



Legislative Assembly of Alberta

The 31st Legislature
Second Session

Standing Committee
on
Families and Communities

Ministry of Hospital and Surgical Health Services
Consideration of Main Estimates

Wednesday, March 18, 2026
9 a.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

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Ministry of Hospital and Surgical Health Services
Hon. Matt Jones, Minister

Cancer Care Alberta
Brenda Hubley, Interim Managing Director

9 a.m.

Wednesday, March 18, 2026

[Ms Lovely in the chair]

**Ministry of Hospital and Surgical Health Services
Consideration of Main Estimates**

The Chair: 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 Hospital and Surgical Health Services for the fiscal year ending March 31, 2027.

I'd ask that we go around the table and have members introduce themselves. Minister, when we come to you, kindly introduce your team at the table. We'll start to my right.

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

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

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

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

Mr. Jones: Matt Jones, Minister of Hospital and Surgical Health Services and MLA for Calgary-South East. At the table with me is Dave Peace, assistant deputy minister of acute care; Will Sawchyn, senior financial officer; Paul LeBane, chief operating officer; and Donna-Joy Tuplin, capital planning.

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora.

Mr. Haji: Sharif Haji, Edmonton-Decore.

Ms Ganley: Kathleen Ganley, Calgary-Mountain View.

The Chair: I'm Jackie Lovely, MLA for the Camrose constituency and chair of the committee.

We do have someone joining us online. Member, would you please introduce yourself?

Mr. Getson: Shane Getson, MLA, Lac Ste. Anne-Parkland.

The Chair: Thank you for joining us remotely today, sir.

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. Please set your cellphones and other devices to silent for the duration of the meeting.

Hon. members, the main estimates for the Ministry of Hospital and Surgical Health Services shall be considered for six hours. Therefore, this is the first of two three-hour meetings. Standing Order 59.01 sets out the process for consideration of the main estimates and legislative policy committees. Suborder 59.01(6) sets out the speaking rotation for the 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 but only if the minister and member agree. If debate is exhausted prior to six hours, the ministry's estimates are deemed to have been considered for the time allotted in the main estimates

schedule, and the committee will adjourn. 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; however, the clock will continue to run. Does anyone object to having a break today? Okay. 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 a microphone in the gallery area and are asked to please introduce themselves for the record prior to commenting. Pages are available to deliver notes or other materials between the gallery and the table. Attendees in the gallery may not approach the table. Space permitting, opposition caucus staff may sit at the table to assist their members; however, members have priority to sit at the table at all times.

Points of order will be dealt with as they arise, and individual speaking times will be paused. However, the block of speaking time and the overall meeting clock will continue to run.

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

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

I'd now invite the Minister of Hospital and Surgical Health Services to begin with your opening remarks. Sir, you have 10 minutes.

Mr. Jones: Thank you, Chair. It's my pleasure to present the '26-27 main estimates for Hospital and Surgical Health Services. I've already introduced those at the table with me, but behind me in the gallery include my chief of staff, Mikayla Janssen; Kyle Warner, my press secretary; and Nelson Shepherd, my ministerial assistant. I would also like to welcome representatives from across our health care system who are with us today, including the interim CEO of Acute Care Alberta, David Diamond; managing director of emergency health services, Les Fisher; the interim managing director and operational director of Give Life Alberta, Deanna Paulson; the chair and interim managing director of Cancer Care Alberta, Brenda Hubley; the interim CEO of Alberta Health Services, Andre Tremblay; and the CEO of Covenant Health, Patrick Dumelie.

Hospital and Surgical Health Services is responsible for acute-care services to Albertans, including hospital care, surgical procedures, emergency health services, cancer care, and organ and tissue donation and transplantation. Budget 2026 reflects the reality facing Alberta's health care system, both the very real pressures we are experiencing today and the responsibility we have to plan carefully, responsibly, and sustainably into the future.

Alberta's population continues to grow at a rapid pace, and that growth is translating directly into higher demand for hospital care, emergency services, surgeries, and cancer treatment. At the same time, patients coming through hospitals today are more complex, with higher acuity needs and longer lengths of stay. Those pressures are not isolated to one facility or one region; they are being felt across the province.

Albertans reasonably expect timely access to care. They expect emergency departments that move patients efficiently, hospitals that are focused on outcomes, and a system that responds when demand increases, all while using public dollars responsibly and transparently. This is the context for Budget 2026.

If passed, Budget 2026 includes \$13.8 billion in expense for hospital and surgical health services. In '26-27 this represents an increase of approximately \$1.7 billion from the previous year's budget. Not only does this funding support rising service volumes, increasing patient complexity, workforce pressures, and inflationary costs; it also provides funding to reduce wait times and improve patient outcomes.

It is important to emphasize that these investments are being made with a strong focus on fiscal stewardship and value for money. Health care represents the largest area of government expenditure, and Albertans rightly expect that funding decisions are disciplined, evidence informed, and focused on patient outcomes.

Hospitals across Alberta continue to operate in a challenging environment. Emergency department visits remain high, in-patient beds are under sustained pressure, and surgical demand continues to grow. At the same time health care workers are managing the cumulative effects of several years of system strain. I want to acknowledge the dedication of physicians, nurses, allied health professionals, and support staff across Alberta's hospitals. Their professionalism, resilience and commitment to patient care continues to sustain the system during these periods of high demand. Workforce stability is essential to system performance, and Budget 2026 supports the delivery of front-line services while longer term workforce planning and recruitment efforts continue across our health care system.

A significant portion of this budget, \$6.6 billion in operating funding, is for acute care. It supports hospital operations, surgical activity, and cancer care. This funding helps stabilize the system today while continuing to build the capacity we need for the future. Budget 2026 continues to advance the acute-care action plan, which is designed to deliver both short-term relief and longer term system improvements. Over the next three years the budget invests more than \$586 million through this plan to address urgent pressures across the acute-care system. A key component is \$525 million to increase surgical activity by delivering 50,000 additional procedures over three years. This will be achieved by expanding operating room capacity and making greater use of chartered surgical facilities for routine, low-complexity procedures, allowing hospitals to focus their resources on patients with emergent and complex needs.

Improving throughput is not simply about increasing activity; it's about ensuring patients receive care in the right setting at the right time and with the appropriate level of care. This approach helps reduce wait times, improve patient experience, and ensures hospital operating rooms are used where they add the greatest value.

Budget 2026 also includes targeted investment to improve emergency department flow, including \$61 million over three years at the Royal Alex hospital in Edmonton. These funds support improvements to triage, admission, and discharge processes, helping patients move more efficiently through the system and reducing congestion in the emergency department. Emergency department congestion is often a symptom of broader system challenges, including in-patient capacity, access to diagnostics, and timely discharge. Addressing these pressures requires co-ordinated action from the continuum of care. Hospitals continue to manage fluctuating demand, including seasonal respiratory illness, supported by daily monitoring, operational oversight, and provincial co-ordination led by Acute Care Alberta.

Operational funding alone is not enough. Alberta also needs the right infrastructure now and into the future. Hospital and Surgical Health Services' budget includes \$1.42 billion in capital funding over the next three years. These investments support major hospital projects, regional facilities, and faster capacity solutions that can be

brought online more quickly to address immediate and emerging needs.

In Edmonton Budget 2026 includes funding to advance planning for new in-patient towers at the Grey Nuns and Misericordia community hospitals, helping to ensure future capacity aligns with population growth and patient demand. Across the province \$63 million over three years is dedicated to developing shelled and vacant spaces, allowing in-patient capacity to be added more quickly and cost effectively where staffing is available.

9:10

Budget 2026 also invests approximately \$315 million over three years to strengthen rural and regional health services. This includes continued funding for the Beaverlodge health centre replacement, planning for the Cardston health centre redevelopment, and targeted upgrades through the rural hospital enhancement program. These investments help ensure Albertans can access safe, modern care closer to home.

In addition to stabilizing day-to-day operations, Budget 2026 places a strong emphasis on performance, outcomes, and delivery across Alberta's acute-care system. Funding decisions are informed by data, clinical expertise, and continuous monitoring to ensure resources are directed to the areas of greatest need. This includes tracking surgical throughput, our emergency department and in-patient length of stay, patient flow metrics, and patient safety indicators across facilities and regions. Operational oversight is supported by regular reporting, provincial co-ordination, and targeted interventions when pressures emerge. This allows the system to respond quickly to demand surges, address bottlenecks, and deploy supports where they will have the greatest impacts for patients and front-line workers. It also supports accountability to Albertans by ensuring investments are linked to measurable results and transparent performance expectations.

A key focus is on improving the patient journey across the continuum of care. That means reducing avoidable delays, improving transitions between services, and ensuring patients receive timely care in the most appropriate setting. It also means working closely with physicians, nurses, and health professionals to align operational planning with clinical realities and patient need.

Taken together, these efforts support a more resilient acute-care system that can manage current pressures while adapting to future growth, changing demographics, and evolving health care needs. They reinforce a commitment to responsible stewardship, continuous improvement, and better outcomes for patients and families across the province. This work is closely aligned with broader system planning, including workforce availability, capital sequencing, and fiscal sustainability. It recognizes that improvements in one area often depend on progress in others, and that lasting change requires co-ordination across programs, organizations, and professionals.

By strengthening how services are planned, delivered, and evaluated, the ministry is better positioned to support consistent access to care, reduce variability, and maintain public confidence in the health system over time. This focus also supports better decision-making at all levels, enabling leaders to balance access, quality, safety, and cost while responding to local conditions and provincial priorities in a disciplined, transparent, and patient-centred manner across our diverse hospital system. It reinforces shared accountability and supports sustained improvement over the long term for patients, providers, and the health system.

Clear governance and accountability are essential when managing a system of this size and complexity. Four provincial health agencies are now established under dedicated ministries. This structure provides clear oversight of funding, performance,

and outcomes across the system. Within this structure, Hospital and Surgical Health Services provides policy direction and funding oversight, while Acute Care Alberta is responsible for commissioning and contracting front-line services.

Budget 2026 reflects a balanced and responsible approach. It responds to immediate pressure facing Alberta's acute-care system while making strategic investments to strengthen hospital and surgical services for the future.

Thank you, Mr. Chair, and I look forward to the committee's questions this morning.

The Chair: It's Madam Chair. You said, "Mr. Chair."

Mr. Jones: Sorry, Madam Chair. It's early for me, too.

The Chair: That's okay. Thank you, 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'll be able to see the timer for the speaking block in both the committee room and on Microsoft Teams.

Now, who among you is speaking first? Do you prefer shared or block time with the minister?

Ms Hoffman: If the minister is open to it, I think we could have a better back and forth if shared.

The Chair: Okay. Minister, what's your preference?

Mr. Jones: Block time.

The Chair: Okay. We'll go with block time.

Please proceed with your questions, Member.

Ms Hoffman: I am going to start this morning by recognizing that we're on Treaty 6 territory and reflecting on the responsibilities of the medicine chest as it relates to that and also the health outcomes that are abysmal for First Nations, Métis, and Inuit Albertans who reside in our jurisdictions of treaties 6, 7, and 8.

I want to also thank all of the department staff, the agency representatives who are here, and other organizational leads who have taken the time to, I'm sure, prepare amazing binders full of rich data that I hope we can delve into over the time we have together today. I will say that in my experience time flies.

The six hours sounds like a long day, but I really am hopeful that we'll be able to have a rich conversation and help demonstrate some of the things the minister outlined in the opening remarks around measurable results, transparent performance indicators, and how we are stewarding what I will argue is one of the most important areas of responsibility for any provincial government. We all know that when somebody you love is sick or injured or when you are, nothing else matters other than your health. I am grateful to all of you for your service in that, and I will do my job as a representative, as the Official Opposition shadow minister in probing a bit with all respect.

I am going to start by talking about cancer treatment and cancer wait times in particular. It's inspired by page 82 of the business plan, where there is this lovely org chart explaining that Acute Care Alberta has four main service providers: Alberta Health Services, Cancer Care Alberta, Give Life Alberta, and emergency health services. There aren't key objectives or performance metrics related to cancer within the business plan, sadly, that I was able to see, and acute care is one rolled-up line item. There aren't disaggregated line items for each of those four different pillars.

I guess the first key question would be around Cancer Care Alberta and allocation of resources to cancer in particular. We all know somebody who has been impacted by cancer or have been cancer survivors ourselves. In primary care, your sort of sister ministry, cancer research screening and prevention had a cut to it. It was on page 74 of the fiscal plan, where I think one of the natural consequences of spending less on prevention and education is that there will be often more incidents. We've definitely seen a significant increase in the incidence of cancer over the last decade in our province, and it's not just related to population growth.

Until the recent government restructuring of the health care system AHS held the operating budget for Cancer Care Alberta. Again, there being no specific indicators on pages 81 to 86 concerns me. Government did choose to create these four different ministries with 12 separate agencies within those. I guess maybe just at a high level if we could have a breakdown for how much Cancer Care is going to be receiving as well as AHS, emergency health services, Give Life Alberta. We know those all report through Acute Care Alberta. That would be, I think, a healthy place for us to start. We also know that health quality Alberta reports to both the ministers for hospitals as well as for primary care, so having a clear breakdown of areas of responsibility and allocation, I think, would be helpful to meeting our objective around transparency.

Under the current government's leadership since the fall of 2022 we have seen significant increases in wait times, particularly for those waiting for treatment for cancer. The Alberta Medical Association has said that today Albertans are waiting significantly longer to see oncology services, receive cancer surgery or cancer treatment than clinically recommended targets. I want to recognize that anyone who's in pain absolutely should have the surgeries that are needed to alleviate their pain, but nobody wants to be the person who's bumping somebody who needs a cancer surgery. It appears that we do have a limited number right now of folks who work in operating rooms, and with the focus of many moving into private surgical centres, either full-time or part time, we've lost our ability to do the highest volume that we need in terms of meeting medical recommendations around cancer surgery wait times.

To see a medical oncologist Albertans, as last publicly reported, wait about eight weeks. The clinical recommendation is four. To see a radiation oncologist, the average wait is weeks. The recommendation is four. When you have cancer growing inside of you, time really slows down. Knowing that something that is so harmful to you has time to continue to grow over those 13 weeks, I think, is paralyzing for many and doesn't inspire a strong sense of hope. Research is really clear that hope is crucial when fighting cancer.

9:20

The AMA says that Albertans' delays are among the highest in Canada. The Alberta government doesn't currently publish the median wait times for cancer treatment. Because, breast cancer treatment commonly includes systemic therapies like chemo, endocrine therapy, or radiation, any delays in treatment directly affects outcomes specifically for breast cancer treatments. For breast cancer every four-week delay in surgery is associated with an 8 per cent greater risk of death, and the delays compound. If you're waiting two four-week chunks, eight weeks, you're 17 per cent more likely to die; a 12-week delay, 26 per cent more likely to die. Again, we're seeing a 13-week wait for radiation oncologists for the typical transition time. It's clear that Albertans have wait times between diagnosis and referral for first treatment that are unacceptable and that they've ballooned significantly.

Specifically for breast cancer treatment, I know it's hard, but I know that we did reduce wait times. We cut them approximately in

half with a focused four-year effort, so I'm hoping that Cancer Care Alberta, Minister, through you, Madam Chair, will be able to provide some more clarity on exactly what's going to be done in this current year's budget given that there isn't a specific line item even identified in the documents that we're being asked to approve for cancer care.

I have a number of documents. I will table them at the appropriate time in the Legislature, but I will provide a copy for the minister and a copy for the chair while we're in committee. I think that's the appropriate process. If it's not, I trust the clerk will let me know.

I'm going to start with a summary document. These are internal documents that have been leaked. I don't know where or how, but I did get copies of them, and I think it's important that we shine some light on some of the results that we've seen when it comes to cancer care because they aren't being published through the annual report or through these business plan documents. These will give us a chance to sort of reflect on some of the facts. Again, I don't know who produced these documents. It says: provincial strategy data and analytics. If I could get confirmation whether they're internal department or Cancer Care Alberta documents, that would, first of all, be helpful, I think, for people to be able to know and how these have informed our decisions on how we're allocating resources here today.

Here's my copy of the summary. It highlights that the referrals have increased by almost 3,000. Again, I don't know the exact timing of this. I think this is about a year old, actually, so I'm sure the numbers are even higher today, but at that time it was an 18 per cent increase over the 2018-19 numbers.

The number of unique patients has also increased by 10 per cent in that same time, so that highlights to me that many, many Albertans are getting cancer for a second, third, or even fourth time, which definitely leads me to wonder if we're doing right for them in the first round of treatment.

The number of patients who are seen outside of the window, again, those medically recommended guidelines, has increased by 68 per cent. Again, every time we delay treatment, we're increasing risk of mortality.

Those are just the first three points within the summary.

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

Now we'll move to the minister for his response. Please proceed, Minister.

Mr. Jones: Thank you, Madam Chair and to the member for those great questions. In terms of our expenses by entity you'll note that our expenses are listed by function, so that 13.7 is broken down by things like acute care, diagnostic and therapeutic services, emergency health services, support services, and so on. I can tell you that the estimated amount that will be allocated to Cancer Care is \$1.2 billion this year. That will be a represented increase of \$250 million. Give Life Alberta: the estimated amount is \$28 million. For AHS it's \$9.959 billion. For Acute Care Alberta, \$1.616 billion. For emergency health services it's \$1.022 billion.

There were also questions about cancer, so I'm going to highlight a few programs, and then I'll get into some actual wait times and surgeries completed within clinically recommended wait periods. First, I'll highlight the diagnostic imaging and cancer care enhancement program. This investment supports installation of new as well as replacement of CT, MRI, PET, and cancer-related imaging equipment, enabling additional exams, supporting timely diagnosis, surgical readiness, and cancer treatment within clinical targets. Modern diagnostic and treatment equipment improves staging, treatment, planning, and care co-ordination, reducing

delays, avoiding unnecessary hospital stays, and supporting provincial, surgical, and oncology priorities.

Procurement activities are under way for year 1 of this equipment, and construction and installation activities are progressing as planned at sites throughout Alberta. Budget 2026 allocates \$280 million over three years supporting modernization of cancer treatment equipment and diagnostic capacity expansion. That's \$94 million in '26-27, \$94 million in '27-28, and \$92 million in '28-29. Some projects that will be delivered by this program include the University of Alberta photon; South Health Campus, some cardiac-capable CT; and Foothills medical centre's PET CT.

Another thing I'd highlight is the Calgary radiopharmaceutical centre, which is a new cyclotron-based radiopharmacy on the Foothills medical centre campus near Tom Baker and the Arthur J.E. Child cancer centre. It will be Calgary's first and Alberta's third cyclotron, producing radioisotopes and radiopharmaceutical cold kits that support positron emission tomography, or PET, and SPECT imaging for cancer, cardiac and neurological care. Alberta reports that city of Calgary development permitting and Canadian Nuclear Safety Commission licensing are required to construct, which have been obtained, I believe, because construction is under way, with a 2029 completion target. This second production source will reduce delivery risk and help prevent cancelled scans. Budget 2026 allocates \$64 million over three years in support of this project. That's \$30 million in '26-27, \$27 million in '27-28, and \$7 million in '28-29.

The next program I would highlight is the Alberta surgical initiative, or ASI, capital program. This program investment supports planning, design, renovation, and equipment, enabling additional operating rooms, recovery beds, and sterilization infrastructure in high-demand communities. ASI capital investments align with surgical plan objectives, reducing wait-lists, improving access, and supporting equitable surgical services across urban and rural Alberta. The program prioritizes projects based on readiness, capacity impact, and community needs while integrating MDRD upgrades and supporting operating room utilization efficiency.

Surgical volumes have increased, with Acute Care Alberta reporting more surgeries being completed as part of ASI's ongoing actions. Various ASI projects are progressing through planning, design, procurement, and construction and operational optimization phases. Budget 2026 allocates \$284 million over three years in ASI capital funding to infrastructure, providing surgical capacity expansion province-wide. That's \$68 million in '26-27, \$90 million in '27-28, and \$125 million in '28-29. Some examples of projects would be 11 new operating rooms for the Foothills hospital, new pacemaker insertion and ECG procedure room for Red Deer regional hospital, and the upgrade of six operating rooms at the Royal Alex hospital and diagnostic treatment centre.

On research and education this includes expenses pertaining to formally organized research approved by an HIA-designated research ethics board, including clinical trials of drugs and devices as well as services such as lab tests and access to health data, innovation, and technology assessment and evaluation and supports required to conduct the formally organized research in ACA settings. Budget 2026 is \$88.7 million versus '25-26, which was \$33 million. This is a change relative to last year's budget of \$55,650,000 or 168 per cent. The \$55 million increase is largely due to the collective bargaining agreement and then new investments in acute care.

9:30

Then I'd like to highlight the Siemens Healthineers cancer innovation value partnership. We're going to be procuring \$800

million of cancer treatment equipment, software, and services over the next year. In return Siemens will invest \$175 million in support of two centres of excellence, artificial intelligence and learning and the research and innovation collaboration fund.

The artificial intelligence global centre of excellence in oncology, data science, and artificial intelligence will create a cancer artificial intelligence and machine learning program with physical space in Edmonton. The learning centre of excellence will create an oncology training site at the Arthur J.E. Child Cancer Centre in Calgary. The research and innovation collaboration will support medical research and innovation projects advancing oncology led by clinicians, researchers, and innovators.

This will help us build a highly skilled workforce with specialized training in cutting-edge imaging, diagnostics, and AI-enabled tools. It'll facilitate knowledge exchange and continuous professional development so that adoption of new innovations is accelerated across our cancer care system and foster a stronger culture of innovation by bringing clinicians, researchers, and industry together to rapidly spread new learnings into better cancer care. This should translate into earlier and more accurate detection of cancers, personalized treatment planning, and improved workflow efficiency by reducing administrative burdens and enhancing real-time decision-making through predictive analytics.

There were questions about cancer surgeries. We did perform a record number of cancer surgeries last year, I believe, increasing 8 per cent year over year. I have December 2025 data here. We did 359 breast cancer surgeries, 114 colorectal, 200 bladder, 71 lung, 90 prostate. The top five combined, that's about 834, and 55 per cent of those were completed within recommended times. Of course, we would like that to be higher, and that's why we're making substantial investments in our surgical and cancer-related programming.

The median wait time for bladder cancer was 29 days. For breast cancer, it was 24 days; colorectal was 26 days; for lung cancer, 34 days; and prostate cancer, 71 days. Of course, we would like to see those be as low as possible, and I think that the investments that I've highlighted will enable us to make better progress on those volumes and also the wait times.

I hope that gives you answers to the majority of your questions on the budgets by entity. Again, cancer care was \$1.2 billion, an increase of \$250 million. Give Life Alberta, \$28 million; AHS, \$9.959 billion; Acute Care Alberta, \$1.616 billion; and EHS, \$1.022 billion; and that's all part of that \$13.7 billion.

We're also increasing surgeries in other areas, as you know. We performed 318,000 surgeries last year. We're on pace to do about 330,000 surgeries this year, thanks to leveraging our internal ORs but also leveraging chartered surgical facilities, which do about 20 per cent of our surgeries. Again, these are lower complexity, more routine – hips and knees, cataracts – and they free up internal capacity to do emergent and more complex surgeries. Across the board we're going to be investing in both settings to make sure that Albertans get the surgeries they need as quickly as possible.

With that, I'll turn it back over to the member for her second set of questions. Thank you, Madam Chair.

The Chair: Thank you, Minister, for those answers. We'll turn it back over to the Official Opposition.

Ms Hoffman: Thanks, Madam Chair. I'll give the pages another document, and thank you to them for making sure there were copies for other folks. I'll stay on the summary that I passed out first, and then I'll get to this other one after all members have it.

So this summary says that wait times have gone from 6.3 weeks in 2018-2019 to 10 weeks in 2023-2024, and then when, I assume,

this was gathered, it was 10.6. Again, through you, Madam Chair, can either the minister or Cancer Care Alberta confirm this data? Can they confirm where this report was from? And can they give us the up-to-date number of what we're at for wait times? I have been told that it's up to in excess of 17 weeks, which is a huge jump, so I would like some concrete information to be able to determine if the budget allocates resources properly or not, which we're being asked to consider here today.

Current oncology wait times are medically inappropriate and impacting patient outcomes and survival. Again, this is one of the summary bullets. Initiatives and work are ongoing to optimize processes and maximize current utilization capacity. The ministers talked a lot about that, but clearly it isn't enough.

Alberta's current oncology workforce and infrastructure is not meeting current demand. I'm grateful that the Calgary cancer centre is likely open since this was prepared and the summary was created, but I don't believe that there is net new capacity in the Calgary zone for in-patient treatments. The only increased number of beds between the Tom Baker and the current Calgary cancer centre were decanted beds from other sites. I would love greater clarity on that from the minister and what's being done to make sure that the building is being used to its fullest capacity, because it is certainly state-of-the-art, world-class designed with both staff as well as patients and family members involved in the process. I think we all want to make sure that that important public investment is meeting the demand for the public.

While the Alberta Cancer Foundation continues to provide significant philanthropic support in cancer research and innovation, some capital equipment, it is not their job nor do they have the ability to fund operations. That is on us as Members of the Legislative Assembly to make sure that the provincial government prepares a budget and that we're confident that it will actually meet the demand.

And, lastly, it says: critical and timely investment is needed to meet clinical demands and ensure timely access to safe, quality cancer care that improves clinical outcomes, patient outcomes, and survival. This is literally life or death for those who are dealing with cancer.

The chart that the pages will bring you very shortly here is a bar chart. I know the minister told one story about bladder cancer surgeries, and that was around what he says the current wait time is. How many of those surgeries are done outside of window or outside of medically recommended guidelines? This report says that it was 49 per cent, and again I think this is over a year old, so what are we at today? What is the number of folks, both hard number, the actual number, as well as the percentage of bladder surgeries outside of window?

Prostate cancer surgeries outside of window: 46 per cent, almost half of those who need surgery on their prostate not getting it in a timely fashion a year ago. What is it at today?

Mr. Lundy: Point of order, Madam Chair.

The Chair: A point of order has been called.

Mr. Lundy: Thank you, Madam Chair. I will call 23(b), but this might more accurately be a point of clarification. Of course, these proceedings are live cast, which is great. I might ask the chair or through the chair to the clerk: the member opposite, whether directly or indirectly, has made it seem like she's tabling some sort of official documentation for this committee, which is of course not the case. Maybe this came off the NDP printer – I'm not sure – maybe she took notes during her own caucus. I don't know. She has herself failed to source this document. Again, for those watching,

this is not an official government document. The member is of course free to ask questions on these topics. That's not what I'm objecting to. I just would like some clarification on whether it would be appropriate to make it seem like we're tabling official documents during budget estimates.

Thank you very much, Madam Chair.

The Chair: Thank you so much.
Opposition?

Ms Ganley: Thank you, Madam Chair. I will be brief since this is an intervention clearly intended to do nothing but waste time. The documents have been provided to everyone. If you would like us to table them, we're happy to do so.

Thanks.

The Chair: Can we clarify: where did the documents come from?

Ms Hoffman: Thank you, Madam Chair. The documents were leaked to me. I am unclear if they are internal department documents or Cancer Care Alberta documents, which I did ask in my first exchange because I think it would be useful for us to be able to know exactly the source, but with leaked documents I don't know exactly where they came from, but I'm gathering that it was probably Cancer Care Alberta.

The Chair: Sorry, Member. Unless you have some source of where this came from, then, I'm sorry, we can't allow them to be tabled here in the meeting. It's just a bunch of words on a piece of paper. There's no legitimate source for where this came from. You've not stated where this has come from. I could have, you know, my neighbour just write a bunch of stuff, type a bunch of stuff and bring it to a meeting. It doesn't give authority.

9:40

Ms Hoffman: I would . . .

The Chair: Please don't interrupt me while I'm speaking.

It doesn't give legitimacy to these speakers. This is all just made up numbers and made up words on a piece of paper. We're here for budget estimates, so let's please reference page numbers. If you would kindly proceed with your questions, but in this regard we won't have any more of these documents tabled because you can't state the source. You can't verify that this is legitimate information, so we won't have it anymore. We're here for budget main estimates, and that's what the minister is here to answer questions about.

Please proceed with your questions.

Ms Hoffman: Thank you, Madam Chair. Through you, again, I'm referring to page 82 of the business plan, which is Cancer Care Alberta. I would love for this kind of breakdown to be in the actual budget documents. I am asking for the minister to either confirm that these numbers are accurate or to provide the accurate numbers so that we can determine what the actual demand is. I believe that they came from Cancer Care Alberta. Through you, Madam Chair, to the minister, I know that in his introduction he acknowledged that Cancer Care Alberta is in the room to be able to answer questions, to be able to get confirmation on what the actual numbers are today. I can assure you that I did not make up these numbers and would love to – I'm always in a learning spirit, so if there's something in the standing orders that dictate what type of documents are allowed to be tabled or referred to, I would welcome that information to be able to understand.

The Chair: There's no source on this. We've gotten legal counsel on this. I'm sorry. They can't be brought forward in this meeting in

this format. It doesn't state where this came from. It just says "summary" and a bunch of words on a piece of paper and "confidential" stamped across it. I'm sorry. We're here for budget main estimates, and you've got all kinds of literature that were provided by the ministries, a breakdown of figures, a thorough review of what we're discussing here today. If you could kindly refer to those documents and page numbers, then we can have some very, you know, good questions asked from both the Official Opposition and the government side of the minister.

Ms Hoffman: I'm going to continue, Madam Chair, through your guidance to refer to the business plan page 82, which refers to Cancer Care Alberta. Again, there are no specific outcomes in the following pages related to cancer care, but this is an important pillar within the Acute Care Alberta work that's being done, and I know from speaking with folks who work in brain cancer, particularly tumour – well, it's all tumours. They have told me that more than two-thirds of the people needing surgery for brain surgery for their tumours aren't getting the care within the recommended guidelines. So I would love for the minister or designate for the minister to be able to tell us what the current numbers are, if that is accurate or not, through you, Madam Chair. Specifically, I would like clarity on what the current wait times are for brain tumour surgery, prostate cancer surgery, bladder surgery, and let's add breast cancer surgery to that list and what is specifically being done in this budget to make sure that we increase life expectancy and allocate resources appropriately for surgeries in those areas.

Again, the number of people available to work in surgical centres has not increased significantly. In fact, the number of oncologists went down dramatically after the province under a former health minister, not the current one, tore up the contract with the Alberta Medical Association. So what specifically is being done? I know that many of those oncologists went to other jurisdictions. It's hard to get them back once they've left, but I think that we are doing a little bit better right now in recruitment. So could the minister give greater clarity on specifically oncology as well as on the number of those specific types of surgeries that I've outlined?

To make sure that we don't deviate from cancer care, I'm going to do something I've never done and give back three minutes because I would really love to get some concrete answers. I think all members of the Assembly care deeply about the patients that they represent who are currently fighting cancer, and they deserve hope and they deserve a provincial budget that's going to make a meaningful difference. Knowing what those specific numbers are, Madam Chair, will help determine clarity on that. Again, if the minister is able to confirm sources for the documents, that would be helpful, I think, for all because we want to make sure that it's reliable information.

The Chair: All right. With regard to this document, Page, I'm going to ask that you please go around the room and collect them again. We don't have a source for this, so if you would kindly collect them and bring them to me, that would be much appreciated. Thank you.

We'll go back to the minister for his answers.

Mr. Jones: Thank you, Madam Chair and Member, for the important questions. Cancer Care Alberta was established as the provincial health corporation with enhanced oversight and responsibility for workforce, operational funding, and delivery of cancer care services across the province. It's responsible for overseeing cancer care, enabling it to focus solely on providing timely, cutting-edge treatment and services. Its revised accountability structure brings cancer care priorities to the forefront. This will

drive a dedicated focus on improving care by reducing wait times and providing the best patient experience. Half of all Albertans will have cancer in their lifetime, so it's essential that this critical element of acute care has dedicated focus and accountability. With a growing, aging, and more medically complex population, increased ability to identify and treat cancers, our system is indeed under pressure.

Cancer Care Alberta developed a '25-26 operating plan for this transitional year, which provides a framework for providing accessible and comprehensive cancer care to Albertans now and into the future. The operating plan focused on addressing the top priorities for cancer care in Alberta: the oncology workforce, capacity, access, wait times, and beyond. Cancer Care Alberta has made strides to help stabilize the performance of the system, and we look forward to sharing further progress in the future.

Alberta's last provincial cancer strategy was developed back in 2013. A new strategy is under way to enable the refocused health system to tackle cancer wait times. Work began in October 2025 across Hospital and Surgical Health Services, Primary and Preventative Health Services, and Cancer Care Alberta to develop a new provincial cancer care strategy to 2035. This will be a public-facing document that sets the strategic direction and priorities for cancer care in Alberta to help ensure the cancer care system can remain responsive and proactive. This new provincial cancer care strategic plan to 2035 will serve as the groundwork to strengthen the system integration and performance across the cancer continuum of care, and it will inform long-term planning and operations on a yearly basis, including prioritized areas for strategic investment to help ensure the cancer care system can remain responsive.

Again, I highlighted in my opening remarks that Cancer Care Alberta's budget is roughly \$1.2 billion, a \$250 million increase from the prior year. It consists of 2,310 FTEs that deliver hospital care, surgical services, emergency and urgent care, and other acute-care programming. Albertans will continue to access health care as they always have. Important to note that there have been no impact to front-line health care workers and their continued dedication to delivering excellent health care to Albertans.

There are many factors that influence patient wait times such as additional diagnostic testing, but each case is reviewed, and treatment plans are adjusted accordingly. Cancer Care Alberta is working closely with oncologists and cancer teams to evaluate every patient's unique case and treatment plan to ensure the patient receives the care they need. We also rely on the judgment of clinical specialists to determine the order of priority of patients based on clinical decision-making and criteria.

Cancer Care Alberta also has a robust clinical review process if something goes wrong in any way. Quality improvement processes exist to ensure that when things can be improved, changes are implemented.

Physician recruitment is a challenge being faced by all jurisdictions, but targeted workforce initiatives are being taken to hire, train, and recruit more oncologists. Between April 2025 and December 2025 36 oncology physicians began their roles. Additionally, 483 other clinical and support staff were hired, which equalled 275.5 FTEs in addition to the oncologist and hospitalist increases. A further 36 oncology physicians have start dates after January of 2026.

Again, Cancer Care Alberta schedules as many appointments as possible for cancer treatments, including surgery and radiation, based on available health system capacity and specified clinical criteria. When necessary, cancer surgeries are prioritized to make sure that those who are most urgent receive care first. Overall, cancer surgery volumes in '25-26 are tracking approximately 6.8

per cent higher than the '24-25 fiscal year, and from April 2025 to December 2025 surgical sites have already completed around 18,500 cancer surgeries compared with 17,330 over the similar time frame in the previous year. From April 2025 to December 2025 there was a 5.7 per cent increase in follow-ups compared to the previous year and a 6.6 per cent increase in new consults for medical oncology compared with the same time period in the previous year.

9:50

There were lots of questions around wait times and procedures completed in and out of window. I have January 2026 information here for you. For bladder cancer: 10th percentile, 13 days; median, or 50th, percentile, 34 days; 90th percentile, 69 days. Breast cancer – I can't read the arrow here – 13 days for the 10th percentile; 35 days for the 50th percentile, or median; 65 days for the 90th percentile. For colorectal: 12 days for the 10th percentile; 28 days for the 50th percentile, or median; and 52 days for the 90th percentile. For lung cancer: 16 days for the 10th percentile; 38 for the 50th, or median; and 71 days for the 90th percentile. For prostate cancer: 34 days for the 10th percentile; 75 for the median, or 50th percentile; and 185 days for the 90th percentile.

Then in terms of what percentage of those are being completed in recommended wait times: for colorectal, 55 per cent; for breast cancer, 43 per cent; bladder cancer, 37 per cent; prostate cancer, 30 per cent; lung cancer, 24 per cent; and for the top five cancers combined, about 40 per cent. Now, it's important to note that these percentages – this is a monthly reporting, so these do fluctuate, and the December time period does have vacations. We also had peak respiratory virus season. So there are impacts, but those are the monthly numbers, the most recent ones that I have available to me. Any further data that you would like, just please request it again, and then we'll try to get it in the next answer, try to pull that data for you.

Again, we're making substantial investments across the system in workforce and facilities and equipment to reduce these wait times. Broadly, our surgical wait times are comparable or in some cases even better than the national average.

With that I'd like to invite Brenda Hubley, the managing director of Cancer Care Alberta, to highlight initiatives under way at Cancer Care Alberta and answer any other questions that the member opposite had.

Thank you.

Ms Hubley: Good morning. I'm Brenda Hubley. I am the interim managing director for Cancer Care Alberta with the privilege of leading our provincial cancer system. As I'm sure you're aware, Cancer Care Alberta supports outpatient and in-patient activity, offering medical oncology, radiation oncology services, outpatient cancer treatment in support of adult patients.

Thank you very much . . .

The Chair: Pardon me to interrupt, but the conversation must flow through the chair.

Ms Hubley: Thank you very much for the opportunity to highlight a number of items that we are working on within Cancer Care Alberta. Certainly, this budget creates the opportunity for us to create better and improved access for cancer care. It will support us in stabilizing and growing our cancer workforce, which has also recently been referenced, the success that we have been having with recruiting oncologists. We are enhancing patient supports. We are improving outpatient capacity. We have increased and continue to increase bed capacity within the Arthur J.E. Child cancer centre as demand requires.

We have shown and we have been increasing outpatient capacity. We've expanded and created satellite outpatient capacity within Edmonton to support more timely access to those outpatient services. Certainly, the ability to provide faster access into the cancer system, which we know is a priority for patients and absolutely the high priority for Cancer Care Alberta, is predicated on having an oncology workforce for those patients to receive that care. The success that we've had both last year in recruiting many additional radiation medical and hematologists to the cancer system is improving the capacity to allow us to do that. With the upcoming recruitments this year we will again be able to increase those supports.

We certainly still do have wait-list pressures, but as noted, they are actually improving, and we are experiencing and seeing more timely access to that first step of care for a patient, which is to enter the cancer system. Once they have had that oncology referral, their time to treatment is within benchmark and some of the best time to treatment, in fact, in Canada. We have higher, more rapid access for radiation oncology and systemic therapy.

The Chair: Thank you so much.

We'll move back now over to the Official Opposition for the remainder of the questions.

Ms Hoffman: Sorry. Did my colleague want to take this block, Dr. Metz?

Dr. Metz: Sure. Yes. Thank you.

Thank you, Madam Chair. I would like to ask some questions about workforce planning, a totally different topic than what we've been on. We know that workforce is really one of the big limits in most of the things that we're doing in the health system these days. Of course, workforce and budget directed toward the activities that have to happen tie very closely together, and it's well recognized nationally and by every professional group that workforce planning is critical. There was a health workforce planning document that was put out in December of 2024 by government. I'm not sure which ministry that came out of, which of the health ministries. I'm wondering where that work is given that the budget line items are very unclear. The responsibility for workforce planning has been moved to Primary and Preventative Health Services, but it does state in I think it's the business plan that hospital and surgical services are partnering or involved in this. It's, of course, completely critical to service delivery, so I can't imagine that the minister would be confident with the deliverables of such a critical thing being totally left in the hands of another ministry, so there must be work ongoing.

I'm wondering if it's line item 1.3 on page 123 of the estimates document, called Strategic Corporate Support and Policy Development, where the workforce planning work is actually happening. I see that that line item has grown by \$11 million in this sector alone, and it's got a combined line item in primary and preventative health, but this is over 50 per cent higher than it was last year. I'm wondering what that work is at this point in time. Is this for consultants? That would be about \$2 million a week for consultants. Is it for extra severance costs? Please, I would like to understand for Albertans what we're getting for this line item and also where this very critical work of workforce planning is happening.

I'm wondering if the departments in our major hospitals are involved, if the hospitals themselves are involved, if the organizations that represent workers and the regulatory bodies are involved in this workforce planning. I note that, you know, a lot of budget increases seem to be going to admin. AHS was well known

across the country as being the slimmest on admin costs compared to front-line costs, and I'm sure that has totally flipped now that we have many different ministries and many different groups that all have CEOs and large admin bodies associated with them. There was a lot of expertise in our system before, but I know, in speaking to many, many of the experts, they really don't have a voice. They're not there to solve problems. I'm wondering if and when some of this strategic support might actually become engaged with the front-line teams.

10:00

In the past we would be asked to solve a problem. We have a flow problem. We have to get people out of the emergency department. Each department would have their own ways of operating and be tasked with solving how they could do that for their patients. But none of that is happening anymore. It's all top down. People that know the system, that do the work are not – they're taken away from being able to have any influence. This isn't to make big changes in the system. This is just to fix day-to-day patient problems. I'm hoping that some of this corporate support might be engagement people or something that can work with these front-line workers.

In summary of that part, I'm wondering: where is the workforce planning money? Who is doing this? What level; what line item is; where is that happening? Is there true engagement? I don't mean town halls. I mean with the leaders that actually can make things happen in all of these programs and can advise on what's needed. What percentage of the budget is now allocated to consultants, to front-line care, to all of the different levels of admin costs?

Next topic is loss of rural surgical capacity. One of the expected consequences of moving simple surgery – I know it's not simple, but it's the less complex patients – to chartered surgical facilities and concentrating complex surgeries in our hospitals is that rural hospitals risk losing their surgical capacity. They need surgeons and anaesthesiologists for things like C-sections that happen acutely, but they need those professionals to be able to work there on an ongoing basis and provide the surgical care to people in the region.

As the efficient way of delivering surgery is quick, in and out, outpatient, which is going to be in specialized centres that are going to probably be in Calgary, Edmonton, and some of our smaller urban centres, we're going to be seeing – because this is what happens in other places – that there's less surgery that can go on in our rural centres and less support to keep surgeons and obstetricians in those areas. I'm wondering how this is going to be supported and funded to recognize that we're looking at a whole system, not just a cost for surgery itself. The consequences, unintended but known, of all of these moves towards super efficiency are going to significantly hurt the capacity in rural areas. Without these surgical experts – they may be primary care physicians trained in surgery or in anaesthesia and doing C-sections – they're going to lose their skills and not be able to do the emergent things as well as smaller things that are better done more locally.

I'm wondering if there is anywhere in this budget that looks at the funding to rural hospitals, which is going to have to be organized differently than our major hospitals. We may have the more acute complex patients, but we're going to have less efficiencies in a smaller hospital. We have to do that because we have to maintain some services in those centres. I can't tell. There's just no detail anywhere in the budget, and it's not mentioned anywhere in the business plan.

I'm going to, then, move on to emergency department wait times. I'm wondering. We'll come back to that in another section, but I note that in none of the sections in the business plan – there's no data for '25-26, and I understand that we're not finished there, but

I'm wondering if there are some interim indications on any of those outcomes like wait times for surgeries, costs for acute care, if you have any interim numbers that you might be able to bring back in the next set of questions.

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

We'll move back over to the minister for his response.

Mr. Jones: Thank you, Madam Chair and to the member for her questions. Alberta's health and hospital workforce continues to face significant and persistent pressures driven by our rapid population growth, our aging demographic, and sustained demand that exceeds current facility and workforce capacity. Urban hospitals and medicine units remain at or near capacity, and pressures are compounded by the growing number of patients who no longer require acute care but cannot yet transition to a more appropriate care setting.

As of August 2025 there were approximately 1,400 alternate level of care patients in hospitals. That directly limits capacity for admissions, surgeries, and emergency care. At the same time surgical demand continues to grow, and even as surgical volumes increase, wait-lists remain under pressure.

In 2025 more than 36 per cent of surgeries were performed outside of clinically recommended wait times, reflecting both workforce and capacity constraints across the system. Historically workforce planning has been largely reactive. There has not been a co-ordinated, long-term approach that aligns workforce needs with population growth, hospital construction, demographic shifts, or that fully integrates our postsecondary training capacity. With domestic, out-of-province, and international recruitment we are changing that.

At the system level the acute-care action plan is addressing immediate pressures by increasing capacity and improving patient flow across emergency, surgical, and in-patient care. In parallel, Alberta's health workforce strategy is focused on supporting the existing workforce while growing future supply through education, long-term planning, innovation, and new and changing models of care. Within that broader strategy, under the workforce resilience pillar of the acute-care action plan Hospital and Surgical Health Services and Acute Care Alberta are co-leading the development of a 30-year acute-care workforce plan. This work will identify current and future workforce priorities for the acute-care sector with specific attention to rural and remote communities. It includes short-term actions and investments to strengthen training pathways and talent pipelines such as increasing postsecondary seats and clinical placements.

At the same time we are taking concrete action to increase workforce supply now. For nursing Alberta has implemented a new four-year collective agreement with the United Nurses of Alberta, making registered nurses and registered psychiatric nurses among the highest paid in Canada. The agreement includes wage increases, commitments to address safe staffing, and a commitment to hire 1,000 new nursing graduates every year through the term of the agreement.

We are strengthening national and international recruitment pipelines. To date 602 internationally educated nurses have been recruited with 408 already placed across Alberta. Importantly, 36 per cent of those placed nurses are working at rural sites, including 32 per cent in rural emergency departments.

We have significantly reduced reliance on agency nursing. Provincially there are now 24 active agency nurse placements, down from more than 300 several years ago. This is supported by initiatives such as the north zone RN locum program and relocation and travel incentives in the northwest and northeast corridors.

We are also supporting new graduates through the graduate nurse transition pilot program, a 12-month province-wide initiative running from 2025 to 2028. This program provides enhanced orientation, mentoring, and learning across AHS, Covenant Health, and Recovery Alberta in both urban and rural settings. The pilot also explores optimizing team-based care through better integration of LPNs. These efforts are delivering results. In fiscal '24-25 1,143 additional registered nurses were added to Acute Care, bringing the total to more than 24,400 RNs.

Since 2021 Acute Care has added more than 3,000 RNs, 1,020 LPNs, and 819 health care aides. Retention is also improving, with one-year RN retention rising from 61 per cent to 69 per cent over the last three years. We're also addressing critical shortages in allied health and clinical support roles. This includes enhanced recruitment and retention incentives for cardiovascular perfusionists, expanded training capacity for diagnostic imaging, laboratory respiratory therapy, EEG technologists, and partnerships with postsecondary institutions to grow Alberta-based talent pipelines.

10:10

For physicians Alberta continues to attract and train doctors, but distribution, particularly in rural and remote communities, remains a challenge. We are addressing this through expanded training seats, rural-based education, international recruitment, and incentives targeted to areas of greatest need. Over the last five years we have increased the number of physicians in the province by 2,260, representing a 20 per cent increase. Since 2023 Alberta has added 60 new undergraduate medical seats and 30 additional international medicine graduate residency positions, and we are expanding residency capacity at the University of Alberta and the University of Calgary. Implemented in 2025, this allows eligible international medical graduates to obtain a full licence without additional practice and readiness assessments. Physician recruitment trends are positive. Alberta saw an increase of 796 physicians in 2025, including 385 new specialists, and the growth rate for specialists exceeds the national average. Emergency medicine specialist supply has increased faster in Alberta than nationally since 2014, and Alberta now has more emergency medical specialists per capita than the Canadian average.

Workforce policy is directed by Hospital and Surgical Health Services, while Acute Care Alberta leads acute-care workforce planning. The provincial health corporations work together to implement recruitment, training, and retention strategies aligned with system priorities. Overall, Alberta is moving from a reactive approach to a co-ordinated long-term workforce strategy, one that addresses immediate pressures, strengthens retention, expands training capacity, and ensures Albertans can access timely, high-quality hospital care now and into the future.

There are questions about our administration. From the statement of operations first, administration would include things like human resources, finance, communications, and general administration as well as the share of administration of certain contracted health service providers. General administration includes senior executives and many functions such as planning and development, quality assurance, patient safety, insurance, privacy, public relations, risk management, internal audit, and legal. Large portions of these costs would relate to transition service agreements with the Health Shared Services organization. The ministry administrative expenses to total expense ratio is 2.4 per cent – 2.4 per cent – which is lower than that of the national average, which is about 4.4 per cent. The source of that is CIHI. So that's the answer to your question. We're lower than the national average, 2.4 per cent compared to 4.4 per cent, as reported by CIHI.

For administration expense 2026-27 is \$342 million. That's compared to \$347 million in 2025-26 or a reduction of \$5.4 million or 1.6 per cent. That reduction is largely due to reorganization and transfers out of the administration to other programs.

Our strategic corporate support and policy development line item, which is \$31.956 million for '26-27 as compared to \$19.938 million for '25-26 is increasing \$12 million, or 60 per cent. This provides business services, including corporate finance and the development and review of strategic health policy, health research, health system quality improvement, and accountability.

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

We're going to move back over now to – no one's indicating. Okay. Go ahead.

Mr. Lundy: Well, thank you, Madam Chair. I appreciate getting . . .

The Chair: Shared or block?

Mr. Lundy: Oh. Good point. Minister, would you like to do shared time?

Mr. Jones: Yes. [interjections]

Mr. Lundy: Well, thank you, Madam Chair. I'll wait for the laughter to die down.

Minister, thank you so much for joining us here today and, of course, to your staff and your support team.

If I may, Madam Chair, a very quick shout-out to the staff at the Leduc hospital. I've had a chance to tour the facility many times, and I'm blown away by the dedication and commitment from the people who serve their communities on the front lines and who are never afraid to tell me what's going on and ask me to pass information on to the minister, which I'm happy to do. Again, I just can't thank the staff enough for serving our community in Leduc at the Leduc hospital.

Minister, through the chair I'd like to start by asking a question that I know is impactful in my constituency. People actually come in, and when I meet with them about health care, they just have a question about the refocusing and the integrated health care system and how all this is co-ordinated, so I'm happy to take some time to unpack that with you a little bit. We know that ensuring Albertans receive timely and co-ordinated care often requires collaboration across multiple parts of the health system. As our province continues to grow, integration between ministries and service providers becomes increasingly important to ensure patients experience seamless care as they move between different services and levels of treatment.

Madam Chair, I'd like to go to page 81 of the business plan. It indicates that the department works with partner health-sector departments – Assisted Living and Social Services, Primary and Preventative Health Services, and Mental Health and Addiction – to deliver the best health outcomes for Albertans across an integrated provincial health system. Minister, can you please explain this integration in practice? What tools does the health system utilize to ensure system integration and a seamless patient experience?

Mr. Jones: Thank you to the member for his question. Just before I answer that, I want to provide a couple of answers that I was unable to in my last block. Just for everyone's awareness, since 2019 Alberta has added 2,260 doctors, a 20 per cent increase; 11,737 RNs, a 32 per cent increase; 484 nurse practitioners, a 74 per cent increase; 2,734 LPNs – that's a 16 per cent increase – and 10,496 health care aides, which represents a 36 per cent increase.

Of course, we're always in need of additional health care professionals, but Alberta is attracting and retaining really record numbers across the board.

I also wanted to go back to the long-term workforce plan. I think this is critical. We need to know exactly what medical professionals we need and where and when, and that's what this 30-year workforce plan is going to achieve. It's going to put the road map out, and we're working with PWC on that. I believe it was about \$1.8 million that was allocated for that work. The idea is to pull all the health system partners, agencies, public health corporations also physicians, nurses, and their organizations and postsecondary so we can collectively build a plan to address chronic shortages of health care workers around the province in various areas.

At the same time, we're also doing a 50-year capital plan. We have hospitals still in operation from the '50s today. They take eight to 10 years to build, so it does seem like we should be planning with at least 50 years in advance. As you can appreciate, building a facility without planning for the workforce would be pointless, so these two projects I view as very collaborative and necessary to do in parallel.

In response to your question – apologies for going off topic there for a moment – Alberta's health system is organized through four provincial health ministries and corresponding service agencies, each responsible for specific parts of patient care, but they work together to support a co-ordinated and seamless patient journey. Integration happens through shared governance and co-ordination planning so services are aligned across ministries and agencies, not siloed. System-wide initiatives like the acute-care action plan help align priorities and service strategies across our system.

Hospital and Surgical Health Services works closely with other health-sector ministries to ensure patients, families, and caregivers experience one connected health system. Primary and Preventative Health Services leads primary care and public health, early intervention, screening, and prevention. The Minister of PPHS also serves as the oversight minister, setting the overall strategic direction for Alberta's health system, including health system and workforce planning. Mental Health and Addiction leads mental health and addiction treatment and supports. Assisted Living and Social Services leads continuing care, home care, and supports for seniors, people experiencing homelessness, and Albertans with disabilities. In practice, a governance framework supports integration of the refocused health system. Within that framework, crossministry and cross-agency tables help to co-ordinate decisions and resolve issues quickly, including regular meetings of provincial health agency CEOs so that planning and service delivery stay aligned across sectors.

10:20

The provincial health agencies function as an integrated provincial system, co-ordinating planning, problem solving, and service delivery so care is consistent and transitions are smooth for patients as they move to community care or to hospital care and back. Key tools that support this integration include shared digital health systems, co-ordinated capital planning, provincial performance reporting, and common indicators that track clinical quality access, finances, and outcomes.

Health Shared Services strengthens integration by centralizing functions like information technology, finance, and human resources, reducing duplication and helping service agencies stay focused on patient care. Health Shared Services and the ministry also work with partner ministries and agencies to standardize contract compliance tools, processes, and governance, using common performance indicators across administrative, clinical, financial, and quality measures. We use these to monitor service

delivery, identify risk, track and escalate issues, and support continuous improvement.

We also have regional and Indigenous advisory councils to ensure planning is responsive to local needs and culturally informed. Workforce initiatives such as rural recruitment and team-based planning help support integrated access across regions. Taken together, these structures and tools are designed to make sure Albertans experience, again, seamless patient journeys no matter where they live in the province.

The Integration Council, chaired by Minister LaGrange and including leadership from the health sector, ministries, and Technology and Innovation, helps identify and drive the tools and processes needed for a single functioning system. Alongside that, there are clear oversight mechanisms, operational and clinical standards, and performance monitoring to support quality, patient safety, and consistent outcomes across delivery sites. When it comes to strategic policy questions around integration, the Integration Council is a dedicated forum to ensure that the accountability we individually have for each of our health sectors is matched by our collective accountability for an integrated system. This ensures that patient care is a priority no matter where an Albertan is in their patient journey relative to our structure.

Hopefully, that answers your question, Member.

Mr. Lundy: Yeah. Through the chair, thank you very much, Minister. Again, I really appreciate it. I have constituents who have questions about how our system is integrated and what that means for the patient outcome, so I really appreciate that you're able to lay some of that out for us here.

I might transition to one of the pieces that you touched on very quickly, and that was the acute-care action plan. Through the chair, I would like to ask a couple of questions on that. I mean, it's obviously really important. As Alberta continues to experience strong population growth, we need to ensure that our acute-care system can meet increasing demand and maintain timely access to care for Albertans. These investments strengthen emergency departments, surgical capacity, and in-patient services and are critical to improving patient flow and ensuring the health system can respond to both current pressures and future needs.

Madam Chair, I'm on page 83. This is outcome 1 of the business plan, that states, "Alberta's government is committed to implementing an Acute Care Action Plan that strengthens emergency, surgical, and inpatient care." Through the chair to the minister: how will the acute-care action plan meet the needs of today while planning long term to ensure the health system is resourced to meet future demands? How does this plan support Alberta's most vulnerable, including infants and youth? And how does this plan build acute-care capacity in the province to reduce wait times and expand access for Albertans?

Mr. Jones: Thank you. A lot of questions there. I'll try to get through them. I also want to provide some, you know, tangible examples of the co-ordination of the health care system. One example would be the \$152 million investment we're making system-wide to make site-specific improvements to hospital triage and patient flow. These investments are designed to support faster assessment, admissions, and discharges across the acute-care system, including specifically at sites like the Royal Alex hospital.

At the Royal Alex multiple partners, including Acute Care Alberta, Alberta Health Services, Assisted Living and Social Services, and Assisted Living Alberta worked collaboratively on a pilot model for transition units for patients who no longer required acute hospital care. The purpose of this initiative is to enhance care planning and to expedite the movement of alternate level of care, or

ALC, patients out of acute-care beds and into more appropriate care settings in the community. This type of crossministry co-ordination helps to ensure that acute-care capacity is available for those who truly need it while also supporting better transitions and more appropriate care for patients whose acute-care journey is complete but who still require alternate care in another setting.

We are also working closely with Assisted Living and Social Services on front-end interventions in emergency departments. This includes the development of a social worker and nurse triage model that embeds social work expertise at the front door of our emergency departments. This approach improves patient flow by better matching patients with the services and supports they need earlier in their care journey.

In addition, transition co-ordinators are working across acute care and community services to help facilitate timely discharges and smoother transitions into community-based supports. More broadly, the acute-care action plan has provided funding to both Assisted Living and Social Services and Mental Health and Addiction to expand community and continuing care capacity. These investments support moving patients, again, out of acute care into those settings, which improves overall system flow and helps ensure that we have acute-care capacity when we need it for acute-care patients.

Collaboration with Primary and Preventative Health Services is also an important part of improving access and patient outcomes. One example of this is the digital front door, which is an interministerial effort aimed at improving how Albertans access health information and services. This will enable Albertans to access the most appropriate care based on their needs instead of defaulting to the emergency department, which is intended to serve the highest acuity cases. Primary and Preventative Health Services is currently leading this work to transform MyHealth records into a unified digital health access point known as MyHealth Alberta account. The future state of this initiative is intended to provide a gateway into community patient portals, virtual services, and other content delivered by provincial health agencies, improving navigation and access for patients.

In the meantime several digital and virtual initiatives have already been implemented collaboratively by Primary and Preventative Health Services and Hospital and Surgical Health Services to support acute-care patient flow and virtual access. These include virtual physician visits and consultations using Zoom, a virtual emergency physician pilot in the north zone, and use of the Jenkins AI scribe to support emergency department physicians and expanded Health Link services, including virtual MD. Additional tools supporting access and system co-ordination include myhealthalberta.ca for general health information, patient portals such as MyHealth records and MyChart, real-time emergency patient access and co-ordination tools to support EMS, and estimated emergency department wait times, which are part of the current digital front door experience.

Taken together, these examples demonstrate how collaboration between health sector ministries is improving patient flow, supporting more appropriate care transitions, and expanding access to virtual and digital services. This co-ordinated approach is critical to ensuring that Albertans receive health services from one connected system, where and when they need it.

The acute-care action plan is also focused on strengthening emergency, surgical, and in-patient care. We're doing this by increasing capacity where Albertans need it most and by improving patient flow so that people can move through the system more quickly. In Budget 2026 we're investing \$525 million over three years to deliver 50,000 additional surgeries, helping reduce backlogs, improve access, and get patients treated within clinically

appropriate timelines. Last year we completed a record 318,000 surgeries. These are an incremental 50,000 surgeries on top of that record volume, and we are already on track to surpass last year's volumes. I think we're on pace for 330,000 this year. We're also investing \$61 million, as I referenced, over three years at the Royal Alex hospital to support emergency department diversion programs, strengthen internal triage and flow, and reduce ALC lengths of stay so beds are available for acute-care patients and we can alleviate pressures on the emergency department.

We're pairing those immediate actions with longer term system capacity by advancing new in-patient bed towers in Edmonton, expanding urgent care capacity so people can access the right care in the right setting, and continuing to modernize EHS to improve response times and support better co-ordination across the system. Taken together, these investments will help improve access, reduce wait times, and deliver better outcomes for patients across Alberta.

10:30

The acute-care action plan's priorities include providing Albertans the most appropriate care in the right setting while alleviating ED pressures, modernizing EHS to ensure paramedics and ambulances are available to respond to true emergency events in a timely manner, targeted initiatives to reduce surgical wait times and increase patient choice by expanding access to timely surgery, moving patients who have completed acute-care treatment to more appropriate services in the community, supporting a growing workforce, operating at full scope of practice with maximum flexibility regarding when and where they work, and focusing on immediate capital demands and long-term capital planning, balancing community and acute-care capital as large capital projects take many years to build.

Budget 2026 allocates more than \$684 million over the next three years to address urgent pressures in the health system, especially in hospitals and emergency departments. ALSS has plans to add 600 temporary bed and nonbed spaces to enhance community care access – this would support up to 600 ALC individuals currently occupying acute-care beds to move – and also 1,778 net new continuing care beds over two years. Again, this will enhance flow in hospitals by enabling us to move people out of acute care into long-term care as medically appropriate.

Mental Health and Addiction is going to add 42 psychiatric beds and we're adding 337 specialized mental health supported living beds to support ED diversion and enhanced community care access. Our capital planning included in Budget 2026 includes planning for two bed towers in Edmonton at the Grey Nuns and Misericordia hospitals – those will be about 350 beds each – and in Calgary two towers, one in-patient and one women's services, that will represent about 400 beds at the Calgary South Health Campus.

Member, I'll turn it over to you for any additional questions.

Mr. Lundy: Thank you through the chair, Minister. I really appreciate that. A ton of information. Excellent news to hear what's going on. I took a particular interest in the increasing. We've been able to increase the number of surgeries, increase our surgery capacity. I can't imagine anyone having an issue with that. That's great news.

I was also listening to your previous answers on workforce planning and the 50-year capital plan, also a 30-year sort of integration plan. Just a very quick question, then. This is on page 83 under outcome 1. It does talk about investing \$2 million to develop the comprehensive long-term capital and workforce plans. Can you just confirm that investment is to develop the plans that you were referencing?

Mr. Jones: Thank you, Chair, and through you to the member. Yeah. The \$2 million investment supports that comprehensive long-term capital and workforce planning that I've referenced in my previous answers. Again, we don't have these. I do not have a 50-year blueprint on where we should be building acute-care facilities across Alberta that factors in population growth or changing demographics or our ability to staff those facilities over time, and I think that we need those. So I think this long-term capital plan and long-term workforce plan will set Alberta, future governments, health care workers, and patients up for a much better experience in the decades to come. I'm really excited about that.

Again, that was PWC that has been contracted to assist us with that work. It will involve collaboration with all of our health ministries, all the health care agencies, public health corporations but also the AMA, physicians, nurses, allied health professionals, and their organizations because we want to get it right, and I think you'll find that we all share the same goal. We want to provide the best care for the patient where they are at when they need it and address those persistent pain points, particularly in rural and remote Alberta and in certain professions; anaesthesiologists, as an example.

There are just certain things that we need to get ahead of, as the government did in addressing the skilled labour shortages that we faced persistently for decades. They put together a plan, and that flowed into investments, into seed expansion and new institutions, and I think it's really worked to address those challenges, so I'm hoping to see the same success here on the health care side.

The Chair: Thank you, Minister.

Let's take our five-minute break.

[The committee adjourned from 10:35 a.m. to 10:41 a.m.]

The Chair: All right. Everyone is back in place here.

Please proceed, Official Opposition, with your questions.

Dr. Metz: I'll continue. Thank you very much, Madam Chair. I'm going to . . .

The Chair: Pardon me. I need to review just the portion here. I need to tell you about the timing. Now we're moving to the second round of questions and responses, and you probably already all know this because we've been through so many segments here. The caucus rotation going forward will be the same as the first round, starting with the Official Opposition, followed by members of any other party or independent members should they join us, and then members of the government caucus. However, the speaking times are now reduced to five minutes for the duration of the meeting.

We'll begin this rotation with the member of the Official Opposition, who will have up to five minutes for questions and comments, followed by a response from the minister, who may speak for up to five minutes. After both individuals have had an opportunity to speak once, we will then move to the next caucus in the rotation. If the member and the minister agree to share time, we'll proceed with a 10-minute segment, during which neither the member nor the minister may speak for more than five minutes. Members are reminded that they may not share any unused portion of their five minutes with another member.

Do you wish to have shared or block time?

Dr. Metz: I'm fine with block time on this.

Mr. Jones: Block.

The Chair: Block it is. Please proceed, Member.

Dr. Metz: It'll take me five minutes to ask the questions about the emergency departments there, anyways. In the ministry business plan on page 84, performance measure 1 has emergency department wait times. Of course, it's about a year out of date but looking as we'd expect. Looking at the times, they quite drastically went up after '21-22 and then increased further in '23-24. I'm asking if there's anything to suggest what is happening with that trend over the past year. Things don't look good here. That's in the urban wait times.

In the rural wait times they increased, but they're definitely not as severe. I am wondering what has been done and what will be done to try and address this. The rural emergency wait times are perhaps not as relevant as emergency closures, and I'm wondering – and if an emergency department is actually closed, they would have no wait times to report. An important metric for rural areas would be proportion of time that the emergency rooms are actually open, as they're expected to be, versus closed. I'm wondering if you would consider adding that as another metric to know where you're getting as far as progress in making the system better.

When we're looking at the problems with emergency department wait times, what are the issues in rural areas? My understanding is that it's lack of staff. Is it physicians? Is it nurses? Is it both all in the same region? I'm hoping that that would be data that would be part of a workforce plan, so we would know exactly where those pinch points are. What is happening in those areas to try to fix those problems?

The wait times in the cities: we know that a good part of that problem is because there's no capacity to even move patients out of the emergency department into the hospitals. You have talked about moving patients a variety of ways, so I don't need you to go over that one again. But I'm hoping we can get some answers there.

Then on the ground ambulance response times: again, is there more data coming? It looks like things didn't really change over the last two years. How about the most recent year?

I'm really wondering about the workforce, the EMS workforce. There was a workforce report in 2022, which was the 2022 EMS task force report. There were a number of items in that report that were specifically there to help workers who are burnt out and to help with retention of workers. I'm wondering if any of those have actually been implemented or taken place. It's been a long time. As of a year ago, talking to workers, those had not been implemented. I'm wondering what the plan is for that and if there are any budget items in here. We do see that the emergency health services budget is actually significantly decreasing on line 2.3 compared to the forecast for 2025-26. I'm wondering how we will be supporting the workforce and what has happened. Why is that line item decreased?

There is also work that's gone on by the registrars of the colleges of paramedics looking at a new graduated system, a training system with a two-year initial training program, giving paramedics a chance to progress and move on in their training. One of the advantages would be retention as well as a better prepared workforce. I'm wondering where that is, if there's anything in the budget here. Maybe it's your partners in postsecondary that would support that.

The Chair: Over to the minister.

Mr. Jones: Thank you, Madam Chair, and through you to the member for the great questions. I want to begin by, of course, acknowledging what Albertans already know. Wait times in our emergency departments are too long, and that's not acceptable. Everyday Albertans rely on emergency departments during moments of fear, uncertainty, and crisis. When someone shows up at an ER, they deserve timely, safe, and appropriate care. Improving

emergency department access and reducing wait times remains a top priority for our government.

Some context: Albertans continue to rely heavily on emergency departments. In 2024-2025 there were approximately 2.3 million emergency department visits across the province, an increase from the year before. More than half of those visits were for urgent, emergent, or life-threatening conditions classified as CTAS 1 to 3. This reinforces that emergency departments are caring for a growing number of very sick, aging, and complex patients. At the same time emergency department pressures are not caused by a single issue, nor is there a single solution. Emergency department wait times are driven by system-wide factors, including in-patient bed capacity and availability, delayed discharges, access to primary and community care, workforce pressures, and increasing patient complexity. That's why our response must be and is co-ordinated across the health system.

While emergency department volumes continue to rise, Alberta's performance remains in line with national averages. However, comparisons are not enough. Albertans expect better. Our focus is on delivering real, measurable improvements on the ground. That's why our government is taking action through things like the acute-care action plan, supported by \$586 million over three years, to address immediate pressures while building longer term capacity. Our approach is centred on three priorities: getting patients to the right care, improving patient flow inside hospitals, and expanding acute-care capacity where it's most needed.

First, we are working to ensure Albertans receive the right care in the right place at the right time. Many people go to emergency departments because they are unsure where else to go. To address this, we're expanding access to Health Link 811, including virtual MD, which connects callers with physicians or nurse practitioners by phone or video, often resolving concerns without the need for an emergency visit.

10:50

We're also developing the health digital front door, which I mentioned earlier, a one-stop digital resource for the 2 million Albertans on MyHealth records. This tool will improve patient navigation, connect people to more appropriate services more quickly, reduce unnecessary emergency department visits, and over time has the potential to function as a digital wait room.

In addition, we're investing \$39 million over three years in planning and land acquisition for eight new urgent care centres across Alberta. These centres help patients receive care faster for nonthreatening issues, improve outcomes, and relieve pressure on hospital emergency departments.

We are also reducing avoidable emergency visits through mobile integrated health, community paramedicine, and other outreach programs that bring care to where patients are, particularly seniors and those with complex needs.

Finally, we are implementing an emergency department frequent visitor program focused on the small number of patients, about 1.2 per cent of patients, who account for roughly 12 per cent of all emergency visits. In some cases these patients are visiting emergency departments 30 to 60 times per year. By co-ordinating care plans and strengthening community supports, we can improve patient experience while reducing these repeat visits.

Second, we are addressing patient flow within hospitals, which is one of the most significant contributors to emergency department congestion. A key challenge is alternate level of care patients, patients who no longer require acute care but cannot be discharged because the right supports are not yet available in the community. At one point 1,500 to 1,600 ALC patients occupied almost one-fifth of all of our acute-care beds in Alberta. Through close collaboration

with Acute Care Alberta and Assisted Living along with social services and mental health and addictions partners, we accelerated transitions into continuing care, home care, and community supports, and since September we've reduced ALC volumes by about 20 per cent, about 22 per cent here in the Edmonton area. That frees up beds, improves patient flow, and eases emergency department congestion.

I'll have more to say in subsequent answers because I see that I'm out of time. Within the emergency departments themselves we are implementing targeted improvements, including expanding the use of nurse practitioners and nurse-initiated protocols.

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

We're moving over to the government side. Members, would you please flag me so I know who is going to be speaking? Yeah. Go ahead, please, Member.

Mrs. Johnson: Thank you, Madam Chair, and my thanks also, through you, to the minister and his staff for being here today and for all you do in this really, really important ministry and very complex and time consuming . . .

The Chair: I'm sorry to interrupt. Is this blocked or shared time?

Mrs. Johnson: I would love shared if the minister is willing.

Mr. Jones: Shared.

The Chair: Okay.

Mrs. Johnson: Thank you, Madam Chair, to the minister. I'd like to talk about urgent care capacity. It's been touched on a few times this morning, and if we could come back there, that would be wonderful. Pressures on emergency departments have become an important issue, as we just heard, for both patients and health care providers. Ensuring Albertans can access the right care in the right setting is essential to improving patient flow and maintaining a responsive and sustainable health system.

On page 83 of the business plan under outcome 1, key objective 1.1, it indicates the ministry will "relieve emergency department pressures by enhancing emergency department operations and providing Albertans with alternative options for the most appropriate care when and where they need it." Through you, Madam Chair, can the minister explain the capital investments that are included in this budget that will support that initiative? As well, what role do urgent care centres play in alleviating pressures on our hospitals, and how can these alternatives improve wait times, expand access, and maximize health outcomes for patients?

Mr. Jones: Thank you, Chair, and through you to the member. Budget 2026 does allocate \$39 million over the next three years to advance the planning and land acquisition of eight new urgent care centres in west Edmonton, south Edmonton, Westview, so Stony Plain, Spruce Grove, east Calgary, Lethbridge, Cypress county, Medicine Hat, Cold Lake, and Fort McMurray. That's \$14 million in '26-27, \$20 million in '27-28, and \$5 million in '28-29. There's also another urgent care project, likely combined with primary care in Airdrie, that has \$2 million of planning allocated to it. So nine urgent care centres across Alberta.

Budget 2026 includes targeted capital investments to improve patient flow and expand clinical capacity across hospitals, supporting the goal of relieving emergency department pressures and ensuring Albertans can access the most appropriate care. This includes \$63 million to develop shelled and vacant hospital space so additional beds and treatment areas can be brought into service

sooner than new construction while longer term planning continues for new in-patient bed towers in Edmonton and Calgary to address sustained demand growth.

These capital measures are intended to increase capacity, reduce congestion, and support safer patient movement through hospitals, and they complement operational initiatives under the acute-care action plan that improve triage, discharge co-ordination, and overall system flow. Budget 2026 includes targeted capital investments to improve patient flow and expand clinical capacity with the goal of relieving our emergency department pressures and ensuring more Albertans can have access to care closer to home.

Some context on developing shelled space: you know, it ranges, of course, on where it is and what it is and what state it's in and what you're trying to turn it into, but it can be developed for roughly half the cost of net new infrastructure. It can also be developed much more quickly. Urgent care centres, again, can be developed much more quickly and less costly than, for example, a full-blown hospital. We do have many Albertans going to emergency departments who could be cared for at an urgent care centre, so we do need to take those 2 million visits and get people diverted to more appropriate care immediately. That's what's going to alleviate some of the pressures on our emergency departments.

Hopefully, that answers the member's question, Chair.

Mrs. Johnson: Thank you, Madam Chair, through you to the minister. Yes, that does answer my question a lot, and I really appreciate it because where I live, moments from Sylvan Lake, which is now almost 20,000 people, there's no hospital. The only one they have is Red Deer and Rocky Mountain House, quite a distance, yet they got an urgent care centre, and it is absolutely fabulous. It's just meeting such great need in the community. So I'm very grateful to hear that answer.

That will take us on to surgical capacity and chartered surgical facilities, a great initiative in the province, I think. Timely access to surgery is a critical component of an effective health care system. Ensuring Albertans receive surgeries within clinically recommended timelines requires co-ordinated planning, sufficient surgical capacity, and the efficient use of available health system resources. On page 83 of the ministry business plan under outcome 1, key objective 1.2, it states that HSHS will

ensure Albertans receive access to surgeries within clinically recommended timelines by expanding the surgical clinical workforce, optimizing surgical capacity, and reserving hospital capacity for the most complex patients by supporting chartered surgical facilities to carry out routine, low complexity surgeries.

Can the minister explain the role of the acute – care action plan in achieving this objective and what immediate and long-term investments will support improved surgical wait times, expand surgical workforce, and improve surgical capacity?

Mr. Jones: Thank you, Chair, and through you to the member. The plan supports key objective 1.2 by co-ordinating investments in workforce, surgical capacity, and infrastructure so Albertans can receive more surgeries within clinically recommended wait times. Budget 2026, again, allocates an additional \$525 million over three years to deliver 50,000 incremental surgeries on top of our record volumes of over 300,000. By expanding the use of chartered surgical facilities for routine, lower complexity procedures like hips, knees, and cataracts, hospitals can reserve capacity for urgent and complex cases, what walks in the door, and what can't be done in a chartered surgical facility. This improves throughput and reduces wait times across the province.

We're also strengthening the specialized surgical workforce, improving centralized, patient-focused scheduling to reduce waits,

and supporting key infrastructure like operating room renovations and medical device reprocessing department upgrades so that hospitals have the sterilization capacity needed to safely increase surgical volumes.

Through the Alberta surgical initiative we're also targeting both parts of the surgical wait, wait 1, which is from referral to specialist consultation, and wait 2, which is from the decision to treat to the actual procedure. For wait 1 we're supporting initiatives like rapid-access clinics so that patients with musculoskeletal issues can get early expert assessment and nonsurgical management and facilitated access to specialized treatment, which uses centralized intake and triage to match referrals to the next available surgeon with the shortest consult wait.

11:00

For wait 2 we're expanding team-based models like the anaesthesia care team; making major infrastructure and capital equipment investments, including \$265 million to improve surgical infrastructure and establish new capacity in rural communities; and expanding chartered surgical facility volumes, which have grown from about 40,000 cases per year before ASI to nearly 65,000 cases in '24-25. It's important to note that chartered surgical facilities provide publicly funded surgery for appropriate lower complexity procedures such as cataracts and orthopaedic surgeries, that I mentioned before, in a safe setting at no cost to patients. They're performed by the same medical professionals, same Albertans. They can be thought of as extensions of our hospital ORs.

By shifting these routine procedures out of hospital, CSFs allow hospitals to again focus on urgent, complex, in-patient surgeries that often require overnight stays. Today CSFs account for roughly 20 per cent of Alberta's surgical volume. I would expect that to increase over time. And we'll be rolling out a phased approach to procuring the surgeries that Albertans require while also continuing to invest in our hospitals and internal ORs and workforce to make sure that we can keep doing record volumes in those settings.

Mrs. Johnson: Thank you, Madam Chair, and through you to the minister. I think in these final seconds we'll see if we can get one more in. It's for emergency health services again. We've touched on this a little bit, and it's for key objective 1.3 in the ministry business plan, page 83. Without the preamble so we can get to the answer, how does stepping down transport – and this is related to ambulances and paramedics – and ensuring emergency health services use appropriateness contribute to the improved EHS wait times?

Mr. Jones: Thank you, Chair and through you to the member for the question. This is a longer answer. I'll try to get through it. Of course, emergency health services plays a critical role in ensuring Albertans receive timely care when urgent and life-threatening medical situations arise. The ministry is focused on modernizing our emergency health services and ensuring that paramedics and ambulances are available to respond to emergency events in a timely manner, with the response aligned to the patient acuity. The core objective of this work is to ensure that traditional emergency ambulances and highly trained paramedics are available for patients who need them most while also improving how the system deploys resources across a wide range of emergency and nonemergency situations.

A key area of focus is on modernizing dispatch and response models, and we're working to match the resource dispatched with the clinical need. This includes removing automatic prealerts, introducing more accurate and evidence-based triage pathways, and embedding additional clinical expertise within dispatch operations.

These changes will help to ensure that advanced life support units remain available when they're . . .

The Chair: It sounded like you weren't quite finished, Minister. I'm hoping there will be an opportunity down the road to hear the rest of the answer.

Let's move now over to the Official Opposition. Go ahead, Member.

Mr. Haji: Thank you, Madam Chair. Yeah. Would the minister prefer block or shared? I'll be fine either way.

Mr. Jones: Block.

Mr. Haji: Madam Chair, the government paid \$70 million up front for medication. Only \$20 million worth of those were delivered, and those that were delivered could not be used. Taxpayers paid another \$1.2 million to destroy it. That leaves \$70 million still in the hands of MHCare. We have a deficit budget in front of us. Of course, resources are so limited that health care staffing is constrained, that difficult budget choices must be made. So my questions today are about how the \$50 million affects Budget 2026, the fiscal plan, as well as the business plan.

I do get that this is not looking back in terms of how it was spent and how it was sole-sourced, but my question is focused on times of looking forward for the fiscal plan outlook as well as the business plan and the government estimates. The first one is: where is the missing \$50 million reflected in the ministry's estimates? If it's not spent and used, it has to show somewhere within our books. Is it included in prior-year adjustments? Is it included in forecast recoveries? Or is it included in contingency assumptions?

Second, does the fiscal plan assume that this \$50 million will be recovered? It's a good assumption. If so, in which fiscal year? It doesn't show in 2026-2027. It's not shown in 2027-2028. It's not shown in 2028-2029.

Third, has this loss or exposure reduced the ministry's ability to fund front-line health care staff, services, or system capacity? If it was there, it would have funded some capacity. Given that it's not there, did it have an effect? In other words, did it contribute to the \$9.4 billion deficit?

Fourth, has the ministry set aside funds? The minister in the House is on the record, Madam Chair, stating that there will be an option of going through court. So my question is: did the ministry set aside funds for legal action? If not, is it an acceptance of the risk that this money may never be recovered?

Finally, can the minister commit to providing this committee with a clear accounting of how this \$50 million is treated in the estimates and the fiscal plan and whether Albertans should expect a recovery or even move on and assume it's a permanent loss?

Either way, all of those need to be reflected in budget assumptions as well as the fiscal plan. In looking forward, I would like if the minister could answer four of these questions in the context of our budgets and forecast for the next three years.

There is 30 seconds, and I'll give that back to the minister's block.

The Chair: Minister, please proceed.

Mr. Jones: Thank you, Madam Chair and through you to the member for the question. Our government is committed to transparency, integrity, and accountability in health system-wide procurement. Judge Wyant's investigation highlighted concerns regarding Alberta Health Services procurement practices, procedures, and management of conflict of interest in this case, and we have acted decisively on these findings. Since the initial

procurements the health system has been restructured, with procurement being moved out of AHS into the Health Shared Services organization and as it relates to chartered surgical facilities in part to Acute Care Alberta.

I'll touch on the Wyant report, which made 18 recommendations. In addition to that, we've also hired RSM, a third party, to review the health-sector procurement practices and really align it with best practices. We are pursuing fair, open, and competitive procurement to the broadest extent possible across acute care and surgeries. We're ensuring all perceived or actual conflicts of interest are managed, disclosed, and enforced both internally and when dealing with suppliers and service providers. We're reviewing legal and contractual frameworks to ensure all applicants and contractors are held to the highest ethical standards. We're strengthening procurement thresholds and signing authorities to prevent misconduct and restore public confidence.

[Mr. Haji in the chair]

11:10

We're communicating to proponents seeking government contracts that Alberta is committed to value for money and transparent, competitive procurement. We're also implementing activity-based funding for surgical procedures, which would enable any accredited and approved provider in Alberta to deliver the same surgeries for the same reimbursement. This ensures fairness, transparency, and equitable access across the province.

As I mentioned, Health Shared Services now leads procurement, contracting, and supply chain management across the health system. Provincial health agencies and provincial health corporations provide expertise to support clinical and nonclinical contracting and vendor management. In addition, we did commission RSM to do a review of our procurement processes.

Regarding the disposal of the remaining children's medication, Alberta Health Services exhausted donation options and, due to product expiration timelines, was unable to identify additional countries to accept the remaining medication, so approximately 800,000 bottles were disposed of. We thank Health Partners International of Canada for taking 651,000 bottles of children's medication to support humanitarian relief efforts in a number of countries, including Ukraine.

With respect to provincial contracts, there's also a review by the Auditor General, Doug Wiley. We look forward to that and, of course, would act on any of his recommendations.

I'd like to touch on the Wyant review and what we're doing with it. In March 2025 the government commissioned an independent review of the procurement policies, practices, and procedures of Alberta Health Services and Alberta health under the Government Organization Act. This was led by the hon. Raymond Wyant, former chief judge of the Provincial Court of Manitoba, and he made 18 recommendations that have all been accepted by the government of Alberta, directed by the Deputy Minister of Executive Council to co-ordinate. While the report did not reflect the subsequent system changes in terms of the restructuring, the recommendations are adaptable and will be implemented through these structures. PPHS and my Ministry of Hospital and Surgical Health Services have assessed each recommendation and categorized them into short-, medium-, and long-term implementation.

For short-term implementation we've got things like implementing a centralized system for online conflicts-of-interest declarations tied to human resources, establishing policies that prohibit any individuals from utilizing their personal e-mail address

for the purpose related to work for the government of Alberta, Crown corporations, or public entities.

For medium term we've got additional whistle-blower protections for employees of AHS who become aware of conflicts they wish to inform management of.

For longer term we've got vendor codes of conduct that would require compliance for all entities contracting with AHS, defining their conflicts of interest and their resolutions, establishing and expanding cooling-off periods.

I see my time is getting short here, but I'll summarize it this way: when the government of Alberta or any of our agencies or entities orders products or services, we expect those to be delivered to the quantity and quality ordered. When that is not the case, we go through every tool available to remedy that, so obviously we work with the vendor in question through any mediation or arbitration that the contract enables, and ultimately we will go to court to protect taxpayer investment.

The Acting Deputy Chair: For the government side, who goes first?

Mr. Singh: Thank you, Chair, and through the chair to the minister. Shared time if it's okay with the minister?

Mr. Jones: Yes.

Mr. Singh: Thank you, Minister, for coming here today. I want to express my gratitude to the minister and team for supporting and committing to implementing strategies that strengthen emergency care and improve patient flow. I'm so glad to see a record-breaking health care budget.

Through you, Madam Chair, my questions are on the issues of how EHS investments that strengthen ambulance deployment, staffing, and response co-ordination can help improve service reliability and ensure equitable access to care across the province. I see page 74 of the fiscal plan indicates that the "Emergency Health Services expense is increasing to \$804 million in 2026-27 and the following two years for improved ambulance deployment, and rural staffing." Can you please, Minister, highlight the role that this funding will play in improving EHS wait times and regional equity in EHS service delivery?

Mr. Jones: Thank you, Chair, and through you to the member. Budget 2026 does increase emergency health services funding to support improved ambulance deployment and stronger coverage across Alberta with a focus on rural staffing, fleet capacity, and better geographic deployment planning. In Budget 2026 emergency health services expense increases to \$804 million, and this supports the EHS provincial health contact centre, which has a workforce of over 4,000 staff. Targeted operating investments include \$4 million to expand mobile integrated health programs, \$1.4 million to add dispatch staff, \$750,000 to replace staffing software, \$3.7 million for staff training, \$8 million for wage adjustments, \$40 million to increase response capacity, and \$2 million for additional facility leases to support operational capacity. Additional capital investments include \$20 million for ambulance vehicle replacement.

Together these investments support both improved response times and more equitable service across regions. Modernized forecasting and dispatch tools help position ambulances where demand is highest, improving response times and supporting more equitable access to emergency care across both urban and rural communities.

I'd just like to go back because I was in the middle of outlining some of our work in the EHS. I was talking about aligning the use of lights and sirens with clinical evidence. This approach prioritizes the most urgent cases while improving safety for paramedics, patients, and the public. The intent is to ensure that emergency responses are timely and appropriate based on patient acuity rather than a one-size-fits-all response model.

To improve overall system capacity, the ministry is expanding ambulance and transport fleets and introducing dedicated low-acuity response units such as the health evaluation and linkage paramedic unit, or HELPU. These units are designed to respond to lower acuity calls and connect patients with the most appropriate care and supports, helping to ensure that emergency ambulances remain available for higher acuity emergencies. In addition, the ministry is exploring nonclinical transport options so that emergency ambulances are not tied up transporting patients who do not require emergency medical care. This allows the system to better manage demand and improve availability across the province. In some rural settings, through you, Chair, to the member, interfacility transfers are consuming 30 per cent of ambulance availability for rural communities. If we can get these nonclinical transport options taking a piece of that, it obviously will make a huge impact on ambulance availability for rural and remote communities.

The ministry is also optimizing Health Link 811 and secondary triage processes to reduce unnecessary return calls to 911. By strengthening secondary triage and referral pathways, patients can be connected more quickly to appropriate advice or care, reducing pressure on both emergency dispatch and front-line resources. Modernization efforts are also specifically designed to support rural and remote communities. This includes improved co-ordination for interfacility transfers, enhanced air ambulance support, expanded coverage models, and targeted recruitment and training pathways aimed at strengthening the rural emergency medical workforce. These measures help ensure that Albertans, regardless of where they live, have access to timely emergency care.

Taken together, these initiatives form a comprehensive approach to emergency health services modernization. They are focused on improving response times for high-acuity patients, reducing unnecessary pressure on emergency departments, and ensuring that paramedics and ambulances are deployed in a way that reflects patient need. This work is essential to building a more reliable, responsive, and sustainable emergency health system.

Chair, I think I've touched on some of the exciting initiatives we have under way, and I'll turn it over to the member for his next question.

Mr. Singh: Thank you, Minister, for great answers. My next set of questions is on expanding cancer care capacity. Through you, Madam Chair, I do know this has been touched on by previous members, but I would hope the minister will probably expand on it.

Strengthening the cancer care workforce and improving access to specialized services can help ensure patients receive treatment within clinically recommended timelines while supporting better health outcomes. On page 74 of the fiscal plan it states, "Cancer Care Alberta's budget has been increased by \$223 million over the next three years to expand the cancer care workforce . . . capacity." Through you, Madam Chair, how will an expanded cancer care workforce and clinical capacity improve health outcomes for Albertans and help retain the workforce we already have in the province? Beyond workforce expansion how will this investment improve access to cancer services for patients across the province?

11:20

Mr. Jones: Thank you, Chair and through you to the member, for the question. As noted on page 74 of the fiscal plan, Cancer Care Alberta's budget has been increased by over \$200 million over the next three years. That's really to expand both the workforce and clinical capacity, which will improve and expand access to cancer care supports and increase spaces in facilities like the Cross Cancer Institute. This funding is focused on supporting expanded access to care while helping to ensure Albertans receive cancer care within clinically recommended wait times more of the time. This investment will continue to support improved and expanded access for cancer patients by augmenting existing operations. This includes equipment renewal and replacement, expansion of the oncologist workforce, which we touched on earlier, and advancing renovations at the Cross Cancer Institute.

A key component of this funding is to recruit into the cancer care workforce. By strengthening staffing levels, Cancer Care Alberta will be able to open additional ambulatory outpatient clinics and expand capacity for consultations and treatment. This additional workforce capacity directly supports increased patient throughput and helps ensure that patients are treated sooner, which is, of course, a key priority in cancer. The funding is also supporting the implementation of new models of care that leverage the full scope of practice of existing health professionals. This includes the integration of new and alternate provider roles, which further expand system capacity. These models allow care to be delivered more efficiently while maintaining, of course, high standards of clinical care.

The Alberta cancer diagnosis program and intake model, along with the patient navigation program, are being refreshed. These changes are intended to improve access for new patients entering the cancer care system and to enhance the supports available to patients and their partners as they move through diagnosis to treatment. The investment also focuses on maximizing use of existing resources across major cancer centres, including the Cross Cancer Institute and Arthur J. E. Child. This includes operationalizing the new ambulatory clinic area at the Cross, which includes six new clinic rooms, implementing an early supported discharge program at both the Cross Cancer Institute and Arthur Child, and adding inpatient surge capacity at the Cross Cancer Institute. These measures help increase flexibility and reduce pressure points within the system.

Expanded cancer-supportive care services are also being supported through this funding. These services streamline referral processes and ensure that patients and their care partners can access the supports they need in a more co-ordinated way. Finally, renovations, equipment replacement, and targeted expansions at select sites will increase capacity and efficiency as we implement new technologies, including with AI. This includes diagnostic imaging and radiation therapy equipment. In diagnostic imaging the adoption of artificial intelligence enhanced tools will support radiologists in interpreting CT, MRI, and X-ray images, help prioritize urgent cases better, and reduce backlogs.

The Chair: Thank you so much, Minister.

We'll move over to the opposition.

Dr. Metz: Thank you very much, and I'd like to thank the minister for telling us about the workforce work being done by Pricewaterhouse. I'm wondering about the timeline for that and what other contracts have been given out by Acute Care Alberta and hospital services. I'm also wondering about the activity-based funding. Where in the budget is that, and how will that be implemented over the next year? Just wondering where it's

allocated, what model is being used. I know it was being piloted. Are there are changes to it? Could this, please, be shared so it's transparent for everyone? Will this really only roll out to AHS, or is it going to be rolled out for all of the providers? For example, we'd understood that if AHS does not meet targets, the funding could be pulled and given to an alternate provider. I'm wondering what the plan for that is.

Next, performance indicator 2(a) is the cost per patient per day in general acute care. I'm wondering if this is inclusive of all costs in the system, including the hospital-based outpatient clinics and if there is any plan to eliminate the outpatient clinics from the acute-care budget? Many of them actually evolved to look after patients in a much less expensive way than having them admitted to hospital, and I would worry that if these were no longer funded, there will be more hospitalized patients again.

Next, on page 126 of the estimates document, it shows that physician compensation is dropping. I'm wondering what that is due to. Is this due to the end of paying stipends? Stipends did traditionally come out of hospital budgets and are added on to fee-for-service or ARP funding to account for the type of work being done and that we need doctors in place all the time doing those jobs even if there isn't always enough work for them to be earning enough income in these other ways, and I'm wondering more about that line item and why it's dropping.

And then infrastructure is a huge issue. On page 126 of the estimates book there were some considerable increases in the cost to repair or maintain health facilities and equipment above the original estimate. I'm wondering if you can tell us what that was for. What was that above the original estimate for? In talking to workers who look after our infrastructure across the system, I've been told of a number of cancelled routine maintenance or upgrades that were meant to be done, and they're very worried about major problems with plumbing, with electrical upgrades, fire alarm systems, that were scheduled and meant to happen, that have been cancelled. I'm wondering if you can explain what each of the two listed budget line items are for. One of them is called Infrastructure Support and the other is Health Facilities and Equipment. Is one of them for staff costs? There are significant increases in that first line for infrastructure support. Is that maybe because, I know, there were a lot of vacancies in a bunch of those positions? Have those now been filled and there's going to be more cost, or what is it that is attributed to all of these infrastructure costs? Are you tracking in some way the actual infrastructure deficits, things that need to be done for the long term, so that things don't crash and we don't have major problems? If you can give us an idea of what that deficit actually is given that it's apparently a lot of projects not going ahead.

Those were the things I wanted to ask about. Thank you.

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

We'll move over now to the minister for his response.

Mr. Jones: Thank you, Chair. A lot of questions; I'll try to get through them.

Health facilities and equipment. In Budget 2025-2026 that was about \$413.8 million, for '26-27 we're estimating \$435 million. That's an increase of \$21.4 million, or 5.2 per cent. And this is a net consolidated estimate amount for health facility and equipment capital. Ministry's funding is for facility and equipment projects and ACA's own source projects for parkades, IT, non-IT, and provincial clinical systems. The increase of \$21.4 million is due to a \$38 million increase to a diagnostic imaging enhancement program and a \$12.8 million increase for National Association of Pharmacy Regulatory Authorities, or NAPRA, funding to bring our

facilities up to standard, off-set by a \$4.13 million decrease to the ASI capital program, \$25 million decrease to rural health facilities revitalization program, and \$246,000 decrease in such sector ACA self-financed projects.

11:30

In terms of changing capital assets, this was \$8.2 million in '25-26, now an \$11 million estimate for '26-27. That's an increase of \$2.8 million, or 34.1 per cent. This is a net consolidated estimate amount for planning funds to review capital investment options related to the Beaverlodge health centre. The \$2.8 million increase reflects updated cash-flow requirements for Beaverlodge health centre replacement, with a carry-over of \$700,000 of unspent funds from '24-25.

Physician compensation and development for '25-26 was about \$1.1 billion. For '26-27 the estimate is again \$1.1 billion, largely unchanged. This is comprised of compensation expenses for physicians and personnel who provide medical-type services and who are remunerated by the health service organization on a salary or contractual basis, including pathologists, radiologists, respirologists, cardiologists, hospitalists, dentists, podiatrists, medical residents, interns, and students. It excludes medical personnel who fulfill a management role. The \$5.8 million increase, which again is nominal in a \$1.1 billion item, is simply due to reorganization or transfers to other entities. So that money would, of course, be found in those other entities.

Capital maintenance and renewal was raised. Budget 2026 allocates \$531 million over three years to support capital maintenance and renewal for our health infrastructure. That's \$166 million in '26-27, \$179 million in '27-28, and \$186 million in '28-29. This helps us avoid unplanned outages, service disruptions, and higher future replacement costs. It's not an area that we're looking to save money. We know that it's going to cost us more and it will affect patient care, so we, of course, do all the maintenance that is necessary.

Medical equipment replacement and upgrade program. Budget 2026 allocates \$90 million to this over the next three years; \$30 million in each of the next three years. This provides province-wide life cycle renewal money that replaces and upgrades high-risk, end-of-life clinical equipment to improve reliability, safety, and service continuity. The investments will support more timely diagnostics and treatment, reduce avoidable downtime, and this is an ongoing program.

Lastly, I'll touch on patient-focused funding. The first phase of patient-focused funding is on track to launch in April and will be used to fund some of the most common orthopaedic surgeries: hips and knees, shoulders and rotator cuffs as well as cataracts at 12 acute-care facilities across the province, including both AHS and Covenant Health. The objective is to improve transparency, efficiency, and increase accountability by assigning a price to surgical procedures and allocating funding according to actual services provided.

Patient-focused funding or activity-based funding promotes operational efficiency and provides incentives for facilities to optimize operating room utilization, increase volumes, and expand access. I believe this covers around 25,000 procedures, and it's roughly \$125 million of procedures. It will be used to inform the expansion of patient-focused funding, and there are lots of safeguards in place to ensure that facilities and their budgets are protected as we pilot this new approach to funding surgeries. We certainly want to increase transparency, efficiency, and accountability, but we also recognize we need to maintain the ability to perform surgeries around the province, particularly in rural and remote settings outside of our major urban centres.

The Chair: Thank you so much, Minister, for the answer. Who's up next? Please proceed.

Mrs. Johnson: Thank you, Madam Chair. I want to roll around back to modernizing emergency health services. We were just getting into this. I'm going to do a bit of a preamble here just to put some context in, and then I've got two questions related to it, just so the minister can expand on the answer he was in the middle of giving and ran out of time with. I want to hear some more about that.

Emergency health services play a critical role in ensuring Albertans receive timely care when urgent medical situations arise. Improving how paramedic resources and ambulance services are deployed can help ensure the system responds efficiently to patients with the greatest need. As I said, on page 83 of the ministry business plan, under outcome 1, key objective 1.3, it indicates the ministry will "modernize emergency health services and ensure paramedics and ambulances are available to respond to emergency events in a timely manner with responses that are aligned with patient acuity." Could the minister through the chair highlight some of the initiatives the ministry is undertaking in support of this objective and, as he began, maybe can expand upon this? Could the minister also explain how this stepping-down transport and ensuring emergency health services use appropriateness contributes to improved EHS wait times, just to expand upon that answer? Then could the minister also address what measures the ministry is taking to track improvements in EHS response times and patient outcomes as these modernization initiatives are implemented?

Mr. Jones: Thank you, Chair and to the member for the question. We touched quite a bit on EHS but happy to highlight some of the initiatives under way. The main goal is to ensure that ambulances are available for those very serious events. We actually have ambulances doing all sorts of things today that other vehicles and different staff could provide. Maybe a primary care paramedic in a non-ambulance could provide care versus a fully staffed ambulance. In rural and remote settings we have hundreds of interfacility transfers where we have ambulances transporting patients, which reduces the availability of ambulances in smaller communities. We definitely want to explore step-down units that could do those interfacility transfers and free up those ambulance resources.

We talked about mobile integrated health units, where we're sending paramedics into community to care for people on site. A real-world example of this is that we have ambulances going to and from seniors' facilities hundreds of times per year. In one case it was hundreds for one facility, and the ultimate hospital admissions were 8 per cent. So we have an ambulance taking people to and from a hospital hundreds of times per year; very few are admitted. There's strong evidence that we can treat people in community or on site and obviously mitigate or reduce the need for all of those ambulance trips. You know, there's a safety concern there in addition to cost and then the consuming of the very important ambulance capacity.

Lights and sirens initiative. We are trying to do a better job assessing the acuity of the event before lights and sirens and sending a full-blown ambulance. We are integrating paramedics into dispatch.

All of this is also part of the workforce side. As we know, EMS paramedics are under extreme stress and pressure at times. We want to provide them additional ways and places to work so that they can find increased career pathways and so we can reduce that burnout and also attract more people to the profession. We're also exploring

potential bursaries for paramedics to attract them as we have a fairly high vacancy rate in EMS at the moment.

Hopefully, that answers the member's question. The idea is to make sure that we send the right resource at the right time, while exploring additional use of step-down units for low-acuity calls and interfacility transfers, caring for people in community on site, fully leveraging paramedics and their training and expertise, which I think will help us build and retain the professional.

Mrs. Johnson: Thank you, Madam Chair through you to the minister, for that answer. Let's change direction here a little bit and go to reducing alternate level of care. We've heard a little bit about this this morning. On page 75 of the fiscal plan it highlights \$91 million over the next three years for expanding capacity in emergency departments and operating rooms, including the anaesthesia and surgical workforce; freeing up spaces through alternate level of care length of patient stays; increasing the use of out of operating room procedures; and building virtual pathways with new space, equipment, staffing, medical supplies, and IT investments.

I have four questions related to this. I'll try to get them all out here. First, how does a reduction of alternate level of care length of stay improve access across the acute-care system, and what role will this funding play, the \$91 million in three years, for improved acute-care delivery? Second, how does freeing up in-patient beds through reduced ALC stays help alleviate pressures in emergency departments and reduce wait times for patients needing admission? I think we've touched on that a little bit; maybe we can expand upon it. Can the minister explain some of the initiatives currently under way to reduce ALC lengths of stay and how the ministry is collaborating with Assisted Living and Social Services and Mental Health and Addiction to ensure patients transition to the most appropriate care settings? Finally, what role does the refocused health care system play in ensuring a seamless patient journey for ALC patients and relatedly improved access and reduced wait times for those seeking acute care?

11:40

Mr. Jones: Thank you, Chair, and through you to the member. This funding does support patient flow initiatives, expanded clinical capacity, and improved discharge co-ordination, strengthening access and efficiency across both the acute-care system and continuing care. Alternate level of care patients no longer need hospital level of care but can remain in acute-care beds when there are barriers to discharge. When we reduce ALC lengths of stay, we free up in-patient beds for patients who need acute treatment and improve flow across emergency departments and hospital units.

This funding supports patient flow initiatives, expanded clinical capacity, and improved discharge co-ordination. It also supports work that improves access to community-based services and other supports that help prevent unnecessary admissions and readmissions, which reduces pressure on acute-care entry points, including the emergency department. Initiatives currently under way include seven-day-a-week discharge into continuing care homes and having our health care providers focus on acute-care facilities with high ALC numbers.

Almost half of all ALC patients are transferred to more appropriate care settings outside hospitals within seven days, and the majority are transferred within 25 days. However, many patients experience delays and stay in hospitals much longer than required, in some cases over 1,000 days. Nationally Alberta ranks better than most provinces, with ALC patient management at 15.2 per cent. Of patient days in ALC status Alberta ranks third best among the

provinces, which averages 16.9 per cent. Only B.C. and Saskatchewan perform better. That was old CIHI data. I actually think we're probably on track to outperform them with the 20 per cent reduction system-wide over the last six to eight months.

Ensuring that ALC patients can transition more quickly into more appropriate home and continuing care or mental health settings frees up acute-care beds, enabling hospitals to admit patients who require acute-care services in a timely manner. In practical terms this means that once someone is in an emergency department and they are admitted – and often they're waiting for an in-patient bed. If that in-patient bed is being occupied by an ALC individual, then they can't be brought upstairs. If we move that ALC patient to a more appropriate setting – say, in a long-term care facility – we can move the EIP patient out of the emergency department up into the in-patient unit. Reducing ALC length of stay does measurably improve patient flow by making in-patient beds available sooner and more quickly so that emergency patients can move up.

We did a recent lift in Calgary, and I was touring the South Health Campus, and the nurses and physicians there: all of them highlighted how incredibly meaningful it was to have their in-patient capacity freed up and to have several patients moved. It made a very tangible difference in their work, and we intend to continue our momentum in this area.

As part of the ACA, Acute Care Alberta, AHS task force, we have developed numerous initiatives to divert patients to the right level of care, optimize patient flow, and help patients navigate the health care system through the patient process. This includes right at our front door diverting people to social supports or homelessness supports as required or directly to mental health and addictions related supports as opposed to everything ending up in and going through an emergency department.

As I touched on earlier, we're also expanding access to urgent care centres. We'd like to see more of those CTAS 4s and 5s handled in the community or primary care or urgent care and have the higher acuity patients continue to present at emergency departments but to be seen and treated more quickly. That's the future model that we're going for. There are also educational campaigns and advertising that will be rolled out to promote this in addition to work on the digital front door, which will enable Albertans to more seamlessly learn about their options for care.

The Chair: Back to the Official Opposition.

Ms Hoffman: Sharing is caring, Madam Chair. Would the minister agree?

Mr. Jones: Block time.

Ms Hoffman: My colleague Mr. Haji asked the minister when we can expect the reimbursement of the \$50 million outstanding from MHCare, and the minister did not respond. If it isn't expected as revenue, is it being tracked as a loss? This is specifically around the Turkish Tylenol and the \$50 million outstanding from the same company at the heart of the corruption allegations. We have read the judge's report, so . . .

Mr. Singh: Point of order.

The Chair: A point of order has been called.
Proceed, Member.

Mr. Singh: Yeah. Madam Chair, a point of order under 23(b). The issue on the MHCare contracts mentioned by the hon. member is

not part of the estimates. It is not related to the matter being under discussion at this committee, so it's a point of order 23(b).

Ms Ganley: Yes, Madam Chair. I think (a), the member referred to a line of the budget, which tends to relate it to the estimates. I would say (b), that the last time I checked, chartered surgical facilities were in the business of providing surgeries, and we are in hospital and surgeries estimates right now. Finally, I think if public money is being spent, it is our obligation as elected members to ask about that public money. If the minister feels inclined to answer, he can answer, but I really don't think this is a point of order, Madam Chair.

The Chair: You know, what I'll say is this: Minister, you can decide whether or not you're going to answer that question, but please proceed, Member.

Ms Hoffman: Thanks.

I just want to follow up as well. PWC was referred to – I think the minister talked about \$1.8 million on workforce planning, referring to last year's blue book. Again, when we're doing the reconciliation, we're looking at budget and forecast, so according to the last, most recent, updated publication of the blue book, based on December 31 numbers, PricewaterhouseCoopers had already received \$6.6 million from Primary and Preventative Health Services. What's the forecast for this upcoming year? What's the estimate on how much is going to be spent from this ministry or from the department, from Acute Care Alberta, or any of the subsidiaries within those? I'm only naming one consulting company. That's the one, I think, that's being referred to most publicly, but how much is the department and its subsidiaries planning on spending on consultant services?

Also, activity-based funding, I'd say, is essentially a voucher system, and we look forward to having greater clarity on exactly how that's going to be applied because, of course, in rural facilities the economies of scale just aren't there. How is that going to be ensuring equitable access so that every Albertan can get the right care in the right place at the right time?

I am going to move now to items – I'm in the estimates, Operating Expense item 1.1, the Minister's Office, a 10 per cent increase; 1.2, the Deputy Minister's Office, a 21 per cent increase; and Strategic Corporate Support and Policy Development, a whopping 60 per cent increase. I think that when all of us talk to our constituents about what their priorities are in health care, none of them have named those line items to me when I've been engaging in the community, so I would like clarity on what the organizational charts are for each of those key areas. Again, that's items 1.1, 1.2, and 1.3. How many FTEs are in each of those areas? Are there other pieces housed in there, like the dismissal and legal costs related to severance packages? If so, how much is in that 2025 forecast number, which, of course, is more – the government spent more than we approved in each of those line items, so how much of that is related to severance or other transition costs? In this year's estimate how much is allocated towards the same or budgeted for the same?

We're being asked to approve both the forecast as well as the ongoing estimate, so, yeah, if we can have confirmation on how much is being spent to date in this current year's budget. How much has the department spent on legal fees to date as well, and where is that housed? I assume that's within Strategic Corporate Support and Policy Development, but that could be wrong. I'd love a breakdown on how much this department has spent on legal fees and how much is being budgeted for the same this upcoming year. Are there other legal liabilities, particularly those related to dismissals embedded

within this line item or others? That line item didn't go down in primary care and it isn't part of Mental Health and Addiction, so I don't think this is a shell game thing. I think this is literally an increase. That's the way that it looks, looking at all the other departments from last year to this year. How many political staff are there this year within the minister's office? Yeah. It just seems like that doesn't align with the main priorities of our constituents.

Previously AHS won international awards for procurement, getting among the best possible price because of economies of scale and purchasing power. Now that the Premier's office has taken a direct lead on much of this work, how is that going to impact this minister's budget and his budget estimates? Does the ministry or any of the service providers still own the political risk but not have the authority to influence those decisions? Will this new office under the authority of Executive Council and the Premier have the ability to override departmental, Acute Care Alberta, or AHS procurement decisions? Will political staff in the minister's office be involved in reviewing or approving contracts? Yeah. Basically, items 1.1, 1.2, and 1.3, I think, deserve much greater clarity.

11:50

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

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

Mr. Jones: Thank you, Chair and to the member for the question. Minister's office, Budget 2025-26, \$491,000; '26-27, \$542,000, an increase of \$51,000 or 10 per cent. This of course oversees development of ministerial policies that are aligned with the broader government objectives. My understanding is that this is the smallest minister's office in government by dollar. I think the average is \$1.1 million, so it's roughly half the average in government. The increase is a result of salary settlements and collective bargaining agreements. Hopefully, that covers that one.

Legal expenses were asked about; \$315,000 is our legal expenses in the current year. Deputy minister's office, 1.2, Budget '25-26, \$791,000; '26-27, \$960,000. This supports the minister in achieving business plan and strategic goals of the ministry, government, and public service. The deputy minister's office leads the development and provides advice to support the minister. It is the link to the minister's office to ensure the work of the department meets the goals and objectives outlined in the department's business plan and the priorities provided to the minister by the Premier.

Then we have the ministerial correspondence unit, which tracks the preparation of correspondence and other requests from the minister's office such as briefing notes on specific subjects or backgrounds for a meeting. I already gave the amounts. That was an increase of \$169,000 or 21 per cent year over year, and the increase is again the result of recent salary settlements related to collective bargaining.

Strategic corporate support and policy development. I think I gave these amounts earlier: \$19.9 million in '25-26, increasing to \$31.9 million in '26-27, an increase of \$12 million or 60 per cent. Ten million of this is to support improvements in the health system, including addressing Wyant recommendations, long-term capital health strategy and sector workforce planning. The member's question, through you, Chair, was related to the PWC. Again, that was \$1.8 million for those workforce capital plans, and I would encourage, through you, Chair, the member opposite to ask PPHS about any of their contracted amounts with PWC.

There were also questions about the children's acetaminophen. My understanding is that \$20 million was written off as it was donated and \$49 million will be found in allowance for doubtful accounts. Questions on this should be made to AHS. Again, I want to make it clear that the expectation across government and

certainly in Hospital and Surgical Health Services and through to our agencies and service providers is that we expect that when the government or any of those entities orders products or services, they will be received and they will be received when they're ordered to the quality and quantity ordered. When that's not the case, the expectation is to go through the escalating tools to remedy the situation: work with the vendor to get the products and services ordered or to get the quality remedied and, if that's not possible, to escalate through to any mediation or arbitration provisions and ultimately, if necessary, go to court. I would expect any service provider or agency to do that, and if you have specific questions, I would encourage you to contact AHS on that one.

In that case I share the member's concern. I share the Wyant review observations and recommendations that procurement practices were not followed. We had limited due diligence performed, limited vetting of alternative providers. We had supervisors signing off without fulsome review. We had agreements put in place without legal review. This should not have occurred. Going forward, I'm certainly accountable as minister as to what my agencies and public health corporations do, and it's my expectation that they align procurement and contracting processes, which are now under the shared services organization with best practices and they go through those important steps, all steps relating to proper due diligence, conflicts of interest, vetting of alternatives, and really achieving value for taxpayer money.

We certainly prioritized public and transparent tender processes. We're doing that in EHS. We're about to roll out over the next year an RFP process for our 30 external EHS providers. We did an RFI for surgical provision, and we're going to be rolling out a three-year process for procuring surgeries, again, all in a public and transparent and equitable process. That is the expectation. In this case those expectations were not met.

The Chair: Thank you so much, Minister.

We'll move over to the government side. Please proceed with your questions, Member.

Mrs. Sawyer: Thank you, Madam Chair, and through you to the minister. Thank you. I guess I get to end with my questions. I want to thank you for the morning and everything that you've been sharing and explaining. Greatly appreciate the work you and your ministry are doing.

I'm going to ask about the expanding surgical capacity and operating room utilization. Improving surgical capacity requires both expanding service delivery and making better use of existing operating room infrastructure to maximize efficiency and patient access. On page 83 of the business plan it indicates increasing surgical capacity and reducing wait times by investing \$525 million through the acute-care action plan to deliver up to 50,000 additional surgical procedures between '25-28, achieved through expanded use of chartered surgical facilities and optimization of existing hospital operating room infrastructure. To the minister through the chair: what changes are being made to optimize hospital OR utilization alongside CSF expansion?

Mr. Jones: Thank you, Chair, and through you to the member. We're of course focused on getting more surgeries done by making the best use of our operating rooms that we already have in our hospitals while also expanding publicly funded surgical capacity through chartered surgical facilities. That means practical changes like extending operating room hours where staffing permits, improving surgical scheduling, strengthening patient preparation so cases don't get delayed or cancelled, and improving co-ordination across surgical teams so we can safely increase throughput.

Hospitals will continue to prioritize the most complex and urgent procedures while more lower complexity, high-volume surgeries are done in chartered surgical facilities. This is an integrated approach that improves efficiency across the system and helps reduce wait times for Albertans.

Importantly, we're planning incremental surgery volumes, including in CSFs, through phased growth, so we can align capacity increases with workforce planning and expand the multidisciplinary teams needed to meet local needs. That includes expanding things like the anaesthesia care team model with assistance supporting registered nurse first assistants and continuing to invest in perioperative training programs. At the same time physician workforce planning is under way to inform future demand and recruitment so we have the right teams in place to support these volumes.

I'd add that we did recently complete at the end of last year a request for expressions of interest for the provisions of surgery across Alberta. We got 25 submissions for current and new entities that want to provide surgeries in Alberta. These are all the same medical professionals that work in our public setting, who want to provide additional publicly funded surgeries to Albertans in private settings. I think this is great, that we're going to increase access and surgical volumes for patients and really get those wait times down and really improve outcomes, which is what we're here to do.

Another exciting initiative that we're working on is leveraging our unused ORs. So in the evenings and weekends when an OR is not in use, is it possible that we could open these up so that health care professionals can provide surgeries in the evenings and weekends, of course, ensuring that the OR time is properly

compensated as it is publicly funded? Again, that can be for providing additional publicly funded surgeries.

The member of the opposition did touch on viewing activity-based funding as a voucher program in a way. I would agree that it is, in a way, a voucher program. We're also looking at an actual voucher program where the concept is that if someone is waiting longer than clinically recommended, they should be notified that they are eligible for a voucher for the procedure that they require within Alberta, where any accredited and approved provider can provide that surgery for that individual and be reimbursed.

What's not well known is that we don't have one surgical wait-list. For example, the 35,000 people that are waiting longer than clinically recommended represent 177 procedures waiting for multiple different surgeons, so this voucher will show Albertans they have options, and they can choose the faster one.

The Chair: Thank you so much, Minister.

Who's speaking next? Are we finished already?

Ms Hoffman: I know, right?

The Chair: What? How did that go by so quickly? You said that right at the beginning, Member.

All right. Well, I must advise the committee that the allotted time for this portion of the consideration of the ministry's estimates has concluded. I'd like to remind committee members that we're scheduled to meet this afternoon at 3:30 to continue consideration of the estimates of the Ministry of Hospital and Surgical Health Services.

Thank you, everyone. The meeting is adjourned.

[The committee adjourned at 12 p.m.]

