will be, again, working with other jurisdictions to actually – they can provide it at cost, so there will be revenue coming in. So the total amount does not contemplate the revenue.

Ms Pancholi: It doesn't contemplate the revenue that you'll bring in from selling. Can I just walk through that a little bit? What is the per-unit cost that you have paid to purchase? How much do you anticipate that you will have to subsidize per unit? And then how much do you expect to sell at per unit? If you've got those breakdowns.

Mr. Copping: Yeah. I may have to get back to you on that. The distributors will be charged $6.78 a bottle, and then they'll charge the regular markup. That will actually be able to get them in at $7.

My recollection is that it was approximately $14 a bottle, like landed cost. We have secured for our own use approximately 1 million bottles. That's for this year, this flu season, and next year's flu season because we are concerned. Actually, you may have seen – like, I've even went to the shelves a couple of weeks ago – we're still short, right? We also want to make sure we're not in the same position the year after for the next flu season, so we're actually ensuring that we have a stockpile. Then the remaining bottles: we are working with other jurisdictions to say, "Do you want that?" and then our intent is to be able to provide them at cost. We're not looking to make money on this but provided to at cost. We're working through that right now.

ADM Chad Mitchell, can you speak to the – do you have more details on the cost per unit?

Mr. Mitchell: You're correct on the numbers.

Mr. Copping: Okay. I actually got the numbers from memory. Okay. We'll run with that.

Ms Pancholi: Thank you, through the chair.

You know, I am a parent of young kids. I struggled with not being able to find those pain meds myself during the winter months, and it was pretty stressful, but I have, you know, gone to the stores recently, and I've actually found that it is available. It's certainly not stocked maybe to the same level as it was before, and perhaps there are disparities across regions of the province – I'm certain that's a possibility – but generally speaking, most parents are able to currently get some Children's Tylenol, certainly, and even Children's Advil. It's even available through Amazon right now. It can get delivered to your doorstep.

I guess one of the questions I have is that, you know, as a parent I am less likely to buy a brand of medication that I'm not familiar with. I know my kids can take Tylenol and Advil. They've taken it before. I mean, is the ministry concerned about the ability to sell these products? What happens if parents are not purchasing it, either because there's enough of the product they already are familiar with or they just choose not to buy that product? What is the sort of mitigation of that for the ministry?

Mr. Copping: You know, the product will be sold, like many of the products right now, because there still is a shortage, behind the counter. The fact that it's behind the counter where someone says, "I need this" – well, you have this option or that option, and this option has a slightly different dosage, but it's perfectly safe. It's actually sold in Europe. I appreciate it is different, but as a parent when you want it and you need it – and I've been there – and you have a kid who's running a fever and you haven't got anything to bring it down and they're crying, you want it right now. The ability to actually have that and make sure that's available for parents is important. We have a stockpile associated with it not only for this season but for next season, and then they will be sold over the piece of the rest of the season. I appreciate your comment saying: I'll go with the old standby that I know. I think that's an opportunity because when someone's going to the counter, you know, they'll have the conversation in saying, "You have these two products" or "You only have one product," which is this one. "Here's how you use it." "Okay; we'll take it."

4:55

Ms Pancholi: Okay. Well, thank you, Minister. I mean, I have no doubts about the safety of the product; it's being approved by Health Canada and all that. No dispute about that. I guess my concern is that we are relying upon – basically, the government has purchased 5 million bottles for approximately 770,000 children under the age of 14 in the province, right? We always knew that there was going to be a lot more product than we would have the market for even at peak times, even at shortage times. In that situation, I mean, is there a contract? Like, how assured can the public be that you're going to be able to resell this product either within Alberta or to another jurisdiction? You mentioned other jurisdictions have expressed interest. Is there a contract in place? Are you expecting to recover the costs? You've basically said that you've paid twice the amount of what the cost is. Obviously, there was demand for it, but how can Albertans get some confidence that they're actually going to recover some of those dollars?

Mr. Copping: Well, partially because we're selling it here and then partially because we actually are having conversations – we haven't reached contracts yet, but that work is ongoing, and we'll keep Albertans up to date. You know, the conversations that I've been having with other jurisdictions where there are still shortages are: it's better to have and not need than need and not have. We were put in that position last fall; we want to make sure that we don't get into it again. It was actually critically important for us to be able to respond to the demands. It's unfortunate that it's taken this much time to actually get through the approval process through the federal government, but we're actually through it now. We have it, and we'll be able to provide it to Albertans.

Ms Pancholi: I think there are two seconds left, so I'll let the time go on that, and we'll chat more.

The Acting Chair: Okay. Thank you, hon. member.

I believe we're back to the government side.

Mr. Yao: Thank you, Chair. To the minister. My first question revolves around EMS. It seems that line 6.2 is a new funding line called Emergency Medical Services Initiatives. You have funding set aside for nearly $90 million, which is a substantial amount of money. If you could elaborate on the type of initiatives this funding will be spent on and how it rolls into the broader health care plan.

And if I could just expand on this question; as an example, with EMS a lot of the issues that EMS encounters are actually within the hospital itself. You mentioned earlier things about the wait times for patients to be assessed, increasing triage. Will the funding come out of this for that sort of thing, or is it other channels? I guess, again, if I continue to expand on it, there's been a lot of misinformation by the opposition about handing off patients in hospitals. Certainly, when we look at the AEPAC report, from the committee that you developed and allowed myself to participate in, recommendations 7 and 8 kind of reflect the concerns around hospital wait times and the transferring of patients. Yeah. Again, lots of misinformation by the opposition on handing off patients. Obviously, they don't understand the medical, legal, ethical issues of abandoning patients. But never mind with that. I'm just wondering if you're able to expand on where the funding will come from to support our emergency departments in this aspect.

Mr. Copping: Thank you so much for the question, and thanks so much for your participation in AEPAC. You know, you brought significant value to that, especially given your background in working in this space.

The $90 million: a large portion of that is to address the AEPAC recommendations, like including the interfacility transfers, and the dispatch review, you know, the recommendations coming out of the PWC dispatch review. The funding for, for example, in the hospitals itself: that's a separate line item. That's coming out of acute care, the line item for that. But we do know that improving

medical EMS response times is one of our priorities as part of our health action plan.

A key component of that, as you indicated, is hand-offs in the hospitals, you know, as we spoke about this morning. Also, as indicated in question period – and there was a clarification put out by AHS yesterday – we are moving forward with a target of 45 minutes as a hand-off, but it's just a target.

It is critically important that, you know, for patients, when they come to the hospital, there is a triage and a positive confirmation, that they're handed off to someone who is actually going to be able to look after them. That is the intent behind it. We're in the process of hiring more staff to be able to help that happen at our 16 largest sites. But that's a critical component. As you know, paramedics want to be paramedics, which is helping individuals, getting them to the hospital, dropping them off, and getting back on the road again, not sitting in the hospital for eight hours. That is not what paramedics want to do. We heard that loud and clear as part of the AEPAC process, so we are driving forward and doing that.

Now, as I said, part of the funding for those additional positions is in the acute-care side of the budget and not in this particular line item. This line item is also looking at, you know, other AEPAC proposals. I mentioned one, the interfacility transfer, which is a big part of it, right? Right now, as you know, we have some of our highest trained paramedics in our ambulances that are kitted out for emergency response, and they're driving patients. Some may need some level of medical care but very low levels. For some, we don't know, and we're just taking them over to the hospital for diagnostics and, actually, bringing them back. You see this particularly in rural areas.

In fact, when I was in Red Deer, I was able to tour the facility there last spring. There were four ambulances in the bay. Every single one of them was waiting for diagnostics to be done and to then take them back to their home hospital. We don't need that level of resource to do that. Interfacility transfers will greatly improve that, so an RFP is out for that right now.

You know, in Calgary and Edmonton and also in Red Deer, actually, we're running a pilot in that regard to be able to do that, and then we'll have to look at how we expand that as we learn from that. So that's what the $90 million is for. As part of the 90-day report we've seen success in getting the times down, but we still need to do more, and Budget '23 helps support that.

Mr. Yao: Thank you so much for that answer, sir.

I know the minister announced several new changes to improve our EMS system over the last several months. Again, there are some examples on page 79 of the fiscal plan of how the government is working to improve response times for EMS, but can the minister provide us with any other examples of improvements we're making to the system to get better EMS results for Albertans?

I appreciate you talking about bringing in separate services to provide transfers. I can certainly talk about my own experiences, where we weren't allowed to leave the side of the patient, and we had to sit there for six hours because of, again, a lot of medical, legal issues about patient abandonment and some other things and hospital staff not necessarily wanting that responsibility when they were so busy dealing with other things. I know that you're trying to address all that. Again, do you have any other examples of some of the improvements that we're trying to do to improve EMS?

Mr. Copping: Thanks so much for that. I'm happy to give a couple more that actually stem from AEPAC, and again thank you for your work in that. There are pilot projects, as you may recall, to maximize the use of paramedics and integrated fire-EMS, which I know is near and dear to your heart, such as reviewing and improving the medical first response; cancelling inbound EMS resources when not clinically required; staffing spare ambulances to support the EMS system when stressed; expanding AHS primary response units to more additional community focused areas – this is leveraging other first responders to be able to provide service – and the pilot in terms of integrating fire and EMS response, to be able to leverage that so we actually have more resources on the road. This came out of the AEPAC. Fast-tracking ambulance transfers at EDs: we continue to do that. We wanted 45 minutes for everyone, but there's also opportunity: can we fast-track even further in terms of the hand-offs?

5:05

We talked about this earlier, sort of giving more supports to paramedics to be able to provide, like, medical response on-site. Part of those supports is also their ability to be able to call back into the system and have a doctor on call to assist them in doing the assessment and the triage and then what they need to do and ensuring that they actually work to their expanded scope of practice. Then, as we talked about before, is the 911 to the 811, just limiting the number of calls that we have, so this is on the demand management.

Again, as you know, there is no silver bullet here. We had a 30 per cent increase over 18 months ago in terms of the call volume. But all of these changes in terms of demand management, in terms of utilizing our resources better, you know, separating out the highest acuity calls and making sure that our ambulances with the highest trained crews are available for that, NAT vans and IFT, separating that out and then adding additional resources in that regard but also adding more ambulances, more staff: all of that combined is starting to get our times down. I'm looking forward to seeing them come down even further.

Mr. Yao: Yeah. I just want to comment on your improvements and the investments that you have made on the dispatch portion. The 811 I find very intriguing, and I look forward to that. When I look at a lot of the principles behind that, I believe that is what Health Link was supposed to achieve but, quite honestly, did not achieve. I think your version, I hope, will be expanded to encompass Health Link, quite honestly, because that's a system that's gone on for quite a while. They didn't really navigate over the years, regardless of who's in government, any improvements to that system. I think that the changes that you've made to 811 will, I hope, carry over into the Health Link aspect, because I think it's a fantastic concept, and it was where things were meant to be. Thank you so much for that, sir.

The Acting Chair: Thank you, Member.

Back to the opposition.

Ms Pancholi: Thank you, Mr. Chair, and thank you to the minister. I'm just going to follow up on a few more questions about the children's medication that Alberta is bringing in. The minister, you know, mentioned, obviously, reselling some of the bottles to other jurisdictions. What is the unit price that the government of Alberta is expecting to charge to other jurisdictions who will purchase some of the children's acetaminophen and ibuprofen?

Mr. Copping: We haven't got any deals done yet, so we'll have to see that. We'll be offering at our cost, because I don't want to make any money on it for Albertans. That's not our intent. Our intent is, actually, to get the supply to Albertans, and also, to the extent that other Canadians can actually benefit from that and others – then fantastic. So that is our intent.

Ms Pancholi: That would be roughly about $14 a unit, then. I mean, that's what we paid for each unit, approximately.

Mr. Copping: Yeah. Plus, there may be some landed cost in there.

I have been corrected, so I just want to correct the record. I have just been told that the product lasts for three years from date of manufacture as opposed to two.

Ms Pancholi: It lasts for three years? Thank you very much. I appreciate that.

Of the 5 million, we're still waiting for 4.5 million, approximately, a little bit less than that, to arrive. When does the minister anticipate that we will have the remainder of the shipment, the remaining 4.5 million, approximately? By what time?

Mr. Copping: We have scheduled – a lot is 250,000, and 250,000 have just arrived. We expect the remaining shipments to arrive over the next I think it's four to six weeks. Then, you know, we're in conversations with other jurisdictions. If other jurisdictions want to purchase, then we're not going to fly them in here; we're going to fly them directly there. We haven't slotted the arrival dates for any additional bottles.

Ms Pancholi: So you don't have an end date by which date all the bottles will have been delivered?

Mr. Copping: No. We haven't scheduled that.

Ms Pancholi: Okay. Thank you.

Does the ministry have an anticipated revenue from this for this fiscal year, for 2023? Is that reflected in the budget, how much they're anticipating to bring in through the resale of some of these bottles?

Mr. Copping: Because we didn't know all of the details, we actually haven't put that in the budget yet. We are required to show the net cost because we actually know what the net cost is now. Sorry. Not the net cost; the actual cost. We are required to show that. Because we don't know what the total revenue is going to be, we haven't shown that yet, and we'll have to make an adjustment over the course of the year.

Ms Pancholi: Okay. My last question. As we do know, the medication is coming. Well, it's with a Turkish company, and we obviously know the tragic circumstances of what's happened in Türkiye and Syria and the thousands of lives that have been lost. I'm just wondering if any future shipments will be affected by what's happened in Türkiye and the earthquake there and if there are any, you know, mitigations in the contracts to address any of that. Do you expect a disruption in the delivery because of that?

Mr. Copping: No. We've had conversations about them in terms of the disruption, that there is no disruption to the supply. But, again, once we've satisfied our needs under the contract, should they say, "Lookit, we need to keep this here," then we're happy to enter into conversations with them.

Ms Pancholi: Okay. So there's that built-in flexibility in the contract, to some degree, to sort of manage . . .

Mr. Copping: Well, we're happy to have conversations with them.

Ms Pancholi: Okay. I appreciate that.

I'll actually turn the remainder of my time over to my colleague MLA Shepherd.

Mr. Shepherd: Thank you. Mr. Chair, through you to the minister, I'm looking at key objective 1.2, attracting, recruiting, and retaining health care professionals in order to build health system capacity and sustainability.

I've got about six minutes. Excellent.

From conversations I've been having with a number of folks, both folks looking to access care and folks who are providing it, it seems there are some building issues when it comes to oncology and cancer treatment. A few times recently, I think, in the House, with the media, we've highlighted some of the growing wait times for Albertans to see an oncologist. The Alberta Wait Times Reporting page shows that over the last three months wait times from referral to seeing an oncologist are ranging in the south zone from eight to 13 weeks; in Calgary, four to 10 weeks; in Edmonton, three to 10 weeks; in the north, two to 10 weeks; with the national recommendation being for a maximum of 10 working days.

My understanding is that there are currently about 16 recruitments ongoing for medical and radiation oncologists across the province, and we are facing some challenges as doctors are leaving and we're struggling to recruit replacements. The remaining oncologists, from my understanding, are tired and demoralized but working as hard as they can. I also understand B.C. has recently announced some new funding to address their wait times. I'm hearing that some of the incentives they're introducing are drawing oncologists away from Alberta. To the minister, through the chair: what steps, I guess, are you seeing being taken, either through AHS or through your office, to address those wait times? Is there anything in this budget specifically for recruiting and retaining oncologists or expanding their capacity?

Mr. Copping: Specifically for oncologists, like, that exact line, there's nothing specific for that exact line item. There is additional funding for recruitment and retention of doctors. Generally, you know, if you take a look at the AMA deal: additional funding in that agreement. We also have over $120 million as part of the broader retention and recruitment of funding for doctors to be able to attract and retain. I also know that – sorry; that was $158 million to support the initiatives for recruitment and retention, which includes but is not limited to the $90 million to strengthen programs to attract and retain rural physicians and $29 million as part of the AMA deal.

I also understand that AHS is heavily involved in the recruitment of international doctors, both specialists and family physicians, you know, particularly in countries where we can fast-track the practice assessments. This is part of the work we're actually doing with the colleges – right? – to reduce the amount of time it actually takes to get the credentials. We fully appreciate that there is a shortage of doctors generally and, in particular, specialties. We talked earlier this morning about anaesthesiologists. That's one. For oncologists and family docs you can see that we're posting. We still have a net increase, overall, in doctors in the province, but the reality is that we still need more to be able to provide the service, so part of our health care plan is actually to do that. Actually, if I could just provide – in 2022 we had 716 physicians that started practice in Alberta, and that contributed to a net gain. That's total amount, but that's a net gain of 254 from 2021. Again, there's always turnover, and there's people retiring, people leaving. We're still getting net gains, but I fully appreciate we need more.

5:15

Mr. Shepherd: I do have some more questions, I guess, along the question of cancer, but given we have about two minutes, I was just wondering, Minister, if you might happen to have any of the information we'd asked about earlier. I know you've been working with your staff. Do you have any updates you'd like to provide?

Mr. Copping: Thank you for asking that question. A number of questions – I'll try to get through this as quickly as possible. You asked in terms of the Alberta surgical initiative and funding for, you know, rapid access clinics. I just wanted to say that the total for what I would call the whole FAST approach – so that includes rapid access clinics, prehabilitation, and other elements – is $42.85 million. Of that, rapid access clinics are $27 million in Budget '23-24 and then $4 million for prehabilitation. You also have $5 million for the Institute for Healthcare Optimization and then $6.85 million for electronic referral system. So that's all combined to be able to drive that.

You also asked on the 127 allied staff that's going to support emergency departments. For staff and support in the budget is $20 million.

You also had a question in regard to just to confirm on the 90-day report: are we apples-to-apples comparison, both in terms of the EMS response times and in terms of red alerts? The answer is yes.

And then you also had a question about Airdrie. You know, what category is it in? Is it greater than 3,000, or is it a metro-urban category for tracking purposes? It is in a metro-urban category.

That's all I've got right now. There may be more coming. I know time is wasting, but if not, we'll get that to you in a written format.

Mr. Shepherd: I appreciate that, and well timed, Minister. I'll look forward to the next block.

Mr. Copping: Excellent.

The Acting Chair: Thank you, gentlemen.

We're back over to the government.

Mrs. Allard: Thank you, Mr. Chair. Through you to the minister, I just had a few questions about some of the metrics in the business plan, Minister. I'm on outcome 1 on page 63. Outcome 1 states, "An effective and accessible health care system that provides Albertans with the necessary care when and where they need it." One of the performance indicators on the next page: the number of registered physicians in Alberta. I see it's trending up, which I think is good, but one of the things I hear quite often is that we have enough doctors; they're just not where we need them. I don't know how true that is. I certainly know that in my community of Grande Prairie there are not enough, and I know that you know that as well. So I'm just wondering if there's been consideration to change the metric. For example, the sheer number of physicians may not represent the full-time equivalents, or it may not represent their panel size or their geographic location. Is there any work being done to have that metric represent what the goal really is?

Mr. Copping: Thanks so much for the question. I fully appreciate that the metrics in the business plan – we put in a high-level metric to be able to show general progress, but it can't capture everything, and if we did, we would actually have 50 metrics on our plan, which is also not helpful. So we put in that one metric in terms of the number of registered physicians, which gives you a general trend line that it is going up, which is helpful. But I fully appreciate it's – we talked about anaesthesiologists and oncologists. Like, some specialists: we don't have enough, and then also we don't have the right distribution within the province. For example, we have a much higher shortage in particular areas like Grande Prairie and other areas of the province, especially rural, like outside the big major cities, even for family doctors. You know, this is intended to be a general assessment of: are we winning or are we losing on this? But I fully appreciate your comments that this one metric will not solve all our problems.

Like, quite frankly, we have some locations where we have enough doctors; we don't have enough nurses. Other locations – and this is part of our health human resource plan, where once we get enough nurses, it says: do we have enough diagnostics technicians? If you can't do the diagnostics, you're not actually doing the surgery at that location. So we are looking at that as part of our broader health human resource plan and actually looking at those particular numbers in our HR plan.

Now, for the purpose of the business plan to be able to provide a high-level overview in terms of how it's going and provide that, I fully appreciate that we need to be looking at all those metrics because at the end of the day, you know, what truly matters is: are Albertans getting the service they need where they need it? Are all of our rural hospitals fully staffed and able to provide that? Are our wait times for seeing a specialist within recommended wait times? Are our wait times for getting the surgery done within recommended wait times? Like, that is the important number.

Then also on your comments – and you're quite right. A head count is helpful, but it's like: how much are the individuals working? So we are also continuing to work with the AMA, and this is a conversation we're having over the next few weeks. How do we come at supporting doctors in seeing more patients?

Again, as we move forward, you know, in that conversation about team-based care, where you leverage not only doctors but nurse practitioners and physician assistants to be able to provide the care, then it's about providing that. It's about: that care is actually getting done.

So I fully appreciate this is one high-level metric. It doesn't measure everything that we need to measure, but it gives a sense of where we're going. That's why we put it in the business plan. To put in 40 metrics just didn't make a lot of sense, but we actually have those numbers, and we'll be actually watching those numbers as part of our health human resource strategy.

Mrs. Allard: Thank you. Through you, Chair, to the minister, thank you for that answer. I'm not surprised that it was a fulsome answer, and you already answered my next question, which was: if we're tracking the number of doctors, what about the number of nurses and other allied health care? So I appreciate that you pre-empted my question.

I guess we have five minutes, so it's going fast. I did want to ask a little bit on page 62, sort of in the same vein of questioning and to the minister's final comments there around having a health home. The last line of the first paragraph says, "increasing the number of Albertans attached to a health home that provides a home base in the health system to receive primary care services and be connected to other health and social services." As you know, through the chair, Minister, I'm very passionate about creating a health home in Grande Prairie, that I think is going to become a reality any time. I'm just wondering: how many of those are happening across the province? Is that something that we're moving to province-wide? How successful has that initiative been?

Mr. Copping: Yeah. You know, our objective, as we announced as part of our health human resource strategy, is that all Albertans have the opportunity to be attached to a health or medical home. This is a combination of ensuring that we actually have enough resources – so that's doctors, nurse practitioners, and other allied health professionals – but it's also in terms of the model that we present. We have a tremendous base to start with with our primary care network. That supports, quite frankly, the vast majority of our primary care physicians to be able to leverage that. That's how we actually get – that's one way; that and different models of care like a blended capitation model. We can get a team-based approach and

have the opportunity for everyone to be attached to a medical home. So that's how we get there in terms of leveraging that.

That's why I'm so excited about the MAPS work, quite frankly, right? You know, how do we support PCNs? How do we change the governance and the funding structure for that? How do we think about the overall governance structure for all of primary care and make sure it's attached to a medical home? Our objective is to actually ensure everyone has that opportunity.

Now, don't get me wrong. There may be some individuals, you know, who don't want that and just want to do a walk-in clinic. Like, between ages 20 and 30 there are some people who may not need that as much, but we also know that for the vast majority of individuals having a continuity of care is critically important so we can actually identify the issues, like the health issues, over a period of time and be able to provide the care.

Quite frankly, it's about prevention, keeping people out of the most expensive door when you're the sickest and actually focusing on primary care. Other countries that do this well are actually reducing their acute-care system – for example, like Denmark – not increasing it, because they don't need to.

It's going to take us some time to get there. Again, that's why I'm excited about MAPS, to give us that blueprint of how we actually get to that and our objective that everyone can be attached to a medical home, not only have the resources to do it, but we have the right model to make that happen, and we're heading in that direction.

5:25

Mrs. Allard: Thank you. It is very exciting.

I know I don't have a lot of time left, so this question may be larger than two minutes affords us, but I'm going to try it anyways. I'm on page 64 under the key objectives, key objective 2.4. I only ask this because this comes up in my constituency office fairly frequently. It says, "Ensure processes for resolving patient concerns are effective, streamlined, and consistent across the province." I guess my question would be centred, through the chair to the minister, around that when a patient can't get a surgery in a timely fashion or when a patient is unhappy with the service they're getting at their health care provider, we often send them back to the health care provider to resolve it. When that's impossible, what is the next step? I guess that when I read this objective, if I look at the case files in my office, there's definitely an element, at least in Grande Prairie, that are not feeling that this is a streamlined process. If you can comment on that in the one minute and 45.

Mr. Copping: Yeah. So the Health Advocate is – and we've actually increased funding in that in the budget to actually add staff, because we did consultation over a year ago and highlighted just how complex our complaint system is. Because it could be – you know, if you don't like the service of a doctor or a nurse, then you can do a complaint to the individual colleges. If it's AHS that's providing the service, you complain to AHS. And sometimes it's all three associated with that. We have a large number, just under 30, of professional colleges in dealing with individuals, plus there are these other complaint processes, so we've decided to streamline the processes. Actually, the first place you go to is the Health Advocate. They can help navigate the process. We'll still need you to do individual complaint processes, but they can tell the story once, push that through to where that needs to go.

Then what's really important about this is that even though we still have reporting from all of these different bodies like AHS and the colleges and even the Health Advocate, it comes in all separately, so it's harder to identify trends. The whole purpose of having a complaint system is that if somebody has a problem with how things are working, we need to not only investigate that and address it appropriately, but number two, we need to identify the trends. Where do we need to make the fixes from a policy or a process standpoint to make sure that that's not going to happen again? You know, our vision is to expand the office of the Health Advocate, allow them to actually be a navigator, control the process. Then eventually we are looking at potentially passing legislation to require that it actually goes to the Health Advocate, but that's down the road.

The Acting Chair: Thank you, Minister.

Now it's back over to the opposition.

Mr. Shepherd: Thank you, Mr. Chair. Minister, I just wanted to continue, I guess, discussing the challenges specifically around cancer care. What I heard there was, I guess, that it's part of the general physician recruitment and retention – there are no specific strategies at the moment targeted at oncologists and oncology.

One of the other challenges that I'm hearing about in the realm of oncological treatment is regarding medical physicists. I'm sure you're familiar. They're a central part of the process in planning radiation treatment, calculating correct dosages, determining the safest path to target tumours with the least damage to surrounding tissue. I imagine you're aware of the challenges we faced. They were contracted as non-union clinical staff; thus, they were caught in the salary freeze that was in place from 2014 up until last year. As part of that, it became increasingly unattractive for many of them to work in Alberta, so we began to lose many to other jurisdictions. Now the pay freeze has been lifted, but what I'm hearing is that we are continuing to lose medical physicists, recently having lost three or four to Victoria, where, again, B.C. is sort of making an investment on a new cancer care strategy and building three new cancer centres. Just through the chair to the minister: are you aware of this? Are there any steps being taken to address this to help recruit, retain, or train and replace medical physicists?

Mr. Copping: My understanding is that there were some concerns that were raised. I'm reaching back in my memory; this is a number of months ago. We were actually able to – you know, AHS, who's actually dealing with these individuals, were able to address some of the pay concerns. That actually is my understanding, that that has happened. But in terms of where we actually, like right now – this is, I think, six to nine months ago. I'd have to check in with the staff and get back to you because I haven't heard that as a current issue. I recognize it was an issue at some point in time and there were concerns about payment issues. That, you know, negotiation actually occurred, and those were addressed. So I haven't heard lately in terms of individuals leaving, but I'm happy to check in on that.

Mr. Shepherd: Thank you, Minister. Through the chair to you, Minister, I appreciate that. My understanding is that at this point even for the Calgary cancer centre we are having to contract some folks in the U.S. to commission the new machinery due to a shortage, so it is something that I think we need to be looking at and considering.

I also understand that we are facing a shortage of radiation therapists. I've been speaking with some contacts at various places, including the Cross Cancer Institute, where they describe the shortage as disturbing. I'm told by folks that are working in the field that there's been a sharp increase in tuition for the radiation therapy program at the U of A, as much as 150 per cent, over the last few years under your government and that the program is on track to only graduate about eight new therapists this year.

Is this something that we're looking to address, I guess, as part of the amounts that are being – again, I know the indication has been that it's sort of general, but is this something you're alive to, aware of? Are there any intentions to try to address this in the training piece? I mean, are these conversations you've had with the Advanced Education minister, perhaps, around these increases in tuition for medical professions that we are desperately in need of?

Mr. Copping: Yeah. The conversation I've had with my colleague is in regard to increasing the number of spots for health care professionals. Very pleased that as part of Budget 2022 there's a $31 million increase, and then Budget '23 was an additional increase – I haven't got the numbers in front of me; that's different budget, Advanced Education – focused on health care workers. I know that my colleague, recognizing that tuition for some programs actually has increased, has also looked at expanding the supports both in terms of bursaries and in terms of loans. We also announced some measures just recently in terms of, you know, capping tuition increases at 2 per cent, the expansion of the period of time from six months to 12 months on repayment of student loans and lowering the interest on student loans. All of that has taken place.

In terms of this specific program, whether or not we have sufficient coming out of there, I'll have to circle back with AHS, but we are as a government investing significant dollars to increase training within our own programs, and that includes allied health professionals.

Mr. Shepherd: Thank you, Minister.

Maybe I'll pivot, then, based on talking about training and specifically about, I guess, opportunities for rural education, training, and recruitment. I had a chance to meet recently with the Rural Health Professions Action Plan, some very good folks, I'm sure, as you're aware. I'm sure you've had many conversations with them over the course of the last few years. Some excellent perspectives and recommendations.

One of the things that was interesting to sort of learn from them in that conversation is that they, around, I think, 2018-19, had their mandate expanded from strictly focusing on supporting and recruiting rural physicians to all rural health care workers. Though they've had a significant expansion of their mandate and certainly, I think, could offer some significant value there, they have not seen any commensurate increase in their budget to sort of support that kind of work. In looking at it this year, I believe we're holding about steady on the RHPAP funding, but I just wanted to get your thoughts on that. Is that something you've considered providing some additional support, especially given the challenges we know we are facing in terms of rural recruitment, retention, and training?

Mr. Copping: No. Thanks so much for the question. Actually, this is a conversation that I've had the opportunity to speak with our parliamentary secretary for rural health, MLA Yao, on, looking at not only how we do ensure that we can support programs like RPAP for doctors but also looking at nurses and other allied health professionals. You know, there has been some significant work that's been done on this. Like, we have expanded funding for rural retention and recruitment in the budget overall – this is for doctors – so RPAP hasn't gone out, but additional funding has gone in terms of the attraction and retention in that regard, including the RESIDE program.

In addition, very pleased working with a colleague, Advanced Education, on training outside the big cities – right? – that initiative. Part of our investment in expanding our programs at U of C and U of A is actually training doctors in remote areas. We've also been focusing on: okay; how do we actually – you know, training local, let's talk about nurses, the Wainwright model, in terms of U of C, doing the four years of training for nurses, two years online and then the two years basically online but still in the hospitals. It's a joint program with AHS at the U of C in the town of Wainwright and also looking to expand that to other areas. That's part of the budget for AHS in Budget '23, to do that.

5:35

And then, also, you know, talking with Parliamentary Secretary Yao – again, we may have enough nurses and doctors, but if you don't have enough technicians to be able to run the diagnostic machines, you're not going actually to be able to provide the service. So what is the next level that we need to actually take this? Now, I'm pleased that as part of the AHS negotiations with the nurses and the HSAA, who represent many of these diagnostic technicians, part of that agreement is – and I'm going to get the name wrong – basically a rural opportunity fund so that they can look at: how do we use that fund to support people moving into rural areas and staying in rural areas? That fund has been negotiated with both the nurses and then with the HSAA and AHS. They're working through: how do we use that fund to be able to do that?

But the training piece is important. We also recognize that it's not just about, again, training. The conversations are ongoing, but we haven't put it in the budget yet. You know, the NAIT, the SAIT, and then these other programs where we can actually go out to rural colleges for the diagnostic, because, again: train local, right? And I know they're not kids; they're young adults. I have one. But they go to school, like, in their local community, get trained up, and then go work in the hospital, right? So we are exploring different opportunities at this point in time. It hasn't made it into the budget yet, but there's next year.

Mr. Shepherd: You're laying the groundwork, as it were.

Mr. Copping: Yes.

Mr. Shepherd: Yes. RPAP did tell me about the Wainwright project, and that certainly sounds like an excellent one. I understand that U of C is now considering expansion, perhaps out towards Drayton Valley, and it certainly sounds like a model that'd be worth pursuing. I certainly took their advice, that we seek more collaboration with PSIs, to heart.

Thank you, Minister.

Mr. Copping: Thank you.

The Acting Chair: Okay. Thank you.

I believe we're now over to the government side of the equation.

Mr. Yao: Thank you so much, Chair. Minister, I just have one final question on EMS, and you touched on it earlier, I believe. It's about the new health workforce strategy, that was mentioned on page 78 of the fiscal plan. Just wondering: how is the Ministry of Health focusing on attracting and retaining more paramedics in the province? I pose this question to you because you have a very good, diverse background. Your forte is human resources, you've worked with a company like CP Rail, and you bring just a plethora of knowledge on this subject.

Certainly, one of the things we identified in the AEPAC meetings in the committee was that, for example, AHS doesn't do exit interviews with people, and I'm wondering if they have identified any strategies to try to identify the deficits that cause people to leave the industry as well as how we can utilize that information to retain these people. I myself was able to survive for a substantially long time in emergency services, but admittedly I was under a different

model, the integrated model, which, you know, we can't brag about here. But, certainly, again, though, with your background are you able to provide any guidance in this health workforce strategy that has been mentioned in the fiscal plan?

Mr. Copping: Well, thanks so much for the question, and again I just want to thank you for your work on the AEPAC committee because, you know, when we originally established that, we recognized that it was not just about getting more workers, but it's actually: how do we support workers? Quite frankly, I'd heard stories that whereas the average career of a paramedic decades ago was 15 to 20 years, now it's less than 10, and that's a problem, right? It's a problem in terms of – and we heard issues about work-life balance. We also heard issues of frustrations with people being stuck in a hospital and not being able to get back out on the street.

We also heard frustrations with, quite frankly, the core flex model, which perhaps in days gone by made sense, where you would work certain core hours but be on call, but this would be for days at a time. When you had the odd call when you're actually on call, that made sense, but when you have the increase in the volume, that doesn't make sense anymore. So very pleased that, you know, part of the budget for 2022 – and we're expanding that in Budget 2023 – is changing the core flex model and actually providing a scheduled work time. Now, it's going to take more people – right? – to be able to do that, but we know we need to do that so that gives certainty to individuals about their work hours, when they're on duty and when they're off duty, and it actually addresses the safety issues given the increased calls. So that's one thing.

The other thing, you know, that we need to address – and this came out in AEPAC – is just more staff. One of the challenges is that when you need to fill X number of staff to be able to do the work but you don't have them there, then that means there's more workload on the individuals who are left there and more overtime, or they're not getting off in time or can't take vacation. That all impacts the work-life balance. So part of that challenge is just simply getting more staff to be able to do that and then more full-time staff so there's greater certainty associated with the job.

And then listening to employees. You know, very pleased that AEPAC, which you were part of and our colleague Parliamentary Secretary R.J. Sigurdson – his work in terms of going out, talking to paramedics, and doing all the surveys: people want to be heard; more empowerment, pushing down decision-making to be able to do that. Again, there's not a short-term fix. This has been a challenge for some time, and coming through COVID, with the shortage in the workplace, has actually made it worse. But as we get the changes in place to get more staff so there's greater certainty – you've got more people who are actually carrying the load – as we continue to listen to the staff and give them more power in terms of their overall job, as you get them out of the hospital so they're doing what they want to do, then we'll actually see improvements in this. Then part of it, too, is getting the – you know, I've heard this loud and clear from paramedics, and I know you did as well. Paramedics want to be quick to respond to these calls. These are their fellow Albertans. This is why they signed up. As those times come down, that'll improve the quality of life.

Then the last thing I'll just comment on, because I know you've raised this as well, is in regard to – and it came out in AEPAC – ongoing mental health supports, ensuring that employees have access to this. It's a challenging job, the trauma that they see on a regular basis, paramedics. Supports need to be able to address that, so we need to have those supports in place. Again, I'm looking forward to, you know, as our colleague works through the AEPAC recommendations – this is 2023's funding. We talked about that $90 million to be able to provide more supports to paramedics so that we have people not retiring after less than 10 years, like leaving the field, but staying for a longer period of time and then make it a better work environment for them as well.

Mr. Yao: Thank you so much, Minister. I really greatly appreciate that and all your answers on EMS. Really, I think paramedics everywhere are really encouraged by a lot of things that your ministry is doing that you've led, and thank you for that.

I'm going to change gears a little bit and go to Indigenous health – okay? – which is quite relevant in my community, in my region. Up in Fort Chipewyan, one of the most isolated communities in the province, you either have to drive an ice road in the winter to get there or fly or take a boat in the summer. That community is under the auspices of the federal government and Nunee health. You know, they provide an adequate service, but truly they haven't been responding to the needs. I know my community up in Fort Chipewyan has been very encouraged by meetings with your ministry on some of the things that you'll be doing.

But my overall question is on page 21 of the government's strategic plan under objective 4. I'm wondering if the minister can provide us with a few specific projects that your ministry is working on with First Nations, Métis, and Inuit peoples to improve access to health services.

5:45

Again, I refer to the fact that in a lot of cases, especially First Nations, by rights that is supposed to be under the auspices of the federal government, and they have not provided the services in a fashion that's been adequate to address a lot of needs. Again I refer to the meeting that you had with my First Nations up at Fort Chipewyan. They came back to me, and they were very encouraged by some of the things that you had to say. I'm wondering if you can perhaps explain to us in greater detail some of the things that your ministry is planning with First Nations.

Mr. Copping: Thanks so much for the question. We spoke earlier this morning, but when you take a look at the health outcomes for Indigenous peoples in Alberta versus the average Albertan, they're simply unacceptable. Now, this is a combination of, you know, access to care, particularly in rural, remote, but it's also wanting to access care. We've heard concerns about discrimination and people not wanting to access care, and quite frankly we need to address that.

We've already been taking action in some regards on this. You know, I talked earlier about how pleased I was with, as part of the Alberta surgical initiative, the Enoch Cree Nation winning the contract in the Edmonton region to provide chartered surgical facilities to do orthopaedic surgeries and use that as a cornerstone of their health campus hub. This is something to provide culturally appropriate care for Indigenous people and anyone else, for all Albertans to be able to do that.

The funding that we've provided for First Nations to be able to make RFPs for our Indigenous stream on continuing care spaces – and we awarded a number on that. We have also reached ARPs, different funding models, because we recognize that for many Indigenous peoples there are high degrees of complexity, so a fee-for-service model doesn't necessarily – you know, our department has reached a number of ARPs with physicians in Alberta to provide improved care and better care to Indigenous peoples.

The last thing I want to talk about is just, with 24 seconds, MAPS. We knew this was a significant issue. We appointed an Indigenous panel, led by Tyler White, the CEO of Siksika health foundation, to identify, you know, not only quick hits but longer term actions that

we can take. Now we are funding, as part of the budget, pieces of that, and I look forward to talking about that.

The Acting Chair: Okay. Thank you, Mr. Minister.

I believe we're back to the opposition.

Mr. Shepherd: Thank you, Mr. Chair. So many things to choose from. Through you to the minister, let's talk about hospitals. The AHS report dated January 2023, in-patient bed deficit projections, stated that Edmonton had a deficit of hundreds of hospital beds, that number expected to balloon to roughly 1,500 in the next few years. It states that the Edmonton zone has been short roughly 500 beds since 2016, on track to be short as many as 3,000 by 2036. The fourth set of numbers from AHS pegs that number at about 1,828 in coming years, even with the 500 new beds that were part of our original plan for the south Edmonton hospital, but the recent documents that have come out that we've seen show that your government's current plans for the hospital have cut its capacity to about 400 beds.

To the minister, through the chair: why would the government be looking at reducing capacity in the hospital when the need is high in AHS and everyone in the system seems to be acknowledging that we are already at a deficit and that that deficit is only going to grow?

Mr. Copping: Just to confirm, the current plan in south Edmonton is actually still maintaining the original amount: it's 436 beds plus 60 shelled. Recognizing that there is a need for additional capacity, which, you know, we will be able to meet as part of the south Edmonton project, we don't necessarily need all that right now, because it's future capacity. So the plan is for 436 immediate – well, immediate when it gets built, and we're still talking down the road – but also 60 shelled. But, again, we're going to continue to do ongoing assessment – right? – to be able to make sure that we have the capacity to meet the needs of Edmontonians.

I also just want to make one other comment. Over time we are also looking to change the models of care, right? When we start thinking about all the work that we're doing right now on our whole emergency departments and in-patient, how do we flow people through faster and then alternate levels of care, which may not be in a hospital bed but may be out in the community or home care, right? So there's ongoing work associated with this. Then on the front end as well: how do we keep people out of hospital? That's actually our objective. Like, other countries that are doing this well actually spend more than we do as a percentage on primary care than they do on acute care. They have better health outcomes and actually spend overall similar or less money than we do per population.

Now, we still need the hospitals. I just want to be crystal clear that we are committed to the south Edmonton project, but we also need to build it and be flexible with it and then actually have flexible capacity. That's why the current plan is 436 beds with 60 shelled, so that we can bring them on if needed. But if we don't need them – that is actually, to be honest with you, where I prefer to be, that we don't need them because we don't actually have the people that need to go into the hospital, right? We are continuing to do the work on the functional planning to make sure that we have a plan that's going to serve the needs of Edmontonians.

One more comment on this as well. We also have in our capital plan doing planning dollars for a Stollery, a new stand-alone Stollery hospital. We get the planning dollars in there. My understanding is that it's going to take some time. Like, this year the next step is the budget. Then you do the functional assessment on the budget. That's also going to provide opportunity, as we pull those resources out of the U of A hospital, for repurposing that as well. It's an opportunity to look at the entire capital plan in terms of what we need now and in the future.

Mr. Shepherd: Thank you, Minister. I appreciate the answer.

Speaking of keeping people out of hospital, coming back to, I guess, the MAPS recommendations and sort of the amounts that are being put forward specifically around the recommendation around implementing stimulus funding for team-based care, I know we've talked a bit about the dollars that you're putting out to PCNs, $125 million for the MAPS recommendations. Then there's the $40 million as per the AMA agreement, $27 million for the increase in patients attached. I just want to be clear. What portion of all of these dollars is specifically for increasing team-based care?

Mr. Copping: The $125 million is for the MAPS recommendation. I just want to tell you that it's a start.

Mr. Shepherd: Right. Of course.

Mr. Copping: We haven't got all the recommendations yet. We've done a rough assessment of some of the initial things that are coming down and what we think might be happening in terms of the $125 million.

Mr. Shepherd: Have you actually broken down, like, which recommendations you're intending to give how much, or is it still kind of very general?

Mr. Copping: No, we haven't. We're still working through that right now, right? But there was a high-level assessment done. You know, when we start talking about team-based care, part of that is not only going to be – there may be some additional funding required. When you take a look at a fee-for-service model versus a team-based care model, the team-based care model, based on our current models – and we're still actually refining our model – is slightly more expensive but not much more expensive than a fee-for-service model, right? So it may not require much additional funding associated with that.

Then the expectation, when we look at the team-based care model, is that it actually will save money because the health outcomes on a team-based model are better, generally speaking, than a fee-for-service model, and that means less hospital time, right? The point I'm trying to make here is that we may not need additional funding to go to a team-based model. We may need some upfront funding to actually do the transformation, but once we get there, net, the expectation is that the funding is actually going to go down on a per capita basis.

Mr. Shepherd: Through you, Mr. Chair, to the minister: what are you building into that in terms of, I guess, parameters and the expected outcomes to monitor and track that and ensure that we are getting those results? We do know that in the past there have been increases in funding for PCNs that did not necessarily yield the kind of results we hoped to see. Now, PCNs, again, provide excellent care and do excellent work, but we haven't always gotten to where we wanted to go. What are you building in with this funding and in this planning to ensure that we're tracking that and, I guess, holding things accountable for the outcomes?

5:55

Mr. Copping: Two elements, right? The first is, you know – and this is one of the issues we've asked the MAPS panel to deal with – to say: "Okay. How do we measure success? Any recommendations on that?" Also, in terms of governance we know that the governance structure for PCNs, the funding model, needs to change. But also: okay; if we're going to provide more funding

to that, how do we actually measure the outcomes and ensure that we're getting the outcomes both from a health standpoint and a cost standpoint, the associated ones? That is one piece, and we've asked for the recommendations from MAPS to be able to do that.

The second piece. You know, I had the conversation earlier about how one of the mandates that I have is looking at HQCA. How do we leverage the HQCA? Yes, PCNs have a governance structure and manage themselves but also have HQCA over top of that to say: okay; how are you doing? The HQCA can take a broader view because it's really hard for the PCNs to say, "Lookit, we're getting the value that we want, but we're actually saving money over here in the acute-care system" – right? – but they don't necessarily have oversight on that.

Giving the HQCA the ability to take a look at those questions, to be able to do it – again, when we look at our health care system and we compare it to other systems around the world on health outcomes and cost outcomes, we typically rank as Canada, you know, 12 or 13. You look at the Commonwealth Fund, that does an ongoing study on this, and we do better than the U.S., which is typically worse than us, 13 or 14. But there are a dozen other countries that do better than both of us, like Denmark, like a number of European countries, like a number of Nordic countries. We need to look to them, which is why part of MAPS was an international panel to look at the experiences in other countries to say: what can we learn here to be able to implement, to be able to do that?

We are going to need to measure the health outcomes and the cost outcomes, you know, recommendations from MAPS in terms of how we do that in the primary care space but also HQCA to be able to do ongoing oversight of all of that.

Mr. Shepherd: Now, I appreciate that, Minister, and certainly recognize, I think, the value of HQCA. I would note that perhaps you might want to consider, then, restoring some of the independence that the HQCA once had. Of course, your government passed legislation early on which took the reporting of the HQCA away from them, from reporting to the House to reporting directly to the minister. We certainly saw some movement there that, I would say, took away some transparency and ability for the HQCA to act in an independent way. If you are committed, that would be one way to do it.

The Acting Chair: Thank you. Your time allotted is up.

We'll go over to the government side.

Mr. Long: Thank you, Chair, and thank you to the minister, and thank you to members of the opposition as well. It's been a very good conversation today, and I get to make a lot of notes myself today based on the dialogue.

Minister, obviously, there's an issue – and I think that we've mentioned a couple of times today that it's not just Alberta that's facing it – and this is around family doctors. I have relatives on both coasts of the country. That's where I spent all my time growing up and then living before I came to Alberta, on either coast of the country. Inevitably, they have major issues in their own provinces, in the Atlantic provinces and in B.C., around health care and in getting family doctors.

I do understand that different jurisdictions take different approaches to addressing the issue. I'll just have a few questions around this. I'll do them one at a time, if that's okay, and have a bit of back and forth. As far as physician recruitment, as mentioned on page 79 of the fiscal plan, I'm just curious if you can provide an update on how you're working with colleagues in cabinet, regulatory colleges, or even nonprofits to make Alberta more competitive in attracting and retaining doctors.

Mr. Copping: Well, thanks so much for the question. As you know, we've had discussions even as we did our tour in your neck of the woods on that. You know, we do have a shortage of family physicians, particularly in rural Alberta, and that actually impacts the ability to provide AHS services, because it's our family physicians that are actually the physicians that are providing services within our rural hospitals. Budget 2023 provides $158 million to support multiple initiatives to recruit and retain health care workers, which includes $90 million for programs to attract and train rural physicians, $29 million to fulfill our commitment in the agreement with the AMA that specifically focuses on rural and underserved areas. You know, it also – and I've mentioned this before – is ongoing work with the College of Physicians & Surgeons to be able to streamline the process. I just want to highlight three things they are doing.

One is practice assessments for physicians coming from countries, you know, with similar training. We have here the practice assessment reduced from six months to three months so that they can get in the chair and start working, basically, in a very short period of time. To do that, that's number one.

Number two is that they're also looking at a stream within AHS hospitals. You know, there is an issue when a foreign-trained doctor comes here but they, again, don't have the level of training and they're not coming from a country with a comparable level of training. They come here, and then there's a recency issue so that if they're not working in the field for a period of time, then they have to go back to square one. While they're waiting for the opportunity to get additional training, such as a residency spot, working in the field can actually deal with that, so the CPSA is working with AHS to provide a stream within the hospitals, you know, a clinical assistant, to be able to allow them to continue to maintain their skill sets under the auspices of a medical doctor here while they're working towards getting an IMG residency spot.

Then the last thing, I think, is the training piece, right? We're very pleased that as part of Budget '23 not only are we increasing the number of seats primarily for rural physicians and actually looking to train them outside, in the big cities – I talked about this in terms of the clerkship and the residencies – but we're also expanding the number of residencies for IMGs so that not only the people who are already here and maybe in this clinical program but also Canadians can actually apply to those and do that. There are a large number of them who go to Ireland and then want to come back here. They don't do their residency there, but they want to come back here to do their residency in rural areas.

All of this is focused on addressing the shortage issue. I appreciate there's a short, medium, and long term. Obviously, leveraging international grads will actually be faster than training our own, but we need to do all of this. In an ideal world would we have started training our own sooner? Yes. But when you haven't done it yet, what's the best time to start? Well, it's right now. We're doing that, and then all of this will enable us to be able to have the family physicians in the rural areas and be able to provide the services that we need.

Again, as we talked earlier, it's not just about doctors; this is about nurses and other allied health professions. We're doing work on that front also with the college of nurses. I don't think I spoke to this earlier today, but both associations, the colleges for LPNs and for nurses, are working together to establish a triple-track program. What that is is a single application with a single assessment so that you're either, you know, assessed as a nurse, an LPN, or a health care aide and get working right away whereas beforehand you actually had to apply to both colleges, go through two separate assessments, so more time and more money. We're actually streamlining that process.

The college is doing it, and then we as a government, working with Advanced Education, are establishing more bridging programs so that, especially if you have nurses from the Philippines, for example, with which we also have an MOU – that's a separate issue – to be able to start addressing this issue, the nurses are assessed. You know, often they will be assessed as an LPN, but with a bridging program it would be expanded, the seats in the bridging program at, for example, Mount Royal University but also other colleges across the province. Then within nine to 12 months they can be qualified as a registered nurse and be able to fill that gap.

6:05

Again, we know there are shortages, as you indicated. It's not just here in Alberta; it's across the country, actually in many nations in the First World. But we have multiple approaches. It's not going to be one single solution to solve them. We're working on the fronts with the colleges, with our postsecondary institutions, you know, different approaches to actually doing the training in rural areas. Train local, stay local.

Then also in terms of our immigration, the federal government is working on and has announced a health care worker stream. I know that we have our rural renewal immigration stream, and health care workers are identified as a key component of that. Attract through immigration, so we speed up the process so that people can come to rural areas and then stay there. Then there's a return-of-service requirement so that they actually stay in the rural areas and then, hopefully, settle down.

One last comment because I think it's important that I share this. This came out of the conversation that we had when we were in your neck of the woods. What a tremendous job our municipalities are doing in terms of working with the provincial government about attracting and retaining health care workers, welcoming newcomers, you know, providing assistance in regard to getting them started. Sometimes that's housing, but sometimes it's other aspects of that to be able to want to work, live, and stay in rural Alberta so that we can actually have the staff that we need to deliver the health care services.

Mr. Long: Thank you, Minister. I was hoping to actually give a plug to my communities for the job they do on attracting and retaining physicians, so thank you for that.

It was sort of funny that you mentioned Dublin as one of the jurisdictions because I think that many provinces around the country – there was an article recently, and I believe it said that 8,400 physicians are trained from Canada in other jurisdictions around the world, Dublin being one that trains a lot of Canadians to become physicians, yet only 14 per cent of those are able to get back in across the Canadian border. I'm assuming that there is a lot of work being done by the provinces with the federal government to try to welcome more of those physicians home since we do need them so desperately and spaces are so limited across the country for training those doctors in our schools.

On that note, I want to thank you for an announcement recently about providing more funding in a couple of rural communities for training of physicians moving forward.

The Acting Chair: Thank you. I believe the time for the government is up.

It's now over to the opposition. I believe the hon. Mr. Feehan is going to be taking up the next round of questions.

Mr. Feehan: Thank you, Minister. I really appreciate the dialogue this afternoon, and I appreciate the chance to talk about a few things.

The first one I want to talk about: really, it's just a discussion more than anything. I was just concerned to see a study released out of the University of Calgary this week about physician attitudes toward Indigenous patients. Dr. Pam Roach put out a study, and the quick, simple outcome of the study: information was sent to every physician in the province, and about 375 of them returned the information. The outcome of the study, essentially, was that, quote: what we did find was that levels of anti-Indigenous bias within Alberta's physicians are unacceptably high. I could go on. I guess that I'm wondering, you know: what do we know about this, and how can Alberta Health Services help to move things along? Are there some programs that are currently in existence? In some way can we respond to this?

Mr. Copping: Well, thanks for raising that. This is an issue. We understand this. The U of C report coming out on this just confirms this. This is work that's being done, I know, with AHS and even Alberta Health. We've drafted an action plan to address Indigenous racism in Alberta's health care system to address these concerns. We also heard it coming from MAPS – right? – and the Indigenous panel. One of their recommendations is training for all health care workers on what is culturally appropriate care.

We've accepted, you know, all of the recommendations both from the Indigenous panel and the MAPS Alberta panel in principle. We are actually working right now and saying: okay, how do we actually roll this out? There is funding in the budget for this. It's going to take some time, right? You know this better than I – and I thank you for this work – but never without us. We need to take action, but we need to take action together with First Nations so that as we develop these plans with them – because, quite frankly, and I said this earlier, the health outcomes for Indigenous people in Alberta versus the average Albertan are far worse and unacceptable, period. We need to fix that, which is why we set up this panel in the first place. But you're right; it's not only about – like, if you feel like you're going to be discriminated against when going to a hospital, why would you go? That impacts care.

Again, I was very pleased when – and I think I mentioned this earlier – Enoch Cree Nation won the bid for the chartered surgical facility for orthopaedic surgeries in Edmonton. That's forming the basis for their health hub. They'll be offering culturally appropriate care in there, but it's not just for Indigenous people. It's for all Albertans, but also they can provide care to Indigenous on the nation. Then their plan is to actually expand the care there. We've also – and you probably know this – reached agreements with a number of First Nations, including the Blackfoot Confederacy, in terms of health tables and how we work together.

One last comment on this, which I'm excited about. Our Indigenous MAPS table includes the federal government, because this is not about who pays for what. Let's first figure out on: let's get the problem solved; how do we actually move forward? Then we'll worry about that after. I was pleased that the federal government announced that they were going to do some funding . . .

Mr. Feehan: Can you just identify where in the budget or how much specifically in the budget is being designated toward this training that you're talking about?

Mr. Copping: Yeah. We have put a line item in the budget for MAPS, which is $125 million, and the element – sorry; I'm just going from memory.

Mr. Neumeyer: Seven point two.

Mr. Copping: Seven point two million dollars. But I just want to be clear. That's a start – right? – because we haven't got the final recommendations. We've got the interim recommendations that came forward.

One thing I was excited about with MAPS. We had Dr. Njenga, who has a wealth of experience from New Zealand, participate in the international panel. How do we learn from other jurisdictions? When you actually look at their ability to improve the health outcomes of the Maori, you know, there's an opportunity there.

Also, Mr. Feehan, I know you know this very well: we have some phenomenal health services being provided by our First Nations right here in Alberta. You look at the Siksika, the work that they're doing. As one example, like, there's part of a national funding which is work being done by a Calgary-based company called Orpyx. They develop soles that actually sense – these are for diabetic patients – the amount of pressure that's on your foot, and it alerts you to when you have to move so that you actually don't develop sores. As you know, diabetics develop sores, and then that leads to being unable to be healed, and it's amputated. The Siksika . . .

Mr. Feehan: We're running out of time.

Mr. Copping: Okay. Sorry.

Mr. Feehan: I'm wondering if we could go on to my second question. I appreciate the answer.

Mr. Copping: Just the one thing about Siksika. They're doing work with Siksika, so I'm really excited about that.

Mr. Feehan: I'm enjoying the information, and I appreciate it.

I also just want to know about the maternal health program that was started in 2016 by the previous government at $1.3 million. It went through Maskwacis and Little Red River Cree to help with maternal health. I'm wondering if that program continues to exist and whether or not there's any thought or hope of growing it or expanding it to other nations besides those two.

Mr. Copping: I'm going to have to get back to you on that. I apologize. I don't have a line of sight on that particular program.

Mr. Feehan: Okay. Looking at it here, the announcement was in December 2016. December 9, just so you can follow that up. I want to know if the program – I want to know all about it. I mean, has it been successful? Did it really help change maternal health in these two Indigenous communities? Is there any hope, if it is successful, of expanding it? Perhaps, if you can do a little dig on that, we'd certainly appreciate it.

6:15

Mr. Copping: Yeah. We can look into that.

Also, you know, it'll be interesting to see, when we see the final report from the Indigenous panel, like, what they're recommending, if they've assessed that program and they think that we need to expand this. Some of their interim recommendations were expanding current programs that are being successful, which we're actually looking at: how do we implement right now?

Mr. Feehan: Thank you.

One other thing that comes up fairly frequently, especially when I'm travelling in the north, is the fact that people need to be medevacked into Edmonton on a regular basis. When a child is in crisis – when a pregnant woman is in crisis, I guess it is, and then a child is being born and they have to go into the NICU here in Edmonton, typically there is a rule that only one parent is allowed to fly down with that person, so it really does eliminate some of the community that is necessary for a family to respond to a child that's in the NICU. Typically, of course, the mother is there with the child, but it means the fathers are primarily excluded.

There have been requests a number of times to try to alter that. You know, members of northern communities just simply cannot afford it. If you're in Little Red and you're at Fox Lake, there's no way you can afford the flight out to come down, at least for many people. There have been requests that the medevac rules be changed to allow further family supports to attend children that are in the NICU. Of course, when they arrive, there are also services provided, so it would mean expanding the services in terms of food and shelter when they're here in Edmonton. I just wonder if you can tell me if that rule continues to exist and if there are any plans to make alterations.

Mr. Copping: Yeah. I'm going to have to get back to you in terms of that rule. I don't know if it continues to exist.

Again, you know, I'm looking forward to – like, all the high-level issues. We've asked the Indigenous panel: what are the issues we need to address so we can actually work on them? This particular rule I'm not familiar with, but I wouldn't be surprised if the panel comes back with two things. We've already started to hear this: how do we support families in communities so we don't have to bring them to Edmonton, number one, right? Like, that's the first step. Then the second step is: what other wraparound supports can we provide here, whether it be . . .

Mr. Feehan: You're just never going to put a NICU at Fox Lake.

Mr. Copping: Yeah. I fully appreciate that.

Mr. Feehan: Trying to accommodate that is the issue. You know, the communities certainly appreciate the services that are provided, but as most northern communities will tell you, there are extreme barriers for a lot of people, and getting full support to them is the hope and the desire.

Thank you.

The Acting Chair: Thank you, hon. member.

We're now back to the government side. Mr. Long.

Mr. Long: Thank you, Chair, and thank you, Minister. Thank you to the member for that line of questioning. Those were really, really important questions to be asked.

If it's okay, I'd like to just touch on a few other points around physician attraction, retaining, recruitment, again, understanding that we do have limited tools as a province as far as, you know, basically not being able to tell physicians where they need to practise. Quite frankly, we need physicians in rural and remote communities. I hope that no one would argue that point around here. I know they won't argue that point in my communities.

With that said, specifically on attracting and retaining physicians in rural Alberta, as mentioned on page 79 of the plan, the budget includes a $12 million increase for the rural, remote, northern program. I was hoping you could provide us an update with the results of this program so far.

Mr. Copping: Well, thank you for the question. The point of the rural, remote, northern program, or the RRNP, is to provide financial assistance to physicians who practise in underserviced areas of Alberta, supporting the recruitment and retention of physicians to live and to stay in those areas. The new four-year agreement between the government and the AMA provides a $12 million annual increase to the existing RRNP over the term of the

agreement, because if you actually just look at the numbers, you know, we have a shortage. Even though we do have incentives that are already there, the reality is that we need more because we're not getting the outcomes that we require. These dollars are targeted at improving access, particularly in those communities facing critical physician supply issues like that. That's where we're targeting that. Alberta Health right now is working with the AMA to develop the specific parameters. We haven't done that yet, but the conversations are ongoing. I may toss that over to ADM Smith in a second.

Now, we haven't done a formal evaluation of the whole program at this point in time, but under the terms of the new AMA agreement we are going to work together to say: how do we actually make sure that we're getting not only the right value for the money but that we actually have structured it correctly? It is an incredibly complex program based on, you know, how far you are away from a particular location, but we have shortages in all those locations, so does that actually make sense? We also recognize that when there's a general shortage, period, often the ones who are impacted the most are the most remote. Then do we need to change the parameters? But then, as we get more general supply, can we actually change them back? This is a work-in-progress.

You know, maybe I can ask ADM Smith to talk a little bit about the work because his team is involved directly in the conversations with the AMA on this.

Mr. P. Smith: Yeah. I think, Minister, you covered it pretty well. I mean, when we look at retention and recruitment, I probably categorize this one right now as more of a retention program than a recruitment program even though it's not that specific. Again, like any program, we want to re-evaluate it, and we need to tweak the parameters to make it more effective. That's actually another very prescriptive commitment under the AMA agreement whereby both parties are tied to a time-defined review to revisit, come forward with recommendations to the minister on it. I think some of these programs you really need to keep evaluating because circumstances change, so that's basically what we're aiming for.

Mr. Long: Thank you for that. In my own role I've taken to talking to professionals, like, one on one. I'm assuming there are ways that our health care professionals can submit their own feedback so it's not just simply coming from the organization. I know that, whether it's nurses, physicians, or other health care professionals, they've provided a whole bunch of different scenarios that will help move government in the right direction and get better outcomes. That's one thing that I do want to commend our health care professionals for, that they want to see us, see our province have better outcomes, see patients get better outcomes, and they're always willing to be engaged with us. You know, I just thank your team. I know that you had a few different dialogues when you were in my communities with some of the health care professionals, and I thank you for the openness to hear that feedback.

Now, that said, I know, staying on physicians, that we have just over 11,000 physicians currently registered to practise in Alberta. In B.C. they've chosen to basically try to combat an issue there, again, that every jurisdiction is having, with more money. I'm just curious: you know, at this point are we able to compete with the other provinces that are just choosing to throw more money at an issue that is a first-world issue? It's not limited to one or two provinces, even. Are we able to compete as a province with those provinces in order to retain our own physicians and to attract new talent?

Mr. Copping: The short answer is yes. You know, I appreciate that B.C. has made a lot of announcements in terms of: we have more funding. They did an agreement in a similar time frame that we did last fall; like, theirs came shortly after ours. Their agreement, just for rough figures, provides an incremental increase of about $708 million, approximately a 13.2 per cent increase over the total funding for physicians. Our agreement is roughly an investment of over $780 million, so it's actually higher than that. But what's really important is that we're starting at a different place, right? If you look at the data from CIHI from 2020 to 2021, we had higher, on average, gross clinical payments in Alberta than they did in B.C., so we still have some of the best compensation in the country for our doctors.

6:25

More importantly than that, we have a good working relationship in the AMA agreement, and we have a commitment to continue to improve our models of compensation. Again, I spoke earlier this morning about, you know, we'll be meeting over the next couple of weeks to actually talk about expanding ARPs, which actually make it better for doctors and enable them to provide additional care.

So we continue to be competitive, but we also know that part of that ability to be competitive is not just having a fee-for-service model but offering different models. We also heard loud and clear from some doctors that there are graduates who are, you know, leaving med schools who don't want to set up a business. They don't want to run a fee-for-service clinic; they want to come in, provide health care, and go home to their families. There's nothing wrong with that, right? You know, we all want to do that, in terms of do our work and then go home to our families and not work in a fee-for-service model, just one after another, and then necessarily work in the hospitals that evening. Some want to do that; that's okay. But what we need to do is create choice.

The one thing that I'm, you know, excited about with the AMA agreement that we reached is a commitment to work on providing choice together – right? – and then measuring that because we also, as I indicated earlier, know we're not going to get it a hundred per cent right. We're going to try something; we may have to tweak that, but to work together to be able to do that, and this agreement lays the foundation of it.

Then, also, the other thing – and I haven't mentioned this before. What this agreement does is that it focuses on what I would call internal equity issues. You know, there's a recognition that they have a spread of doctors in terms of family physicians making this much and some specialists making much higher amounts. There's a recognition of that, and to address those internal inequities, as part of our agreement we actually focus our dollars on the areas where we had the biggest challenges, like family physicians, like psychiatrists, and like those in community service. Then we funnel more money in the overall agreement to them to be able to continue to attract and retain.

So, you know, I would have to say that we are extremely competitive. We're working together to become even more competitive – different models and different choice and options for doctors – and we have a commitment, like, as part of this agreement to continue to work on that so we can make sure we have the doctors . . .

The Acting Chair: Thank you, Minister.

I will pass it over to the opposition if you want to have the last word. At least, the last word before I get the last word.

Mr. Shepherd: Thank you, Mr. Speaker. I see we have – Mr. Speaker. Mr. Chair. Who knows? Perhaps in the future, although no; I guess you are on your way out, so it would have to be at least four years from now.

I think I'll just take the last minute, again, just to give my thanks to the minister and to the staff and everyone that is here to support him today. Certainly, Minister, while we have had our share of disagreements, I think, and probably still have some very differing perspectives on many points, I do certainly have respect for the manner in which you've carried out your work and the service that you've given over the last few years and do appreciate, as I said, some of the more collaborative nature that you have brought. I think, certainly, we all recognize our health care system remains under extreme pressure – I would say still in a state of crisis – and certainly health care workers, I think, have endured a lot. And unfortunately – I will be honest – I think due to many decisions of your government there has been a significant loss of trust.

So I certainly hope that as we come up, I guess, to the coming election and we see what happens on the other side, whoever does form government will take the opportunity to rebuild that, that we have some transparency and openness and communication with our front-line health care workers and an ongoing collaboration so we can all put our best foot forward in delivering these services for Albertans.

Thank you, Minister.

The Acting Chair: I want to thank everybody on the committee for their hard work, their good questions, and for the service you've given to Albertans today. With that said, I must advise the committee that the time allotted for consideration of the ministry's estimates has concluded.

I would like to remind committee members that we are scheduled to meet again on Monday, March 13, at 7 p.m. to consider the estimates of the Ministry of Service Alberta and Red Tape Reduction.

Thank you, everyone. This meeting is adjourned.

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

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