



Legislative Assembly of Alberta

The 31st Legislature
Second Session

Standing Committee
on
Families and Communities

Ministry of Primary and Preventative Health Services
Consideration of Main Estimates

Tuesday, March 17, 2026
9 a.m.

Transcript No. 31-2-8

**Legislative Assembly of Alberta
The 31st Legislature
Second Session**

Standing Committee on Families and Communities

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Goehring, Nicole, Edmonton-Castle Downs (NDP), Deputy Chair
Sigurdson, Lori, Edmonton-Riverview (NDP), *Acting Deputy Chair

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* substitution for Nicole Goehring

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Standing Committee on Families and Communities

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Ministry of Primary and Preventative Health Services

Hon. Adriana LaGrange, Minister

Matt Hebert, Chief Operating Officer

Primary Care Alberta

Dr. Kim Simmonds, Chief Executive Officer

9 a.m.

Tuesday, March 17, 2026

[Ms Lovely in the chair]

**Ministry of Primary and Preventative Health Services
Consideration of Main Estimates**

The Chair: All right. We're ready to go. Good morning, everyone. I'd like to call the meeting to order and welcome everyone in attendance. The committee has under consideration the estimates of the Ministry of Primary and Preventative Health Services for the fiscal year ending March 31, 2027.

I'd ask that we go around the table and have members introduce themselves for the record. Minister, when we get to you, if you would kindly introduce the colleagues with you at the table, that would be great. I'm the MLA for the Camrose constituency and chair of the committee, Jackie Lovely. We'll begin to my right.

Mr. van Dijken: Glenn van Dijken, the MLA for Athabasca-Barrhead-Westlock.

Mrs. Sawyer: MLA Tara Sawyer for the outstanding constituency of Olds-Didsbury-Three Hills.

Mr. Lundy: Good morning, everyone. Brandon Lundy, MLA for Leduc-Beaumont.

Mrs. Johnson: Good morning. Jennifer Johnson, MLA for Lacombe-Ponoka.

Mr. Singh: Good morning, everyone. Peter Singh, MLA, Calgary-East.

Member LaGrange: Good morning, everyone. Adriana LaGrange, Minister of Primary and Preventative Health Services. With me, starting on my right: Matt Hebert, chief operating officer; Elaine Phillips, executive director and executive operations; my DM Matt Torigian; and Shakeeb Siddiqui, assistant deputy minister of finance and SFO.

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora.

Ms Sigurdson: Good morning. Lori Sigurdson, Edmonton-Riverview.

Mr. Haji: Good morning. Sharif Haji, Edmonton-Decore.

Dr. Metz: Good morning. Luanne Metz, Calgary-Varsity.

Ms Chapman: Amanda Chapman, Calgary-Beddington.

The Chair: I'd like to follow up the substitutions for the record. The hon. Lori Sigurdson will be substituting as deputy chair for Ms Goehring; Mr. van Dijken for Mr. Getson.

A few housekeeping items to address before we turn to the business at hand. Please note that the microphones are operated by *Hansard* staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of meetings can be accessed via the Legislative Assembly website. We don't have anyone participating remotely, so I'll skip that portion. Everyone, if you would kindly set your cellphones to silent, please, for the duration of the meeting.

Hon. members, the main estimates for the ministry of primary and preventative health shall be considered for three hours. Standing Order 59.01 sets out the process for consideration of the main estimates in legislative policy committees. Suborder 59.01(6) sets out the speaking rotation for this meeting. The speaking

rotation chart is available on the committee's internal website, and hard copies have been provided to the ministry officials at the table. For each segment of the meeting blocks of speaking time will be combined only if both the minister and the member speaking agree. If debate is exhausted prior to three hours, the ministry's estimates are deemed to have been considered for the time allotted in the – hold on just a second. Should members have any questions regarding speaking times or rotation, please e-mail or message the committee clerk about the process.

With the concurrence of the committee I'll call a five-minute break near the midpoint of the meeting. However, the three-hour clock will continue to run. Does anyone have any issue at all having a break? All right. Seeing none, we'll have a break.

Ministry officials who are present may, at the direction of the minister, address the committee. Ministry officials seated in the gallery, if called upon, have access to the microphone in the gallery area and are asked to please introduce themselves for the record. Pages are available to deliver notes or other materials between the gallery and the table. Attendees in the gallery may not approach the table. Space permitting, opposition caucus staff may sit at the table to assist their members. However, members have priority to sit at the table at all times. Points of order will be dealt with as they arise, and individual speaking times will be paused. However, the block of speaking time and overall three-hour meeting clock will continue to run. Any written materials provided in response to questions raised during the main estimates should be tabled by the minister in the Assembly for the benefit of all members. Finally, the committee should have the opportunity to hear both the questions and the answers without interruption during estimates debate. Debate flows through the chair at all times, please, members.

I now invite the minister of primary and preventative health to begin with your opening remarks. You have 10 minutes.

Member LaGrange: Thank you so much, Chair. I'm very pleased to be here to present Budget 2026 for the Ministry of Primary and Preventative Health Services. I, first, want to acknowledge all of Team Health that's here beyond the ones that are in the front here; all of the ones in the gallery and back in the department who do an amazing job each and every day.

This budget reflects our renewed focus on providing access to primary and preventative health services for every Albertan. Primary and preventative health care is the foundation on which our whole health care system rests. This is where it starts. We know that regular primary health care can catch issues when symptoms start to show, resulting in the right care from the beginning, helping to prevent smaller issues from developing into larger health problems that become more serious and put pressure on acute-care and emergency departments.

I want to say that we are the first province to ever have a ministry of primary and preventative health, so I'm very cognizant of what we're doing here as setting a trend right across Canada.

This is the bedrock of our approach to health care in Alberta, but our true anchor for primary health care goes deeper than this. Effective primary health care is really about people and the relationships they develop with each other. We all need a trusted connection with our primary health care providers. Those are the ones who know our histories, who celebrate milestones with us, and help us to navigate the twists and turns along the way. They walk with us in our journeys and become lifelong trusted partners.

Budget 2026 supports this goal. In total Budget 2026 provides \$12.7 billion for Alberta primary and preventive health services, an increase of \$1.5 billion from last year. We did not take this request for an increase lightly. Our province's fiscal reality is being shaped by global uncertainties, rising costs, and rapid population growth.

Other factors such as the increasing average age of patients in Alberta are driving greater complexity within our health care system. Even with these pressures, our focus remains on ensuring that Albertans can access the health care they need close to home and the support they need from their families and communities.

This is why in Budget 2026 we are making a record \$7.7 billion investment in doctors, increasing spending by 22 per cent from last year. This increase reflects our promise to provide every Albertan with timely access to primary care right across the province. This is an investment worth making. We are fortunate to have many of the best doctors in Alberta and that over 13,000 of them are now calling Alberta home. Alberta has consistently ranked among the highest in physician growth rates in the country for the past few years. Doctors are choosing Alberta as a place to stay and practise, and we will continue to support them, building a primary care system that will withstand fiscal and population strains.

We know that it takes a whole team of practitioners to ensure every Albertan is connected to a primary care provider. Budget 2026 supports our nurse practitioner primary care program with an investment of \$26 million in the '26-27 fiscal year. This is a 75 per cent increase from last year. Alberta's nurse practitioner primary care program is the first publicly funded initiative of its kind in Canada. It supports nurse practitioners in operating their own practices or practising autonomously in existing primary care settings. Our continuing investment reflects our belief that nurse practitioners are an integral part of Alberta's primary health care team, especially outside of the urban areas.

Budget 2026 also reflects our commitment to provide Albertans with access to drugs and treatments they need. We're investing a combined \$2.88 billion on drugs and supplemental benefits, pharmaceutical innovation and management, and support for some of the latest drugs and treatments available. We're continuing our support for the most vulnerable through drug coverage for seniors and low-income Albertans.

Budget 2026 will provide consistent and high-quality primary care for those in underserved communities as well. We know Albertans living in rural and remote areas face barriers in getting the timely health care they need close to home, so we're continuing to support primary care in rural and remote Alberta. In 2026-27 the rural health professions action plan has almost \$9 million allocated to support the attraction and retention of rural health professionals. Our continued investment in training and supporting health care professionals in rural communities encourages them to stay and build their practices there, strengthening primary care in all areas of the province.

Budget 2026 also includes \$5 million to support the work of midwives to deliver crucial care for women, their newborns, and families. Midwives help Alberta mothers access high-quality maternal health care even in very small communities across the province.

We're also committing \$6.1 million to improve health outcomes for First Nations, Métis, and Inuit throughout the Indigenous innovation fund and Indigenous patient navigator grants. The Indigenous innovation fund will continue to support primary health care services designed and delivered by Indigenous communities, including elder care, cultural reconnection programming, and community facility upgrades. The Indigenous patient navigator grant program will improve access to culturally safe primary health care for Indigenous patients. These navigators will help patients overcome barriers, access resources, advocate for their needs, and co-ordinate their progress through the health care system.

9:10

Budget 2026 will also invest \$1.8 million to develop an Indigenous tool kit for health care providers. It will help health care professionals provide respectful, informed, and culturally safe care with First Nations, Métis, and Inuit in Alberta. We will also explore models of Indigenous-led clinics, incorporating familiar foods in primary and acute-care settings and enhancing the Indigenous support line.

Preventative health care in Alberta is being supported through Budget 2026 investments; \$140 million will support immunization efforts in our province. This investment will strengthen routine childhood and seasonal respiratory virus vaccine programs by maintaining a stable vaccine supply and supporting access to immunization. And \$8.2 million will address sexually transmitted and blood-borne infections in our province. These infections affect the health system by driving up substantial costs in labs, primary and acute care, and pharmaceuticals. By preventing and treating infections that are often curable, we will reduce the impact on our health care system and provide overall public health.

We approach this budget knowing it is as much about fiscal responsibility as it is about maintaining the gains we have made in primary and preventative health care. This budget will ensure thoughtfully delivered services that will support and secure the health of Albertans through a time of unprecedented pressure. From strengthening the services they need close to home to supporting the health care workers that provide those services, Budget 2026 is investing to ensure every Albertan has access to high-quality, reliable primary health care.

Madam Chair, I'm happy to say that these record investments are something that we're very proud of, and I look forward to answering all the questions that are out there.

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

We'll now begin the question-and-answer portion of the meeting. For the first 60 minutes members of the Official Opposition and the minister may speak. Hon. members, you will be able to see the timer for the speaking block both in the committee room and on Microsoft Teams.

Member, would you like to have blocked or shared time? Who's speaking on behalf of the Official Opposition?

Mr. Haji: Yeah. I prefer shared.

The Chair: Minister, what is your preference?

Member LaGrange: I prefer blocked.

The Chair: We'll go with block time. Please proceed with your questions, Member.

Mr. Haji: Thank you very much, Madam Chair, and thanks, Minister, for the overview, as well as the department team for the background work that has been going on for a while before the budget was presented. Appreciate the work.

The minister has allocated \$653 million to Primary Care Alberta, which represents an increase of approximately \$360 million, or more than 50 per cent. Through the chair, can the minister clarify whether these funds represent programs that have been transitioned from other areas of the health care system that has been divided into a multitude, a number, of blocks? Can the minister outline which programs account for the increased investment if it's not a transfer of programs from elsewhere?

The description in the government estimates does not provide details on how this funding will be allocated within Primary Care Alberta. Through the chair, can the minister provide a breakdown

of how the \$653 million will be allocated within Primary Care Alberta? This is in the government estimates, line 2.4. How much of this increase will be directed towards administrative? What's the proportion of overhead costs? How much will go directly to front-line services? This is in the context that the government has divided the ministry of health into multiple ministries. At the same time quite a number of agencies have been created with the intent of reducing overhead costs, so I am interested in understanding how much overhead costs will be within this 600-plus million dollars that is blocked in line 2.4.

The ministry's business plan on page 135 also references \$5 million allocated to midwifery initiatives, which the minister has alluded to. Under which specific budget line does this fall within the government estimates and the funding allocated?

Primary care networks are the primary delivery mechanism of team-based care, primary care services in the province. Historically PCNs have been funded through the four-cut funding model tied to physicians' participation. The minister has stated publicly in the House and alluded now in the minister's statements that the number of physicians practising in Alberta has increased significantly. Given that not all family physicians participate in PCNs, can the minister tell us how many physicians are participating in the PCNs today compared to the previous year, and what is the percentage of increase? If the number of physicians participating in primary care has increased, the volumetric funding to the PCNs should also increase; however, this does not appear to be reflected in the government budget as well as the government estimates. Therefore, can the minister explain why PCN funding does not appear to increase in proportion to the reported growth in family physician numbers?

The business plan on page 135 also indicates \$26 million allocated in the 2026 budget to support the nurse practitioners program, which the minister also alluded to in the opening remarks. Is the funding being allocated through Primary Care Alberta, line 2.4, or through the primary care networks, which is line 2.2, within the government funding envelope? Historically, some larger PCNs accumulated surpluses due to their size and physician numbers. Can the minister provide an update on the current state of PCN surpluses across the province and if the budget line allocated for the PCNs reflects or includes or accounts for the surpluses that may exist in the previous fiscal years?

For MAPS, or modernizing Alberta's primary care system, reference is made on page 136 of the business plan to allocating \$50 million per year for the next three years for implementation, but the budget allocation, page 189 in the government estimates, for this year alone is \$81 million. I would like if the minister could clarify the discrepancies between the business plan and the government estimates and explain the purpose of the additional \$31 million, which is not mentioned or explained in the budget as well as the budget notes.

Turning to population and public health. Overall, outside of physician compensation, I kind of disagree. The ministry's budget for 2026 has not increased. In my view, it's decreased, if you take away the physician compensation, approximately by a billion from the 2025-2026 budget, even before accounting for inflation or population growth, all those factors. I called it one billion, but it is \$967 million, to be precise, but close to a billion reduction. One of the largest reductions appears within population and public health, which this year was reduced by 56 per cent compared to the previous 2026-2027 budget. This can be seen on page 139 of the business plan on the statement of operations. While program support within the population and public health increased by \$60 million for salaries, supplies, and services from the 2025 budget, several lines associated to direct service delivery have been cut: \$1

million cut for protection, prevention, and wellness; \$1.8 million reduction in cancer research, screening, and prevention; \$326 million cut in public health services for disease and injury prevention. Together these changes represent nearly \$400 million in cuts. The real reduction is greater when you factor in inflation and population. Can the minister also outline why funding for salaries, supplies, and services in program support line 5.1 increased by \$60 million and explain how this increase will benefit Albertans?

I also note that in schedule 22 of the government's 2026-2027 fiscal plan table the ministry's FTEs allocation increased by almost 500 FTEs. Can the minister explain why the ministry's staffing has increased by over 50 per cent for 2026 and 2027? Again, I will bring the committee's attention back to the intention of the refocus or reorganization of the system that was to reduce overhead costs and increase allocations that go to front-line workers, specifically with the current state of the health care system due to the increased pressures and reduced capacity.

9:20

Turning again to line 5.5 of the government estimates. Communicable disease programs focus on preventing and controlling disease reportable under the Alberta Public Health Act, including immunization programs, outbreak investigations, and public health surveillance. These services are specifically important as Alberta is currently experiencing an increase in measles outbreaks. There was an announcement of an outbreak of tuberculosis the end of last year, and STI infections, among other communicable diseases, have been on the rise. How will a \$326 million reduction on public health affect communicable disease prevention and response capacity? Does the ministry immunization program fall under this line item, and if yes, how will this cut affect the public health immunization planning and service delivery? How will the minister address increasing outbreaks when there are cuts to the public health and public health services budget lines?

Another important work that happens within the public health and population health is emergency preparedness, and programs are part of the public health services. The role and the mandate are to ensure that the health system can respond effectively to public health emergencies and disasters, including infectious disease events, whether it is epidemic or pandemics, and other natural disasters or human-caused emergencies that pose a threat to the health of Albertans and require rapid, co-ordinated response across the health care system. Often the government plays a role, and health preparedness plays a big role.

During the COVID pandemic Alberta Health Services emergency and disaster management teams played a critical role in maintaining essential operations and preparedness mitigated some of the pandemic consequences that Albertans could have experienced. My question is, through the chair, what direct impact will the specific cuts of \$1 million from the protection and prevention and wellness have on Alberta's emergency preparedness and the \$326 million reduction have on our provincial public health response capacity? These staff reductions, with areas of our emergency preparedness and response, would be directly implicated. In the face of these significant cuts, how will the minister protect the health of Albertans during the next public health emergency, God forbid?

Another critically important role . . .

The Chair: That's it for the member's time. We'll move over to the minister for her response.

Member LaGrange: Great. Thank you so much. Lots of great questions there. I'm going to start by addressing the inaccuracy that I just heard in terms of cuts. There are no cuts in my budget. In fact, Madam Chair, as I said earlier, I have a \$12.7 billion budget, which is \$1.5 billion more than last year, which in fact translates to a 13 per cent increase from Budget 2025. I think what the member was alluding to was that, yes, because of refocusing and because of the fact that Alberta Health Services is no longer overseeing everything within Alberta health, that in fact some of the services that were under Alberta Health Services, such as public health, is transferring to Primary and Preventive Health Services. Through that transition from Alberta Health Services to Primary and Preventive Health Services, the dollars are being put into the proper locations, and in fact public health has as much, if not more dollars allocated to public health. We have \$140 million allocated to immunization and making sure that we have a very strong public health system.

I'm really excited about the changes that are coming, because the policy portion of public health will be within my department, hence why we had all those people, those FTEs, that are now transferred into the department that currently weren't there. The member opposite talked about all of the additional staffing. Well, the additional staffing is because of the changes and the moves that we've made to make sure that we have a strong public health system, but it's now embedded within Primary and Preventive Health Services, where it probably should be all along, because it's really about preventing illness within the general population.

When I look at communicable diseases, yes, we had a measles outbreak, as was seen right across Canada and globally. We allocated an additional \$1.2 million to make sure that we had a strong response to that using social media, making sure that our public health nurses, et cetera went out to those communities. We've seen great success in the uptake of the measles vaccine as a result of it, but we are going to continue to do more.

If I can go back to the first question on the \$653 million Primary Care Alberta transition. Again, there is a transition of public health dollars. That's why those numbers are different from what was allocated.

When the member asked about physicians: I want to break down the physician increase because Budget 2025-26 was \$5.368 billion, and Budget 2026-27 is \$7.271 billion for physician compensation. This is broken down by: \$6 billion in fee for service, \$283 million in the primary care physician compensation line item. Based on claims, it's a 50 per cent growth from '25-26. That is also \$22 million in the PCPCM administration top-up for physicians – it's 50 per cent growth as well – and \$122 million in the PCPCM panel management, a 30 per cent growth. That's why we're seeing all that additional growth. We've gone from 10,600 doctors in the province to over 13,700. Got to get that number right. It keeps climbing all the time so we have got to make sure that's the right number. I also want to remind the members that not all of those 3,000 are family physicians. About half are specialists because we also need anesthesiologists, et cetera.

To continue on with that particular line item, \$216.3 million is in academic medicine; \$336 million in clinical alternative relation plans, that was a 12.1 per cent growth; \$114 million in rural, remote, and northern program, so that's an 11.6 per cent growth; \$95.5 million in physician on-call program; there's \$15 million in the physician recruitment and retention support program; and \$105.9 million in physician support programs, comprised of \$54 million for the medical liability reimbursement, \$35 million in continuing medical education, physician family support, and compassionate assistance programs, \$8.9 million in accelerating change transformation team, the \$4.3 million physician locum supports, \$3.7 million in physician learning grants.

There's also a \$1.4 billion increase that is primarily attributed to population growth, patient age, complexity, and rate increases related to the expenditures under the Alberta Medical Association agreement. The increase also includes \$20 million for additional surgeries under the acute-care action plan. The increase in net saving initiatives related to the adjustments to health service codes, such as sinus, X-ray, surgical dermatology, ophthalmology, and the discontinuation of the business cost program. The '25-26 forecast of \$6.8 billion is a \$962 million increase. All to say that we are supporting our physicians. We want to make sure that they're well supported, that they're amongst the highest paid in all of Canada, and that we can attract and retain those great physicians that we currently have.

On the primary care networks, the member is correct that we are going to be changing to regional primary care networks in the upcoming year. There has been an increase in that overall fund, I believe it was \$15 million just going off the top of my head, to account for additional enrolment. Of course, with the new regional primary care networks, which we will be spearheading here in the next number of months, we are looking forward to having more doctors right across the whole province be panelled. We have seen increases in the number of doctors that have gone on to CPAR, which allows us to actually find out how many are panelled.

When we look at the number of people in Alberta that are panelled to physicians, we are seeing an increase. CIHI data in '24 said that 84 per cent of Albertans were panelled. The most recent study by Global actually showed that we're closer to 87.6, nearing 88, which is one of the highest in all of Canada. I won't rest until we're at 100 per cent of people who want to be panelled to have an actual primary care provider overseeing them because not everybody does, but the vast majority do, so we want to make sure that 100 per cent of those who want to be panelled are in fact panelled.

Nurse practitioners. We have additional funding for nurse practitioners. The nurse practitioner association: they're the ones that actually administer the funding for the nurse practitioner primary care program, and so that does not come out of the PCN, although we do have nurse practitioners. We've seen huge growth in nurse practitioners across the province. We went from roughly about 170 nurse practitioners. We're now well over a thousand nurse practitioners in the province. As of October 31, 2025, Alberta had 1,054 nurse practitioners with active licences. There are 50,640 Albertans panelled to nurse practitioners currently, and we can see that continuing. We currently have 88 with a number of other nurse practitioners in queue to take on additional panels.

9:30

Approximately 8 per cent of the nurse practitioners who were approved to join the nurse practitioner primary care program outlined plans to work on First Nations reserves or Métis settlements, and I'm hearing really wonderful things, anecdotal stories about how much they love their nurse practitioners within the various communities that have them.

We saw a huge increase in interest in going into postsecondary for nurse practitioners. When we introduced the new primary care program, we actually saw that we had over a thousand RNs who applied for 50 spots. So we're actually increasing the number of spots for nurse practitioners across the province, and I think Advanced Education for recognizing the need to have additional nurse practitioners do the work that is required. They're also looking at developing specialty programs for nurse practitioners that would address ER concerns, nurse practitioners with additional specialties in emergency rooms and other disciplines. So that is very exciting for Albertans.

Let's move on to the next one. On the MAPS, we're continuing to address the recommendations that came through modernizing Alberta's primary care system. That was one of the largest engagements done in the province to ensure that we have a strong primary care focus within our province. We're continuing to address those recommendations. As well, we had a parallel Indigenous MAPS that was ongoing, and those recommendations are being addressed through the work that the department – and I'll just remind everybody that, for the first time ever, my ministry actually has a division for Indigenous primary health care.

The Chair: Thank you so much, Minister.
Back over to the Official Opposition.

Mr. Haji: Thank you, Madam Chair. I think none of my questions were related to the physicians' funding and the number of physicians. The budget that is in front of me under population and public health – that's line 5 of the government estimates – shows cuts. The minister says that it doesn't show cuts, and I have outlined in my questions \$1 million cut in protection, prevention, and wellness. My question is: how will that impact deaths related to injury? This is the third leading cause of death in Alberta. One point eight million cut in cancer research, screening, and cancer prevention. That is shown in the budget. Three hundred and twenty-six million cut to public health services for disease and injury prevention. That's shown in the budget. Those are the questions that I have asked. I will give the minister another opportunity to respond to those cuts that will directly impact population and public health.

Speaking on immunization, the minister had pointed out that the government is investing \$140 million in immunization, and I assume this is basically around the supply aspect of vaccines. The government estimates show that the funding for vaccine supplies has been reduced. It has not increased. Yes, the budget shows \$140 million, but the previous budget was \$153 million. That is a difference of \$13 million in cuts while funding for immunization program supports remained flat compared to the previous fiscal year. This comes in a year that we all know that Alberta experienced the deadliest influenza season in the past decade. Through the chair, what assumptions did the ministry use to justify the reduction in the vaccine supply funding despite Alberta's increased influenza-related mortality, declining immunization coverage, and active measles outbreaks that are continuously being reported? Does the reduction in vaccine supply funding reflect lower projected vaccine uptake, changes in procurement or pricing, reduced inventory target, or anticipated program scaling back? It has to be one of those, so I would like if the minister could clarify why \$13 million was cut despite (a) an increased population, despite (b) low vaccine uptake, despite (c) an increased mortality in, for example, influenza-related deaths.

Given that immunization support funding is flat, the support aspect of it, how will this ministry improve vaccination coverage rates, particularly among children, seniors, and high-risk populations? What tactics and strategies will the ministry put in place to ensure that vaccine coverage goes up? Has the ministry modelled the fiscal and health system impacts of the continued low vaccination coverage, including the increased hospitalization cost? That comes with cost as well and downstream pressures on acute-care capacity, which we have experienced over the past couple of months or a year. Are any of these savings from the reduced vaccine supply funding reallocated in the areas within the ministry at least to improve vaccine uptake and increase coverage?

Back to the population and public health, I think that is another area where I really want to speak to. Breast cancer: like, on budget line 5.4, which focuses on cancer research, screening, and

prevention, breast cancer is one of the most commonly diagnosed cancers among women, with approximately 1 in 7 Alberta women expected to develop breast cancer in their lifetime. Alberta currently reports one of the highest mammography participation rates in Canada, with 84 per cent of women aged 50 to 74 reporting a recent mammograph, compared to the national average, which is 79 per cent. Kudos to Alberta women on that. Breast cancer screening programs were transferred to Primary Care Alberta in 2025, and the PCN now delivers screening co-ordination, reminder letters, follow-up support as well as public and provider education.

Meanwhile 5.3 of the government estimates and 5.4 support health promotion and protection, screening, and education of cancer, including breast cancer. Will the minister please outline what breast cancer screening, health promotion, and education programs are funded by Primary Care Alberta and what the funding allocation to these programs are for 2026-2027? Does the PC allocation of funding also reflect a reduction in funding to prevention and wellness programs, which includes screening-related supports? How will the funding reduction in lines 5.3 and 5.4 ensure that our better breast cancer screening participation does not decline from the current 84 per cent that we have?

I'll turn to the drugs and supplementary benefits, line 4 of the government estimates. The ministry offers nongroup coverage administered by Alberta Blue Cross to help low-income Albertans under the age of 65 who do not have other health insurance. I note that the minister alluded that there was an increase on those budget lines. This coverage helps for participation, medication, essential services such as ambulance care, clinical psychology, home nursing, and chiropractic care. Funding for this program appears on line 4.4 of the government estimates. Can the minister provide the number of Albertans currently covered under the nongroup coverage program?

The minister mentioned that there was an increase to that, but when you look at line 4.4, yes, there is an increase if you compare it to the budget, but – this is an important piece – when you look into the government's own forecast, there will be a reduction by \$25 million. The government forecast shows that this is how much we need, but the budget shows less \$25 million than what we currently need, which basically means that we're cutting in terms of the current need. Will the ministry change the eligibility criteria to accommodate those who currently qualify as shown on the government forecast? Will any services be reduced or eliminated in eligibility if eligibility is not changing?

How will the ministry ensure Albertans continue to receive necessary coverage if eligibility and benefits are not changing? In the event that we make changes to this, this will have an implication on the downstream of the programming with acute-care capacity as well as hospital capacity. We will experience the crisis that we are facing on that. If the minister could provide some details on that, that would be great.

9:40

Line 4.5 of the government estimates funds health benefits for assured income for the severely handicapped. How many AISH recipients received health benefits under this program last year? The Premier has said on the record that people are moving to Alberta to access benefits such as AISH. Does the ministry have any data that shows an increase in the number of individuals arriving from other provinces or territories who are also accessing AISH benefits? If so, why is this not reflected in the budget?

I have one minute, so we'll see if I can squeeze in this part here. The department also oversees services, including diagnostic imaging, clinical nutrition, rehabilitation services, audiology, physiotherapy, occupational therapy, respiratory therapy, speech-

language pathology. Within this other health services budget there is a cut that shows about – the cost of these services in line 7.7 of the government estimates shows budget cuts of more than \$1 billion. The breakdown of these cuts is not shown in the business plan, fiscal plan, or government estimates. One wonders where these cuts are coming from. Through the chair, can the minister provide a breakdown of where these reductions, that account for \$1 billion, will be made? Examples include rehabilitation services, including physiotherapy, occupational therapy, speech pathology. How will programs like this be affected by the reductions in line 7.7 of the government estimates? What changes will the ministry make to accommodate the needs to face the \$1 billion reduction by the government? If the minister can provide some details on that, that would be greatly appreciated.

Now I'll give the minister back – there are five seconds left of my time. Just to get some answers.

The Chair: Well, thank you so much, hon. Member.

We'll turn it back over to the minister for her response.

Member LaGrange: Thank you, Madam Chair, and thank you for those questions. First, there are no cuts. I am going to reiterate that. In fact, the \$1 billion that was alluded to was the reallocation from Alberta Health Services. As we do the transformation, these things are moving and shifting, but the money is still there. When you look at the overall budget of health care, it's \$34.4 billion. That's an increase from last year, which, I believe, was closer to \$28 billion in consolidated total health spending. My budget is up 13 per cent.

When I look at diagnostics, just on laboratory services alone there's \$20 million invested annually to improve the lab equipment across acute care. We're improving access. Effective April 1 Alberta Precision Laboratories is in fact transitioning to Primary Care Alberta. That's why there's an additional movement of individuals and funding to Primary Care Alberta. This will mean better services with no job losses and no new costs for Albertans.

There was a 40 per cent decline in wait times. Province-wide wait times have declined since 2023 by 40 per cent even as patient volumes have increased by 15 per cent. We have more volume, but our wait times are going down.

More testing: testing is increasing at 1.5 times the rate of Alberta's population growth. Over 96 million tests, a record number of tests, were completed last year. That's a 15-million test increase in just five years.

Province-wide APL operates 63 patient service centres and 130 regional and rural laboratories across the province as well two urban hub labs in Calgary and in Edmonton. We've got \$60 million being invested over three years to modernize those lab services and another \$35 million being invested over three years to support the consolidation and expansion of the genetics and genomics laboratory in Budget 2026. That's all about making sure that we can do that preventative work. As soon as we can – you know, if people have a genetic predisposition to something, the sooner we know that, the more we can target resources and supports to them.

We've got a growing workforce. We have, in fact, 702 combined laboratory and X-ray technologists in Alberta as of December 31. This is a 32 per cent increase since 2015, 27 combined lab and X-ray technologists more than we had in 2024, and we're going to continue to increase those numbers. Again, no cuts. There is reallocation, so you might have to look on a different line item for those numbers that the member indicated in his first question, but it is really just about finding those line items.

In influenza, I can tell you that we provided a universal influenza vaccination program this year, as we have every single year, and we had roughly the same number of individuals that took us up on that

offer. In fact, what we saw is that the reason that there was a more severe result was because the vaccination was mismatched to the actual strain that was the predominant strain. I know there are three strains, two of which this vaccine that was offered this year worked very well on. The other more aggressive strain: it did not work as well, so we did see people getting sicker, but that was right across Canada. There were no reductions in the access for influenza vaccine, and, in fact, we continue to have a very strong public health system where we continue to provide those vaccines. Eighty per cent of seniors did take – let me see here. I just want to make sure I get the right numbers here. Yes.

The coverage in influenza season has continued to be somewhat – let's just say that people in Alberta are continuing to utilize the vaccines that are available to them, but what I have seen happen is that we are in fact taking a targeted approach for COVID vaccine. We're complying with NACI's recommendations. They are the Canadian health centre. They provide us with recommendations. That's what we did when the COVID vaccine was taking place.

What we saw, because we took a targeted approach versus the universal approach that existed previously because the federal government was funding a universal approach, and now they have recommended a targeted approach, was that, in fact, we had less cost. There was a slight amount change in that, but, again, \$140 million to make sure that we have a very strong immunization program across Alberta, that we will continue to provide universal influenza vaccine in the year to come. We also provide RSV, as well as COVID in a targeted approach, and we're going to continue to do all of the children's immunizations as well.

On mammography, let me just pull the numbers, because I'm seeing some good success. We are doing breast screening. We're one of the first provinces in Canada to lower the age to 45 for screening options for women to go and get done. In 2019 the result was that roughly about 66 per cent of the population in the age category were getting their breast cancer screening done. Now we're at 68 per cent in '24-25, and we're targeting a higher percentage. We're targeting over 70 per cent. That will continue to increase. I'm happy to say that we are also bringing in cervical cancer screening, colorectal cancer screening, we're expanding that as well, and influenza immunization continues to be strong as well. On the breast cancer, we will be making an announcement very shortly to lower the age even further. Stay tuned for that because I anticipate that announcement coming very quickly here in the coming weeks.

I think I would like to turn it over to Dr. Kim Simmonds, who is the CEO of Primary Care Alberta, to just update us on some of the things that are happening because there are some really exciting things happening in primary care on the screening side of things as well as how we're going to look to increase our immunization right across the province.

9:50

Dr. Simmonds: Thank you. Technology is not my skill set. I like numbers as an epidemiologist. Thank you, everyone. I'm Kim Simmonds. I'm the CEO of Primary Care Alberta, and I'm absolutely delighted about some of the questions you asked. Primary Care Alberta is just . . .

The Chair: Sorry. The conversation still needs to flow through the chair, not to any members.

Dr. Simmonds: Sorry, MLA Lovely. Thank you.

I did want to speak to some of the really exciting initiatives that we'll be undertaking with the allocated funds from the department. One of the first ones is cervical cancer screening. Alberta is going

to be one of the first provinces that's going to move towards HPV primary testing. That's a move away from the Pap test. We are working right now and continue to work on a pilot program for that self cervical cancer screening, so we can get people who live in rural and remote areas of the province, focusing on our Indigenous population and other vulnerable Albertans. We expect to see results in the coming years of increased cervical cancer screening, which we expect will help support the reduction of overall cervical cancer screening, in alignment with the Canadian Partnership Against Cancer's goal of eliminating cervical cancer by 2050, so we're working towards that.

With regard to breast cancer screening I do also appreciate the opportunity to speak to that. Alberta has mobile vans. Again, with our focus in Primary Care Alberta and our mandate, which is to make sure that we can provide care across the life continuum and across the province no matter where you live. With that, we have two mobile mammography vans that go around the province and serve our rural and remote areas. Those are advertised, before they go, through clinics, also through moms' groups and other activities, making sure that we reach Albertans who may not live in a large centre. That has been a huge advantage for us to try and make sure that while our screening rates are really high, that they are high consistently across the province.

I wanted to also mention that with breast cancer screening we're taking a data-driven approach, looking at those who have not been screened and looking at the root causes for why they haven't been screened for breast cancer. For Primary Care Alberta and myself specifically, cancer screening is one of the most cost-effective, best things we can do.

The Chair: All right. That's the time.

We will head back over to the Official Opposition.

Mr. Haji: Thank you, Madam Chair. I do see where there is a reallocation, and I have no problem in terms of the minister reallocating budgets in different lines. One thing that I want to note for the committee is that this is a budget; this is not Public Accounts where you look back; this is a budget where we look forward in terms of what we're going to spend in the next year.

The reallocations: yes, I see there are reallocations. The minister's office reallocation has increased by \$2.5 million; primary care has increased; program support by \$1.5 million; drugs and supplemental benefits program support cost has increased \$2 million. Those are reallocations, and I can see those ones. What I don't see the minister respond to: a good example is within the population of public health, line item 5.5, public health services in the estimates. It's in the budget. Last year it was \$384 million, rounded up. The current budget is \$58 million. I see that as a reduction. I don't see that as an increase. It's a direct program delivery; it's not a support. Those are some of the things that need to be clarified. I get that the minister's overall budget didn't reduce. That's very clear, yes, but in terms of within the ministry: how much are we spending on front line and programs that will impact on the lives of Albertans? is where I'm concerned, and that's where I see some sort of reductions. If the minister could clarify that, that would be great.

I will turn to the private-pay diagnostic and imaging. There is a \$1 billion cut in terms of the diagnostics and therapeutic line. I would like to know in terms of what the \$1 billion reduction is that's happening within that line and what it means. In Budget 2026 the minister's estimates show a reduction of more than \$1 billion in diagnostic and therapeutic services funding compared to the previous fiscal year budget.

In Budget 2026 the ministry's estimates show a reduction of more than \$1 billion in diagnostic and therapeutic services funding compared to the previous fiscal year's budget. At present Alberta women can self-refer for mammogram screening, and this service is publicly insured. Through the chair, can the minister – and I've heard the minister alluding to it, that age reduction will happen, which means that we will be seeing more screening happening within the population. However, that is not reflected in the budget. The numbers don't show that we will see an increase of that uptake. The numbers don't align with what the minister is saying and what I see in the budget.

Can the minister confirm for the record that self-referred mammogram screening will remain an insured service in the Alberta health care insurance plan through the 2026-2027 fiscal year? Is any portion of the publicly funded cancer screening being reclassified, delisted, or transitioned to a self-referred, private-pay model as a result of the diagnostic and therapeutic services funding reduction? Does the \$1 billion in cuts reflect lower service volumes, changes in fee schedules, a shift to private delivery, or delayed or cancelled capital or operating investment? We just have to see where it is coming from when it's taken away from here.

Did the ministry conduct modelling on the impact of these reductions on wait times for publicly funded diagnostic imaging, including mammogram, MRI, and CT scans? I do understand that there is work that's going on with the regulations, but what safeguards are in place and have been considered in terms of the developing of the budget to ensure that reductions in public diagnostic funding do not disproportionately impact early detection outcomes, particularly for breast cancer and other screen detectable conditions?

Turning to the overall budget, more than 55 per cent of the ministry's budget is funded through federal transfers, which is quite significant compared to other ministries. That comes mostly from general revenues. Given that Alberta may be heading towards a referendum during this budget period, one could significantly affect Alberta's relationship with the federal government. Has the minister considered or modelled scenarios where federal transfers are delayed, reduced, discontinued, tangled into negotiations and conversations that could affect in terms of transfers, hence impact on terms of services that are to be delivered? Specifically, what contingency planning has the department undertaken to assess the potential budgetary impact of disruption of federal funding? Has the ministry developed risk scenarios outlining the short-, medium-, and long-term impact on service delivery? Which programs would be the most exposed to changes in the federal funding, and what mitigation strategies are in place to protect front-line services, continuity of care for patients, and ensure disruption doesn't happen.

Has the minister engaged Treasury Board or other departments to co-ordinate crossgovernment planning for such fiscal consequences? What assurances can the minister provide to Albertans that essential health services would remain stable during any period of uncertainty? Will the minister commit to transparency by tabling any scenario planning or fiscal assessments that have been undertaken this far by the Legislative Assembly?

The department team pointed to the colorectal cancer screening, so I have some questions around that as well. Screening and early detection remain the most effective. I agree. They're the most effective strategies for improving outcomes and reducing downstream acute-care pressures. How does the ministry plan to retain colorectal cancer screening participation rates under the current budget reductions? If reduction is not what the minister prefers to use in terms of the current reallocations, using the minister's terminology in that, are any changes being considered to

colorectal cancer screening criteria, age thresholds, eligibility, or other mechanisms to manage the cost reductions? What impact does the ministry anticipate these funding reductions will have on diagnostic stage treatment intensity for colorectal cancer patients?

10:00

Some quick questions around the changes that have been happening. Can the minister confirm that the restructuring of the health system is now complete? Are there any temporary transition terms or contracts that will remain active past April 1, 2026? If so, for how long and what cost implications will that have? And has that been reflected in the in the budget deliberations? Can the minister provide evidence that this restructuring has increased patient attachment or improved patient satisfaction with primary care? Can the minister table any evidence that efficiency in the primary care system has increased as a result of restructuring? If that has not yet been achieved, what are the timelines that we will see that happen, that attachment has increased as well as provider-patient connections have improved? Will the minister provide Albertans with the total cost to taxpayers for our government's change in terms of the dismantling of AHS and establishment of a new ministry?

The provincial health agencies. Between 2023 and 2026 were any unbudgeted costs absorbed within AHS or individual ministries rather than recorded as part of the restructuring? If so, what are they? Given that \$85 million allocated for the restructuring was supplemented with an additional \$81 million in 2025-2026, can the minister confirm that the total cost of the restructuring is now over \$166 million? Will the minister outline what is included in the total cost of the restructuring? For example, is the more than \$30 million for the government to spend on severance packages during this restructuring included in this total? Does the total also include \$53 million in government-approved consulting contracts for the health care system restructuring? How many consultants involved in designing the restructuring were also contracted during the implementation phase, and how many of these will be considered within the 2026-2027 budget?

The Chair: We'll go back now over to the minister for her response.

Member LaGrange: Thank you, Madam Chair, and thank you for the questions. Thank you for acknowledging the reallocation, but again the member continues to state that there's a \$1 billion cut, which, in fact, is not accurate.

I will go to 7.7, which says diagnostic and therapeutic services including funding for diagnostic imaging, clinical nutrition, and rehab services such as audiology, occupational, physical, and respiratory therapy, and speech-language pathology. The \$1.1 billion decrease is primarily due to reallocation of funding from the former Alberta Health Services regional health authority to Health Shared Services and Alberta Precision Labs. Again, you need to find it in a different line item. I know it's confusing. Given the refocusing, we have to shift between different areas, but that is exactly – and cancer care, in fact, is still in the budget, but it went to Cancer Care Alberta. That is the new ACA, that now will be found in the ACA budget going forward. It's taken out of our items, but put into the other budget because, of course, it now falls under Cancer Care Alberta, so we want to make sure that they have the proper funding for that.

On the \$363.3 million decrease that was mentioned in line item 5.5, it's primarily due to the transfer of public health functions from former Alberta Health Services regional health authority to Primary Care Alberta and to my department. The transfers consist of

medical officers of health as well as the safe health environments, medical affairs, and public health surveillance groups to the PPHS department. As well, various contracts: physician, midwifery leadership and shared resources, community health centre, public health, chronic disease management, elements 2.4. That is the explanation for those.

On the drugs and pharmacy piece. When I look at – we have a \$2.2 billion investment in Budget 2026 for drugs and supplemental health benefits across the province. Nine hundred and thirty-nine million dollars are for operating expenses for the drugs and supplemental health benefit programs to support seniors, low-income support programs, and Albertans with long-term disabilities; 1.7 million is the number of Albertans that access clinical pharmacy services every year, an 80 per cent increase since 2018. So Alberta has more pharmacies per capita than anywhere in Canada. Alberta has 4,484 pharmacists and 1,717 community pharmacies, more total pharmacies than any other province except Ontario and Quebec.

Over 5,000 Health Canada-approved drugs are covered under the drugs and supplemental health benefit programs. We have the second-highest drug coverage. Alberta's public drug coverage covers about 40 per cent of all expenditures toward prescribed drugs in the province. This is the second-highest among all provinces; Ontario is 41 per cent. We also cover 100 rare-disease medications, so Alberta currently covers more than 100 drugs for rare diseases through various programs. We spend \$643 million in Budget 2026 for three outpatient drug grants for cancer, cellular therapy, and specialized high drug costs.

When I look to the question around the federal government – when the Canada Health Act was first initiated, we had about a 50-50 split with the expenditures that provinces were spending on health care in their provinces. Right now we're spending \$34.4 billion, but we will be getting \$7 billion from the federal government. That's roughly about 22 per cent of our overall expenses. We as a province and all the other provinces across Canada have been advocating for a very long time, and I look to the members opposite to also help us in that advocacy to get that number up to at least 35 per cent because, of course, costs are continuing to grow in all provinces on this.

The current challenges that we're seeing with the funding that we get from the federal government: often it comes as targeted funding or grant funding. One of the grants that is expiring this year is the shared priorities grant, and we're seeing a reduction in services. It's really unfortunate that these grants come in and then they are not continued on. I can talk about many other grants from the federal government that align with that, and that does not help Albertans when they become reliant on some of these programs and then that funding does in fact become eliminated by the federal government. We're going to continue to make sure that our province gets its fair share, and we'll continue to advocate for that, but again, we need to make sure that any programs that are funded are sustainable.

On the colorectal screening – I just pulled that number up just so that I can share that. In 2019-2020 we had roughly about 55 per cent of the population taking advantage of that screening. We're now at 57 per cent in '24-25. I want to see that number continue to rise because, again, through the screening, if we can catch those cancers early, then they can be dealt with much more quickly and much more effectively, and people have a much higher prognosis of surviving the illnesses.

It was asked earlier about the nongroup coverage and in '25 – let me just make sure I've got the right numbers here. Sorry. It's the AISH drug benefit enrollee numbers was asked. In '25-26 we had 86,950; in '26-27 we estimate that number to be 88,000. We are going to have the same coverage for anyone who's on AISH, on

ADAP. Any of those programs are continuing to have health care coverage as per usual, and we're going to make sure that we protect our most vulnerable. The \$25 million in the nongroup that was less in the forecast is because we are going to a payer of last resort. In fact, we will see savings through that program. So it is making sure that we use our dollars efficiently. If there are other programs that are first payer, then we should be the last payer, and we should use government funding for that. That goes back to a previous question that was asked. I wanted to make sure that we did answer that for you.

10:10

On the attachment and restructuring numbers. We are pretty well through the refocusing. There are still a number of elements that are moving our way as we continue to bring primary care over as well as public health – sorry, public health into primary care, I should say. Shared services has really just started functioning independently. I could get into a very long, lengthy question, but I know I only have one minute left. I was actually going to ask Matthew Hebert, who's been instrumental in actually seeing the refocusing through – it's been yeoman's work. There have been a lot of moving parts. As you know, to stand up four pillars and to do it as seamlessly as we've been able to do it, with as little disruption to the front lines while in fact increasing our front line by tens of thousands of practitioners has been nothing short of astounding. I thank everyone within our health care system who have been able to make that happen.

We are starting to see the results of that. We are attracting more practitioners to our province, as I said, more nurses, more doctors, more allied health care professionals. We are continuing to increase the number of services we are providing to Albertans through our screening programs. We are attaching more to family practitioners soon. I anticipate that we'll be able to say that most Albertans will have a primary care home. That will be truly great news. Of course, we don't want the emergency room to be the first door they go through. We want that to be the last door they go through. So to have a strong primary care system will be . . .

The Chair: Thank you so much. Minister, that concludes your time for this segment.

We'll now move to 20 minutes for the government caucus members. Member, do you prefer block or shared time with the minister?

Member LaGrange: We can do shared time.

The Chair: Okay.

Please proceed with your questions.

Mr. Singh: Thank you, Madam Chair and through you to the minister and sincere appreciation to the minister for being with us today and for the team's presence. I would like to extend my gratitude to the minister and the full team for their efforts in supporting the health and well-being of Albertans and, of course, a record-breaking budget of \$34.4 billion. Thank you, Minister.

It seems the minister is more willing to talk about health system refocusing. This ministry was created as part of a major shift, the way health care is done in Alberta. Having a dedicated ministry for primary and preventative services signifies an important step in prioritizing prevention and community-based care, moving away from a hospital-central approach. I see the fact sheet on page 133 of the business plan includes a rundown of the ministry's basic structure and roles. Through you, Madam Chair, to the minister: given that this is a new ministry in a recently refocused health care system, could the minister please provide a high-level overview of

this ministry's departments and responsibilities? What are some of the primary areas of focus for the ministry in its first budget cycle? How has the move away from a single, massive health agency increased the efficiency within our health care system as a whole? How does the ministry continue to liaison with other relevant ministries to ensure a co-ordinated health care system overall?

Thank you, Minister.

Member LaGrange: Thank you. I'll start by saying, as I said earlier, that we are the very first province in all of Canada to have a dedicated Ministry of Primary and Preventative Health Services. It is responsible for strengthening Alberta's primary care and public health systems and improving population health outcomes. The ministry provides policy direction. It has legislative oversight, funding, and system monitoring to ensure Albertans can access timely, safe, and high-quality primary and preventative health care.

PPHS, which is primary and health services – I'm just going to go with PPHS – supports the health and well-being of Albertans through their lives by focusing on promoting wellness; co-ordinating safe, person-centred, quality primary health care services; strengthening health workforce planning; and overseeing provider compensation; as well as enabling innovative health information technologies and implementing the new direction for Alberta's health care system. Importantly, this includes overseeing the integration of the refocused health care system. I can tell you that, you know, if you go to MyHealth records, we had roughly about 170,000 people on it in 2018-2019. Now we have close to 2 million people accessing their health records online, which is excellent.

The ministry is composed of the Department of Primary and Preventive Health Services, Primary Care Alberta, Health Quality Alberta, and Health Shared Services, each with distinct but complementary roles. Together they focus on primary care delivery and co-ordination, public health and prevention, health workforce planning, digital health enablement, health benefits administration, and system oversight to ensure value, quality, and accountability across the health care system.

In our first budget cycle the ministry focused on establishing a strong foundation for primary and preventative care. Key priorities included improving access to primary care providers, particularly in rural remote, and underserved communities; strengthening the health workforce through recruitment, retention, and new compensation models; and reducing pressures on acute care by investing in prevention and early intervention; as well as advancing digital health and health information systems to support more integrated and efficient care delivery.

The ministry also prioritized Indigenous-led approaches to care, culturally safe services, and population health initiatives aimed at improving long-term health outcomes for Albertans. The ministry also completed work to establish the refocused health system and supported the stand up of a new health system entity. That's all in the first year that we stood up the Primary Care Alberta.

The refocused health system has also moved away from a single, centralized agency to a new sector-based model that is already strengthening accountability, transparency, and system performance. The refocused health system assigns clear responsibility for service delivery and quality to each provincial health agency and its respective ministries, enabling more focused oversight and faster decision-making. Each PHA is now accountable for measuring and reporting against priorities set by the sector minister and the oversight minister. This clearer accountability framework supports continuous improvement and innovation within each sector. At the same time the enhanced role of Health Quality Alberta supports consistent performance standards, monitoring, and public reporting right

across the system, and we're really looking to strengthen Health Quality Alberta even further.

To increase transparency for Albertans, government has launched a new health system performance dashboard, announced on January 16. This tool provides clear, accessible, and up-to-date information on how the system is performing and how care is being delivered in communities right across the province, allowing Albertans to track progress and see where improvements are being made. We want to be super transparent with the public, and now they can go online and see that for themselves.

Accountability is shared right across the health care sector ministries in the refocused health care system, including Primary and Preventive Health Services, Assisted Living and Social Services, Mental Health and Addictions, and hospital and surgical services. The oversight minister's role also provides strategic oversight and co-ordination across the entire health care system. The four ministries work collaboratively to support cross-sector ministry policy development, system planning, and service integration to ensure seamless patient care.

Co-ordination occurs through formal governance mechanisms and crossministry initiatives, including bodies such as the Integration Council, which brings ministries together to address shared priorities, system risks, and opportunities for alignment. We meet on a regular basis. I have never seen this level of co-ordination and collaboration amongst ministries before, and it's really refreshing to see. This collaborative approach ensures the refocused health system functions as a single, co-ordinated system for Albertans while allowing each sector to remain focused on its specific mandate and its responsibilities.

Thank you for those questions. I appreciate it.

10:20

Mr. Singh: Thank you, Minister, for your answers. Albertans and Calgary-East constituency really appreciate the hard work that has been invested in improving access to primary care and ensuring Albertans have access to a primary care provider.

In my next set of questions, through you, Madam Chair: physicians and recruitment and retention. I see a robust, qualified, sustainable workforce is vital to every aspect of our health care system. That said, a major challenge facing every province is physician recruitment and retention. It is simply not possible to achieve health care targets without qualified and available staff. Improving access to primary care and ensuring Albertans have access to primary care providers requires a consistent and capable workforce. This is important now and in the future as we look to the long-term sustainability of our health care system.

Looking on page number 189 of the 2026-2027 estimates document, I note that line item 3 to 3.3 details a number of increases for doctors' compensation, program support, physician services, physician education, and recruitment. Through the investments made in Budget 2026, I would like to look at expected outcomes for 2026 and 2027. Through you, Madam Chair, to the minister, would the minister please indicate how many new doctors will be trained through the investments being made in Budget 2026 and, similarly, how many new doctors will be recruited?

Member LaGrange: Thank you for that question, and happy to reiterate the fact that we are making a record investment in our physician compensation, which also includes education and development and recruitment. This is a 22 per cent increase from last year, as I've said on numerous occasions. Our efforts are working. Between 2020 and 2025 Alberta's medical schools trained an average of 510 new doctors annually. Close to 520 are expected to graduate in '25-26. We also know that there is a particular need

for supporting rural health and are continuing to work through the rural health action plan to make sure that we have those resources, those people in our rural communities.

One of the ways that we're doing that is to invest \$16 million into a rural and remote family medicine resident physician bursary pilot program to support family medicine residents in Alberta committing to a three-year return of service in rural and remote locations. What we are finding is that we have a lot of interest in that area, and we've been very successful. The program closed on December 31st. It's a pilot program. It closed December 31st, and we have 132 medical residents, physicians who are expected to start serving rural and remote communities within the next little while. Bursaries are \$125,000 for a rural stream or \$200,000 for a remote stream. They're available when the medical students in their final year of an undergraduate medical program sign on and have committed to those contracts, and then they do a three-year return of service.

The other piece that I'll add is that the latest data from the College of Physicians & Surgeons, as I said earlier, indicates that we are now closer to 13,700 physicians in the province. This is a net gain overall, and we're going to continue to work with our postsecondaries to make sure that we can continue to increase in high-specialty areas because we know we have a shortage in certain areas. There's been a concerted effort particularly, as I said earlier, to address the rural remote issue by making sure that we have programs in rural communities, whether it's in Grande Prairie or the one in Lethbridge, to make sure that we're addressing those issues.

Mr. Singh: Thank you, Minister, for the answer. Through you, Madam Chair, my next question is continuing with page 189 of the 2026-2027 estimates document, line item 3 to 3.3. In addition to recruitment and retention efforts, it is equally important to examine the capacity for medical education and training systems. A sustainable physician workforce begins with ensuring there are sufficient medical residency seats available to train the next generation of doctors. Without adequate residency positions, qualified medical graduates may be unable to complete the training required to practise, limiting our ability to grow the physician workforce in a meaningful way. If we are serious about improving access to care and addressing long-term workforce shortages, expanding residency capacity may be part of the solution, especially increasing the number of residency seats in high demand and in rural or underserved communities.

Through you, Madam Chair, can the minister please indicate how many medical residency positions are being funded through Budget 2026 and what is being done to increase these seats through Budget 2026?

Member LaGrange: Thank you for the question. As of February 1, 2026, there are approximately 1,700 government-funded medical residency positions in over 120 resident programs at the University of Alberta and the University of Calgary. Each year the government of Alberta provides funding to the University of Alberta and the University of Calgary to educate and train the right number and mix of physicians and surgeons to meet the province's physician workforce needs. This includes funding for approximately 450 new residency positions for the Canadian medical graduates and international medical graduates program. We know we have a number of students that have travelled outside of Canada to get their medical training. We want to see those young people come back and serve Albertans. They're proud Albertans who've gone abroad to study, and we want them back here, so we have increased seats

in medical residency positions, and I'm proud of the work that's ongoing in this area.

Mr. Singh: Thank you, Minister. Through you, Madam Chair, can the minister elaborate on some of the initiatives being done to retain physicians in Alberta in Budget 2026 and, similarly, what initiatives are being done to recruit physicians either from other provinces and internationally?

Member LaGrange: Great question. We're encouraging more international medical graduates to set up practice in Alberta by streamlining our registration policies and processes. As of March 2024, the College of Physicians & Surgeons of Alberta expanded the list of organizations that can sponsor international medical graduates to include individuals, private medical clinics, businesses, municipalities, and other legally recognized entities. Prior to this it was only AHS that could recruit international medical graduates. Once that changed, we saw that more and more interest was coming to Alberta.

In June 2025 the College of Physicians & Surgeons of Alberta also launched the approved jurisdiction route for international medical graduates whose education and training are deemed substantially equivalent to Canadian standards. So building on the success of the accelerated jurisdiction route pilot launched in 2023, international medical graduates from approved jurisdictions are now eligible to direct full licensure without any additional clinical or competency assessments. This will further speed up the recruitment process by waiving certain requirements, reducing red tape, and lowering the cost to international medical graduates.

Government also launched a rural and remote family medicine resident physician bursary pilot program. It's a big mouthful, but it has been very successful, as I said earlier. We have 130 bursary recipients that will be delivering patient care in rural and remote communities on a three-year return of service.

Finally, the rural health professions action plan supports the attraction and retention of rural health professionals, including physicians through various initiatives including continuing medical education and professional development support, return-of-service programs to optimize rural health care, financial support for postsecondary learners through rural medical school award programs and bursaries, mentorship programs for first- and second-year medical students, as well as accommodations for rural medical and health professional learners because sometimes when they get to those rural communities, they need a place to stay, and we need to make sure that those are available for them.

Mr. Singh: Thank you, Minister. Through you, Madam Chair, I see in the government of Alberta estimates for 2026-2027 on page 189, line item 3 goes over physician compensation and development. Through you, Madam Chair, can the minister please update this committee on the development and investments being made to Alberta's physicians regarding compensation? How does Alberta physicians' compensation rank among other provinces? And through Budget 2026 what percentage or proportion of the health budget is dedicated to physician compensation?

10:30

Member LaGrange: Well, thank you for the question. Roughly about a third of all of health care spending is dedicated to physician compensation. Budget 2026 includes \$7.7 billion in fiscal '26-27 for spending on physician compensation and development. That will increase to \$8.7 billion by '28-29. These record-setting investments will keep Alberta's physicians amongst the highest paid in Canada and will maintain the province as a very attractive location for physicians to practise.

On April 1, 2025, Alberta implemented the new primary care physician compensation model, or the PCPCM, for family medicine physicians, including rural generalists. The new model makes Alberta's family doctors the strongest paid and most patient-focused in the country. In conjunction with the new PCPCM we're increasing compensation for family physicians under the alternative relationship plans to ensure that the important services provided by family medicine specialists in our hospitals are also maintained. We want to make sure that both are equally as strong. Recent funding commitments also include \$200 million over two years for primary care stabilization, which is in addition to the \$780 million in new investments that were negotiated as part of the Alberta Medical Association agreement. There was an agreement negotiated in 2022, but the PCPCM actually is in addition to that agreement.

We recognize the need to have a strong family medicine funding model, and if we compare it to previous funding models that were tried in, say, 2016, 2017, 2018, where we saw only a handful of physicians go onto the new model that was proposed at that time, I believe, you know, over a course of a number of years – it was called the blended cap model – to date we only see roughly about 64 physicians on that model that was proposed way back when. With the new primary care physician model within the first year we have over 1,100 physicians on it already and more as they recognize the strengths of that new primary care physician model and are taking advantage.

The Chair: Thank you so much, Minister.

We'll take our five-minute break now. See you in five minutes, everyone.

[The committee adjourned from 10:32 a.m. to 10:38 a.m.]

The Chair: All right, everyone. That's our time.

We are going to move now to – where are we moving? Who is asking the next set of questions? Please proceed, Member.

Dr. Metz: Yes. Thank you very much. I'm wondering if the minister would go with, like, a semi back and forth where I can ask a block on certain topics or if she prefers to stick with full block.

Member LaGrange: Just full block, please. Thank you.

Dr. Metz: Full block. Okay. The first thing is that it is challenging with all of the moves of dollars between ministries to be able to track where different programs and different items get moved and have landed, especially when they're only partially moved as far as trying to understand what's going on. I'm wondering if the minister, probably through her staff, would be willing to provide a tracking document of moves of different budget items so that we could see in writing what moved here and there so that we can actually understand what's been moving between different programs.

The next questions relate to MAPS. In the strategic plan on page 18, priority 2, objective 1 states that phase 2 of MAPS will be implemented during this three-year time frame. I'm wondering: which year will the phase 2 start? Phase 1 was supposed to be completed a year ago, yet according to the ministry's own website, which tracks progress, it shows that many of the phase 1 actions are only about 10 per cent complete. Furthermore, item 2.3 on page 189 of the government estimates shows that the operating expense budget for MAPS is dropping by over 50 per cent, and page 136 of the business plan states that \$50 million per year over the next three years will be allocated to implement phase 2 of MAPS.

I know that there are different components within MAPS and that different parts of it will be planned and then ready for implementation at different times. I'm hoping that we can get some

better understanding of where that's going so that we can clarify in the budget exactly where this implementation is happening and what is still in the planning phase. Also, wondering how the budget can have dropped so much, yet the work expected is unfinished, and we're going into what's typically a more expensive phase, which is implementation. I'm wondering how much of that planning money was on refocusing rather than on the MAPS planning. It seems like a lot of money went into the planning, yet we don't actually have new metrics. Everything is just numbers of physicians still. I'm wondering if there is a plan moving forward to actually upgrade the metrics so that they're more meaningful and we can see that more outcome is being delivered.

Key investments in the modernization will rely a lot on work done by primary care networks. As we've discussed, that is a very flat item despite the fact that we're hearing that there are more physicians. Assuming there probably are more attached physicians, and we would expect that the PCN funding would need to go up to provide services to those more physicians, I really don't know where in the budget the funding for implementation or for these newly attached physicians is going to come from.

Next in the business plan on page 135 key objectives are to increase the number of Albertans attached to primary care providers by 2 per cent and implement the Alberta workforce strategy. The last version published on the website of the Alberta workforce strategy was from December 2024. I'm wondering if the minister can confirm how this increased attachment that we're hearing about will be achieved. Are there any targeted funds . . .

The Chair: That's your time, Member.

We'll move over to the minister for her response.

Member LaGrange: Thank you. I'll start with the last question. We are seeing increased attachment, as I said earlier. CIHI had us in 2024 at 84 per cent attachment. The OurCare Survey that was just recently done nationally has us at closer to 88 per cent attachment. Again, we're going to continue to work on that. We currently have approximately 800 health care providers, of which over 700 are physicians that are taking new patients across the province. I'm certainly happy to give the breakdown on whether they're north, south, et cetera if anyone is interested on that particular piece. We are seeing that increased attachment, but as I said, we'll continue to work on that until we see 100 per cent of everybody who wants to be attached being attached.

On the PCN budget line item we're going to continue, as I said earlier, to move towards a regional primary care network. Through that network we're going to make sure that everyone – right now there are 39 PCNs across the province. They don't cover the whole province geographically, and we're going to align the regional primary care networks to the health corridors and make sure that they are in fact able to attach everyone throughout that geographical area.

10:45

On the transitions. It has been a lot of work to do the transitions. We've been very thoughtful, and at times we would like to have moved faster but we had to make sure that we were thoughtful, moved positions, and did the work to ensure that we didn't create any unintended consequences.

With that, I'll turn it over to Matt Hebert, who, as I said earlier, has done the yeoman's labour on the transitional pieces.

If you could speak to those items.

Mr. Hebert: Thank you, Minister.

Madam Chair, on transitional costs relating to refocus, what would be notable about this particular budget is that it reflects two

significant events. One would be that the restructuring of the health system is finally fundamentally complete, and by that I mean that what was the regional health authority, which was Alberta Health Services, has largely been allocated to one of four provincial health agencies in a number of provincial health corporations. The other event is the restructuring of what was Alberta health into two separate ministries. The consequence is that in this budget a number of programs that would have traditionally been attributed to the regional health authority or to the ministry of health have now been reallocated in a number of ways, which entirely reflects the government's policy direction on how to organize the system going forward.

As it relates to the Ministry of Primary and Preventative Health Services budget, that reflects the reality that Primary Care Alberta is now fully established, so that reflects the shift of primary care in public health programs to that organization. As of April 1 Alberta public laboratories, or APL, will be assigned to that organization. That change is also reflected in the budget here today. Additionally, as far as public health is related, there are a number of public health programs that will also ultimately be transferred into the ministry, and those changes are also reflected within this budget.

There are a number of instances where there are programs that are within the responsibility or the accountability of Primary and Preventative Health Services but are delivered through Acute Care Alberta, again, as it relates to lab, diagnostic imaging, and some other programs. Those changes are also reflected within this budget, and it does reflect the reality that there are a number of programs that cross across multiple sectors, but there are some clear accountabilities that relate to the Minister of PPHS as the oversight minister.

The last thing that is reflected in this budget, the minister referred to its creation, is the new Health Shared Services provincial health corporation, which was created on December 1st. That organization is responsible for delivering corporate and support services across all sectors within the refocused health system, and their budget changes are also reflected in these estimates.

The Chair: All right. We'll go back to the government side. Go ahead.

Mrs. Sawyer: Thank you, Madam Chair.

The Chair: Shared or block?

Mrs. Sawyer: I was about to ask that.
Minister?

Member LaGrange: Shared.

Mrs. Sawyer: Okay. Thank you. I wanted to start, through the chair to the minister, just talking about the challenges we can have. We are a very large province, so having access to high-quality care is high on the priority and should be something wherever we live. On page 133 of the PPHS business plan the rural and remote family medicine resident physician bursary pilot program is listed as being a successful and innovative workforce planning program that is serving rural and remote communities. Obviously, as a rural MLA that is something that is of extreme importance to my constituents.

In relation to that I have to say that, you know, I was at a dinner a couple of months ago, because the Olds and area attraction and retention group actually bring in every year for two days medical students, LPN students, RN students to show them what it's like. So I got to see what they did for a couple of days, and I joined them for dinner to discuss and give the pitch as to why we need more of them to choose rural, and it was really exciting. Quite frankly, most

of those students got to experience what a local curling rink is like, and of all the things for them to enjoy, it was seeing the fellowship at the curling rink and learning to curl. So this one is of very interest.

To the minister, could you outline who is eligible for the program and how many residents were funded through the program? How does the program help grow the number of physicians in rural and remote areas, and how does the program retain physicians and keep them working in rural and remote areas?

Member LaGrange: Well, thank you for the question, and I agree with you. I think it's very exciting. I've heard the same in my conversations with the medical resident students themselves and medical students in general that they have a renewed optimism in all of the various programs that we are providing to attract and retain physicians.

The program provides bursaries to 132 medical residents at the University of Alberta and University of Calgary; 119 are rural bursaries, and 13 are remote bursaries. The applicants must be registered full-time in the family medicine residency program at the U of A or U of C, including those in an enhanced skills residency program, or they must be in an undergraduate medical program and matched to the aforementioned residency programs. In addition, applicants cannot enter another post-residency return-of-service commitment, and they also must be willing to sign a letter of participation acknowledging a return-of-service commitment to practise in eligible rural or remote communities and provide three years of full-time service, a minimum of 15,210 patient visits within five years of completing their family medicine residency program.

It's very specific, but as I said we've had a lot of interest and 132 are now on that residency program. The bursary is designed to allow recipients to settle in a single rural or remote community to complete the return of service or to practise as locums and move around to varying communities. The locum option was introduced in order to allow new physicians the opportunity to spend time in communities and find a place that feels like home because, of course, once they experience rural – you're a rural person; I'm from a farm as well; we farm just east of Red Deer, my husband and I – we know that they will love it, and they will tend to want to stay there and put down roots.

While bursary recipients are only required to provide three years of service in return for funding, the length of time is designed to be long enough to grow roots in that community, as I said. Longer term retention of physicians who receive the rural and remote family medicine resident physician bursary will be determined by other critical initiatives under way by the government of Alberta, including MAPS initiative, health system refocusing and incentives, including the rural remote northern program. So we have those as well.

Mrs. Sawyer: Thank you very much, through the chair to the minister, for that. Yes, it is definitely exciting. Thanks for highlighting that. I do want to quickly just comment, if I may, to thank you for explaining the refocus because I have a lot of constituents who are looking for a little bit of clarity of the separation of the ministries and what that meant. The way I often had explained it – you did it more eloquently and in the detail they needed, but I said that the definition of insanity is doing the same thing and expecting a different result. Credit to our government, out-of-the-box thinking, and for you to be able to relay how the four ministries are working together in that collaboration. We're seeing the results, so it's exciting for me to be able to give you and your ministry the opportunity to highlight it.

I want to focus on nurse practitioners, but I just had to put that in. The country-first innovative program is the one I wanted to discuss.

It's increasing capacity for Albertans to access primary health care. Page 135 of the business plan highlights the nurse practitioner primary care program, and it's through that, as you've mentioned, that it's possible for nurse practitioners to provide autonomous patient care either through their own practices or within existing primary care settings in various areas. You had mentioned it and alluded to it, but I do know some people within our area who were quite excited to transfer from being an LPN into this program. I saw their Facebook posts and how excited they were and what they were doing, so credit. Seeing that reception, the growth, it's clearly working. Performance metrics on page 136 of the business plan shows 1,054 registered nurse practitioners in Alberta in 2025. To the minister through the chair: would you please inform the committee what investments and funding are allotted to the nurse practitioner primary care model, if you could, as well as how many nurse practitioners have joined or started their own clinics?

10:55

Member LaGrange: Happy to. The program started on April 1, 2024, and as I said, it was the first of its kind launched in Canada. You will see that many other provinces have developed very similar programs across the country because, of course, we all have the same needs to improve primary care. My ministry is also providing Nurse Practitioner Association of Alberta, the NPAA, a \$2 million grant over the next three years to help implement the compensation model, recruit nurse practitioners to participate and provide supports as they work to set up their own practice.

The total forecast for '25-26 is approximately \$25 million. The compensation for the nurse practitioners practising under the NPPs that currently exist is \$22.5 million. The remaining seven nurse practitioners that are going to be starting their practice are also expected to be starting here very shortly, and that's also in the current budget. The total forecast – that was for the '25-26 year. For '26-27 it is approximately \$35 million, so you see we've gone from \$25 million to \$35 million, an additional \$10 million to add additional capacity. The compensation is for 101 nurse practitioners for operational and approved practice. Approximately \$9 million will be available to fund applicants approved in the '26-27 year under the new program. We're looking to make incremental increases.

We also are seeing how it breaks down by region. Of the current 88 are 35 in Calgary, 31 in Edmonton, six in central, three in northeast, five in northwest, four in southeast, and four in southwest. Upcoming we will have two more in Edmonton, one more in central, and two in the northwest, and pending one in Calgary and one in Edmonton. We're getting a good cross-section, but again I would say that there is huge interest in our postsecondary programs. That's why our postsecondaries are looking to expand their programs and also to provide those specialty areas for nurse practitioners.

Mrs. Sawyer: Thank you. Well, just to build on that – I think I can get this squeaked out and give you the 30 seconds or less – when we're talking about that success and more uptake, can you just let us know how many nurse practitioners are in the queue to apply to be in the nurse primary care program and how many applicants we have in our university and continuing education spaces to become nurse practitioners in Alberta?

Member LaGrange: As you earlier indicated, we have 1,137 nurse practitioners licensed for practice in the province. It's a 60 per cent increase since 2020 and an average annual growth of 12 per cent. Currently in the cohorts in Alberta we have 296 students from Alberta that are either at the U of A or at Athabasca University,

which are the two programs that currently support the program. We have 528 that are also from outside of Alberta, and we have 11 international students. Again, strong support, but as I indicated we can grow those programs even further because for the spots that were available initially, which initially were about 50, we had over 1,000 applicants. We're seeing very strong response; hence, we increased the number of seats.

The Chair: Time. Over to the Official Opposition.

Ms Sigurdson: Thank you very much, Madam Chair. I'm pleased to ask some questions specifically focused on seniors. I'm looking at page 189 of the estimates and line items 4.3 and 4.4, seniors drug, dental, optical and supplemental health benefits. We know that the copay increased this year, causing further hardship for seniors. As we age, we often need medication to support us to live at our optimum. The UCP is now penalizing seniors by making them pay \$10 more for each prescription. That adds up if you have more than one. Sadly, some seniors are having to choose between groceries and needed prescription drugs. Why is the UCP further burdening seniors with this significant increase?

Also, another part I did ask the minister of seniors, the Minister of Assisted Living and Social Services, but he said that I should ask the health minister, so that's what I'm doing: does the 9 per cent income threshold reduction in eligibility for seniors apply to this program? Does that mean that that 9 per cent that's on all other programs for seniors is also applied to this program? I just would like clarification on that. How much more will seniors have to pay out of pocket for dental and optical, and does the budget reflect this change in eligibility if there is one, indeed?

Now I'd like to move on to line item 1.4, and it's about the Health Advocate's office. Back in 2019 the office of the Seniors Advocate was eliminated by the UCP. The minister at the time said that seniors would be supported by the Health Advocate and the closure of the Seniors Advocate office meant there was no longer a duplication of services, yet two-thirds of the Seniors Advocate staff work was related to financial and social service issues. The last report of the Health Advocate indicates that these issues are out of scope of the Health Advocate, which seems bizarre based on what the previous UCP minister said. Would the minister please explain this discrepancy?

The advocate report lacks detail, having very little substantive information. When you compare the numbers of inquiries from the last Seniors Advocate report to the most recent one, they're kind of similar, but shouldn't the numbers be much larger as the Health Advocate responds to the entire population's concerns, not just to seniors? Has the minister met with the Health Advocate at least on a quarterly basis? What's the advocate reporting regarding seniors? Again, the minister of seniors declined to answer that question.

The Health Advocate indicates she expanded her staffing team and now has a senior policy analyst researcher. Despite this, the annual report does not identify any analysis of policy or trends. What are the policies and trends concerning seniors?

The most recent report from the advocate is 2023-24. There is no report from the 2024-25 time period. Why is that report not available? When will it be available? This report is long overdue.

In the annual report the advocate indicates that the health charter guides her work, and in the health charter it says that

when economic, fiscal and social policies are being developed by the Alberta government, the impact of those policies on public health, wellness and prevention will be considered and steps taken to ensure that public policy is [health] policy.

Is this being done? I see no evidence of it. Why is nothing being identified by the advocate? This is certainly part of her responsibility.

Now I'd like to talk a little bit about the Health Quality Council, and I'm looking at item 9, page 190 of government estimates. At a time when we need more help following the reporting outcomes and there is an increased role for the Health Quality Council in the implementation of MAPS, how can the ministry decrease the Health Quality Council budget? It's been decreased in this current budget. What's being cut, and how can the Health Quality Council help build a sustainable health system with less funding?

I mean, these are significant gaps in the reporting of the government. I'm certainly very concerned about, you know, the commitments that the UCP has made regarding the Seniors Advocate being folded into the Health Advocate, yet seniors are not being served well by the Health Advocate, and really the report lacks significant detail in how much – it doesn't really talk about any kind of macrolevel analysis even though apparently there is someone who has that role.

The Chair: Over to the minister.

Member LaGrange: Thank you, and thanks for those questions. When we look at our seniors, we want to make sure that we are doing everything we can. These are individuals who have built this province, built this country, and we want to make sure that we honour them and that we continue to provide the services they need. When we look at the benefits that are provided, just for information and clarity, Alberta's government offers premium-free supplementary health and benefit coverage to all Albertans 65 years of age and older through the coverage for seniors program. The changes that are being made are to ensure that seniors who already – because we're living longer and in better health, right now in Alberta 1 in 7 Albertans are 65 years of age and older. Soon that's going to be 1 in 5. We're seeing people remain within the workforce, and oftentimes they have better programs and better coverage through their workforce plans. We've introduced legislation to make sure that they are not discriminated against and that they can continue to remain on those plans, but for everyone else there is the coverage for seniors program.

11:05

Eligible seniors receive assistance with the cost of basic dental and optical services through the dental and optical assistance for seniors program. The drug costs under the coverage for seniors program are a significant cost driver for the health benefit program expenditures in the province, but we see that as an investment and a return for all of the great work of our seniors just for being Albertans and having built this great province.

We are in fact changing some of the rules in this area to be the payer of last resort, as I had indicated earlier, but when we look specifically at the question about the drugs, the copays going up slightly from \$25 to \$35, these numbers had not increased at all for well over a decade when we all know that costs have gone up significantly. Had those costs been indexed over those years, the cost would actually be over \$45 per drug, but we continue to make sure that our costs are as low as possible. In fact, of the seniors on the program 95 per cent do not pay the maximum copay. That is the maximum copay, but the vast majority of individuals do not pay that amount for sure.

On the eligibility, I believe the 9 per cent that you're talking about was on the eligibility for a certain program that falls under Assisted Living Alberta, and Assisted Living Alberta would be the best to speak to that particular line item. It does not affect any of

the services that are provided under the seniors' drug and supplementary benefits. There is nothing that is changed as a result of that for these individuals that are here on these programs.

The Health Advocate position came to Primary and Preventative Health Services from HSHS, hospitals and surgeries, only in the last little while. The office is shared with the Mental Health Patient Advocate, and there is a person that does both those roles. When we look to the Health Advocate, it supports all four sectors, and they're working with all four sectors to provide services and to navigate the system, is my understanding. We're going to continue to make sure that we strengthen that role as time goes on as it has increased the ability for seniors to actually access supports.

There has been no change to the funding to Health Quality Alberta. They're actually strategizing on how they are going to continue to support us. In fact, they're very excited about their renewed role within health because they see themselves as being able to provide us with more metrics that we can reach and that quality assurance that we really want. Over the years their role had been lessened, and I've worked very hard to strengthen that role, so I'm really excited working with Health Quality Alberta. I see many good things coming out of that area. They are appreciative that the budget has remained the same and that they were able to continue the great work that they are always doing for us.

I guess I've got five seconds, so I really can't say too much more other than happy to continue on answering your questions.

The Chair: Please proceed, Member. Go ahead.

Mr. van Dijken: Good. Thank you, Chair, and thank you, Minister and all your support staff, for being here. I'm going to kind of refer back to the previous conversation with my colleague on nurse practitioners and the value that they provide for our medical system within Alberta, and I'm going put a plug in for Athabasca University. Athabasca University in my riding currently enrolls about 650 nurse practitioner students, about 160 of those in Alberta, and is one of the largest graduate programs within Canada, within the nation. It's exciting to see the expansion of the nurse practitioner program and the ability for nurse practitioners to practise within Alberta, but of course we need to backfill spaces. The RNs that are moving into the nurse practitioner world need to be replaced to continue to ensure that every facility is able to have the RNs that they need as well.

Alongside expanding permanent primary care capacity, Alberta, alongside every other province in the country, continues to rely on agency nurses to address immediate staffing pressures. It's not a long-term solution. Minister, I know you've mentioned this many times. Looking at the main estimates document, I see that according to line item 7 on page 190 other health system services and supports are over \$2.2 billion. With that said, I'd like to ask about new incentives that the health system is using to attract nurses into the field and bring private nurses, contract nurses into the public system. Would the minister please outline any investments or programs that will incentivize private nurses back into the public system? Also, would the minister explain compared to previous years by what per cent has Alberta decreased its reliance on agency nurses?

Member LaGrange: Thank you. Great questions. Like you, I was really surprised to see the number of agency nurses that were being utilized, particularly through the pandemic. It ballooned right across the country out of control, and we needed to get that number back in line. Agency nursing is only utilized when all other options have been exhausted with existing employees. You know, we want to keep those nurses working full-time, or if they want to work part-

time or casual, within our system. What we have seen in agency nursing utilization has been a decrease of 87 per cent between 2022 and 2023 and the '25-26 fiscal year. It's a huge decrease, but we've also seen that our nursing complement has increased. That's great news for us because we are able to attract them into our programs and into our facilities.

AHS is committed to building training capacity in our rural communities. They continue to work closely with the postsecondary partners to develop local education and training opportunities for nurses and students in rural areas. I think that's really been beneficial. AHS has also continued to expand its rural nursing education program for nurses in practice and leadership roles to increase capacity and retention.

Nurses in the public have access to a range of built-in incentives under the collective agreements, including benefits and pension. At this time there are no specific or targeted incentive programs designed to attract nurses back from the private sector, but the nurses that are working in the private sector are a relatively small number. The fact that, as I said, we've seen a decrease in agency nursing and more nursing – I think also what contributed to that is that we had a very strong collective agreement that we just recently settled that makes our nurses some of the highest paid in the country. There's also a supernumerary where 1,000 nurses every year will be hired from the graduating program and they will have mentorship for up to a year. That will also help them, you know, become comfortable in their new roles.

Mr. van Dijken: Thank you, Minister.

I'd like to hone in on line item 2 on page 189 of the estimates document. Funding for nurse community initiatives would fall under that. While the major cities remain key hubs when it comes to health care in Alberta, rural and northern Alberta have seen issues when it comes to recruiting nurses. It's been a concern in my riding, where without availability of RNs we see hospital closures and the like, but I see that the government is making it easier for credentialed nurses from outside Alberta or Canada to bring their skills, helping internationally educated nurses by streamlining immigration processes and addressing regulatory barriers. I would like to ask this question on this issue, if the minister could please explain if this funding includes the \$7,000 nurse bursary program to attract more nurse graduates to rural Alberta. Can the minister tell us how this bursary program works, and what other initiatives are there to recruit more nurses to our rural hospitals and care centres? Does the minister have an estimate on how many nurses we can expect to come to rural areas as a result of investments through Budget 2026?

11:15

Member LaGrange: Great questions. I will start by saying that the Northern Alberta Development Council bursary program is administered through the Ministry of Advanced Education, so it's actually through that program. It provides up to \$7,000 per year for a two-year maximum and is nonrepayable if nurses agree to live and work in northern Alberta for a set period. It really is to get them there, as we said earlier with the physicians. They're going to love rural Alberta, and the vast majority tend to stay. I believe the number is upwards of around 70 per cent tend to stay when they've been exposed to rural Alberta if they've never come from that area before.

It's part of the collective agreement between AHS and UNA, the nurses' union; \$22.5 million per fiscal year will be invested to implement the rural capacity investment fund. This fund will be used to support initiatives aimed at addressing recruitment and retention challenges experienced in the north, central, and south

zones. The RCIF is currently being updated by AHS and UNA and its stakeholders to align with the new collective agreement. The fund targets positions deemed to be difficult to recruit to based on indicators like high vacancies, positions unfilled for more than 90 days, high turnover, mutual agreement between AHS and unions, and the funding supports initiatives such as incentives for new hires, retention bonuses, site-specific recruitment strategies, and broader workforce stabilization efforts.

AHS is working closely with postsecondary partners to develop those local education and training opportunities for nurses and students in rural areas, and a collective initiative between AHS and the University of Calgary is offering locals the opportunity to pursue their bachelor of science in nursing in Wainwright, Drayton Valley, and Bonnyville, and the program is expanding to Drumheller and Claresholm, with the first intake targeted for fall of 2026. So lots of great programs that have been started.

Also, you wanted to know the expected numbers with the movement of nurses and other health care providers throughout the year. We do not have exact numbers, but we do anticipate that as of January 2026 we know that 414 internationally educated nurses have joined Alberta's nursing workforce with new cohorts arriving every month. Recruitment of these nurses is intended to fill vacancies where there have been long-standing vacancies and no local candidates. Again, happy to say that we've seen recruitment in all areas of the province. This includes Westlock, Claresholm, Stettler, Edson, Rocky Mountain House, Castor, Viking, Whitecourt, Valleyview, Vulcan, Hinton, Barrhead, and Edson, so we are seeing them go to all areas of the province. Having spoken to a lot of nurses and having many in my own extended family, there's a renewed excitement about nursing across this province.

Mr. van Dijken: Good. Thank you for that answer. One village in my constituency, Boyle, also has IENs helping to fill the void in rural Alberta.

I want to look at continuing education and nurses increasing their skill set, nurses applying to become nurse practitioners – we've talked about that – and LPNs becoming RNs. Would the minister please explain if the funding for primary care health systems, with approximately \$81 million allocated in Budget 2026, is going towards continuing education and what we would call nurse bridging programs in order to strengthen our health workforce?

Member LaGrange: Yes. We're going to continue to offer those programs, as I said earlier. Our postsecondaries are really looking to even expand because nurse practitioners also want to expand their skill set. They want to work to full scope. There are many prescribing nurses.

The Chair: Thank you so much, Minister.
Over to the Official Opposition.

Dr. Metz: Thank you very much. I'm going to talk about physician workforce. Item 3 on page 189 of the government estimates document shows that there is the funding of \$7.7 billion for physician compensation and development. At a press conference and again we've heard that physician compensation and support has gone up 22 per cent. Can the minister please explain for the record why the increase to physician services is so large and how those funds will be used given that the increase to physicians is actually about 1.6 per cent, not 22 per cent? This is about half the increase that MLAs are getting. The budget contains no prior year comparable, but looking at prior budgets, the program support line nearly doubled from \$8 million in '23-24 to \$15.9 million in '26-27. Does this budget support the cost for administration of physician services, particularly in the ministry, and does this

support include the cost of the consultants that are being hired by the ministry in droves so that we can see where that money is actually going?

The '26-27 budget line item for physician education and recruitment actually decreased by 2 per cent from last year and has changed very little over the past two years. What is really being done to recruit? We know that B.C. has had major increases in recruitment numbers. While I understand that many of those physicians coming from the United States are coming to places that are more progressive, which kind of cuts Alberta out at this time, it's really difficult to see if we're not actually trying to get American physicians to come here.

With regard to workforce planning where would the funding for this be in the budget? Is it perhaps under ministry support services, page 189, item 1.3, strategic corporate support and policy development, or is this elsewhere? How much is the ministry allocating to health workforce planning in '26-27, and how does that compare to the previous two fiscal years?

Before acute care and primary care split, this item – that's the line 1.3 – was together, and if we look at the amounts for this and the budget in acute care, this line item has grown by about \$10 million each year over the last two years. Can the minister please let us know – that's over a million dollars a week – what Albertans are getting for this?

Now, in Honouring Our Roots the Indigenous Primary Health Care Advisory Panel recommended the need to build and grow the Indigenous health workforce for the future and prioritized pragmatic and innovative practices to recruit and retain Indigenous learners in health care roles. That is recommendation 2.4, page 12, in the Way Forward implementation plan. Will the minister tell us what progress her ministry has made since 2024 in recruiting and retaining Indigenous people into health care roles, and how many Indigenous people were recruited to the Alberta health workforce last year? Indeed, within the ministry are Indigenous leaders and Indigenous people involved in leading these developments? I realize that there is a group within the ministry. Is this filled with Indigenous people?

When will the minister be able to provide us with accurate metrics that show what care is being delivered rather than the number of registered providers such as hours of care spent delivering comprehensive primary care, after-hours care, emergency services by different types of providers? This will help with future workforce planning.

Thank you.

11:25

The Chair: All right. Perfectly timed, Member.
To the minister for a response.

Member LaGrange: Thank you. Again, I want to share all the great news that's happening within our physician compensation. Particularly, as I've indicated before, it's a \$7.7 billion overall spend, a 22 per cent increase. The members opposite continue to mischaracterize that, but the truth of the matter is that this is where it's going to be spent: \$6 billion is in physician fee for service – that's direct services payment to doctors who are providing services to Albertans – \$283 million in the PCPCM, the primary care physician compensation model for base claims; an additional \$22 million for the PCPCM administrative top-up is for their administration elements of their practices; \$122 million is in the PCPCM panel management, which has seen a 30 per cent growth. Of course, with that growth means that there are more Albertans that are attached to primary care providers. Three hundred and thirty-six million dollars is in the clinical alternative relation plan.

Those are the ARPs. Doctors who are perhaps not doing fee for service would be on a clinical plan. It's more of a contractual basis, but again, that's a significant amount, \$336 million.

There's \$215.3 million in academic medicine; \$114 million in the rural, remote, northern program. We have \$95.5 million, physician on-call program; \$15 million in the physician recruitment and retention support; \$105 million in physician support programs, which are comprised of \$54 million in medical liability and reimbursement, \$35 million in continuing medical education for physician family support, compassion, assistance programs. We have \$8.9 million in the accelerating change transformation team. We have \$4.3 million in the physician locum services, \$3.7 million in physician learning grants. That is a \$1.4 billion increase primarily attributed to population growth. There are more people, so they're providing more service.

Patient age, complexity, and rate increases related to the expenditure under the Alberta Medical Association agreement. For those who don't know, the agreement was signed in 2022. It provided a 1 per cent in year 1, a 1 per cent increase in year 2, a 1 per cent in year 3, and last year, which was '25-26, was actually an arbitrated settlement just recently of 3 per cent. That was in addition to all of the other enhancements. That doesn't include the PCPCM, as I had indicated earlier. That was up and above. That was negotiated off negotiation cycles. We are going into new agreement negotiations here very soon.

In 2025-26, a forecast of \$6.3 billion: I think I've already addressed that one, so I won't go back to that.

On the education side that \$7.7 billion also includes education: \$187.2 million in academic medicine, health services programming; \$182.9 million in resident physician service compensation; \$69.9 million in physician education and development; \$9 million in the rural health profession action plan; and \$1.3 million in the Lloydminster physician on-call program. Again, we are providing more services, more physicians. I would say that what has been stipulated, a \$7.7 billion overall budget, 22 per cent increase, is the correct number.

On the item where it was program support – let me just go to that item – the \$1.7 million increase is primarily related to the settlement of Alberta public services' collective bargaining agreements. We saw we were able to settle with many of our health care professionals this year and those allied health care professionals. Those are increases, so we've made sure that our numbers actually reflect those increases.

Let me see. While the member made some derogatory statements about people not wanting to come to Alberta, that is not the case. In fact, we are seeing more and more physicians coming to Alberta because they do see us being a leader in so many areas, and I would love to celebrate all of the great things that are happening in Alberta. We are seeing more doctors coming from the U.K., from the U.S.A., from Australia, from other jurisdictions.

The Chair: Thank you, Minister. That's your time.

Who's up next? Go ahead, Member.

Mrs. Johnson: Thank you, Madam Chair, and through you thank you to the minister and to her team for being here today for sharing with us, for the clarification so that we can never go far from the truth, if I may say so.

I want to talk a little bit more about continuing education. My colleague from Athabasca-Barrhead-Westlock began on this, and I want to continue it because it's a little bit close to my heart. I was a registered nurse. I did my training here at the University of Alberta and a lot of that training at the Misericordia hospital here right here

in town. I love what is happening in our nursing profession. I'm going to circle back, and I'll just repeat the question for clarification.

The nurses across Alberta are looking to increase their skill sets and continue their education. I'm given to understand this is evidenced by a large uptake in nurses applying to become nurse practitioners and LPNs becoming RNs. Continuing education strengthens the skills of nurses, gives better career satisfaction, which makes for a better patient experience.

Line item 2.3 on page 189 is about modernizing Alberta's primary health care system with approximately \$81 million allocated in Budget 2026. Would the minister please explain if this funding is going towards continuing education and nurse bridging programs in order to strengthen our health workforce, and are there any other line items this minister can point to that demonstrate a commitment to empowering nurses to build on their skills?

Member LaGrange: Happy to explain further on that one, for sure. The government of Alberta has allocated \$500,000 to the Alberta Nurses Educational Trust, or ANET. It was formerly called the Alberta Registered Nurses Educational Trust. This ANET is to administer continuing education grants to more than 200 licensed practical nurses and registered psych nurses, enhancing professional development opportunities right across Alberta's nursing workforce. Alongside this new funding ANET also manages the registered nurses endowment that funded 1,440 RNs' applications in the last fiscal year. It distributed \$550,000 for education and learning purposes such as events, conferences, specialty nursing certificates, and degree-level studies.

Beyond that the government of Alberta has also invested \$794,733 over four years to support the Alberta Association of Nurses' internationally educated nurses, or IENs, nurse navigator program to help IENs access guidance tools and in-person support that they need to navigate Alberta's licensure process and pursue meaningful employment in our health care system. Since 2023 Advanced Education has invested \$18.2 million to add a total of 1,827 seats in bridging programs for internationally educated nurses seeking licensure to practice in Canada, including \$7.3 million to create 626 seats in existing programs over three years, which is '22-23 through to the '24-25 and through the INE seat expansion and \$10.9 million to create 1,221 seats in newly created programs over three years from '23-24 through '25-26 through the INE program expansion. Over \$12.7 million has been provided to support students accessing the rural health professions action plan bursary for internationally educated nurses, or the BIEN, program plus administration fees. To date 450 IEN students have been funded through the BIEN program.

Nurses who are furthering their education can also apply for bursaries through the Northern Alberta Development Council, which I've already spoken to earlier, which provides that \$7,000 per year for two years, and that is nonrepayable if they agree to live and work in northern Alberta for a set period of time. Really good news. We're really trying to recruit those new nurses and keep them here.

Mrs. Johnson: Thank you, Madam Chair, through you to the minister for that great answer. I want to make sure that we have enough time for this, so I'm actually going to skip ahead a little bit to midwives because, again, this one is really important to me not just as a retired registered nurse but now as a grandma whose daughters-in-law are accessing this amazing opportunity and the skill set in Alberta, and I'm just thrilled with it. Yes.

11:35

Midwives do have a major role in primary health care and providing services to Albertans. I was very pleased to see Budget 2026 is recognizing the important contribution that midwives make to our province. As highlighted on page 135 of the business plan, the government is committing \$5 million to invest in projects that support midwives to deliver timely, adaptable supports and services during the pregnancy, childbirth, and postpartum periods. Increasing access to maternal care through the midwifery strategy will reduce pressure on hospitals and improve access to maternity care in rural and remote areas.

I'd like to know a little bit more about what Budget 2026 is doing in regard to midwifery. Would the minister please update this committee on what PPHS's vision is for the future of midwifery and what funding will be allocated for that vision? Also, how can the ministry work to better integrate midwives into rural care teams, and with the changes being made to primary care, how does this refocus impact midwifery?

Member LaGrange: Thank you. Great questions. Like you, as a mother of seven and grandmother of eight many of my daughters and daughters-in-law have used midwives.

I was saddened to see that Saskatchewan actually has a stronger midwifery program than Alberta does. I think we need to do better here in Alberta, and that's why we are continuing to expand our services. We recognize that midwives do provide an important role in making sure that women have the supports that they need while they go through the pregnancy journey. Thirty million dollars annually is spent on midwifery services. That includes the base operating funding. Priority efforts for midwifery are refocused on improving services across the province, particularly in our rural remote regions and services to Indigenous communities.

Our government is investing a total of \$10 million over three years for the Alberta midwifery strategy to strengthen the midwifery workforce and give Albertans more access to maternal health services, particularly, as I said, in rural and Indigenous communities. Funding was allocated as follows: \$2 million in '24-25, \$3 million in '25-26, and we're growing it to \$5 million in '26-27. In '24-25 Primary and Preventative Health Services provided grant funding in the amount of \$1,397,342 to the Kihew Awasis Wakamik Cultural Society, or KAWCS, an Indigenous organization to train Indigenous individuals to become second birth attendants, develop an Indigenous midwifery education curriculum, and establish a dedicated Indigenous care centre for clinical training.

In '25-26 three million in grant funding will be awarded to seven organizations that are proposing innovative solutions to enhance midwifery services and address gaps in rural remote and Indigenous communities. PPHS is currently in the final stages of that grant call, and then we'll process and allocate those funds within the fiscal year. These seven grants are to improve access to maternal health services in various rural Indigenous communities across Alberta, also to create a first of its kind bridging program for internationally educated midwives and streamline the assessment at the college level, enabling faster entry to Alberta practice, improved data collection to enable health workforce planning. The remaining \$5 million will be awarded through a grant call process in '26-27.

To answer your question on how to integrate them into rural teams, the government acknowledges that there are some challenges, but we are continuing to address those challenges. The remaining \$5 million of the Alberta midwifery strategy will be awarded through a grant call, as I said earlier, for the '26-27 year to promote the integration and public awareness of midwifery practice

and a team-based model within primary care, initiate engagement with underserved populations, promote interdisciplinary models of team-based care, and align midwifery demand, capacity, and effectiveness through evidence-informed monitoring and evaluation. We're seeing that particularly at the PCN level. They're really getting into those communities and being involved and then going out to the broader communities.

Then as far as how does the refocus impact midwifery, PCA is a new provincial health agency that oversees the governance, coordination, and delivery of primary health care, and, of course, midwives are an integral part of that, really getting them embedded into that health care team, making sure that everybody is working together for the betterment of the patient that is being served. In this case it's not only the mother; it's the child or children if they're having more than one as well as the overall family. I know for those who've had a midwife for their journey throughout their pregnancy, they really appreciate it.

The Chair: Thank you so much, Minister.

Go ahead, Member.

Mr. Haji: Thank you, Madam Chair. I have a couple of questions to follow up. One is the increasing cancer screening by expanding delivery as well as eligibility. We've heard that the eligibility will increase by reducing the age, meaning that more people will be accessing cancer screening. The delivery will also increase, because I've heard that there will be mobile strategies to increase access. Basically, in the combination of those two, what that means will be that there will be more people who will be accessing cancer screening than the current state, but that is not reflected in the budget, so I'm asking one final time for some explanation on how that would be possible. If you have not increased the allocations that you put in there and you have increased the volume that will be coming for cancer screening, then you have a discrepancy, which is not making sense to me. Again, this is not treatment; this is prevention and screening, so this doesn't fall under the cancer centre. I'm looking for some questions, some answers on that.

The other thing is about the overall budget. The minister and I can disagree in terms of whether people will be charged for vaccines or not, but we could agree on $2 + 2 = 4$ and $2 - 2 = 0$. The overall budget from last year, the 2025 budget, was \$11 billion. The current budget is \$12 billion. There is additional money that came in, which is around, as the minister said, \$1 billion. That is the Alberta precision lab as well as the shared services, so there are additional budget lines that were not there that were brought in. What that means is that if you take that out, then there is actually no increase on the base budget between 2025 and 2026. However, I will agree that there are some reallocations within, and those reallocations impacted direct program delivery on the public health and population health services budget lines. That is where I'm having a problem in terms of – that technically will mean direct cuts on those direct delivery programs.

The questions that I have are some questions that I've initially asked. How will this impact on communicable diseases surveillance, prevention promotion; How will this impact on our emergency response and preparedness; and how will this impact on unintentional injuries that remain the third leading cause of death in Alberta? I'm underscoring the importance of sustained prevention investments in this, but the budget lines within the government estimates show that there is a cut. Will the minister outline which specific prevention and wellness programs are being produced or eliminated under 5.3? What criteria are used to determine which prevention programs would absorb these budget cuts? There is no problem to identify in terms of: "Okay. This is not a priority. Now

we're moving to this." We're just trying to understand which ones are going to be impacted. Has the ministry assessed the long-term health system and fiscal impacts of reducing prevention funding, particularly related to avoidable hospitalization and emergency department use?

Those are some basic questions based on the government estimates document that we see. Yes, there is reallocation, but those reallocations would lead to some cuts to direct program delivery, but increase with overhead government operational costs. I've looked into that, and it totals about \$300 million increase on overhead costs if you look at each of those budget lines. If the minister could clarify some of those I will really, really appreciate it.

I can give back 10 seconds to the minister.

11:45

The Chair: Well, thank you so much, hon. member. We will move now back over to the minister for her response.

Member LaGrange: Thank you. First, to address the overall budget: as I said, you know, \$12.7 billion for my budget, a \$1.5 billion increase, that's a 13 per cent increase from Budget 2025. Yes, the member is correct that there were revenues that came in, but there were also revenues that went out to other agencies, the other pillars. When we look at that, there are no overall decreases because the budget for health, in total, is \$34.4 billion, which is a huge increase from last year where it was sat around \$28 billion to \$29 billion. Again, the increase to my ministry is \$12.7 billion overall but a \$1.5 billion overall increase, 13 per cent increase.

Again, to the physician spending compensation, which is one of the biggest line items within my budget, it's a \$1.4 billion increase from budget last year. I've already read numerous times where that money is being spent, and it's all being spent on physician compensation. We want to get as much of the funding directly to the front lines because that's where we're going to see the biggest impact. It's in our workforce. In health care roughly about 75 to 80 per cent of funding goes directly to the workforce. It's in salaries and making sure that we have a well-compensated workforce, as I indicated earlier.

Around the increases to cancer screening: some of the innovations that we're going to be using are proving very valuable, and we're seeing that right across – they're evidence-based – is that we can use new technologies. Where colonoscopies were being used on a regular basis before for colon cancer testing, colorectal testing, now the FIT test is being used. It's point-of-care testing that you can do in the comfort of your own home, if I can put it that way, that will, in fact, catch some of these early cancers. It's much more cost effective as well. It's a way to increase the screening, particularly for those that perhaps don't have a family history.

For those that do have a family history – like myself, I lost both my father at a young age and a younger sister at the age of 29 to colorectal cancer, so I know how important it is to have that follow-up. As I said earlier, we're seeing that the screening has gone up from 56 per cent, but we're targeting 60 per cent in the upcoming year, and I'd like to see it even higher than that.

We're going to continue to make sure that we're offering screening. We know that lung cancer is one of the number one cancers in Canada and in Alberta, and we now have a mobile lung cancer screening unit that will go out to rural remote areas to do that screening, very much like the prostate Man Van screening that goes out to our rural communities, the breast cancer screening that goes out to our rural remote communities. In breast cancer alone those mobile units that go out do upwards of 40,000 screenings per year. You know, those are 40,000 – a good percentage of those early

cancers are caught at that early stage, so we need to continue to make sure that we are doing that.

There is no reduction to surveillance and management. There's no change to emergency disaster management. Again, all of that remains. We prioritize that because we want to be ready in the event that something adverse were to happen. We're going to continue to do that prevention. That is why the title of my ministry is Primary and Preventative Health. How do we prevent individuals from going into an emergency situation? As I said earlier, I don't want the emergency room door to be the first door you go through. It should be the last door. If we have people attached to their primary care homes, where they have access to their primary care provider, where they have a team of individuals. Sometimes you need your family doctor, but other times you may need a different type of professional. Whether it's a dietitian, whether it's mental health support, we want to make sure that those teams are built. Through the regional primary care network that's going to be happening. It's already existing in primary care networks, but as I said, we want to expand that.

The Chair: Thank you so much, Minister.

Over to the government side. Please proceed, Member.

Mr. Lundy: Well, thank you, Madam Chair. Thank you, Minister and team. Honestly, thank you, Minister, for just providing some highlights and guidance on the importance of preventative screenings and services. As I often hear you say, you know, of course, we're all touched by the health care system, and we're all appreciative of the efforts that your ministry puts forward on the preventative side. At the end of the day, it's just better outcomes for our families, which, I think we can all agree, is incredibly important. I, of course, would like to maybe ask a few specific questions on that.

Sorry, Madam Chair, I probably missed the window. I assume that we are going back and forth with the minister?

Member LaGrange: Yes.

Mr. Lundy: Okay. Great. Thank you for that.

Maybe if I can hone in a little bit on the diagnostic imaging and enhancement program. This sort of bleeds into the preventative side, so I'm happy to ask a few questions about this. Madam Chair, I will be referencing page 135 of the business plan. Key objective 1.2 relates to strengthening primary and preventative health care services by reducing wait times for laboratory and diagnostic services to deliver faster, more effective care. I would like to focus this question on any improvements towards the diagnostic imaging enhancement program and how it will impact diagnostic wait times. Through the chair: can the minister please explain how the diagnostic imaging enhancement program functions?

Member LaGrange: Sure, happy to. The diagnostic imaging enhancement program is aimed at modernizing and expanding Alberta's diagnostic and cancer care capabilities, addressing the growing demand for timely and accurate diagnosis and cancer treatment. Budget 2026 includes \$280 million over two years under the Hospital and Surgical Health Services, or HSHS, targets as part of a province-wide capital investment initiative to replace end-of-life diagnostic imaging equipment across Alberta, including MRI and CT scanners and improve cancer care capabilities. This program is fully funded, managed, and delivered by HSHS. I can tell you that when I was still overseeing that, we were seeing that roughly about 65 per cent of the diagnostics were coming to end-of-life, so we really needed to address that.

Mr. Lundy: Thank you, Minister. Through the chair maybe a couple of quick follow-ups on that, then. Thank you for sharing that \$280 million dollar investment. Can the minister maybe comment on how this will improve front-line health care professionals' working conditions? An additional follow-up through the chair: how will the diagnostic imaging enhancements program reduce diagnostic wait times?

Member LaGrange: Well, as I said, when you have older equipment and it's breaking down and, you know, the practitioners are having to wait for replacements or the time that it takes to even just utilize that old equipment, it becomes problematic. It takes time, and, of course, it increases wait times overall. The diagnostic imaging enhancement program will replace outdated equipment, as I've said, and install advanced diagnostics imaging technologies and cancer equipment, ensuring that health care providers have access to the tools necessary for early disease detection and more efficient patient care.

If anyone has seen some of the new equipment – oh, my gosh – it is, like, absolutely outstanding. It also uses, you know, AI technology, et cetera that can quickly interpret results, more so than in the past. This initiative aims to address the growing demand for diagnostic imaging, including CT and MRI scans as well as cancer treatment and other diagnostics. We've seen huge increases in all of those areas.

The diagnostic imaging enhancement program addresses critical infrastructure gaps, ensures facilities are equipped to meet current and future clinical demands, and enhances the quality of images, leading to more accurate diagnoses for Albertans.

11:55

Our modernized equipment also enables integration with artificial intelligence tools, as I've said, and supports more efficient workflows, contributing to improved access and long-term system sustainability.

Furthermore, the integration of AI into the MRI workflow has improved access and wait times by speeding up the rate of each scan, with a target to increase scanning by 40,000 MRIs per year using existing staff and equipment. With the same equipment, same staff, we're going to be able to do 40,000 more. That's good news for Albertans.

Mr. Lundy: Thank you so much, Minister, for that information.

I've toured the new diagnostic facility in Leduc, and it's quite impressive with the technology that we've seen being able to be incorporated.

I'd like to maybe switch gears a little bit although I think it's the same type of conversation but related to laboratory services. You know, we know how important these services are so that Albertans can access timely health care and receive prompt, accurate laboratory testing particularly during, as you've mentioned, the transition across Alberta's laboratory system.

Through the chair, I'd like to ask the minister if she can explain what concrete steps are being taken to stabilize laboratory services in Alberta and what might be included as part of some of these investments.

Member LaGrange: Happy to share that our government is investing \$60 million over three years to modernize our laboratory services and infrastructure through a phased facility upgrade, expansion of patient services centres, replacement of end-of-life

equipment, and adoption of automation and digital systems. There's just a lot that we can do to make sure that Alberta Precision Labs, who is the supplier of lab services for Alberta, does in fact, you know, have the resources and the supports they need. These investments will ensure reliable, timely diagnostic services for Albertans, improve access, reduce wait times, support equitable testing in urban, rural, and remote communities, and enhance efficiencies while easing pressure on our laboratory workforce.

What we include in that is the replacement of end-of-life laboratory equipment to reduce service disruptions and improve diagnostic quality and accuracy. It also expands testing capacity in patient services centres to increase demand for laboratory services across Alberta. It's the adoption of automation and digital systems to improve operational efficiencies by supporting accreditation standards and reduce long-term system management costs. These investments are designed to enhance the stability, efficiency, and responsiveness of our lab services. I know that Alberta Precision Labs targets making sure that anyone who comes in to have a service has it done within less than 30 minutes. Right now their rate is roughly about 23 minutes, so they're meeting and exceeding their target. Kudos to them. They're doing great work.

Mr. Lundy: Thank you, Minister. I appreciate those key updates.

Maybe I'll close with a program I don't think we've talked about yet, and I am happy to ask this question on behalf of several of my colleagues who very generously shared information with their families or newborns. Of course I'm talking about the genetics and genomics laboratory in the Alberta newborn screening program. The Alberta newborn screening program is critical for early detection and treatment of conditions that can significantly affect infant health and outcomes. Through the chair, can the minister explain what is being done to enhance this program and how it will lead to improved screening quality and better access for families in Alberta?

Member LaGrange: Absolutely. With the minute I have remaining, I'll say that Budget 2026 invests \$35 million over three years to support the consolidation and the expansion of the genetics and genomics laboratory. It's because we actually do want to increase the Alberta newborn screening program, which currently screens for 22 serious, treatable conditions. This program successfully screens most of Alberta's newborn infants for these conditions and it can be treated early when they are found to have that condition. The sooner we can diagnose them, the sooner that we can treat them. In 2023 the Premier's mandate letter directed me to add four new conditions to that screening panel, but we have to expand the laboratory ability to do that. Hence, we're investing that \$35 million so that we can upgrade the equipment and make sure that we have everything we need to in fact be able to provide that service to Albertans. I know it's comforting to parents to know that we do screen for those illnesses.

The Chair: All right. Thank you, members. That concludes the time allotted for consideration of the ministry's estimates.

I'd like to remind committee members that we're scheduled to meet this evening at 7 p.m. to consider the estimates of the Ministry of Public Safety and Emergency Services.

Thank you, everyone. This meeting is adjourned.

[The committee adjourned at 12 p.m.]

