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

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3:30 p.m.

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Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participant

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

3:30 p.m. Wednesday, March 18, 2026

[Ms Lovely in the chair]

Ministry of Hospital and Surgical Health Services
Consideration of Main Estimates

The Chair: All right, everyone. I'd like to call the meeting to order and welcome everyone in attendance. The committee has under consideration the estimates of the Ministry of 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 for the record. Minister, when we get to you, please kindly introduce the officials with you at the table. I'm Jackie Lovely, MLA for the Camrose constituency and chair of the committee. We will start to my right.

Mrs. Johnson: Thank you, Madam Chair. Jennifer Johnson, MLA for Lacombe-Ponoka.

Ms Pitt: Angela Pitt, MLA, Airdrie-East, subbing for MLA Brandon Lunty.

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

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

Mr. Jones: I'm Matt Jones, MLA, Calgary-South East, Minister of Hospital and Surgical Health Services. I'm joined at the table by my ADM of acute care, Dave Peace; also, Paul Lebane, chief operating officer; Will Sawchyn, senior financial officer; and Donna-Joy Tuplin, capital planning.

Mr. Eggen: Good afternoon. I'm Dave Eggen, MLA for Edmonton-North West.

Ms Hoffman: Sarah Hoffman, Edmonton-Glenora.

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

Ms Wright: Good afternoon. Peggy Wright, MLA, Edmonton-Beverly-Clareview.

Mr. Deol: Good afternoon. Jasvir Deol, MLA for Edmonton-Meadows.

The Chair: Now we'll go to the members participating remotely. Mr. Getson, would you kindly introduce yourself.

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

The Chair: Thank you, sir.

I'd like to note the following substitutions for the record. Hon. Ms. Sigurdson will be substituting as deputy chair for Ms Goehring. Ms Pitt will be substituting for Mr. Lunty. Mr. Stephan will be substituting for Mrs. Johnson from 5:30 to 6:30.

A few housekeeping items to address before we turn to the business at hand. Please note that the microphones are operated by *Hansard* staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of meetings can be accessed via the Legislative Assembly website. Members participating remotely are encouraged to turn your camera on while speaking and mute your microphone when not speaking. Remote participants who wish to be placed on the speakers list are asked to e-mail or message the committee clerk, and members in the room should signal to the chair. Members, please let's make sure we all have our devices on 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 a total of six hours. For the record I would note that the Standing Committee on Families and Communities has already completed three hours of the six hours of debate. As we enter our fourth hour of debate, I will remind everyone that the speaking rotation for these meetings is provided for under Standing Order 59.01(6), and we are now at the point in the rotation where the speaking times are limited to a maximum of five minutes for both the member and the ministry. These speaking times may be combined for a maximum of 10 minutes. Please remember to advise the chair at the beginning of your rotation if you wish to combine your time with the minister's. Members are reminded that they may not share any unused portion of their five minutes with another member.

With the concurrence of the committee I will call a five-minute break near the midpoint of the meeting; however, the three-hour clock will continue to run. Does anyone object to a break today? All right. Seeing none, we shall have a break.

When we adjourned this morning, we were three minutes and 16 seconds into an exchange between Mrs. Sawyer and the minister. I now invite Mrs. Sawyer to complete the remaining time in this rotation. You have five minutes and 44 seconds.

Mrs. Sawyer: Thank you very much, Madam Chair. Through you to the minister, I'll just get right to it, if that's okay, since we were in the middle. Might as well.

I wanted to talk to you about emergency department congestions if we could, please. We're all aware that there are challenges when visiting emergency departments when it comes to the wait times. They are long. We know this, and when patients are waiting for extended periods before being admitted to an in-patient bed, I think it's very, very good to see the ministry is making targeted investments to improve the patient flow and reduce those congestions in our hospitals, and I thank you for that.

On page 83 of the business plan, noting $152 million for reducing emergency department congestion and in-patient bottlenecks by investing $152 million in targeted system and site-specific improvements to hospital triage and patient flow, including investments at the Royal Alexandra hospital, to support faster assessment, admissions, and discharges across the acute-care system, to the minister through the chair: what specific improvements are being implemented, whether it be triaging models, staffing, new processes, or digital supports?

Mr. Jones: Thank you, Chair, and through you to the member. The $152 million investment referenced supports site-specific improvements to emergency department triage, patient flow, and discharge co-ordination so patients can be assessed, admitted, and, ultimately, discharged more efficiently. That includes enhanced triage models, expanded clinical staffing such as nurse practitioners, and improved rapid assessment processes. Hospitals are implementing new flow pathways, rapid discharge units, and better access to diagnostics and lab services supported by digital and operational improvements that strengthen bed management and speed up admissions and discharges.

Alberta is improving patient flow through a co-ordinated system-wide approach under the acute-care action plan, which is focused on increasing capacity, reducing bottlenecks, and modernizing how care is delivered. We're doing this through expanding acute-care bed capacity by planning, again, more than 1,000 new in-patient

beds in Edmonton and Calgary and converting temporary surge beds into permanent year-round capacity to reduce congestion and improve access, which we did in advance of this respiratory virus season. We're reducing alternate level of care pressures by improving discharge planning and expanding home care and continuing care capacity so patients can move more quickly to the most appropriate care setting. Again, we've reduced the alternate level of care patients across the system by about 20 per cent over the last six to eight months.

We're modernizing hospital operations through redesigned patient pathways, standardized discharge practices, and integrated command centres that support real-time decision-making and better bed management. We're improving flow into the system by expanding urgent care centres, strengthening access to primary and community care, improving triage, and helping Albertans find the right care outside of hospitals. I did touch on the eight urgent care sites that we are planning and going forward with land acquisition in addition to – I see the member from Airdrie is here – a $2 million exercise looking at an urgent and primary care facility for Airdrie. We're also strengthening the acute-care workforce by adding nurse practitioners, physician assistants, associate physicians, and specialized nursing roles to support evolving models of care and keep beds operational. We're implementing targeted hospital-level improvements such as at the Royal Alex, as referenced in the question, with successful initiatives being measured and then scaled, if successful, across the province and other busy sites.

We're also working with Assisted Living and Social Services and Mental Health and Addiction to help increase access to continuing care, assisted living supports, and mental health and addiction resources in the community so Albertans can get the most appropriate care they need, ideally, in community settings. This includes increasing the number of community care spaces, including 12 new psychiatric beds and 30 permanent community care beds, ensuring Albertans in crisis can receive timely support and also, of course, reduce ED congestion.

We're working with ALSS to increase the number of continuing care spaces across the province. ALSS is undertaking the largest build of continuing care spaces in the history of the province. Acute Care Alberta is collaborating with Assisted Living Alberta to ensure that ALC patients in acute-care spaces can access continuing care, home care, or social supports more quickly, more easily, again, easing pressure on our hospitals.

I've touched on it before, but we're also developing the health digital front door, which will be a one-stop resource for the 2 million Albertans on MyHealth records to access their medical information and services, which will improve patient navigation, reduce emergency department congestion, and potentially create digital wait rooms. Ideally, you are able from your home to put in your symptoms or issues, and it will connect with your historical medical information, look at your proximity and wait times of the appropriate facilities, and recommend them. Of course, you can go anywhere. Then you'll receive a notification of when you should go. That's the future state. Rather than making everybody go to the emergency room, waiting for hours on end, there is and there will be a better way.

With that, I'll turn it over to the members for their next sets of questions. Thank you.

Mrs. Sawyer: Thank you, Minister. I will just say in my two seconds that nothing – oh, never mind.

The Chair: Thank you.

We'll move over to the Official Opposition. Please proceed with your questions.

Ms Hoffman: Thank you very much. I'm going to touch now on lab services and the privatization to DynaLife and then reappropriation. The Auditor General's most recent report said that at least $125 million was lost in that process and

> while we received a considerable amount of information, it is important and necessary to emphasize that we did not receive all the relevant information we requested and cannot be certain we had access to all pertinent information . . . documents were either not provided or were heavily redacted.

I'm going to guess that that – and I think the minister even said that FOIP was part of 1.3, the strategic corporate support and policy development line item, which is increasing this year by 60 per cent. Obviously, working with the Auditor General isn't FOIP, but is that where folks that are involved in the redaction of documents would be housed?

I should ask – sorry – are we sharing or are we . . .

3:40

Mr. Jones: Block, please.

Ms Hoffman: Okay.

That will be my first question that I hope to have a concrete answer on. I know the minister wasn't a part of this file when that was undertaken, but I am hoping that he can point to what is happening in this budget and under his leadership to make sure that we are compliant moving forward and transparent in working with the Auditor General but also with all Albertans.

I want to thank him for giving some numbers this morning on cancer surgery wait times. I will say that 185 days for prostate cancer surgeries is – I just can't imagine being one of the people in that group. Well, I don't have a prostate, number one, but also if I loved somebody who had one or if I was someone with a prostate waiting for cancer surgery, 185 days is just nowhere near the window. Anyway, second would be an opportunity to give more detail on the wait times for cancer surgeries.

Also, my question this morning was around the number of beds in the city of Calgary for cancer treatment. I know that there are four new beds at the Arthur J.E. Child, but I know that there's a whole wing that hasn't opened yet. I'm hoping we can get some clarity on plans for that as I don't see anything in the budget related to expanding capacity at the Arthur J.E. Child. Four beds, but I think that they were taken from Peter Lougheed. Can we get clarity on that? Is there actually any net new capacity in the city of Calgary for in-patient cancer treatments? If not, what are we doing to grow the capacity that we have there? Certainly, demand is growing. As was highlighted earlier, over 18 per cent increase in demand. Yeah. That is those two areas.

Then I am going to touch a little bit on – between morning and afternoon I had a chance to look at the *Journal*, and there is a opinion piece that was published today by Stacey Litvinchuk, and I will table it in the House according to our standing orders upon the next time we convene. Stacey is the former senior program officer for surgery in Alberta Health Services, and she is really highlighting the fact that the rolled-up number that's being reported around the provincial budget doesn't feel like apples to apples. She clarifies that the percentage of what's being directed toward patient care rather than administration: we're not clear on that. What the newly created health agencies are costing taxpayers: that isn't being directly communicated. And then wanting more clarity around wait times around all of these surgeries for all Albertans. I think for somebody who used to be a director in that area, she probably has good reason to ask those questions.

I will say, and I believe this is the first time this minister has been responsible for the outcomes and objectives in the business plan, that I think Albertans would appreciate much clearer, measurable

objectives, and highlighting that a number of areas don't have any objectives measured, like the cancer care piece, in the budget documents isn't super helpful. So I'm hoping that next year this minister or any other minister can come with much clearer proof. This is definitely something that the former head of this area is calling for as well.

She goes on to say that this isn't a partisan issue; this is a mathematical question. "Health care is not an abstract line . . . It is chemotherapy delivered on time . . . a cardiac bypass performed before it comes too late . . . [or] a parent finding a family doctor." We know from primary care that the funding for PCNs isn't expected to go up, so that means that there are no new patients expected to be panelled with family doctors. This does feel like it's eroding the trust, and I would welcome the minister to give us more transparency on these items and others today.

Thank you.

The Chair: Over to the minister for his response.

Mr. Jones: Thank you, Chair and to the member for her question. The transition of lab services was not executed to the level that Albertans would expect, and it did result in service disruptions to patients, and it did cost us money. The good news is that it was transitioned back and service was quickly restored. What's most important is that patients are now, of course, getting the lab services that they require. We've co-operated with all reviews and investigations into that transaction, and we'll continue to do so.

Alberta Precision Labs will of course be transitioning from Alberta Health Services to Primary Care Alberta effective April 1, 2026. The transition aligns lab services with where most patient interactions occur, community and primary care about two-thirds, while preserving APL's critical role in supporting acute and hospital-based services. Acute-care needs will continue to be met through service agreements and system level co-ordination without fragmenting lab delivery or duplicating governance. There'll be no change to hospital-based lab services. APL continues to work on staffing and recruitment to maintain their services and manages increasing workload pressures in their integrated provincial lab service model, and acute-care hospitals continue to provide 24/7 access to diagnostic lab testing to support emergency care, in-patient treatment, surgery, and critical care services. The governance refinements will strengthen oversight and accountability while maintaining uninterrupted access. Hospital labs access will be uninterrupted through this AHS transition to Primary Care.

We're also looking at expanding hours and flexible scheduling. This will of course support patient access but also hospital flow. Hospital outpatient labs remain open to support patients receiving care in hospital-based clinics in rural communities. Same-day appointments and walk-in options, including the save-my-place feature, continue to improve access for patients.

The APL organizational structure is set up as a functional provincial portfolio, including a dedicated hospital lab services team. The team is led provincially with its own staff and services that align with clinical corridor hospital services. These teams are dedicated to managing the unique needs and challenges in the acute setting, whether that's large urban or a regional setting or a rural, remote setting.

There was a question around cancer beds. We have 106 of the 160 beds open, and 10 new beds opened in the fall of 2025. We're, of course, happy to share when additional beds open. It's good news, and it's a priority for us to expand access.

In terms of diagnostic and therapeutic services the 2025-26 budget was $2.195 billion. The '26-27 estimate is $2.456 billion, which is an increase of $261 million, or 11.9 per cent. This is largely the result of collective bargaining, and then it's off-set by a $78 million APL transfer, which is starting in the '26-27 fiscal year. There's also a $10.4 million increase in inventory consumption due to inflation of supplies and increased volumes, but the increase is largely driven by collective bargaining. Happy to share that.

We're making some changes to procurement, as I highlighted in previous answers, but I'd like to share some other things that we're doing. First, Hospital and Surgical Health Services conducted a thorough review of acute-care procurement processes to identify gaps and strengthen transparency, accountability, and efficiency. As I mentioned, we hired an independent expert third party to review procurement across the organization. We're expecting their work will conclude this year, and then we'll be able to evaluate their recommendations and implement them.

Alberta Health Services has transitioned to a provincial health corporation, and that's going to strengthen oversight and clarify roles. We've centralized procurement responsibility to the Health Shared Services organization. Hospital lab services will be provided to HS through formal service agreements, again ensuring clear expectations and accountability. And the health system is of course acting on all recommendations as made by Chief Justice Wyant and as outlined by the Auditor General. We'll continue to collaborate to ensure that transitions are effective and there's responsible management of public funds and continuous improvement in procurement. This particular transaction was not handled well. It has been remedied, and that's good news for patients.

The Chair: Thank you so much, Minister.

Over to the government side. Please proceed, Member.

Mrs. Johnson: Thank you, Madam Chair, and through you to the minister.

The Chair: Shared or . . .

Mrs. Johnson: Shared time if the minister is willing.

Mr. Jones: Yes.

Mrs. Johnson: Thank you.

The first question – and there will be two of them – is about expanding urgent care and pediatric access. Many families in our province have shared how important it is to have timely access to urgent care and specialized pediatric services without always needing to rely on busy emergency departments, so I was encouraged to see the ministry making targeted investments to improve access to care closer to home for Albertans.

3:50

On page 83 of the business plan it notes that enhancing access to urgent, specialized, and pediatric care is by investing $76 million to establish eight new urgent care centres and construct a new stand-alone Stollery children's hospital in Edmonton . . .

Ms Pitt: Woo-hoo.

Mrs. Johnson: Yes.

. . . improving access to care closer to home and reducing pressure on emergency departments. So the two questions are: first, how were priority locations determined for these eight urgent care centres? I believe we've talked about them previously today. How are those locations determined? Second, how will these investments improve pediatric access and reduce emergency department pressures in the surrounding sites?

Mr. Jones: Thank you, Chair, and through you to the member. The priority locations for the eight urgent care centres were identified using data-driven analysis of emergency department use and population demand across local geographic areas. We focused on communities where high volumes of nonlife-threatening visits show a clear need of an alternative care setting, including high-growth communities and areas where expanded hours and services can reduce pressure on nearby hospitals. Establishing urgent care centres in those areas helps people get timely care for less critical conditions while reducing pressure on nearby hospital emergency departments.

The eight planned urgent care centres would be in west Edmonton; south Edmonton; WestView, so Stony Plain and Spruce Grove; east Calgary; Lethbridge; Cypress county, Medicine Hat; Cold Lake; and Fort McMurray. They are intended to improve access to appropriate care closer to home and support emergency departments in focusing on the most critical care.

The new stand-alone Stollery children's hospital will expand our capacity to deliver highly specialized pediatric care and support growing demand for children's health services. Budget 2026 includes $37 million to advance land acquisition and planning for the stand-alone Stollery. This funding supports the early planning work required to ensure Alberta can meet pediatric demand not just today but decades into the future.

Pediatric tertiary care requires specialized infrastructure, purpose-built clinical space, and highly integrated services that differ significantly from adult acute care, including complex pediatric cardiac care and things like neonatal intensive care and pediatric intensive care, also transplant services and specialized surgical and medical programs that cannot be delivered in community hospitals. Dedicated pediatric infrastructure improves access to specialized treatment, clinical research, and family-centred care environments and strengthens Alberta's provincial self-sufficiency by reducing the need for potential out-of-province transfers for complex cases. By strengthening pediatric services at a specialized facility, the system can better manage complex pediatric cases while reducing pressure on emergency departments and general hospitals.

We're also ensuring pediatric care is integrated with adult tertiary services, academic medicine, and specialized workforce planning. When the purpose-built pediatric facility is operational, the existing acute-care beds within the University of Alberta hospital will be available to convert to adult acute-care beds, improving capacity and patient flow. As the U of A site is under quite a bit of pressure, that will be some greatly appreciated space.

With that, I'll turn it back to the member, Chair.

Mrs. Johnson: Thank you, Madam Chair, through you to the minister. So exciting to hear about the Stollery coming, and I'm looking forward to a lot more details coming up in the next few years about that. Thank you, Minister.

We'll move on to health research and education investments. I do often hear from health professionals and even students in my constituency about the importance of continued investment in training, education, and research to ensure Alberta has the skilled workforce needed to support a strong health care system, including a Stollery children's hospital. I was therefore pleased to see the budget reflects a commitment to long-term planning in this area. On page 126 of the estimates there is a line item for research and education totalling about $89 million. This shows long-term planning is being taken seriously by this government.

Through you, Chair, I have three questions for the minister. Could he please tell us what investments are included in the line item? Second, will these education funds go to residency seats or other health human resource training? Finally, what does this mean for building a stronger health system in Alberta?

Mr. Jones: Thank you, Chair, and through you to the member. The research and education line supports two core areas: formally organized research carried out in acute-care settings and formal education programs for undergraduate and postgraduate technical, professional, and medical students and trainees. In '26-27 this line item totals roughly $89 million, reflecting the scale of support required to sustain both research activity in acute-care settings and formal education and training environments needed to develop the health workforce of tomorrow.

On the research side this includes expenses for formally organized research approved by a Health Information Act, or HIA, designated research ethics board, including clinical trials of drugs and devices. It also includes the services and supports required to conduct that research in acute-care settings such as access to health data, innovation supports, and technology assessment and evaluation. Much of this work is supported through a mix of sources, including industry and pharmaceutical companies, government of Alberta funding, the northern Alberta clinical trials centre, and other external entities and foundations.

On the education side these expenses support formal training programs for a range of learners and include administration of the academic medicine health services program as well as formal training and education for clinical and technical professions. This is distinct from routine orientation and in-service education for staff and library costs, which are accounted for under other support services. These education funds support, again, much-needed training. In addition, we also have the resident physician services grant to Acute Care Alberta at $182.6 million for '26-27, which supports resident physician services and training as part of building and sustaining the future workforce that we're going to need.

Mrs. Johnson: Again thank you, Madam Chair, through you to the minister.

Probably my final question here today has to do with organ donation and transplants. I want to acknowledge the important work the ministry is doing to strengthen organ donation and transplantation services across Alberta. For many families organ donation represents a life-saving opportunity, and improving co-ordination across the system can make a meaningful difference for patients waiting for transplants. Page 86 of the business plan notes:

> [Strengthening] organ donation and transplantation outcomes province-wide by investing $25 million over five years to complete the stand-up of GLA, establishing the corporation as a centre of excellence for coordinating organ donation and transplantation services and increasing donation rates and capacity.

My two questions for the minister. First, what are the priority outcomes for Give Life Alberta's stand-up in the next one to two years? Then, how will the stand-up of GLA ensure Albertans have better access to organ and tissue donation and transplantation?

Mr. Jones: Thank you, Chair, and through you to the member. Over the next one to two years Give Life Alberta's stand-up is focused on strengthening organ and tissue donation and transplantation outcomes across the province by improving co-ordination, building consistency in practice, and increasing overall donation rates and capacity. Budget 2026 supports this work by investing $25 million over five years to complete the stand-up of Give Life Alberta.

A key priority is to establish GLA as a centre of excellence for co-ordinating all donation and transplantation services. That includes strengthening public and professional education, increasing

awareness of organ and tissue donation, and supporting a strong donation culture so more Albertans are informed and more opportunities for donation can be realized. The organization will also focus on high-quality donation-related patient and family care, responsible stewardship of the gifts of organs and tissues, and consistent high-quality transplant care. As the organization's mandate is finalized, the objective remains to optimize donation processes and overall system performance so Albertans have improved access to life-saving transplants.

I'm pleased to share that the metrics are improving. We're also looking at making it easier to identify that you'd like more information to become an organ and tissue donor through our tax filing system. We don't have enough time in this segment, but I may also get the managing director of Give Life Alberta to share some of their current work and, really, successes that were reported in their recent annual reports.

Thank you.

Mrs. Johnson: It would be good to hear that. Thank you through you, Madam Chair, to the minister and his team.

4:00

The Chair: All right. That concludes the government section.

We'll move now over to the Official Opposition. Please proceed, Member.

Ms Sigurdson: Thank you, Madam Chair. It's my pleasure to ask some questions of the minister and his public servants. I'm going to focus on home care, and I'm looking at pages 125 and 126 of estimates, where it's outlined the line items there. We know a significant issue in the acute-care system is that emergency departments and acute-care facilities in general have Albertans occupying beds that are at a different level of service than they need. Of course, these are referred to as alternative level of care status, and the minister himself referred to them in his opening remarks. When someone occupies a bed but does not require the intensity of care offered in the care setting, this can be problematic for the system. I want to ask the minister – I guess maybe I'll just clarify. Can we go back and forth, or is it block time?

Mr. Jones: Block time, please.

Ms Sigurdson: All right. Block time.

What budget amount has been set aside specifically for home care and supportive living that will help reduce the number of people in alternative level of care status in our acute-care hospitals?

I also just want to move on now to some issues in our home-care system. We have some fundamental flaws that make it very challenging for families. One key issue is the lack of qualified available staff. Staff are paid low wages and thus often do not have training or education, sometimes the proper skills. A stable and reliable staff are important as those needing support are vulnerable. Certainly, we know a lot of seniors, people living with disabilities are the folks receiving home care. What's the government doing to improve this situation?

Another issue is the allocation of hours for home care. I've, you know, heard extensively from Albertans regarding this, many, many stories of not receiving adequate home care to properly maintain vulnerable citizens in their homes. This situation puts the citizens at risk, which may lead to hospitalization, which, of course, is not good for anyone. It costs a lot more, and people want to be in their homes and do well, and sometimes eventually moving to continuing care if their needs aren't being properly cared for in their home setting. How is the minister addressing this issue to ensure that clients are provided with the right amount of care at home?

Another concern is in the self-managed care system, clients that require more than 40 hours of care. You know, these are people who need extensive care, and they could have profound challenges. People can still be maintained at home, but they must be assessed, and at times they need more than 40 hours of care. They have to ask for an exception, and getting these exceptions is extraordinarily difficult. Many times people are turned down and they appeal, and it's a very challenging situation. People who are already vulnerable can be put in very dangerous situations. Their families can be overburdened if they have family caring for them. How's the minister streamlining this process so those who require this level of care are able to access it?

There are also issues in the self-managed care system impacting families' experience due to the administrative burden from human resource responsibilities that many families may not know how to manage or do not want to manage. Some families may contract with agencies; however, agencies often require families to pay up front before government funding is received, sums that many cannot manage, thousands of dollars, Madam Chair. Thus, home care becomes a service, even if it's the right one, which is unaffordable for the family. In addition, barriers of intersectionality, language, culture, sexual orientation make it difficult to find home-care workers who have the knowledge and sensitivity to serve the clients. What's the minister doing to address these issues so Albertans may live in their community, which, of course, is where we all want them to live? We know that the government has said repeatedly that they want to support that.

Addressing these key issues in the home-care system I think will go a long way to supporting Albertans to be able to age in their communities and, you know, live more fulfilled lives, because people want to be in their own communities.

I'll leave that to the minister to answer those questions.

The Chair: Thank you so much, Member.

Over to the minister.

Mr. Jones: Thank you, Madam Chair and through you to the member for the question. The items in our budget under home care would be comprised of home nursing and support related to integrated sites that did not transition to ALA, pediatric personal care, and complex children's services at home. In Budget '25-26 that was $3.3 million, roughly. In Budget '26 we're projecting $7.6 million, or an increase of $4.3 million, 130 per cent, and this is largely driven by collective bargaining agreements.

Again, the majority of this activity is in ALA, but we are improving access to growing the supply and investing in more service providers and a wider variety of services. That includes targeted investment in wraparounds and specialty services to prevent the need to move into facility-based care. The goal is to make home care more available and so comprehensive that it can serve as an alternative to facility-based care. Increasing home-care funding was part of the three-year continuing care transformation funding, and providers that we provide grants to are expected to identify a sustainability plan by the end of their funding agreement.

ALSS gives a base budget to ALA. This money is then allocated by zone and spent on service providers. As an example of this in practice, a person would call a central number or they would be referred by a friend or family member, someone from ALA would have a short chat with them to assess how urgently they require care, and then someone would come to their location and perform an assessment. Service delivery will be authorized based on unmet needs and funded entirely by government based on their assessment of need. In certain parts of the province ALA does deliver this service directly. In others they have authorized vendors, like

Bayshore or CBI, who would employ health care aides and other staff and own their own equipment. A case co-ordinator oversees this process. A few days after service delivery begins, they do a check-in to ensure visits are happening. Reassessment of the client's condition and services required occur at regular intervals.

Things like nonmedical supports – shovelling sidewalks or home repairs or cooking – are not typically included. They're typically organized by municipalities although Healthy Aging Alberta does some of this work. The vision for ALA is to centralize nonmedical and medical supports into one place to ensure better co-ordination and integration across the system. Alberta has been a front runner nationally in ease of access, having a single number to call as a door into the system. Of course, there are areas for improvement, including better case co-ordination, assessments, and looking at the person holistically and centralizing the provision of services. That's why we're increasing investment also on the nonmedical side. That's some information. I would encourage you to contact ALA if you'd like to learn more about that.

Then, also, because there's been a lot of questions about cancer care, I just wanted to highlight a couple of initiatives that I didn't highlight in my previous answer, including one that we're very excited about, which is proton beam therapy. We are currently developing an RFP to bring our proton beam therapy to Alberta. We did do an expression of interest process, where we had a number of different prospective providers wanting to bring the service to Alberta in a number of different ways. So there will be a formal RFP in the coming months. For context, we're currently sending people who require proton beam therapy to Florida at great cost and great burden to families. We can absolutely become the first province to provide that in Canada and at a cheaper cost on a per-case basis and way cheaper and more convenient for family that accompanies the patients to the United States.

We already touched on the Arthur J.E. Child. We haven't talked too much about the $800 million a year Siemens Healthineers partnership with the Alberta Cancer Foundation, but basically we're going to be substantially replacing and updating our oncology treatment equipment over the next eight years. We're going to be leveraging artificial intelligence and creating two new centres of excellence in cancer care, which is going to help us with workforce development, attraction and retention.

I touched on the Acute Care plan and the 50,000 incremental surgeries. This will, of course, also impact our ability to do cancer surgeries. So that's good news there. We did touch on the renovations at the Cross Cancer Institute and the Calgary radiopharmaceutical centre at Foothills medical centre. And then we're also making a lot of investment in our diagnostic imaging equipment through the $280 million, three-year investment to update and expand CT, MRI and PET. Again, more access and leveraging AI to do things faster and better. It's good news for patients.

Thank you.

4:10

The Chair: Thank you so much.

Over to the government side.

Mrs. Sawyer: Thank you, Madam Chair.

Minister, to be formal, would you like shared or blocked, please?

Mr. Jones: Shared, please.

Mrs. Sawyer: Thank you, Madam Chair.

Going into some numbers for a minute: consolidated adjustments. When we are going over the estimates, not everybody understands the numbers, knows how to read the numbers, so I think this is a great opportunity for us to allow you to explain how everything is being presented and how we arrived at the consolidated budget figure so that the transparency in the adjustments helps ensure the overall financial picture of the ministry is understood by everybody who has chosen to tune in today.

Page 125 of the estimate lists includes a reconciliation from voted supply to the consolidated estimate with consolidation adjustments. So the two questions I would have, through the chair to the minister: can you explain the largest consolidation adjustments and what they represent operationally? As a follow-up, how do these adjustments affect transparency for Albertans trying to understand spending changes?

Mr. Jones: Thank you, Chair and to the member opposite. The consolidation adjustments in the estimates are accounting adjustments that align voted supply amounts and entity amounts not voted on to how expenditures are reported on a consolidated basis for financial reporting purposes. In '26-27 this includes a total of $9.9 billion in adjustments to voted supply and entity amounts not voted on to represent program spending on a consolidated basis. These adjustments provide a reasonable reflection of the portion of entity expenditures that are funded by the Ministry of Hospital and Surgical Health Services. The difference between entities' amounts not voted and the consolidated adjustments generally reflects the portion of expenditures that are funded by another ministry or supported through own-source revenue such as donation or investment income.

Acute care is comprised predominantly of patient care units such as medical, surgical, intensive care, obstetrics, pediatrics, emergency, day and night care, clinics, day surgery, and contracted surgical services. This segment also includes operating recovery rooms.

Mrs. Sawyer: Thank you very much to the minister through the chair.

Obviously, I'm a rural MLA so this next question is going to gear a little bit to that on rural health infrastructure, something that obviously is incredibly important to my constituents. What I know and what I hear from them all is how important sharing investments in rural hospitals and the urgent care centres and the primary care infrastructure is in order to allow them to be able to receive care without travelling long distances because we do have such long distances often depending on where they're at. Page 122 of the estimates states that "Rural Community Initiatives [provide] support to the development of Primary Care Centres program, rural urgent care centres, rural hospital enhancement program and rural health facilities capital program."

I will say that with Airdrie being right next to where I am – it's only 30 minutes – that's where I go for a lot of my things. So I'm as excited . . .

Ms Pitt: Super.

Mrs. Sawyer: Super-duper excited.

Ms Pitt: Super-duper excited.

Mrs. Sawyer: . . . as my fellow MLA.

Ms Pitt: Very exciting.

Mrs. Sawyer: You're distracting me.

To the minister through the chair: what rural capital projects are prioritized in '26-27 under the initiatives, and how will these investments reduce patient travel and improve local access?

Mr. Jones: Thank you, Chair and through you to the member. Budget 2026 prioritizes rural health infrastructure through programs like our rural hospital enhancement program and rural health facilities capital investments, supporting upgrades, modernization, and targeted expansions so rural Albertans can access essential services closer to home. These investments are focused on strengthening local diagnostic, urgent care, and in-patient capacity, which reduces the need for patients to travel long distances to larger centres for services that can be safely delivered closer to home where they live.

By upgrading facilities and expanding local service capabilities, we can improve timely care and access, support rural workforce stability, and strengthen outcomes for rural Albertans while also reducing pressure on our major larger regional and urban centres that receive these transfers. I would also add that it would reduce interfacility transfers, which is a priority on the EMS side. These investments strengthen local diagnostic, urgent care, and in-patient capacity, and projects included would be things like emergency department renovations in Wetaskiwin, Barrhead, Bonnyville, and St. Paul; medical device reprocessing upgrades in Brooks, High River, and Peace River, which enable us to do more surgeries; new EMS stations in Slave Lake, Valleyview, and Redwater, and these projects improve local access to emergency, diagnostic, and surgical services closer to home.

The member, through you, Chair, highlighted going to Airdrie for medical care. In fact, the vast majority of residents of Airdrie have to go outside of Airdrie for acute care about 80 per cent of the time, and this includes 5,000 births per year. We're excited to expedite planning for a facility to serve the needs of that rapidly growing population, one of the fastest growing in the country and soon to be our third-largest population centre. Excited to work on that, and thank the members through you, Chair, for their advocacy for getting those facilities built.

I'll turn it back to the member for the next question.

Mrs. Sawyer: Thank you very much, through the chair. Yeah. We got a little sidetracked chatting because we genuinely are very excited with what's going to happen there. Yeah.

You touched on it briefly this morning, so I want to actually give an opportunity to allow you to expand a little bit about the additional in-patient beds at the Grey Nuns and Misericordia hospitals. It was on page 112 of the capital plan, and it references $7 million to add in-patient beds to the Grey Nuns and Misericordia hospital. Bed availability has been top of mind for Albertans, and they want to know what is being done to advance relief on system pressures. Through the chair to the minister, can you tell us how many beds are being added to the two sites and how this will make an impact on system capacity and patient flow improvements? How will this investment position our health care system to meet future demands?

Mr. Jones: Thank you, Chair, and for the question. As referenced, page 112 of the capital plan references that planning is under way to advance new in-patient bed towers at the Grey Nuns hospital and the Misericordia community hospital. Together, these two projects would add up to 700 new acute-care beds in the Edmonton area, doubling capacity at each site with up to 350 beds net new. This represents a significant expansion of Edmonton's acute-care capacity and will have a positive impact on the overall health system because, of course, the Edmonton area serves a much larger area of northern Alberta and even provides care to neighbouring provinces.

Increasing in-patient bed availability allows hospitals to better manage demand, particularly during periods of high pressure, and supports more timely admissions from emergency departments into appropriate in-patient care settings. By expanding acute-care capacity at these two major community hospitals, the system will be better able to move patients through emergency departments and into in-patient units. That increases patient flow, reduces congestion in our EDs, and helps ensure beds are available for patients who truly require hospital-level care. Investing in additional in-patient capacity at the Grey Nuns and Misericordia is an important step in addressing the rising demand.

Of course, we have a rapidly growing population. They're getting older, presenting more complex. We've touched on that before. The build of acute-care capacity has not kept pace, so the acute-care beds per capita in Calgary and Edmonton has declined substantially over the last 10 to 15 years. We are seeking to catch up and then, through the 50-year capital plan and 30-year workforce plan, to make sure we're never in the circumstance again where we have to play catch up on something as critical as acute-care capacity.

I would also highlight that there are other initiatives that are relevant to these sites and other major hospitals in the Edmonton area. We have a redevelopment exercise that we're doing at the Royal Alex to see what we can do there. It's a very old facility under a lot of pressure, and we have $63 million earmarked for the development of shelled and vacated space.

One other initiative which I'm very interested in is a review of the top 16 sites, including all the majors in Edmonton, as to what could be decanted or moved and provided outside of the hospital – think of outpatient, ambulatory – so we can backfill it with that desperately needed acute-care capacity. This is the most expensive real estate. It should be adult acute care first and foremost, of course, with the Stollery being developed to handle pediatrics. That's the vision. I think over the next 10 years you will see a substantial build of acute-care capacity across Alberta, particularly in the Edmonton area and Calgary area as that's where the biggest pressures are today, with them serving not just their catchment areas but, of course, the north and south of Calgary and other provinces.

Thank you.

4:20

The Chair: All right. We'll move over to the Official Opposition. Please proceed.

Ms Wright: Thank you, Chair and through you to the minister. My comments are going to concern primarily workforce and workforce planning. We're going to begin with the business plan, page 83, specifically having to do with key objective 1.2, which is all about access to surgery by expanding the clinical workforce, and as well key initiative 1.5, which is about growing the health care workforce, including enhancing recruitment and retention and ensuring that that workforce is available when and where it is required along with developing that 30-year long-term workforce plan that the minister was recently talking about.

I note that one initiative to support all the key objectives is to expand that acute-care capacity in major urban centres – and we've talked about it just recently – by adding those 700 additional acute-care beds. However, we also know that we're in the midst of a present nursing shortage and that in fact – and I don't know if this prediction still holds true – we were indeed predicted to be 9,300 nurses short by the year 2030. In addition to that, Chair, a recent survey noted that over 40 per cent of new Alberta nurses generally are starting to leave the profession before they turn 35. I'm worried, first of all, about a disconnect between workforce planning and this sort of fact that there's a bit of a disconnect between the number of nurses newly graduated from Alberta's postsecondary institutions and the numbers that are actually hired into full-time positions. We

certainly do know that there are times during surgical procedures when nursing staff is at a premium, but it's not necessarily always because of the lack of nursing staff. It is sometimes because of the lack of allied health care staff as well. So I'm wondering: what are the steps the government is undertaking right now, understanding that there's work on that 30-year plan, to ensure the retention of the current nursing staff that we have, most particularly in terms of those nurses who are not only relatively new to the profession but also those whose practice is surgical in nature?

Is the government consulting with other jurisdictions in addition to working with the Canadian Federation of Nurses Unions alongside the United Nurses of Alberta? Much research has already gone into what is, of course, a pan-Canadian issue. Given the current overcapacity is the government considering looking and working with nurses to establish minimum nurse-to-patient care ratios, much like B.C. is working on at the moment and much like Nova Scotia has agreed to as well?

I'm wondering, too, in terms of that workforce strategy and in terms of hiring that's going on right now: is there a focus on hiring permanent full-time staff rather than temporary full-time staff, particularly for those who are interested in growing their careers here in Alberta? Is there an interest in providing guidance to those provincial health corporations that they continue to move away from hiring temporary or casual nursing staff, those agency nurses?

I'm wondering, too, if that estimated number of that over 9,000 nurses short by 2030 still applies. If it does or even if it doesn't, what data is informing that research?

Then moving on to the allied health care workforce, we certainly do know that shortages of people like occupational therapists, physiotherapists, cardiovascular perfusionists: it is quite acute, and these shortages do have a profound impact upon patient care. I'm wondering what the government is doing currently to alleviate the pressures right now for staff, particularly in those roles that are critical to successful surgeries and therefore patient outcomes. I'm wondering what work has been done crossjurisdictionally, again, because we do know it's a cross-country issue.

I am also wondering specifically in terms of EMS staff, which of course includes paramedics – we've got a group of folks who are sometimes, it seems, working over 30,000 extra hours of overtime each month, which accounts for about 12 per cent of all hours worked by paramedics throughout the province. Call volumes have increased, particularly when compared to just three years ago, and unfortunately that call volume is absorbed at the expense of paramedics both in terms of their physical and psychological health. I'm concerned, of course, that the current mandatory offloading policy simply won't be enough to account for all of that. So I'm wondering – because there was a report that came out in 2025 which talked about although there was funding to fully staff ambulances, it didn't actually happen during that time.

There was also a report that had some 98 recommendations, and it was given to the emergency services provincial advisory committee, and I'm wondering how many of those recommendations are outstanding. How will acting upon those recommendations inform overall workforce planning?

Finally, very, very quickly, there is an issue with the targets for the ambulance response times. I note that the targets between this year and '28-29 remain the same. This is on page 85. I'm wondering why they remain the same if the idea is to improve care and response times.

Thank you.

The Chair: Thank you so much.

Over to the minister.

Mr. Jones: Thank you, Chair and through you to the member for the important question. Alberta is undertaking a range of initiatives to make sure that our province has the workforce needed to support our hospital system and surgical program today and into the future. We're continuing to work with Acute Care Alberta on the health workforce strategy, which is a framework to retain and support our existing workers while also expanding education and training pathways to strengthen our ability to attract and retain new workers.

We're also expanding scope of practice for many of our medical professionals; for example, trying to leverage nurse practitioners, enhancing the scope of pharmacists, and trying to greater leverage things like nurse-initiated protocols. Under the workforce resilience pillar of Alberta's acute-care plan the province is developing a 30-year provincial acute-care workforce plan, a data-driven road map for informing future investments, policy, and system workforce planning. This plan will also include short-term recommendations for investments and tactics that will address the most significant gaps and priorities in provider training, recruitment, and retention.

I think this is a key point to talk about because we don't have that today. I don't have a 10- or 20-year plan for how to address shortages of key health care professionals or a plan that speaks to how we're going to address where health care professionals want to live and work, so we need to find a way, and we're doing this through bursaries and trying to train people in the communities we need them to work in the future. Now we're starting to think longer term proactively, and we're trying to use bursaries with return of service to ensure that we have the rural and remote coverage.

As the members in this room will know, through you, Chair, we've also expanded access to medical school training in rural settings. There are 100 more seats available in northern and southern Alberta. The idea, again, is the same. If we train people from an area, they're more likely to live and work there, and we're trying to reduce barriers to internationally trained health care professionals, which of course we're doing in conjunction with all the other provinces.

This 30-year acute-care workforce plan will be a data-driven workforce forecast of long-term supply and demand across all clinical professions in acute care. It will include scenario analysis. You want to look at high and low forecasts. We've seen incredible population growth over the last few years. It's important that our plans can accommodate different population growth scenarios, different ways people age, or we're seeing a lot of people move to the major urban centres, so that has to be factored in as well. Then we're going to result in a strategic action plan that will set out recommendations for system-wide actions and investments. Investments could be, for example, establishing new postsecondary institutions or expanding programming. It could be greater leveraging of bursaries. It could be a number of different initiatives, but that's what this work is going to inform.

I should also highlight that we've obviously had collective bargaining agreements ratified. AHS is now offering significantly increased compensation, including recruitment bonuses for things like cardiovascular perfusionists. These higher rates and these new incentives we expect to help close some of those recruitment gaps and help with retention. Acute Care Alberta is leading efforts to train more combined lab and X-ray technologists, CLXTs, and diagnostic sonographers through working to secure additional educational seats at NAIT and SAIT. That's another part of the long-term workforce plan. We want to be integrated with our postsecondaries so that they are training what we need for when we need it. Again, I highlighted that there was a similar exercise that went on over the last 10 years as it relates to skilled trades, and that resulted in, again, a blueprint or a road map that could inform government policy but also government investments, and then it

was paired with educational and awareness campaigns. It did successfully move the needle on shortages in skilled trades over the next decades.

4:30

We're also exploring establishing long-term arrangements with out-of-province training facilities like the B.C. Institute of Technology to fund and secure educational seats for EEG students from Alberta to grow our technician workforce, and we've partnered with the Alberta Society of Radiologists and the Canadian MRT association to increase respiratory therapist enrolment.

While workforce supply challenges continue across health systems, Alberta is seeing clear signs that the recruitment is working.

The Chair: All right. We've had another member join us. Member Stephan, we'll just give a minute for your microphone to work here, and if you would kindly introduce yourself for the record, that'd be great.

Mr. Stephan: Delighted to be here, Madam Chair. Jason Stephan, Red Deer-South.

The Chair: All right. Where are we with the timing? That was the minister. We're going back to the government side. Ms Pitt, please proceed.

Ms Pitt: Thank you, Madam Chair. Good afternoon, Minister and team. I'm so pleased that much of this afternoon has been talking about Airdrie's future health care. I think that's an important conversation in the fastest growing city in Canada. It's been a journey for our residents, so I appreciate you taking our health care needs so seriously and look forward to future fun. Let's call it that.

I have some questions to ask about health infrastructure investments, that often include a wide range of capital streams, from equipment replacements to specialized upgrades that support front-line care, particularly important because urgent care facilities like ones in Airdrie don't operate as well when things like X-ray machines or other diagnostic machines or equipment are down. Ensuring that these investments are co-ordinated effectively for existing and new facilities help maintain reliable services and ensure that health facilities have the tools and infrastructure needed to deliver high-quality care.

On page 122 of the estimates list under 3.1 it describes infrastructure support programs, including multiple capital streams. How does the ministry ensure co-ordination across equipment replacement, imaging enhancement, pharmacy compounding upgrades, and EMS vehicle capital? And can you talk about some sort of projects in this line item?

Mr. Jones: Thank you, Chair, and through you to the member. Co-ordination across our infrastructure support capital streams is achieved through integrated capital planning led by the Ministry of Hospital and Surgical Health Services, working closely with our partner ministries, provincial health agencies, and, of course, Alberta Infrastructure. This approach ensures that investments across different programs such as medical equipment replacement, diagnostic imaging enhancement, or pharmacy sterile compounding upgrades and EMS vehicles are planned and sequenced together rather than in isolation.

Investments are prioritized using system-wide planning, life cycle asset management, and clinical demand analysis. This means decisions are grounded in evidence about equipment condition, clinical risk, patient volumes, and where investments will have the greatest impact on capacity, reliability, and patient care.

An example of this in practice is: we look at the data and we see that we put 72,000 kilometres on our ambulances a day, which means that we need to replace an ambulance almost every four days in Alberta. Of course, we would want to plan our capital process based on things like that.

By co-ordinating capital streams through a single planning framework, the ministry ensures that equipment, infrastructure, and fleet investments are aligned with service delivery priorities and patient needs across the province. This reduces duplication, addresses the most urgent operational pressures first, and helps ensure capital investment works together to support safe, efficient, and high-quality care for Albertans.

The infrastructure support line funds targeted capital projects that are focused on maintaining and modernizing our health delivery, and these investments do support a wide range of projects that the member through you, Chair, referenced in the question, things like medical equipment replacement, diagnostic imaging upgrades, pharmacy, EMS vehicles. Those would be examples of those.

I think it's another important point that if we have a successful 50-year capital plan, it's going to help us on the facility side. It's also going to help us know what equipment we need. It's going to help us know what vehicles we need. That work will all tie into this. For example, our EMS capital investment is $20 million for ambulance vehicle replacement, which helps maintain a reliable emergency response fleet across the province.

We work with AHS, Acute Care Alberta, and Primary and Preventative Health Services to ensure our capital requests don't just reflect our needs but operational realities, site infrastructure constraints, and workforce availability. This includes aligning equipment purchases with staffing realities, artificial intelligence integration – that's a big thing; we're putting it in our CT scanners – and teleradiology so investments deliver real system-wide benefits for patients and providers. PPHS is managing the lab services enhancement program, which aims to modernize lab services and infrastructure through phased facility upgrades, the expansion of patient service centres, replacement of end-of-life equipment, and the adoption of automated and digital solutions. These investments will ensure reliable, timely diagnostic services for Albertans while improving access, reducing wait times, and supporting equitable testing in rural, urban, and remote communities; and enhance efficiency and ease pressure on our lab workforce.

Ms Pitt: Thank you, Minister through you Madam Chair. I should say thank you, actually, for your swift move when we found out the X-ray machine at our current Airdrie urgent care facility was down. There was a mobile one on-site. We appreciate you taking this seriously. I know we're sort of in a, I feel like, limp along stage in our current urgent care situation. Anyway, those are one of those things that just happen. Equipment gets old and needs to be replaced. Anyway, thank you for that.

Another question for you. Page 82 of your business plan notes that the

> Ministry of Hospital and Surgical Health Services remains committed to regulatory approaches and program delivery that reduce unnecessary government oversight and emphasizes outcomes, in order to improve access to government services, attract investment, support innovation and competitiveness, and grow Alberta businesses.

In conversation with health providers in my constituency I often hear about the importance of ensuring that administrative requirements do not create unnecessary barriers to delivering care. Doctors want a doctor, nurses want a nurse, and not fill out paperwork and other endless, often unnecessary, tasks that go along with it. In addition to providing strong oversight to protect patient

safety, what specific regulatory or administrative burdens are being reduced in 2026-2027, and where is your red tape reduction in your ministry?

Mr. Jones: Thank you, Chair and through you to the member for the question. Our government has had a focus on red tape reduction, reducing it by roughly one-third across government. I think the estimated savings on that are over $2 billion. But beyond that it enables things to move faster in Alberta. We often talk about business, but the same is true of health care. Reducing unnecessary regulatory and administrative burdens is removing duplication and delay so providers and administrators can focus time and resources on delivering care while maintaining appropriate oversight for quality and patient safety. As this work advances, the ministry will continue to emphasize outcomes and accountability and will ensure that changes to processes are implemented in a way that supports consistent standards, transparent performance expectations, and, of course, safe clinical operations across the system. In other words, burden reduction will be pursued in a measured way that protects patients, supports the workforce, and ensures the health system remains accountable for results.

The burden reduction will not come at the expense of quality oversight or patient safety. The intent is to simplify and streamline administrative requirements where they are duplicative or do not add value, while maintaining the standards monitoring and accountability mechanisms that protect patients. As changes are implemented, the ministry will continue to work with Acute Care Alberta and system partners to ensure expectations are clear and performance is monitored and that any issues that affect quality or safety are identified and addressed through appropriate governance and operational controls.

How I view red tape. I'll give you an example, through you chair to the member. When I came into this ministry, we had a number of foundations that were doing fantastic work to address some of the needs of their communities. They had raised money, for example, for CT scanners or for surgery robots or for rehab pools, and it was just taking forever to move these projects along. Through the great work of ministry officials in the department of HSHS and partner ministries we removed those roadblocks, and we've seen the CT scanner initiative in WestView move forward, the CT scanner initiative in Fairview move forward, and the rehab pool here in Edmonton move forward, and I believe that the surgical robot in Red Deer is also moving forward.

4:40

That's another area where we want to leverage and enhance the ability of foundations and communities to do what they want to do in health care. The system should reflect their priorities, and by removing the bureaucratic red tape around that and really letting them do what they want to do and put their money where they want to put it, often leveraging public investment alongside it everybody wins. It's enhanced access for patients in the case of CT. You've got better access to diagnostic imaging, which, of course, is going to expedite care and treatment, and robotic . . .

Ms Pitt: Sorry. Not to interrupt, but I have a quick question about proton beams in the last, like, 10 seconds. It sounds like *Star Trek*, and we need further conversation on whatever the heck that is.

The Chair: All right. We've had another member join us. Please introduce yourself for the record, Jasvir.

Mr. Deol: No. I'm already here.

The Chair: Oh, you're already here. All right. But you're next to speak.

Mr. Deol: Yes.

The Chair: Go ahead.

Mr. Deol: Thank you, Madam Chair. Madam Chair, through you to the minister, would you like to share the time or . . .

Mr. Jones: Let's do block.

Mr. Deol: Block. Thank you.

Thank you, Madam Chair. My question is actually around capital plan details, page 112. Alberta is facing a severe shortage of acute-care beds, and the strain on our health care system is being felt by families in real time. According to the Statistics Canada hospital survey data when the Grey Nuns community hospital opened in 1988, Alberta had approximately 12,000 acute-care beds. Nearly four decades later our population has almost tripled, specifically in the city of Edmonton, yet the capacity has declined roughly to 7,000 beds, almost to half. That gap presents not just a policy failure but growing risk to patient safety across the province. And on top of this, when the UCP government took office seven years ago, they made some deliberate choices to cancel critical infrastructure. They cancelled two hospital projects, and they cancelled a superlab project that was through to the construction phase already. At a time of rapid population growth and increasing demand, these decisions have deepened system pressures rather than alleviating them.

The human cost of this strain is profound and deeply troubling. My constituent Prashant Sreekumar tragically lost his life after waiting more than eight hours in an emergency room for care. His story is not isolated. Across Alberta families are sharing painful accounts of delayed treatments, overcrowded emergency departments, and care that is stretched beyond safe limits.

Madam Chair, I have repeatedly heard the minister reference the addition of 200 new beds at Grey Nuns hospital. However, this government fiscal plan raises serious questions on page 112. The capital plan allocation for the in-patient towers at Grey Nuns hospital and Misericordia community hospital totals only $4 million combined. Last year it was allocated $1 million. There was no difference in the project, no improvement. This year the allocation increases to just $2 million. These figures do not align with the scale of urgency required to deliver new acute-care beds in the near term. I'm afraid every time the minister is referring to the information of an additional 200-bed in-patient towers at Grey Nuns hospital, he is referring to $2 million. That means Albertans should not expect meaningful capacity increases for several more years at all, or maybe – we don't know what's going to happen next. This growing gap between the announcements and actual work risks undermines public trust.

Finally, Madam Chair, the concern extends beyond a single project. That ministry has also failed to fully utilize funds already allocated to multiple health care infrastructure projects across the province. On page 112 it shows that 12 other projects did not receive the money or the money allocated last year was not really spent. At a time when capacity shortages are critical, how can this government justify leaving vital resources unspent while Albertans are continuing to suffer consequences?

My constituents are very concerned, and my community members around at least four ridings in the southeast: they're very concerned. There is even a nonpartisan town hall on the crisis in health care that is being held on March 24. I would also encourage the minister to attend and please listen to Albertans' concern first-hand.

Your health care policy is unfortunately not working. It's not helping. Albertans need the bed capacity right now, not five years from now, not four years from now. Also, as the minister said in QP, we are not seeing any triage doctors coming as the government has itself, you know, investigated and came to the . . .

The Chair: To the minister.

Mr. Jones: Thank you, Chair, and through you to the member I'm pleased to highlight progress we're making under our capital plan. The member did reference the Grey Nuns and Misericordia project, which have $7 million in Budget 2026 for planning of the two bed towers, 700 net new spaces, 350 per hospital. It is an unfortunate reality that we should plan and design facilities before we build them, so it is part of the construction process. Constructing billion-dollar towers probably does not end well if we don't go through those steps.

I'd also highlight some of the 300 beds that are currently under construction. We've got the neurosciences intensive care unit at the U of A. There are 24 there. We have the Red Deer regional redevelopment hospital. There are 200 there. University of Alberta day surgery: there are 18. La Crête, nine. That's maternity and advanced ambulatory care. We've got ICU work at the Maz and U of A, and through ASI we have six beds at Fort Saskatchewan and 28 at Sturgeon. That's a total of 296 under construction with varying timelines from '26, this year, to 2029.

We also have over 2,000 beds in planning and design. That includes many of the projects that we've touched on today. For example, the new stand-alone Stollery children's hospital: that would be roughly 321. The Alberta Children's hospital in-patient expansion: that would be 50. We've talked about the Cardston health centre, I believe, 24. Grey Nuns tower, 350. Mazankowski shelled spaces: there are opportunities in levels 4, 7, and 8 for 61 spaces. Misericordia community hospital tower: again, 350. Peter Lougheed, level 6 shelled space: there's opportunity for 29 spaces there, and the modernization of the Royal Alex could represent, again, hundreds of spaces. South Health Campus has opportunities for ICU expansion and shelled space development. There are 30 spaces there, actually more that we've identified there. Across the two towers, so the women's health tower and the in-patient tower: that could be over 400 beds. And Strathcona community hospital expansion: the idea there is 116 beds with, I believe, 34, 36 more shelled for future surgical and medical needs. Walter C. Mackenzie level 2 redevelopment: that could range from 22 to 36 beds; and Whitecourt community health centre, 14 beds.

That's over 2,000, and it's certainly my priority to move all those projects along as quickly as possible. We've already acknowledged that we are behind in acute-care capacity, particularly in the Edmonton region and Calgary, which is why we've moved quickly through the acute-care action plan to bring forward some large capital projects.

Some other capital projects that I'd like to highlight include the Alberta kidney care project in Calgary. This is $36 million over three years: $3 million in '26-27, $15 million in '27-28, and $18 million in '28-29. This project will construct a new 25-bed renal dialysis unit at Richmond Road diagnostic treatment centre to replace the northwest dialysis centre currently located at Northland Village Mall. This is required to meet current needs but also build capacity for future demand. It will expand the stations from 18 to 25 and address functional, physical, and infection, IPC, issues. So that one is moving forward. The functional programming is complete, and it's going to advance to the design stage.

4:50

The next project I would highlight is the Beaverlodge health centre replacement. This was if not the oldest then one of the oldest AHS-operated sites in the province. It's reached its end of life. The town of Beaverlodge has partnered with Landrex, a land and community development company, to develop the new Mountainview health complex, which will replace the Beaverlodge municipal hospital, and AHS will lease space in this facility. Construction has already started. It started in the summer of 2025, and it's projected to be complete early in 2028. This is $181 million over three years: $11 million in '26-27, $170 million in '27-28, and $18 million in '28-29.

The next project I would highlight is the Cardston health centre replacement. This is also one of the oldest sites in the province, built in 1959 with an addition in 1981. It's past its life and no longer meets modern safety or accessibility. There's $74 million in budget over the next three years to advance the redevelopment of the site in Cardston.

The Chair: Thank you so much.

Over to the government side. Please proceed, Member.

Mr. Singh: Thank you, Madam Chair. Through you to the minister: are we going shared time?

Mr. Jones: Yes.

Mr. Singh: Thank you, Minister.

My questions are on page 81 of the business plan, which describes that Acute Care Alberta "also monitors and reports on sector performance; oversees commissioning and contracting of acute care providers; administers funding and conducts financial reporting and analysis; and supports quality management and provincial programs." It is clear that strong performance management and clear contracting expectations are important to ensuring patients receive consistent, high-quality care across the province. Through you, Madam Chair: what changes have been made to contracting and performance management to ensure providers meet expectations?

Mr. Jones: Thank you, Chair, and through you to the member for the important question.

I just wanted to answer the quick question that was thrown in at the end. Proton beam therapy is precise radiation treatment that uses protons instead of X-rays to target tumours, delivering maximum dose to cancer cells while minimizing damage to surrounding healthy tissues. You want to do this in very sensitive areas. We do not have it in Canada. We send our patients to Florida, in the United States, at great cost. We did an expression of interest; there were multiple parties who had different ways of bringing it to Alberta with support of the Alberta government. We will be formally launching an RFP in the coming months, and we've already notified those interested parties of that. It's my hope that it will not only meet the needs of Alberta but also help with the needs of Canadians.

In answer to the member's question, which is what I should be answering, we are strengthening contracting and procurement management by working collaboratively with Acute Care Alberta. In particular, we're working to collect, validate, and report on provider compliance and contract compliance outcomes, especially for chartered surgical facility contracts, so that expectations are clear and performance issues can be identified and addressed in a timely way. We're also standardizing those contracts as much as is possible, of course recognizing that we are procuring different surgeries in different areas of the province.

Risk-based reporting is provided to ACA to support review and follow-up with CSF providers, including corrective actions where required. ACA's contracting and commissioning team leads joint performance conversations together with ACA's surgical care Alberta team and my department and the CSFs to review outcomes, discuss performance trends, and ensure contract expectations are consistently met. At the same time, we are enhancing acute-care performance reporting, including emergency department performance monitoring to better identify ED pressures and support system-level interventions and planning.

My department is working with ACA to standardize performance reporting, beginning with the top 16 hospitals under phase 1 and expanding to more extensive operational reporting in subsequent phases. Later phases are also expected to include workforce metrics so we have a clearer picture of capacity pressures and get better targeted actions alongside other ED initiatives and broader provincial workforce. This will be key as we move to site-based leadership. It will be key as we expand our utilization of chartered surgical facilities for low-complexity routine surgeries. There will be no tolerance for a decline in quality of patient safety if a surgery is not performed in a hospital.

With that, Chair, I turn it back to the member for the next question.

Mr. Singh: Thank you, Minister, for such a detailed answer.

Through you, Madam Chair, my next set of questions is on health information technology system integration. I see page 125 of the estimates shows us there is $419 million for information technology. As service providers become more integrated into the health care system, we need to ensure network reliability while also maintaining secure patient records. With Calgary becoming a tech hub for Canada, there are opportunities to leverage the existing ecosystem and talent here in the province. In my constituency of Calgary-East I often hear from health professionals about the importance of having modern, reliable digital systems that allow providers to focus on patient care rather than administrative burdens.

With Calgary emerging as a growing technology hub in Canada, there are also opportunities to leverage the talent and innovation already present in our province. Through you, Madam Chair, can the minister please tell us what investment he is making in information and technology and how strategically important to the health care refocusing it is to ensure that health care providers have the most up-to-date and user-friendly systems?

Mr. Jones: Thank you, Chair, and through you to the member for the question. Health information technology investments support modern, secure, and reliable digital health systems that clinicians and teams rely on every day to deliver the best care. As reflected in the estimates, this includes approximately $419 million for information technology in '26-27, supporting the infrastructure and digital capabilities needed to maintain network reliability, strengthen cybersecurity, and protect patient records as services and providers become more integrated. These investments strengthen clinical information systems, digital infrastructure cybersecurity, and data integration across the health system. The objective is to ensure patient records are protected, systems are durable and reliable, and information can be accessed appropriately when it is needed to support clinical decision-making.

We are working to expand virtual home hospital to include patients discharged from emergency departments. VHH, as it's known, is a clinical service that takes staff, equipment, technology, medications, and skills usually provided in-hospital and delivers hospital care to selected people in their homes, facilitating earlier discharge for patients. Virtual observation is a technology-supported safety initiative that allows trained AHS staff to remotely monitor patients through secure video systems.

Rural ambulances are often tied up for hours completing interfacility transfers or responding to nonurgent events. This can leave communities without EHS coverage and contributes to long response times for life-threatening emergencies. To improve EHS service in rural and remote communities, EHS will add or reallocate resources specifically for low-acuity calls and interfacility transfers while modernizing urban response plans that impact rural coverage. Modelling tools and historical data are being used to determine where our mobile integrated health, or MIH, and low-acuity response resources like HELPU can best strengthen rural coverage.

The extension for community health outcomes, or ECHO, uses telehealth technologies to train and support primary care providers to care for hepatitis C patients. ECHO provides resources and support to nine of the 53 Indigenous communities in Alberta, representing improved access for around 74,000 Indigenous people.

In January of 2025 AHS launched the virtual emergency physician, or VEP, pilot program to support rural EDs facing service disruptions due to lack of on-site physician coverage. The model uses an AHS emergency physician from within the corridor and remotely services patients at the rural ED with nonlife-threatening presentations, connecting to on-site staff and patients using Connect Care and telephone or videoconferencing. This model is intended to support on-site nursing, improve patient flow and user satisfaction. The off-site virtual physician collaborates with local on-site staff, speaks with patients, orders tests and medications, supports on-site nursing staff with initiating interventions within their scope of practice, and transfers or discharges patients. Emergency health services remain available to transfer high-acuity patients to a nearby facility with in-person ED physician support if required.

5:00

In addition, the department is working closely with colleagues in Primary and Preventative Health Services to develop a digital front door, which will enable Albertans to navigate health care programs and services, ensuring their needs are met in the most appropriate setting more quickly. We're also exploring opportunities to safely and appropriately optimize the use of artificial intelligence via our provincial electronic health record, Connect Care, to improve the patient experience and support effective and efficient utilization of our health care workforce.

I would say that using modern technology, of course, improves patient care and improves the efficiency of that care and accessibility, but it's also going to be key to recruitment as the modern workforce is going to expect that they have modern tools available. We're already seeing this on the surgical side, where there's a great desire to have robotic assistance in certain surgical environments. So I think we have to continue to do this and, of course, to bolster our cybersecurity protections in the modern world.

Thank you, Chair.

The Chair: Thank you so much, Minister.

Let's take our five-minute break, everyone.

[The committee adjourned from 5:02 p.m. to 5:07 p.m.]

The Chair: Let's resume. We'll go to the Official Opposition. Please proceed.

Ms Hoffman: Thank you very much, Madam Chair and to all members. I'm going to take this next little chunk of time to ask the minister if he wants to go back and forth.

Mr. Jones: Let's go block.

Ms Hoffman: Then I will start by asking about outcomes-based funding. I will say that I see a lot of parallels between OBF and FFS, when one of the main answers we get regularly around physician compensation is that we need to move more off fee for service and more onto blended cap or onto other types of remuneration that are more predictable. Moving to outcomes-based funding, assuming that it happens within this fiscal year, I think that there are going to be a lot of pressures on the Acute Care budget, and I know that already. You know, hospitals don't shut down ever and patients get served, but I am curious how – first of all, there are so many different models of outcomes-based funding implemented around the world. I'm curious to know which ones the minister is looking at for inspiration and which models he anticipates would meet the needs.

I also want to reflect on the fact that in other departments we've seen one formula designed for all, that certainly hasn't worked in education around the weighted moving average. In declining enrolment areas, it's been highly helpful, which is great, but in areas of high growth it has been behind the times and really punitive in those areas. So are we looking at different formulas for different types of hospitals? Are our tertiary hospitals going to have a different outcomes-based funding model than our rural regional hospitals and so forth? Those would be some of the questions on that.

Also, the minister has talked about not wanting to, you know, put construction money into the budget for the Misericordia, for the Grey Nuns, for the South Health Campus in Calgary because it's premature. I will say that it is far delayed. It was the 1980s the last time Edmonton had a new community-based hospital, the Grey Nuns, and since then, fortunately, a new community-based hospital was built in Calgary, South Health Campus, and it has certainly served a large demand.

Edmonton has grown almost as much, and the population of the city has essentially doubled since the Grey Nuns opened originally. So we do need a new community hospital, an additional one, and it would have been great if seven years ago, when the former minister put the project on halt, he had just looked at the data and moved forward with building a new community-based hospital. We really do need new emergency capacity and new acute-care beds in the same building. That's one of my reflections on that.

I do also want to give the minister an opportunity to talk a little bit more about – he started talking about vouchers this morning, so I'd like to know more about what he sees in that regard. I was sort of paralleling outcomes-based funding as a bit of a voucher system, and it is voucher-lite, but he said that, through you, Madam Chair, he is considering a larger voucher system so that if the health care system that is available here through the public universal program isn't meeting recommended clinical guidelines that people could take the value of what it would cost to have the procedure done in a public hospital and use it to go elsewhere. That definitely doesn't seem consistent with the tenets of the Canada Health Act to me.

I'm just wondering: how would the minister see this complying with the tenets of universality, accessibility, portability? How does the minister see this not being out of line with the Canada Health Act? How far along the thought process is this concept for the minister? Is it embedded within the current budget that we're here looking at? Is that, for example, under 2.2 in the main estimates? Yeah.

Then, along that line of privatization, essentially, around the voucher piece, American-style privatization – if we could go back and forth, we could have a debate about this, but sadly we can't go back and forth. I just have to talk about American-style health care for another 35 seconds. I do think the idea of telling those who can afford to travel abroad or go to a private system locally and pay a top-up, is not what Albertans are asking for, and that it was made very clear that there wasn't going to be privatization in the last provincial election, but it definitely seems with talk about a voucher system that that isn't the reality here today.

I'd love to have those concerns put to rest and to be able to know about specifically OBF models that the minister thinks are good.

The Chair: The minister.

Mr. Jones: Thank you, Madam Chair and to the member for her important questions. First, I'll touch on privatization. The integrated health care system, which represents roughly $32 billion, is predominantly public. The vast majority of it is public. All of our hospitals are public. What we talk about is augmenting public delivery with private delivery where it makes sense. For example, in our chartered surgical facilities, if you have publicly paid surgeries that could be provided by the same medical staff, same Albertans in a private OR, again, 100 per cent publicly funded, that will enable our hospitals to focus on more complex cases that require urgent stays that can't be done in a CSF so that their ORs are also ready for what walks in the door. That's a win-win for everyone. I don't view that as privatization of the system. I view that as augmenting aspects of the system where it makes sense. In a lot of areas it won't make sense, and that's why you see the vast majority of the $32 billion system remaining completely public delivered and funded.

The member opposite, through you, Chair, asked about the voucher program, so I'm pleased to talk about this. The vision here is that patients who are waiting longer than clinically recommended would receive notification that they're eligible for a voucher to have their procedure performed by another accredited and approved surgeon or facility within Alberta. Some context here. We have today roughly 75,000 people waiting for surgery; 35,000 of those, or roughly 44 per cent, are waiting longer than clinically recommended. This 35,000 represents about 177 different procedures. What most Albertans who I talked to are not aware of is that there's not one wait-list. There is a wait-list depending on which surgeon you're waiting for, which surgery you're waiting for.

The intent is, through a voucher program, to connect Albertans who are waiting longer than clinically recommended with another path to get the surgery they need faster through another surgeon or another facility. I view this as expanding access and enhancing our ability to attract surgeons, retain surgeons, and keep activity in Alberta, whereas currently we have Albertans and health care professionals travelling to other jurisdictions to do surgeries. I think that's ridiculous.

This program is still in development and is subject to change, particularly as we engage on it. The program would roll out in phases, where phase 1 would focus on lower acuity and complexity patients and leverage unused or incremental capacity, particularly in our chartered surgical facilities, but also in our internal ORs.

5:15

The program, to answer your question, if we move forward, would be funded through the acute-care action plan, those 50,000 incremental surgeries that we've budgeted. I can say that we've recently approved to move forward with engagement on this. We,

again, think it's just a way of expanding access and getting people waiting longer than clinically recommended access to their surgery. The program, if it moves forward, will be informed by engagement with physicians and other medical professionals.

The other questions related to activity-based funding or patient-focused funding: I did touch on this before, but the intent here is really to improve transparency, efficiency, and increased accountability on our spend. I was going to refer this to one of the main people working on this, but I only have a minute.

The pilot of this will roll out at 12 sites. It'll include hips, knees, and cataracts, roughly $125 million of procedures, about 25,000 procedures, and we've built in guardrails to more or less hold current providers whole because we want to learn from this pilot before the program is leveraged further so that we implement it correctly and get the desired result.

Again, if you think long term, we want to ensure that surgical activity in particular is provided where it makes sense, where that option exists. You're always going to need capacity for what walks in the door, but for the 75,000 people who are waiting for surgeries, we obviously want to provide that in the most efficient way possible, and that's where I see a lot of opportunity. If we basically put a price on a surgery and any accredited or approved provider, internal or external, can do that, I think we can leverage patient-focused funding to do more surgeries more efficiently, which is good news for the system and patients.

The Chair: Back over to the government side.

Mrs. Sawyer: Thank you, Madam Chair. Minister, if I may request shared?

Mr. Jones: Yes.

Mrs. Sawyer: Being formal so I don't get in trouble from the chair for not asking. I'm learning.

We've talked about the Grey Nuns and the Misericordia hospitals, but I'd like to talk about the Royal Alexandra hospital and capital planning surrounding that, if I could, through the chair. On page 112 of the capital plan, it notes $5 million has been allocated for planning related to the Royal Alexandra hospital in Edmonton. It is one of the province's major centres for emergency medicine, surgery, and rehabilitation, serving not only residents of Edmonton but also patients from across the north zone who do rely on the site for specialized and urgent care. Given the important role the Royal Alexandra hospital plays within Alberta's acute-care network, can the minister tell us what infrastructure at the RAH will be upgraded? As well, how will this funding contribute to improved wait times for patients and contribute to more efficient patient flow?

Mr. Jones: Thank you, Chair, and through you to the member, the Royal Alex is a critical component of Alberta's acute-care system, providing emergency in-patient and specialized services to Edmonton and northern Alberta. It's experiencing significant infrastructure pressures associated with the age, utilization, and evolving care requirements.

This investment will support critical early stage planning to address the aging infrastructure, sustained capacity pressures, and operational constraints while establishing a robust evidence base to inform future phased redevelopment decisions.

The planning investment for the Royal Alex supports early work to assess and define improvements that are needed at one of Edmonton's busiest acute-care facilities with a particular focus on emergency department capacity and patient flow. The planning work will evaluate ED capacity, clinical support spaces, opportunities to improve how patients move from assessment to treatment, admission to discharge.

The intent is to identify practical modernization opportunities and develop the information required to support a future capital request and decision, including upgrades that would improve or reduce congestion, expand bed availability, and overall operational efficiency. The Royal Alex is planned to grow from 926 beds to potentially 1,214 beds over the long term, adding close to 300 beds through phased modernization in alignment with Edmonton's broader acute-care strategy. Of course, these things would improve patient flow by identifying infrastructure and operational improvements that would support improved patient flow, and they'll be examining current patient flow across the ED and in-patient units to help identify where upgrades or modernization would reduce that congestion.

The $5 million capital planning funding includes a detailed site master plan, functional programming, schematic design of a new clinical services and support building, plus the enhanced emergency department with a potential interim expansion and renovation of the existing emergency department. This would provide urgent relief to the current ED while a new permanent ED would be constructed in a new acute services building.

With the adoption of Connect Care as our provincial electronic medical record, health care staff would have access to critical knowledge and information to support their assessments and clinical decision-making when deciding to admit patients to the hospital. For patients with recurring health conditions and presenting symptoms, exceptional care plans are documented in the Connect Care record, which support timely and appropriate discharges as well as connections to primary care and home care supports to work towards stabilization in the community. Connect Care also produces discharge reports for primary care providers to support patients as they transition back to the community.

With that, happy to take the next question from the member.

Mrs. Sawyer: Thank you to the minister for that through the chair. Of course, I'm going to go straight into another question relating to rural. Still within the capital plan on page 112, $60 million has been allocated for the rural hospital enhancement program. The program plays an important role in strengthening health infrastructure in communities that rely heavily on their local hospitals for both urgent and specialized care. We had previous announcements supporting expansion at the Northern Lights regional hospital in Fort McMurray, which I know they're very happy with. It's a critical health facility not only for residents of the Wood Buffalo region, but also for communities across the northeast of the province. Through the chair to the minister: can you please elaborate on what upgrades or new services we can expect at the Northern Lights regional hospital, and along with that, can you touch on any updates to the planning for the Indigenous wellness space for the hospital and speak to the importance of that?

Mr. Jones: Thank you, Chair and through you to the member. Funding through the rural hospital enhancement program supports targeted infrastructure improvements at rural and regional sites so facilities can continue to deliver safe, reliable services and meet growing demand. At the Northern Lights regional health centre this work is expected to strengthen clinical service capacity, patient care spaces, and supporting infrastructure needed to sustain operations. These types of upgrades would help the facility continue to serve communities across the Wood Buffalo region and northeastern Alberta with care that is delivered closer to home.

Planning is under way for the redevelopment of underutilized level 4 space to address growing demand for neonatal, pediatric,

and related acute in-patient services, specifically development of a level 2 neonatal intensive care unit, or NICU, to support from level 2 to level 4 to enable clinical adjacency with neonatal services and improve care co-ordination and integration of supporting clinical and family-centred spaces to enhance continuity of care and patient experience. Advancing this work would improve local clinical capacity, reduce reliance on transfers to tertiary centres, and strengthen access to timely appropriate care for infants, children, and families in the region.

Planning for an Indigenous wellness space at the Northern Lights regional health centre reflects the importance of culturally appropriate and culturally safe care environments within our hospitals. These spaces can support traditional healing practices, provide areas for families to gather, and create environments that support culturally respectful care experiences. Integrating Indigenous wellness spaces within hospital facilities can improve patient comfort and strengthen community engagement and support better experiences for Indigenous patients and families. I've seen this in work as I toured something like 27 hospitals around the province meeting Indigenous patient navigators, which were always well received and doing incredible work. We certainly want to leverage them and also leverage these spaces to provide more culturally appropriate and better care to patients, especially in areas that serve a large Indigenous population.

5:25

Mrs. Sawyer: Thank you, Minister. If I could say, through the chair, being that this is, you know, my first estimates, and I've got to sit on quite a few different ministries, I am very much in appreciation of the care and attention to creating spaces for the Indigenous community to better serve them. I just think that's notable and something I wanted to mention.

Okay. Staying on page 112, I'm going to continue in the capital plan, this one with respect to medical equipment replacement and upgrades. There's a line item in there for medical equipment replacement and upgrades. Buildings do get more attention. Aging equipment sometimes gets overlooked despite its vital importance to health system operations, and as the MLA mentioned, you've already helped replace some in her area. Through the chair to the minister: what kind of impact are we expecting from that program? Will the upgrades target specific types of equipment or medical specialties, and what role does this program and its support for state-of-the-art theaters of care play in health workforce retention and recruitment?

Mr. Jones: Thank you for the question. The medical equipment and replacement and upgrades program will play a critical role in ensuring that our hospitals can continue to deliver safe and state-of-the-art care. While new buildings and expansions are important, modern and dependable medical equipment is essential to how care is actually delivered today and into the future. By replacing aging diagnostic and treatment equipment, the program helps reduce service disruptions and equipment downtime that can delay care, like the experience, through you chair, as referenced by the Member for Airdrie-East.

Reliable equipment supports smoother day-to-day operations, improves clinical efficiency, and increases diagnostic and treatment capacity across hospitals. These upgrades also contribute directly to better patient outcomes and shorter wait times. When equipment is modern, functioning reliably, and able to support higher volumes, patients can be diagnosed and treated more quickly. Overall, the program ensures hospitals across Alberta can maintain high-quality care, support front-line clinical teams, and meet patient needs by keeping essential medical equipment running.

The Chair: Thank you so much. We will move back over to . . .

Ms Hoffman: Myself.

The Chair: Yourself. Very good.

Ms Hoffman: Thank you very much, Madam Chair.
Want to go back and forth this time?

Mr. Jones: Block.

Ms Hoffman: I'm going to start by giving the staff some time to be able to gather these numbers because my first question here is around closed emergency department hours in the last fiscal year and what we're doing this year to reduce those closed fiscal hours.

Just looking at the last two weeks, there were closures for emergency departments in Smoky Lake, in McLennan, in Hinton, in Coronation, in Athabasca, in Spirit River, in Hinton again. I'm confident that nobody is proud of those experiences, and as somebody who grew up a rural kid in a town where you had to drive half an hour to get to the closest hospital, if it was closed, it would have been devastating for us and I really feel for the folks who are in these communities, and those of us who can, yeah, have empathy for them.

How many hours in the last fiscal year were emergency departments in Alberta closed? What were the most frequent closures? I think it was Hinton, but I'm just going off the news releases. So how many hours was Hinton closed, or what was the highest frequency, and how many hours was that one specifically closed? What are we doing to address that in this budget to make sure that we get back to having the H on the side of the highway stand for full-service health care in those municipalities and all municipalities? That's the first one I want to touch on.

Secondly, I had a great time meeting with med students earlier this week and talked to a number of them about the joys of staying in Alberta first of all and, second of all, trying rural placements. One of the number one reasons – this isn't new. This is something that they've been raising for quite some time and that I didn't have time to fix in my four years. One of the number one things that they talk about is there being no rental market in a lot of rural communities where they would be interested in working or at least doing an observation round, maybe a short-term placement.

What brought us to rural Alberta in the first place, our family when I was growing up, is the fact that there was a principalship and a teacherage that came with it for my parents so that they didn't have to worry about housing. They didn't have to worry about the mortgage crisis, and we had a great place to live less than a block away from the school. Who doesn't want, you know, a principal within a block of the school, and who doesn't want doctors, med students, or residents or eventually fully practising physicians to be within close access to hospitals? Have we considered what we can do around that rental market in particular?

Also, I want to say that when I've visited with some long-serving – I remember talking to a family physician in Wabasca about why he chose to work there. It was that he was an international grad, and they offered him a car and a place to live, and that made the idea of moving to another country much more feasible. He knew it was going to be a small town, and here he was 20 years later still practising there. I think that there are a lot of opportunities if we don't silo everything out and just think that it's about compensation. It really is about culture and ease of transition in a lot of these communities. Are we doing anything to address the housing crisis and lack of rental housing in these communities?

In this next chunk of time I will talk about proton beam. I am always excited for new opportunities for treatments and new and

evolving ways to save lives. I think that a lot of people were hoping that the proton beam would be available at the Calgary cancer centre, that it would be housed in-house, that it wouldn't be – that it could be a draw to work in the public system within a publicly funded, publicly delivered hospital. Again, I know that the minister is trying to play catch-up from under a prior minister and the consequences of tearing up the contract that had been negotiated with physicians to attract oncologists back to the province of Alberta. I know that there are a number of people who were hoping that the proton beam would be in-house. If the minister could talk about why it is he's decided to do an RFP and not have it under a traditional procurement model and have it be a service provided within the public health care bundle, publicly funded, publicly delivered, that would be helpful.

Again, to reiterate: the number of hours emergency departments were closed, what the most frequently closed one was and what's being done to address that, if there's anything in this budget related to housing and particularly housing in rural communities, and proton beam. Those are the three areas for this time, please.

Mr. Jones: Thank you, Chair, and through you to the member for again a great set of questions. I'd like to thank the member through you, Chair, for her service to Alberta as a health minister and for working on these same challenges, I'm sure.

A service disruption refers to the inability to meet minimum required levels of service delivery to ensure access. This results in either closure or service reduction; for example, reduced hours of operation or a lack of obstetrics. Service disruptions can occur for several reasons, including staffing shortages, lack of physician coverage, planned facility enhancement, and even natural disasters, fires.

Many rural ED service disruptions are due to staffing and physician shortages, the majority. Service disruptions are a temporary measure. They are not the first option to mitigate operational challenges. Sites exhaust other options prior to implementing a service reduction, and every effort is made to ensure Albertans continue to have access to care. This includes keeping nursing staff on-site in the affected emergency department to assess patients and referring them to alternative care options, including alternate EDs in other communities or providing the care required within a nurse's scope of practice or arranging EHS transfer to a higher level of care.

Every effort, again, is made to prevent service disruptions. Hospital operators may implement operational strategies to prevent service disruptions that include use of a locum or agency staff, increased part-time and casual staff hours, offering overtime, reassignment of staff between services or sites where possible and appropriate, rescheduling or cancellation of vacation in extreme cases, enacting other provisions in collective agreements such as mandated overtime, use of management staff as appropriate to cover clinical duties, and use of locum physicians, physician assistants, or nurse practitioners to cover gaps in medical coverage and collaboration with EHS. Alberta's government is committed to ensuring that all Albertans, no matter where they live, can access timely health care.

Like much of Canada, Alberta faces a shortage of health care professionals in certain areas. This is a key factor contributing to ED closures and service disruptions. The rural health professions action plan provides several programs and initiatives to support the attraction and retention of health professionals for rural practice. PPHS has oversight over this, but a long way of saying we are trying to train people in these communities so they're more likely to live and work there, which would of course reduce service disruptions. We're offering bursaries, often with return-of-service requirements, and we're using things like virtual ED physicians to try to keep emergency departments open.

5:35

In response to the specific questions that the member opposite had for affected communities, some of the most impacted sites would be Grimshaw, Boyle, Consort, Hinton, Two Hills, Bow Island, Coronation, Swan Hills, and I do get a daily report on this. Again, every effort is made to mitigate these service disruptions, but the member opposite did ask for those examples. Where did I put that? Ah, here it is. Apologies. As an example, many of these disruptions are due to lack of physician coverage or obstetrics. For example, Barrhead health centre has obstetric services paused from March 14 to April 7, and EMS is available to transfer patients to neighbouring facilities.

Boyle has limited ED hours due to a lack of clinical personnel, and Bow Island: of course, persistent limited ED hours due to a lack of clinical staff, where we're using alternate care options outside of listed hours. Again, nurses are often on-site. EMS can transfer patients as required, or patients can visit a nearby ED. We are working to bolster our workforce in rural and remote Alberta, again, by trying to meet people where they are, to train them where they live, offering bursaries.

The member also talked about accommodation. In addition to the great work that municipalities are undertaking in this area, there are also postsecondaries that are working on providing accommodation to medical students, and PPHS provides a grant to an organization that is providing places to live for medical professionals to live and get educated and trained in rural settings. So there are initiatives across the board to address these service disruptions, which are primarily physician related or clinical staff related, and I did highlight in my earlier answers our progress on recruiting medical professionals to Alberta over the last five years, which is substantial, and I think it will help.

The Chair: All right. Where are we going next?

Ms Pitt: I'll do it.

The Chair: Okay. Go ahead now.

Ms Pitt: Thank you, Minister. Thank you, Madam Chair. Minister, I have some questions that I'd like to start with, some questions about Airdrie and page 112 of the capital plan. There's $2 million allocated for the Airdrie north Calgary regional hospital plan. Can you give us an update on that budget allocation, page 112, the $2 million for Airdrie north Calgary regional hospital planning?

Mr. Jones: Yes, I can. Thank you very much. There are actually two planning exercises that involve Airdrie, one that we're doing in conjunction with Covenant Health. They're interested in doing something similar to the wellness centre that they have here in Edmonton, some form of combined urgent care and primary care centre, so we're working very closely with Covenant and excited for the potential of that project. The other is broader than Airdrie. It includes areas as far as Chestermere and north Calgary. We want to do a comprehensive needs assessment for the entire area and think well into the future to make sure that we're not in a situation where the majority of residents of Airdrie, for example, are seeking medical care outside of their city, which, of course, is also contributing to pressures that we see in north Calgary and our Calgary hospital.

Both of those planning exercises are under way, and we're doing them in a way that we don't duplicate our work. We want them to leverage each other, but they are different planning exercises. One

is specifically for a facility that Covenant is interested in, and there's great support. As the member knows, through you, Chair, there's great support from the city of Airdrie. There's great support from the local MLAs and residents, so we certainly are excited to see that planning work go forward on the Covenant proposal.

At the same time we do want to make sure that we address the acute-care requirements for the entire area that is broader than Airdrie, so both planning exercises, I think roughly $5 million in total, are under way. I'm hoping to get some preliminary results this year so that we can move forward to the next step.

Ms Pitt: Perfect. We're hoping for the same. Thank you, Minister.

My friend and colleague from the Cardston area has some questions that he would like to ask. First, he wants to thank you for the $74 million that's been allocated for a new Cardston regional hospital. This is again on page 112 of the capital plan. The existing Cardston health centre has long served the community, but many residents in the region have expressed concerns about the need for modernized facilities and expanded services. Given Cardston's location near the southern border many residents currently travel significant distances to Lethbridge or even Calgary to access certain health services. Investments to strengthen health infrastructure in southern Alberta can help ensure patients receive care closer to home. The questions through you, Madam Chair, are: can the minister tell us what services will be at this hospital? How large of a catchment area will it serve? What will this investment mean for southern Alberta?

Mr. Jones: Thank you for the questions. Again, this is one of our oldest facilities. The new Cardston regional hospital or health centre will replace the aging Cardston health centre and is intended to strengthen local access to essential health services in southern Alberta.

The existing facility, built in 1959 with a 1981 addition, is past end of life and no longer meets modern safety, accessibility, and IPC expectations. The Cardston-Kainai area serves over 16,000 residents, including the Blood Tribe, Hutterite, LDS, and Mennonite communities, with complex health needs. The new centre will integrate emergency and acute care with community programs, allied health, public health, home care, mental health and addictions, including, ideally, Blood Tribe health services, improving co-ordination, local capacity, and patient outcomes. Planned services are expected to include emergency care, acute-care beds, diagnostic services, and community-based health programs.

The facility will serve Cardston and surrounding rural communities, helping residents access care closer to home and supporting more consistent local service availability. Modern facilities will of course improve patient care versus the 1959 and expanded 1981 facility, and having appropriate local services can reduce pressure, again, on regional sites or Calgary sites.

I'm excited for this project. There was tremendous advocacy from all involved. That's another example of how we're building acute-care capacity to meet the needs of Albertans not just in the major urban centres but everywhere.

Ms Pitt: Excellent. Super. Okay.

Actually, we're just going to stay on page 112, capital plan. I note that $40 million has been allocated for EMS capital improvements, another hot-button topic, issue in Airdrie. Investments in emergency medical infrastructure are critical to ensuring ambulances, equipment, and facilities are available to support timely response when emergencies occur. In many rural and remote communities residents rely heavily on local ambulance services, and while response times have improved since their peak in 2022, ensuring consistent and reliable coverage across the province remains an important priority.

The questions, Minister, through you, Madam Chair, are: can you tell us what this funding will be for and how this will alleviate system pressures in ambulance response times across the province? Will these capital improvements limit patient transfers and relocation of ambulances, particularly relocation from rural service to urban centres? Third question: can you explain how the investment will help ensure emergency health services are there for patients when and where they need them?

Mr. Jones: Thank you, Chair and to the member for this great question. The EMS capital investment will replace aging ambulances with modern, more reliable vehicles, keeping our ambulance fleet resilient and equipped with the necessary clinical equipment. Budget 2026 includes a $40 million EMS capital investment over two years to support replacement ambulances and upgrades where needed.

This EHS vehicles capital program is a sustained, multiyear investment to replace aging ambulances, upgrade equipment, and strengthen readiness so front-line crews can respond safely and reliably. Fleet renewal supports province-wide response capacity, reduces downtime and maintenance risk, and also helps keep more ambulances available for emergency response, which supports better response times across the province. The program provides predictable, disciplined, and transparent upgrade and replacement of the EMS fleet. These capital improvements also complement operational reforms such as improved dispatch workflows, triage, and efforts to reduce hospital handover and offload delays so crews can return to service more quickly and be available for the next emergency call.

5:45

EHS modernization efforts also include centralizing interfacility transfer co-ordination, helping to ensure the right resources are assigned to the right call. Combined with a strengthened and more reliable fleet, this will support more stable rural and remote coverage and better deployment of our fleet. These investments will be complemented by additional work on deployment planning. I've already touched on the interfacility transfer resourcing. At the same time, we're also modernizing initiatives like improved dispatch workflows, strengthening alignment between response levels and patient acuity, and expanding alternate care pathways, including collaboration with Health Link 811 to redirect appropriate low-acuity callers. Together these measures preserve ambulance capacity for life-threatening emergencies and support a more reliable system.

Ms Pitt: Perfect. Great. I have some time.

I actually want to ask about the Alberta hospital Brain Centre in the capital plan. There's a funding expansion for the University of Alberta hospital Brain Centre. Brain health is super important. Adding capacity to treat more patients with brain conditions, given the population increases to Edmonton and surrounding areas, is crucial to providing patient flow and higher quality of care. Through the chair, Minister, can you explain what this funding will support? How many beds or services will be added? What's the expected impact of this project? Are there any other innovations we can expect in this space to get more out of our current facilities?

Mr. Jones: Thank you, Chair. This funding supports the expansion of the U of A hospital Brain Centre, one of Alberta's leading facilities for neurological and neurosurgical care. The project is focused on strengthening specialized care for patients with complex

neurological conditions. Specifically, the investment supports an ongoing expansion that will add 13 new neurointensive care unit beds at the U of A hospital. Increasing intensive care capacity at the site will help ensure patients with high-acuity neurological needs can be treated right there, right away.

The expected impact of the project is improved patient flow, better access to surgery and specialized treatment, and more timely care for patients with complex conditions. It's important to note that this will of course serve patients beyond Edmonton, including northern Alberta and even neighbouring provinces. It's a priority of ours certainly to expand our neuro-ICU capacity, and this is a project that will do just that.

The Chair: Thank you so much.

We'll move to the Official Opposition. Please proceed.

Ms Wright: Thank you, Chair. Just a few more questions, Minister. Minister, would you like to share or do block time?

Mr. Jones: Block.

Ms Wright: Okay.

All right. Beginning again with key objective 1.3, which has to do with emergency health services, we find that on page 83 and also pages 84 and 85 in the business plan and performance measure 1(b) on page 84. I note that in the '24-25 annual report it says that $704 million was spent "to expand EHS and respond to the 98 recommendations from the Alberta Emergency Services Provincial Advisory Committee . . . and the EHS Dispatch Review." I'm wondering how many of those 98 recommendations, Chair, might still be outstanding as well as if there are still additional recommendations outstanding having to do with sustainability of the system itself.

There were also recommendations having to do with staffing models and pilot projects, performance, accountability, and my question is: how will acting upon those recommendations inform that overall workforce planning document, that 30-year planning document, going forward for the ministry? When can workers expect all recommendations to be acted upon? How will outcomes be measured, and then will there be a final summon to report?

Then looking at specifically performance measure 1(b), what I'm noticing is that the actual figures in terms of the timeliness of ambulance services for those response times when you're dealing with a high-acuity person within certain demographic zones – it says here that in '24-25 we had: large communities, 13.7 minutes; communities over 3,000, 16.7 minutes; rural communities with under 3,000 residents, 33 minutes; and remote communities, 64. For 2026-27, in the targets on page 85, it notes 12 minutes, 15 minutes, 40 minutes, and 60 minutes. My question really is that it's the same targets for the '27-28 and '28-29 years, so I'm wondering if there's an error there or if we're really looking at not wanting to get those response times down for those different areas.

Then looking again at that issue of growing the health workforce, including enhancing recruitment and retention but specifically with some of those allied health workers – and many folks here have mentioned the cardiac perfusionist as an example because there are very few seats across Canada for those really highly specialized folks. We know, again, it's absolutely a crisis throughout the country, and I certainly do understand that there are some recruitment incentives at the moment, but right now there aren't enough of these folks in order to do the cardiac care and the surgeries that are required. I'm wondering again what work might be done at the moment crossjurisdictionally, if we're talking to other provinces, if there's kind of a pan-Canadian plan, if we've talked to representative unions, if we've talked across ministries to improve the working conditions, particularly for those workers who are doing that work right now, because without those folks people's lives are at risk. It isn't just about the people whose lives are at risk, of course; it's about the quality of life for the folks who are doing those jobs and things like moral injury, that sort of a thing.

Also, in terms of the retention of nurses specifically – this is all about that workforce planning bullet there – I'm wondering if the government is, again, consulting with other jurisdictions across the province, if there's been any work done with the Canadian Federation of Nurses Unions, because they've put out some really good research materials in the last number of years and as well because we know that other provinces are currently working on this, again, pan-Canadian issue.

I will ask this question again as well. Given current overcapacity in many hospitals, is the government looking at working with nurses to establish a minimum nurse-to-patient care ratio, much like British Columbia is introducing, or a safe staffing framework such as Nova Scotia has agreed to do? We know that nurse-patient ratios are associated with a positive impact upon patient care. There was a study done about a year and a half ago that talked about good nurse-patient ratios save lives. One of the study's coauthors said that there was one study that actually showed a 7 per cent rise in death rates when those ratios aren't appropriate. Mandated ratios save lives and also, of course, reduce injury rates, burnout as well as reduce the moral distress of not being able to provide optimum care for those staff members.

I will leave it at that.

The Chair: All right. We'll move over to the minister for his response.

Mr. Jones: Thank you, Chair, and through you to the member for the question. Every minute counts during a medical emergency, so improving emergency health services response times is critical to ensuring that our ambulances arrive quickly when time matters the most. That's why we've been modernizing emergency health services, and that's why it's one of our top priorities under the acute-care action plan. Our goal is clear. Every Albertan, regardless of where they live, must have timely access to emergency care. To achieve that, we are expanding front-line EHS capacity, recruiting additional health care professionals, and optimizing hospital handover procedures so ambulances are on the road faster.

The targets listed: there's no error there. We want to have ambitious targets but also realistic targets in the short term. There's a lot of modernization and change under way and a lot of pressure, including on our workforce, so better to underpromise and overdeliver than the opposite.

Budget 2026 reflects that priority. The government is investing $145 million over three years to upgrade our ambulance fleet and equip paramedics with state-of-the-art equipment. We have also committed the $40 million that I highlighted over two years to repurchase vehicles and acquire additional equipment to improve care.

We're also changing how the system works. As part of the health system refocusing EHS transitioned from Alberta Health Services to the new Emergency Health Services Provincial Health Corporation under Acute Care Alberta and has been operational since September 1, 2025. This is more than a structural change. It is a shift in how decisions are made, accountability is enforced, and services are delivered to improve response times, recruitment, retention, and co-ordination across the province.

5:55

We acknowledge that response times have increased or remained unchanged in many communities, which is exactly why modernization

is under way. The key measures of EHS performance are response time. In ’25-26 year to date the 90th percentile response times for the most urgent calls were about 14.7 minutes in metro and urban communities, a 7.2 per cent increase from 13.7 minutes the prior year; 17.6 minutes in communities over 3,000 residents, up from 16.7; and 33 minutes in rural communities under 3,000 residents, which is basically maintaining; 63.1 minutes in remote communities, representing a 2 per cent improvement from the previous fiscal year.

These pressures are driven in large part by how ambulances are used. Previously ambulances responded with lights and sirens to 77 per cent of calls even though national and international research shows that only 10 to 20 per cent of all calls are truly time sensitive. Over four years Alberta recorded 267 collisions involving ambulances with lights and sirens activated. Aligning lights and sirens use with clinical need reduces collision risk, improves paramedic safety, and preserves rapid response for life-threatening conditions.

One other improvement already implemented is the elimination of ambulance prealerts, which we completed in October 2025. Previously ambulances were dispatched as soon as an address was confirmed, before clinical acuity or scene safety was established. Evidence from jurisdictions such as British Columbia, Nova Scotia, Wales, and New Zealand shows that removing prealerts reduces unnecessary deployments and overresponse. This change ensures emergency resources are reserved for true emergencies.

In terms of – I see time is short. I want to include this. We had the Alberta EMS provincial adviser report, and 42 of those recommendations are complete and 11 are in progress. From the dispatch review 30 are complete and about 15 are in progress. One of those examples would be converting a number of high-use to core flex units, to fully assembled units, which, of course, increases capacity. We’ve also changed how ambulances are assigned to calls. The previous closest unit model often sent advanced life support resources to low-acuity calls, leaving fewer advanced care paramedics available for critical patients.

Under the revised clinical response model we will match patient acuity with the most appropriate resource, keeping advanced care paramedics available for life-threatening calls. I’ve touched on them a few times. We’ve got HELPU units, which are step-down single paramedic response units for low-acuity calls, mobile integrated health units, which care for people where they’re at and reduce transport or hospitalizations. We’re also using paramedics in dispatch to make sure that we are more appropriately sending the right resource at the right time.

I have a lot more on EHS, but I do not have a lot more time, so thank you for the questions. Happy to answer more EHS questions.

The Chair: Perfectly timed, Minister.

Over to the government side. Please proceed, Member Stephan.

Mr. Stephan: Thank you very much. I’d like to request block if it’s agreeable. Block is best.

Mr. Jones: Okay.

Mr. Stephan: Block is very good. I know the members opposite really like block. Block is just super.

With the five minutes that I do have in this great block, I’d like to talk about page 112 of the fiscal plan. I think everyone knows what I’m going to ask about, the Red Deer hospital redevelopment – so exciting – as well as the Red Deer interim cardiac cath lab. Madam Chair, earlier this month it was a very good day in Red Deer, a very, very good day. We had the opportunity to join city council members, my colleague Minister LaGrange, and we went to the Red Deer regional hospital. We were able to view shovels in the ground, big shovels, not little shovels, and a lot of shovels in the ground. There’s a lot going on here, a lot of wonderful things going on at the hospital. I know that the budget for this year budgets $239 million for the redevelopment and then in ’27-28 $382 million and then in ’28-29 $415 million. That aggregates to over a billion dollars. That’s a super big number, super-duper big number.

The Chair: Did you have a question for the minister?

Mr. Stephan: I do, but I have a few more minutes.

The Chair: Only a couple.

Mr. Stephan: I only have a couple.

This is going to be a transformative expansion. This will be beneficial not only to the Red Deer urban area but also all of central Alberta. The Red Deer regional hospital serves about 400,000 people.

The Chair: Including Camrose.

Mr. Stephan: Including Camrose, so lots of great people.

To the minister. A couple of things. First of all, in terms of this expansion, this transformative, amazing expansion, how will we see an improvement in services for families and individuals in the Red Deer area? And in terms of the cardiac cath lab – and I know we’re going to be talking about a similar cardiac cath service for the south zone, which is just great – how do we anticipate seeing improved health outcomes with this specific service provided in the interim for individuals and families not just in Red Deer but central Alberta as a whole?

I know that this is of great interest, actually, to many of the physicians in central Alberta. In fact, when the hospital expansion got cancelled by the NDP – the expansion actually got cancelled, which was very bad – there was a formation by physicians of a group called SHECA. SHECA stands for the Society for Hospital Expansion in Central Alberta. They weren’t being treated very fairly in central Alberta, and SHECA came up with some amazing numbers. It wasn’t just the NDP, Madam Chair, but some prior governments. You know, in terms of per capita funding for families and individuals in the central zone, they weren’t being treated very fairly relative to other zones in the province. That wasn’t very good. I appreciate the great work of SHECA. That really came about because the NDP, unfortunately, cancelled that hospital expansion. That was very bad, but now it’s exciting to see movement towards more fairness in central Alberta that for so many years was neglected.

I’d love to hear about how this hospital expansion and cardiac cath services are going to improve health outcomes for the families and individuals in central Alberta. With that, I’m excited to hear the answers from the minister.

Mr. Jones: Thank you, Chair, and through you to the member for his questions but also his advocacy for central Alberta and Red Deer. I’m pleased to clarify that the math of the member opposite is correct, that Budget 2026 does include roughly $1 billion over three years towards the $1.8 billion redevelopment and expansion of the Red Deer regional hospital, one of Alberta’s largest health infrastructure projects ever.

The Red Deer hospital investment significantly strengthens access to both cardiac and broader acute-care services in central Alberta by expanding local capacity and modernizing care delivery. It will add 200 new in-patient beds, going from approximately 375 to 575 total. It will include six new operating rooms and expanded

emergency and outpatient services. It will introduce two permanent cardiac cath labs, and the project will also expand ambulatory care. This means more patients will be able to receive specialized and timely care closer to home, reducing system pressure and improving outcomes.

The interim cardiac cath lab referenced in the member's question, through you, Chair, is an interim solution delivering immediate benefits, with opening expected in 2027. It will provide diagnostic and interventional cardiac procedures locally and reduce reliance on transfers to Calgary and Edmonton. The interim lab will improve access to time-sensitive cardiac care closer to home for residents of central Alberta, patients who are currently forced to travel. Of course, that's going to reduce a lot of the travel burden, enable faster treatment for time-sensitive cardiac events when minutes matter, and improve regional system efficiency.

6:05

The Red Deer project is actively under construction, as the member highlighted, through you, Chair. Major work, tower and infrastructure work, is under way right now. Full completion is targeted around 2030 or 2031. Let's shoot for 2030 or earlier. Importantly, residents will see incremental improvements before full completion, and interim projects like the cardiac cath lab will ensure earlier access gains.

In summary, the Red Deer regional hospital investment is transforming care in central Alberta, adding 200 acute-care beds, expanding surgical and cardiac services, and modernizing the Red Deer hospital. The interim cardiac cath lab opening in 2027 will provide life-saving care closer to home, while full redevelopment by 2030-31 will deliver a significantly expanded modern hospital for the region.

Thank you.

The Chair: Are you going to ask them another question?

Ms Hoffman: No. They did block.

The Chair: You did block. You just lost two minutes. Member, when you do block time you have to use up all your time, both the member and the minister.

Minister, you still have 2 minutes if you wanted to say anything else.

Mr. Jones: Thank you for the question.

The Chair: Okay.

Please proceed, hon. member.

Ms Hoffman: Thank you very much, Madam Chair. I feel like today has just flown by, and I do want to get a little deeper into some of the numbers. Alberta emergency departments in 2024 were closed for 34,400 hours. I was hoping to get clarity today about what the total rolled-up number of hours was in 2025 and what our target is for 2026. Obviously, the target is zero, but that's not realistic given how many closures there have been in the last two weeks, and it will take time to implement a path to make us get to the point where we can rely on emergency departments being open consistently. So I'd love clarity, an answer. Hopefully, it's in the binder. If it isn't in the binder, then I would certainly welcome the minister to table that tomorrow in the House as this is approximately the time of year that that document does get rolled up together. It's when it was released last year for the 2024 numbers.

Next I want to talk about: the minister, in response to questions I asked around the voucher system, talked about there being a significant backlog of surgeries, which is true. The last number I saw was about 80,000 people waiting. I certainly welcome a correction if that is not accurate anymore. What was reported at that time was that nearly half of those 80,000 people were waiting longer than clinically recommended guidelines.

Critical surgeries, particularly cardiac and cancer procedures, are experiencing severe delays, as we talked about a bit this morning. In October only 11 per cent of cardiac bypass surgeries were completed within clinical guidelines or clinical targets, down from 60 per cent in 2016. Sixty per cent is still not good enough, but 11 per cent is incredibly dangerous, so I would like some clarity on what realistic targets are for that in this upcoming year.

While the minister talks about there not being a co-ordinated wait-list, I would propose that we create one rather than further disaggregating the health care system. I think that we've seen a lot of chaos over the last few years, particularly the last year. A co-ordinated wait-list, I think, is one of the things that the minister said could have been helpful, and I would argue that we can absolutely do that. Whether it's by zone or whether it's province-wide, I trust that there are many experts who do work in this area. In fact, in the time when I was minister Dr. Metz was lead for neurology in Calgary, and they did create co-ordinated wait-lists for the Calgary zone, and it cut wait-lists, I believe, by 70 per cent.

Sometimes, as the minister noted, your doctor will refer you to one surgeon. Sometimes your doctor will refer you to two or three surgeons, and then you're on multiple people's lists. Sometimes people will go to the first appointment and then when they get called for a second one, they don't go because they've already seen one, or sometimes they do go, and that's an even bigger waste on the health care system. So I would fully support being very collaborative and working in an across-the-aisle, bipartisan way to implement some of those strategies that we did use to help address wait-lists in certain specialties on a broader scale.

I think that this is something that Albertans would love to see, and we don't need to wait until after the next election to do it. If the minister is keen to do it now, we certainly would be very receptive to that. If that's the problem, I'd say let's fix it. I think that a centralized system would prevent queue-jumping, and it would make sure that patients with more knowledge and time aren't the ones who get to the top of the list but patients who have the greatest acuity and that we're managing our wait-list in a much more focused and patient-centred way. So that would be one solution.

I have one minute left. At the same time, the minister has talked about wanting to increase capacity. We're at risk of losing surgical capacity in the Edmonton zone and, I'm sure, probably elsewhere. What's happening right now with hospitalists and the stipend situation is distressing. I highlighted it in the Legislature a month ago when the budget was tabled and brought a number of these hospitalists to come and request an opportunity to meet, and they have also requested other opportunities to meet.

I don't want to talk about the negotiations; I do want to talk about what strategies we're using to make sure that patients who have their surgeries scheduled for April 1 and moving forward don't see further disruptions to their care. Already we know that about half of Albertans are getting their surgeries within the clinical guidelines, and if we lose this capacity, it's going to make it even worse. It's not just orthopaedic surgeons that rely on hospitalists. There are thoracics and a number of other areas, through you, Madam Chair.

The Chair: To the minister.

Mr. Jones: Thank you. Excellent questions from the member opposite. We know there's more work to do on surgeries,

particularly on wait times, and we are committed to improving the timeliness and accessibility of health care in the province to ensure every Albertan receives the care they need within clinically recommended timelines. That is the goal.

As I mentioned earlier, we have approximately 75,000 people across Alberta waiting for various surgeries, and roughly 35,000 – this is current data – are waiting longer than clinically recommended. These 35,000 surgeries represent 177 different procedures, with the top categories being hip, knee, cataract, and hernia. Growth in wait times occurs at times even with increased volumes due to population growth, aging demographics, and increasing case complexity. Workforce shortages, including anaesthesiologists, surgical nurses, and other specialized clinical roles are also impacting the system's ability to maintain full surgical capacity. Acute Care Alberta is working with Alberta Health Services and system partners to strengthen workforce stability, improve capacity, and support more timely access to surgery.

Operating room utilization is influenced by multiple factors beyond just physical space, including staffing, case complexity, patient readiness, and postoperative bed capacity. Alberta is focused on addressing these constraints through improved scheduling, co-ordination, and oversight to ensure available operating rooms are used as effectively as possible. Acute Care Alberta is currently exploring innovative solutions to improve OR utilization, including during the evenings and weekends.

We are committed to completing a record number of surgeries this year. Again, last year we did 318,000. We're on pace for 330,000, and that's before the majority of that 50,000 incremental surgery envelope really gets going. In the first three quarters of '25-26 we were ahead of schedule, completing 102.7 per cent of our targeted baseline volumes.

As an example of progress, in September of 2022, 90 per cent of people waiting for hip replacement received their surgery in 74.2 weeks or less. That decreased to 56.8 weeks as of November of 2025, a substantial reduction. Another example of progress: in September of 2022, 90 per cent of people waiting for knee replacements received their surgery in 87 weeks or less. As of November 2025, that wait time has decreased to 72 weeks. Further to this, we expect to perform 3.7 per cent more surgeries this year than last year.

The Alberta surgical initiative has really been a significant driver of this record activity. It focuses on the entire surgical pathway, not just on procedure volume. It includes system improvements such as referral pathway redesign, which the member referenced in her question, better wait-list management – again, we don't want multiple people on multiple wait-lists; we want to know where people are actually at – rural optimization, and use of data to improve accountability and transparency. ASI is the government's plan to ensure that Albertans receive their required surgeries within clinically appropriate wait times. It focuses on improving the surgical journey from the time the patient seeks advice from their family doctor all the way through to when they're referred to a specialist and then ultimately to surgery and rehabilitation.

6:15

We're expanding surgical capacity by renovating and adding operating rooms across the province, including in places like Brooks, Calgary, Camrose, Edmonton, Fort Saskatchewan, Grande Prairie, Innisfail, Lethbridge, Olds, Ponoka, Rocky Mountain House, St. Albert, and Stettler. These efforts support Alberta's broader acute-care action plan to increase access efficiency and patient flow.

The ASI includes a variety of measures aimed at reducing referral and surgery wait times, increasing capacity, and improving access to surgery. Surgical wait times are again reported in two separate intervals that capture different stages of the patient journey. Wait 1 describes the period from referral to specialist consult while wait 2 is the period from a decision to treat or ready for surgery to the actual procedure.

In 2022 we implemented a very successful program called FAST, Facilitated Access to Specialized Treatment, to enable family doctors and other providers to refer patients to a surgeon with the shortest wait-list or to the patient's preferred surgeon. FAST falls under the purview of Primary Care Alberta and the Ministry of Primary and Preventative Health Services. The program continues to expand, with specialties joining by the day. From January to September 2025 I'm pleased to report that FAST received a total of 125,000 referrals.

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

We're going to move back over to the government side. Please proceed with your questions.

Mrs. Sawyer: Thank you very much, Madam Chair. Through you to the minister. We have touched on this, but there's no such thing as not digging deeper, not learning more. There's more, I think, we can unpack to allow you to speak. With respect to the diagnostic imaging enhancement program it is the first step in a patient's care journey. We've discussed how delays can have ripple effects across the system. It affects the specialist referrals, the surgical scheduling. So the fact that we have this expansion in investment for diagnostic capacity is important.

On page 112 of the capital plan there's $280 million that's been allocated for the diagnostic imaging – I'm having trouble saying "diagnostic" today – enhancement program, a significant investment aimed at strengthening imaging capacity across the province. Can the minister elaborate on how this investment will increase capacity and help patients get the testing they need? Can you also clarify if these dollars are for hospital and acute-care use, or will it also contribute to creating efficiencies for in-community testing?

Mr. Jones: Thank you, Chair and through you to the member for the question. Diagnostic imaging and diagnostics are a critical part of the patient journey, supporting timely diagnosis, safe treatment decisions, and effective care across emergency, in-patient, surgical, and cancer services. As outlined on page 112 of the capital plan, Budget 2026 indeed allocates $280 million over three fiscal years to the diagnostic imaging enhancement program and cancer care program to expand CT, MRI, PET, and cancer-related imaging capacity and reduce wait times across Alberta. A key focus of this investment is replacing and upgrading diagnostic imaging equipment that is reaching the end of its useful life. Newer equipment is more reliable, safer for patients, and capable of higher throughput, which allows more scans to be completed each day. This multiyear end-of-life equipment replacement and expansion helps address rising diagnostic imaging demand while reducing downtime caused by aging and less reliable equipment.

The diagnostic imaging enhancement program also expands capacity by replacing aging CT, MRI, PET, and specialized imaging equipment with more modern technologies. These upgrades improve image quality and enable faster scan times, which increases overall system capacity and helps to shorten diagnostic imaging waiting times. By expanding and modernizing our fleet, patients will be able to access the testing they need sooner.

These investments are also closely aligned with cancer care needs. The program modernizes and expands Alberta's cancer-related diagnostic imaging capacity by replacing end-of-life equipment and introducing advanced technology that supports earlier detection and more timely treatment. Timely access to diagnostic imaging is essential for cancer patients, and this investment will help accelerate diagnostics and improve outcomes by ensuring patients can access advanced imaging technologies when they need them most. In practical terms this investment supports hospitals and cancer centres across the province by increasing diagnostic imaging capacity, improving reliability, and reducing the bottlenecks that often delay care. By enabling faster access to imaging, patients can move more quickly from diagnostics to treatment, which improves patient flow across the health system and supports better outcomes. Taken together, the $280 million in this program will strengthen our capacity, reduce wait times, and help Albertans get the care they need.

Apart from CT and MRI, the diagnostic imaging and cancer care enhancement program also includes other imaging equipment, which should be highlighted, including general radiology, ultrasound, and other ancillary equipment which are being implemented across multiple rural sites, for example in Pincher Creek, Two Hills, and Cochrane to name a few, so certainly going to support our hospitals.

Mrs. Sawyer: Perfect. Thank you to the minister. On page 112 of the capital plan there's $63 million being allocated over three years for developing shelled and vacant spaces. I really think we need to cover this a little bit more, using the space that we have. Can the minister tell us how many spaces he's making fully operational, at which sites, and how much more capacity we can expect? As well, given that acute care covers many areas, is the minister also collaborating with other departments or organizations outside of government to see what the best uses of these vacant spaces are?

Mr. Jones: Thank you, Chair. Developing shelled and vacant space is a practical way to increase capacity more quickly by bringing existing, underused spaces into service rather than waiting for entirely new builds to be completed. Acute Care Alberta is conducting a facility space optimization study meant to ensure there is no space in acute – care facilities that isn't being put to the most optimum use. This initiative supports the development of previously constructed shelled and vacant spaces within existing health facilities, maximizing the value of prior capital investments. Developing existing space can be delivered more quickly and cost effectively than constructing new facilities, allowing us to more quickly stand up the acute-care capacity we need today.

In addition, planning works are under way for other shelled space available in health facilities such as the QE II Ambulatory Care Centre in Grande Prairie. This funding will be used to increase bed capacity by developing shelled space such as at the Maz heart institute in Edmonton, where level 7 and 8 are currently shelled, which could be developed into 26 in-patient beds on each floor, totalling 52 new in-patient beds. The shelled space at Peter Lougheed Centre in Calgary will be developed to house a 29-bed medical surgery in-patient unit. This funding also supports planning work for other shelled spaces across the province so future opportunities can be prioritized and advanced in a co-ordinated way as capacity needs grow.

I would also highlight that we're also conducting a facility space optimization study and assessments of the conditions of our rural health facilities, and the objective is the same. We want to know where we have opportunities to more quickly and more efficiently and at less cost build additional acute-care capacity out of shelled, vacated, or potentially decanted spaces. If something can be moved, of course there's an opportunity to redevelop it into something more necessary for that particular acute-care setting. So lots of work to do, lots of exciting projects in both our urban and rural areas.

Mrs. Sawyer: Thank you to the minister through the chair. Since I've only got a couple more minutes, I want to just do a bit of a conclusion, because we've talked about so many different things from surgical capacity and emergency services to capital investments in hospitals and equipment and some of the efforts for patient flow improvements and access to care in our health system. I think this has allowed a clearer picture of how the ministry of hospital and surgical health plans to strengthen acute care in Budget '26-27. Since we're almost done, I would have this final question to the minister through the chair: looking ahead to the upcoming fiscal year, what is your biggest priority or concern ensuring Alberta's acute-care system continues to meet the needs of patients across the province, and what initiatives or improvements are you most looking forward to delivering over the coming year as this budget is implemented?

6:25

Mr. Jones: Thank you, Chair, and through you to the member for what is a very big question. Looking forward to the fiscal year '26-27, my biggest priority will be to ensure that Albertans are receiving fully integrated access to care across our health system. Acute care doesn't exist in a vacuum, and outcomes in hospitals are directly influenced by how well the rest of the health system is functioning and connected. Under the refocused health system, it is critical that all parts of the system are working together. That includes Primary Care, Mental Health and Addiction, continuing care, and Acute Care. When these areas are aligned, patients experience smoother transitions, care is delivered in a more appropriate setting, and pressure is reduced across the system as a whole.

Ensuring this level of integration requires close collaboration among the four health sector ministries. Each ministry has a clear mandate, but we are working together on a daily basis to ensure services are co-ordinated and that Albertans experience one connected health system rather than fragmented points of care. This collaboration is essential to delivering the quality, access, and consistency that Albertans rightly expect and deserve. As we move into the upcoming fiscal year, the focus will remain on strengthening these connections across the system and ensuring that the refocused health system is operating as intended. By continuing to work collaboratively across ministries and care sectors, we are focused on ensuring that Alberta's acute-care system can continue to meet the needs of patients across the province.

Some other highlights. I'd like to see significant progress on our emergency department wait times and patient experience. I'd like to see reductions in EMS response times, I'd like to see the surgical backlog to be reduced in a material way, and also to stand up more pediatric care. Let's get the kiddos what they need. Thank you for the question.

Ms Pitt: Point of order.

The Chair: A point of order has been called.

Ms Pitt: I was sneezing.

The Chair: You were sneezing. Okay. So used to saying that phrase.

Well, members, what normally happens is the Official Opposition starts. I'm just explaining what's happening. Normally what happens is, with the timing, the Official Opposition starts the

questions, and the timing is set up in such a way that the officials, the government end. But because you did not use up all your time, it ends up that the Official Opposition gets these last few minutes, so this is the penalty for when you don't take your time.

Opposition, this is yours.

Ms Hoffman: It's the reward, Madam Chair.

Would the minister like to share the last two minutes?

Mr. Jones: I would.

Ms Hoffman: Heck yes. Okay. I just want to talk about EMS, and the minister did mention EMS. The estimates line item for 2025-26 was significantly less than the forecast. The overspend was nearly 20 per cent more than what was budgeted, $143 million. This year's estimate is significantly less than the current year's forecast. With a growing population, such a significant number of people experiencing injury, particularly psychological injury among that workforce, I'm worried that that line item isn't realistic. I know that we have significant sick time with EMS, so could the minister talk about a strategy in managing that and what we're going to do to actually get close to this estimate? It seems unrealistic to me.

Mr. Jones: Yeah. Thank you. The actual expected all-inclusive budget for emergency health services is expected to be just north of $1 billion, and there are initiatives under way to address the very real pressures on workforce that you have highlighted. Of course, we're trying to recruit more paramedics to reduce reliance on overtime. There are a number of initiatives under way. I'd like to see work on a bursary be developed. At the same time, we want to expand paramedics' opportunities to work in different environments, so I highlighted that we have step-down units. Those HELPU units. I've highlighted that we're putting paramedics in dispatch and in mobile integrated health units, and I think this is going to provide more career options and also some diversity in what their day looks like.

Ms Hoffman: Thank you. If I could just ask the minister to please look at the community paramedicine program that was in place in 2019. I worry that perhaps it was eliminated because it was an NDP initiative, and I would like the minister to look at the evidence because the evidence that I recall is that it was producing great results, and I would like him to consider relaunching that program.

Mr. Jones: Will do. We'll take all good ideas, and I think we're all aligned that we want to see world-class emergency health services that support our workforce and make the investments that are necessary to get ambulances where they're needed and when they're needed. Thank you for the questions.

The Chair: All right. Well, that's our time. I apologize for the interruption, but I must advise the committee that the time allotted for consideration of the ministry's estimates has concluded. This concludes the consideration of the 2026-27 main estimates by the Standing Committee on Families and Communities.

Thank you, everyone.

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

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