Access to Acute Care

ACCESS TO ACUTE CARE

IN ALBERTA

PROVINICIAL DAY OF ACTION

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CMSA Calgary Medical Students Association

UNIVERSITY OF ALBERTA MSA MEDICAL STUDENTS' ASSOCIATION

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Executive Summary of the Provincial Day of Action (PDoA) 2025

Acute care is a cornerstone of Alberta's healthcare system, providing critical and often lifesaving interventions for individuals facing urgent and complex medical issues. Whether managing general internal medical complications, high-risk pregnancies, cancer diagnoses, or surgical emergencies, acute care services are essential for delivering timely, specialized treatment that improves outcomes and saves lives. Acute care is delivered in hospitals, emergency departments, and specialized units by interdisciplinary teams of physicians, nurses, and allied health professionals.

Alberta's acute care system is under immense strain. As the province's population continues to grow (at nearly twice the national rate) demand for acute medical and surgical services has surged, outpacing staffing and infrastructure capacity. This imbalance has resulted in growing wait times, increased burnout among physicians and staff, and worsening health outcomes for Albertans. Key specialties such as general internal medicine (GIM), obstetrics and gynecology (OBGYN), oncology, and general surgery are all reporting significant challenges in recruitment and retention, resource limitations, and systemic barriers to care delivery.

The impacts of these pressures are far-reaching; Albertans are waiting longer for diagnoses and treatments, patients with complex chronic conditions remain in hospital longer than necessary due to bed shortages, and rural and marginalized populations face pronounced barriers in accessing timely care. The COVID-19 pandemic exacerbated these problems, revealing systemic vulnerabilities in staffing models, care coordination, and infrastructure investment.

To medical students, this is our future workplace: a system under immense pressure and strain. It should come as no surprise why acute care was chosen as a topic of concern for medical learners across the province and the theme of PDoA 2025. To ensure the sustainability and equity of Alberta's acute care system, targeted investment and policy reform are needed. This document outlines key concerns and proposes evidence-informed solutions to improve acute care access, efficiency, and outcomes, including:

1. **General Internal Medicine (GIM)**
   Action Item #1: Expand Allied Health Support - Invest in clinical assistants, social workers, and after-hours care teams which can reduce hospital stays and the need for GIM doctors to handle non-physician tasks.
   Action Item #2: Increase GIM Beds & Alternate Level of Care (ALC) Options - Invest in more beds and long-term care (LTC) planning will reduce ER wait times and improve discharge rates.

2. **Obstetrics and Gynecology (OBGYN)**
   Action Item #1: Enhance compensation models - Remove the gender bias in procedural reimbursements when compared to fields like urology.
   Action Item #2: Improve maternal-fetal outcomes - Expand access to prenatal and perinatal care with enhanced pregnancy screening and centralized care models.

Action Item #3: Expand comprehensive care - Recruit health professionals, such as family doctors and nurses, which can help improve access to women's health services.

3. **Oncology and Cancer Care**
   Action Item #1 Increase Recruitment and Retention of Oncologists - Continue improving compensation agreements to retain and attract a stable workforce while considering other metrics that contribute to physician job satisfaction.
   Action Item #2 Improve Wait Times for Oncology Care - The Province's recent investments in cancer care is promising, but workforce, referral, and care integration improvements are needed to reduce wait times.

4. **General Surgery**
   Action Item #1: Increase Staffing - Increase the number of anesthesiology residency positions, anesthesia assistants, perioperative nursing and support staff in addition to expanding family practice anesthetists' scope of practice.
   Action Item #2: Renew Compensation - Modernize Alberta's Alternative Relationship Plan (ARP) rates to better align with fee-for-service (FFS) compensation, while enhancing incentives for after-hours care, on-call services, and complex case management.
   Action Item #3: Appropriate chartered surgical facilities (CSF) investment - Avoid over-investment in CSFs, prioritize investment in acute care beds and LTC capacity to free up inpatient beds for surgical patients needing overnight stays.

Introduction

Acute care is the backbone of Alberta's healthcare system, delivering vital services to patients with urgent and complex medical needs. When access to acute care is strained, patient outcomes suffer, wait times increase, and healthcare workers are pushed to the brink. Today, Alberta's acute care system is at a tipping point.

Alberta's population grew by 3.9% between 2023 and 2024, nearly double the national growth rate, placing significant pressure on hospitals and acute care providers (Statistics Canada, 2024). Simultaneously, the province faces a growing shortage of specialists across multiple fields. General internal medicine (GIM) physicians are increasingly tasked with non-physician duties due to staff shortages, contributing to burnout and medical backlogs. Alberta's aging population has outpaced hospital bed capacity, leading to bed spacing, delayed discharges, and increased mortality, especially among seniors and patients in rural or Indigenous communities.

Alberta also faces a shortage of Obstetric and Gynecologist physicians (OBGYNs) amidst rising patient volumes. Poor relative financial remuneration under a fee-for-service model is a significant deterrent; gynecologic procedures are reimbursed up to 50% less than equivalent urologic surgeries, a disparity that reflects systemic gender bias and contributes to the pay gap affecting female physicians who dominate the OBGYN field (Chaikof et al., 2022). In a broader view, maternal and newborn health is at risk with the rate of premature births in Canada rose from 7.1% in 1993 to 8.3% in 2023, its highest in 50 years (Statistics Canada, 2023). One in five

pregnant individuals miss first-trimester genetic screening due to poor access to early prenatal care, especially in rural and underserved areas (Varner & Ray, 2023).

In regards to cancer care, Alberta requires 50 new oncologists over the next three years to meet demand, yet only 25 are trained in Canada annually. Existing oncologists cite unsustainable workloads, insufficient support staff, and inadequate compensation as key drivers of burnout and physician departures from the province (Alberta Medical Association, 2025). Recent investment in increasing the compensation

Surgical services also face mounting challenges, including staffing shortages in anesthesiology, perioperative nursing, and support roles are limiting surgical capacity and delaying procedures. Alberta's outdated Alternative Relationship Plan (ARP) rates no longer align with the fee-for-service model, creating disincentives for after-hours and complex surgical care. Furthermore, overinvestment in chartered surgical facilities (CSFs) diverts funding from acute care hospitals, limiting inpatient capacity and creating bottlenecks for surgical patients requiring overnight stays.

This paper outlines evidence-based recommendations across Alberta's acute care system, focusing on sustainable recruitment and retention strategies, equitable and timely access to care, allied health support, compensation reform, and strategic public investment, to ensure Alberta's healthcare system can continue to meet the needs of its people.

Recommendations:

General Internal Medicine

General Internal Medicine (GIM) is a specialty that focuses on caring for patients with complex disease. Family physicians may refer patients to GIM to manage illnesses like diabetes or heart failure. In hospitals, GIM doctors care for patients who are not currently undergoing surgery or are not in the emergency room, and also act as consultants for surgeons and ER doctors.

Alberta's population boom, coupled with an aging population, has increased the cohort of medically complex patients. GIM doctors are needing to take on non-physician tasks to maintain the flow of patients in and out of the hospital. Our proposed action items will benefit patients by increasing the efficiency of patients being admitted and discharged into the hospital and also alleviate the increasing burden that GIM doctors are bearing.

- ***Action Item #1: Expand Allied Health Support*** *- Invest in clinical assistants, social workers, and after-hours care teams which can reduce hospital stays and the need for GIM doctors to handle non-physician tasks.*

The rising complexity of inpatient care and GIM workload in Alberta hospitals underscores the urgent need for better clinical support. Staff shortages are pushing physicians beyond their roles, increasing burnout and administrative strain. Without adequate support, pressure on GIM services risks destabilizing the entire hospital system.

Weekends, holidays, and evenings create significant gaps in care, as many hospital services operate at reduced capacity during these times, requiring GIM physicians to manage a higher patient load with fewer resources. A team-based approach will enhance efficiency, safety and allow GIM physicians to focus on complex medical decision-making (Falcetta et al., 2024). Increasing the scheduling hours of clinical assistants, such as nurses and physician assistants, can provide essential bedside care and procedural support, while allied health providers, including social workers, pharmacists, and rehabilitation providers, can improve transitions of care and reduce hospital length of stay.

Increasing allied health support, specifically in pharmacist support, can also greatly improve patient care and safety. For instance, of 151 patients admitted to GIM at one of Alberta's hospitals, only 2 had a medication history completed without discrepancies; 52% of these patients required changes to their medication admission orders after pharmacist review (Baran et al., 2025). These lapses reflect staffing shortages, Connect Care workflow issues, and the growing complexity of patient care, underscoring the need for multidisciplinary approach. Effective and safe inpatient care requires a collaborative team, including dieticians, pharmacists, occupational therapists, physiotherapists, psychologists, Indigenous health liaisons, and social workers. Supporting GIM means supporting all pillars of the multidisciplinary team.

- ***Action Item #2: Increase GIM Beds & Alternate Level of Care (ALC) Options*** *- Invest in more beds and long-term care (LTC) planning will reduce ER wait times and improve discharge rates.*

Alberta's population grew 9.64% from 2020 to 2024. The province's senior population (65+) increased by 20.4% over the same period (Government of Alberta). The complexity of medical care increases with an aging population due to the higher prevalence of chronic conditions, reliance on multiple drugs to manage conditions (polypharmacy), and the need for a multidisciplinary approach. However, the number of beds and support staff for GIM services has remained stagnant (Amato, 2023). More complex patients require longer hospital stays, which reduces the hospital's ability to admit new patients, leading to a backlog of patients who need to be admitted while waiting in the emergency department (ED). With fewer available beds in the ED to see and treat patients, ED wait times increase.

Patients admitted to GIM are frequently assigned to a bed in a hospital unit other than the one they require care from, known as 'bedspacing'. In Alberta, about 35% of patients experience bedspacing, which has been shown to lead to inefficiencies in disease management, leading to longer hospital stays (Kohn et al., 2021). Bedspaced patients face higher mortality rates (Bai et al., 2018). Therefore, it is crucial to increase the number of beds dedicated to GIM care.

The patient discharge process has been slow due to a lack of Alternative Level of Care (ALC) options. ALC patients, often seniors aged 65 and older, contribute to hospital gridlock as they have no appropriate place to transition. It is estimated that a single ALC patient occupying a bed results in four emergency department patients experiencing delayed access to care per hour (Sutherland & Crump, 2013), a phenomenon known as 'hospital gridlocking' (Smalley et. al, 2020). Whatley (2020) estimated that each ALC-occupied hospital bed costs up to $1,200 CAD per day in staffing and resources.

Alberta has implemented an *Access and Waitlist Management* policy, but further investment by improving discharge planning after hours and continuing to expand access to long-term care facilities would yield a stronger return on investment to improve hospital gridlocking. Increasing the capacity of hospital beds, supportive staff for GIM services and improving social services for ALC patients is essential to address the increase in patient demand, reduce bottlenecks and improve efficiency in the healthcare system. These measures would reduce ED wait times, increase GIM capacity to admit more patients, and, most importantly, improve long-term health outcomes for Albertans.

GIM staffing and bed shortages in urban centres also aggravate healthcare inequities in rural and remote regions. Patients in rural areas often need to be transferred to other zones when they require resources not available in their home communities. Transfers may also be necessary given the shortage of GIM specialists in centres like Grande Prairie and Red Deer. However, rural patients may be less likely to be accepted for transfer given the increased demands on GIM, with rural physicians reporting "delay[s] in trying to convince [urban centres] that they should see the patient" (Boothby 2023). Delays or declined patient transfers disproportionately affect Indigenous remote communities, given the higher proportion of remote

residents who identify as Indigenous (O'Sullivan et al., 2022, Statistics Canada, 2023). Indigenous patients are also more likely to be admitted to hospital in services like GIM (Vigneault et al., 2021), yet many Indigenous patients report experiencing discrimination by healthcare providers. Additionally, 21% of First Nations people living off-reserve report that their cultural needs were not respected in a healthcare setting (Statistics Canada, 2024). This highlights the need for increased access to culturally appropriate Indigenous support resources in GIM, which can only be accomplished with increased support staff.

Obstetrics and Gynecology

Obstetricians and gynecologists (OBGYNs) play a critical role in safeguarding women's health across the lifespan, from adolescence to childbirth, menopause, and beyond. As physician-surgeons, OBGYNs provide both obstetrical care, which includes prenatal, perinatal, and postpartum services, and gynecological care, which encompasses the diagnosis and treatment of conditions affecting the female reproductive system. In Alberta, OBGYNs practice in a variety of settings including hospitals, clinics, private practices, and academic institutions. Hospital-based obstetrical care is typically delivered through dedicated labor and delivery units that include triage, emergency services, and surgical suites, allowing patients to see OBGYNs and receive urgent reproductive care directly, without having to go through the general ED.

OBGYNs are facing numerous difficulties that are impacting the availability and accessibility of women's health services. With Alberta's population growing almost twice as fast as the national average, access to OBGYN care is diminishing due to a critical shortage of specialists, increasing patient volumes, reduced support from other healthcare disciplines, and poor financial remuneration that discourages physicians from entering or remaining in the field in the province (Alberta Medical Association, 2025; Jeffrey, 2024). Women's health needs support; these obstacles are putting the health of Alberta's women, mothers, and newborns at risk.

- ***Action Item #1: Enhance compensation models*** *- Remove the gender bias in procedural reimbursements when compared to fields like urology.*

Fair remuneration is an important factor for physicians when selecting a practice location. While healthcare economic theories show that physicians consider commitment to communities and patients in making career decisions, they especially value receipt of fair and relatively uncomplicated compensation models (Wranik & Durier-Copp, 2011). Since the early 2000s, physicians across Canada have critiqued fee-for-service (FFS) methods of remuneration as being administratively intensive and prioritizing the volume of patients seen over the quality of healthcare provided (Canadian Medical Association, 2020; Gringon et al., 2002; Wranik & Durier-Copp, 2011). However, Alberta still maintains one of the highest FFS payment proportions across Canada (Canadian Medical Association, 2020; Gringon et al., 2002; Wranik & Durier-Copp, 2011).

There is disparity in the fee-for-service remuneration codes for obstetrics and gynecology compared to those designated for specialties like urology (Chaikof et al., 2022). A 2022 study by Chaikof et al. found that comparing the billing in Canada for paired gynecologic and urologic surgical procedures, reimbursement was significantly lower for gynecologic procedures performed on female patients than for urologic procedures performed on male patients. Across Canada, the average difference between billing for gynecologic procedures was 28.1% lower than for urologic procedures (Chaikof et al., 2022). For example, when comparing vestibulectomies (a procedure where tissue is removed from the vaginal opening to relieve structural pain) to adult circumcisions (the anatomical equivalent for those assigned male at birth), the vestibulectomy, on average (across Canada) is reimbursed at fee 130% (or 1.3 times) less than the circumcision (Chaikof et al., 2022). Notably, although ovarian detorsion is a more

invasive, lengthier, and a riskier surgical procedure than testicular detorsion, ovarian detorsions are reimbursed at a difference of over -50% when compared to testicular detorsion reimbursement (Chaikof et al., 2022). When investigating differences by province, Alberta was found to have a significant mean difference in reimbursement between gynecologic and urologic procedures (Chaikof et al., 2022). This disparity in procedural reimbursement reflects a gender bias in remuneration for assisting female patients, but also contributes to the pay gap that disproportionately affects female physicians as OBGYNs are predominantly women themselves (Chaikof et al., 2022; Pickel & Sivachandran, 2024).

Creating an environment where women physicians, and physicians in specialties that serve female patients, feel supported means working to dismantle systemic factors that perpetuate misogynistic gender biases in payment and remuneration models. To improve recruitment and retention of OBGYNs, they must be guaranteed equitable and appropriate compensation for surgical procedures. Compensation should reflect the time spent performing the surgery, the risk of the procedure, and the skill necessary to perform it.

- ***Action Item #2: Improve maternal-fetal outcomes*** *- Expand access to prenatal and perinatal care with enhanced pregnancy screening and centralized care models.*

The rate of premature births in Canada has increased from 7.1% in 1993 to 8.3% in 2023, with the rate in 2023 being higher than in any of the previous 50 years (Statistics Canada, 2023). This trend underscores the importance of improved access to prenatal health care services to reduce and prevent preterm births, especially in Alberta, as this province has one of the highest rates of preterm birth in the country (Alberta Children's Hospital Foundation, n.d.). In the past 5 years, there have been major strides in funding research to address this problem in Alberta with projects ongoing at the University of Calgary and Alberta Children's Hospital (University of Calgary, 2024). The main focuses include collecting data on preterm pregnancies, identifying what factors put women at higher risk, developing a rapid lab-based diagnostic blood test, and using machine learning to generate personalized risk scores for pregnant women allowing for earlier intervention and support (University of Calgary, 2024; P3 Cohort, n.d.).

Similar initiatives have been done in Ontario, with research ongoing in identifying high-risk pregnancies through lab testing and screening tools (Gladstone et. al). This approach shows potential in identifying these individuals early and allowing them to get connected to the necessary resources including Prevention of Preterm Birth Clinics which are widely used in Ontario. These facilities provide women who have had previous preterm births to more robust health services, improving outcomes for following births (Ontario Fetal Centre, n.d.). Continuing to invest in research that identifies high-risk patients and providing more comprehensive care to women who are deemed high-risk would allow for better resource allocation by focusing on high risk pregnancies and providing them early interventions to reduce preterm birth and associated complications (Muraca et al., 2018).

Gaps in access to prenatal care disproportionately affect rural and underserved populations. 20% of pregnant individuals miss first-trimester genetic screening due to limited access to early pregnancy care (Varner & Ray, 2023). This issue is compounded by the fact

many adults of reproductive age lack a primary care provider, who often serves as the first point of contact for prenatal care. Improving access to primary care providers can ensure continuous monitoring and early interventions throughout pregnancy, reducing the reliance on emergency departments. In Ontario, approximately 40% of pregnant patients sought emergency care during or shortly after pregnancy, largely due to the inability to access early pregnancy services (Varner & Ray, 2023). Addressing inefficiencies, by working towards centralized care models that streamline access to early pregnancy care, prenatal visits and management would not reduce the rate of emergency department visits, but also improve continuity of care, resulting in better fetal and maternal health (Varner & Ray, 2023). Another important strategy could involve expansion of midwife-led continuity models of care which have been shown to significantly contribute to the prevention of preterm birth in several ways. Implementing these models of care presents a viable strategy to mitigate preterm birth rates in Alberta. These models involve consistent care provided by a known midwife or a small team throughout pregnancy, childbirth, and the postnatal period. Such models can reduce the likelihood of preterm birth before 37 weeks by approximately 24% compared to other care models (Sandall et al., 2013). Expanding access to midwife-led continuity care in Alberta could yield significant benefits, particularly for vulnerable populations in rural and socioeconomically disadvantaged areas.

- ***Action Item #3: Expand comprehensive care*** *- Recruit health professionals, such as family doctors and nurses, which can help improve access to women's health services.*

OBGYN, like all specialities, relies on the expertise of multiple allied health professionals. Primary care physicians, nurses, family practice anesthesiologists, pharmacists, family medicine obstetricians, and other allied health, in addition to OBGYNs and residents, are required for appropriate patient care. This interrelatedness means that gaps in any area of healthcare can have an effect on access to OBGYN care. For example, a shortage in primary care access means gynecological screening programs, chronic disease management, and prenatal care is affected (Alberta Medical Association, 2025). Limited access to anesthetic care for OBGYN procedures means wait times are extended. Utilizing allied health and resources in a more efficient manner could help offload some of the pressures currently being faced. For example, better access to primary care, including family medicine obstetricians, may lead to the prevention of avoidable complications requiring an OBGYN referral. Utilizing family practice anesthesiologists and nurse-led sedation where appropriate could improve access to surgical care. When the healthcare system is recognized as the cohesive unit it is, solutions integrating the roles of multiple professionals can be deployed and have a profound impact on patients.

Focusing on the future of OBGYN professionals is also important to ensuring the continuity of obstetrical and gynecological care. New suggestions are being made in the literature to identify problems with Albertan OBGYN residency training and to propose solutions to improve work quality (Regan et al., 2024). Specifically, fatigue was identified as a major barrier to OBGYN residents, especially in on-call shifts. While it is important to recognize that the importance and demands of OBGYN care can be tiring, proposing solutions to more effectively address fatigue in the workplace could help sustain the future of OBGYN care. For example, utilizing problem boards for non-urgent pages was a solution that sought to address unnecessary drivers of fatigue and inefficiencies in OBGYN care.

Cancer Care

Cancer diagnoses in Alberta are increasing at a rate that outpaces the recruitment of oncologists. In 2013, 16,600 cancer cases were diagnosed in Alberta, with 102 practicing oncologists. However, in 2022, the number of cancer diagnoses jumped to 23,300, an increase of 40%, whereas the number of practicing oncologists was 122, an increase of only 20% (Alberta Health Services, 2023). Researchers estimate that the number of cancer cases in Alberta will rise 29% by 2030 and 56% by 2040 (Alberta Health Services, 2023). Although the Province recruited 17 new oncologists in the 2024–2025 fiscal year, 10 of those positions replaced retiring physicians, 2 hires were unsuccessful in applying to the College of Physicians and Surgeons, and 1 has moved to another province (Alberta Doctors' Digest, 2025).

- **Action Item #1 Increase Recruitment and Retention of Oncologists** - Continue improving compensation agreements to retain and attract a stable workforce while considering other metrics that contribute to physician job satisfaction.

The Alberta Medical Association (2024) notes that in the last four years, only one of eight Alberta radiation oncology graduates and two of seventeen Alberta medical oncology graduates were successfully recruited to practice in Alberta. Failed oncologist recruitment and staff departures have been attributed to low salaries and high workload levels (Alberta Medical Association, 2024). Alberta needs 50 oncologists over the next three years to meet demands, but only 25 are trained in Canada each year. The new Cancer Care Alberta (CCA) Physician Agreement which was reached in March, 2025 is a positive step, offering physicians an 11% increase in remuneration, retroactive to April 1, 2024, with a 20.1% compounded increase over the agreement term. This agreement recognizes the need to remain competitive with other jurisdictions to hopefully recruit and retain more oncology specialists. However, more work is needed to ensure that cancer care in the Province remains timely and accessible to all Albertans. While contractually guaranteed remuneration is an important consideration in physician recruitment strategies, there are other metrics by which physicians choose whether or not to stay in a practice setting. Alberta’s struggle to retain cancer care physicians and graduates is rooted in a complex interplay of compensation models, system capacity, and policy bottlenecks.

Outside of basic compensation agreements, physician retention is also compromised by inadequate after-hours support and declining compensation for availability. The Physician On-Call Program (POCP) saw a $10 million funding cut in 2020, dropping from $103 million to $93 million (Alberta Medical Association, 2024). Many physicians providing critical overnight or surge coverage are not remunerated at all. Oncologists working late hours or managing urgent inpatient cancer care are often paid through outdated billing codes that fail to reflect the intensity and complexity of that care, particularly at night. When on-call burdens are high and compensation is low, burnout follows, worsening turnover and patient delays (Alberta Medical Association, 2024). Physicians must be fairly compensated for on-call and after-hours work, especially in oncology, where this effort by physicians can be life-saving.

Alberta's investment of $800 million over eight years in a cancer innovation value partnership with Siemens Healthineers and the Alberta Cancer Foundation will help replace expiring equipment and mobilize new technology to provide better and more effective early detection of cancer, and if executed properly, be an incentive to attract new talent with state-of-the-art equipment. This announcement also promised a new Learning Centre of Excellence in Cancer Care and a separate Artificial Intelligence Centre of Excellence in Cancer Care. While these investments are welcome, it is important that the Province remains committed to proper recruitment and retention of cancer care physicians to see this process through; without a strong and supported workforce, the full utility of the substantial investments into this new infrastructure will not be realized.

- ***Action Item #2 Improve Wait Times for Oncology Care*** *- The Province's recent investments in cancer care is promising, but workforce, referral, and care integration improvements are needed to reduce wait times.*

Wait times for cancer care in Alberta have significantly exceeded national standards, which recommend patients see an oncologist within four weeks of referral and begin chemotherapy within another four weeks (Alberta Medical Association, 2024). As of 2024, Alberta patients face median wait times of 7.5 weeks to see a medical oncologist and up to 13 weeks to see a radiation oncologist, with an average of 7.3 weeks (Moir & Barua, 2024). In comparison, Ontario offers significantly shorter waits; 1.1 weeks for medical oncology and just 2.2 weeks for radiation oncology (Moir & Barua, 2024). Countries like France and Switzerland provide even faster access to care. In France, patients typically see an oncologist within one to two weeks, with treatment commencing within four. Similarly, Swiss cancer centers like Inselspital Bern have consultations scheduled within 7–10 working days (Alberta Health Services, 2023). These comparisons highlight a need for system improvements in Alberta to ensure timely, equitable cancer care, when there is a high level of time-sensitivity to receive proper care.

With the increasing use of genetic technologies in cancer diagnosis and management planning, oncologists must continuously adapt to keep pace with evolving treatment options (Pantziarka et al., 2021). Over the past two decades, the number of FDA-approved anti-cancer drugs has more than tripled, from 90 in 2002 to 290 in 2024, adding to the complexity of oncology practice (Pantziarka et al., 2021). While these advancements have led to improved patient outcomes, they have also increased the workload on oncologists, necessitating a larger workforce and more support for physicians (Tableau Public, 2024).

Delays in cancer diagnosis and treatment negatively impact patient mortality and quality of life. Even a four-week delay in initiating cancer treatment is associated with increased mortality (Hanna et al., 2020). For example, each four-week delay in surgery was linked to a 6-8% increased mortality, and a delay in radiotherapy for head and neck cancers was associated with a 9% increase. In Alberta, interviews with 33 physicians identified several key themes contributing to delays in cancer diagnosis (Botey et al., 2021). These key themes included: time constraints in primary care clinics, challenging non-specific symptoms, lack of longitudinal patient care, and prolonged wait times for diagnostic investigations. These physicians highlighted difficulties accessing specialists and confusion about the referral system.

Transferring cancer care in the province to a new structure under Acute Care Alberta, could further increase confusion for family physicians and primary care physicians to know where and how to refer patients for cancer services. It is important that the Province, in making these changes, consult and communicate with physicians and allied health workers in making these changes. The Province must also be ready to provide the administrative backing and support necessary to ensure there are no disruptions to patient care during these transitions (United Nurses of Alberta, 2025).

General Surgery

- ***Action Item #1: Increase Staffing*** *- Increase the number of anesthesiology residency positions, anesthesia assistants, perioperative nursing and support staff in addition to expanding family practice anesthetists' scope of practice.*

Alberta is facing an anesthesiologist shortage with only 10 physician anesthesia providers per 100,000 people (Leir et al., 2024). Despite higher healthcare spending as a percentage of GDP per capita, Canada has fewer anesthesia providers than countries like Korea, Italy, and Norway. As a result, operating room closures and delays in elective surgeries have become increasingly common (Drost, 2024; Lee, 2023). Although the number of anesthesiologists increased by 14.9% from 2016 to 2021, demand continues to outpace supply due to an aging workforce, rising surgical volumes, and growing healthcare needs (Leir et al., 2024).

To address anesthesiology staffing shortages in acute care settings, strategies include increasing the number of anesthesiology residency positions, recruiting more IMGs, streamlining the licensing process for foreign-trained anesthesiologists, and implementing task-sharing initiatives, such as allowing Family Practice Anesthetists to manage more routine cases and expanding the utilization of Anesthesia Assistants in operating rooms.

There are also significant shortages of other medical staff (eg. surgical nurses, clinical surgical assistants, physician assistants) and non-medical staff (eg. trained housekeeping staff). Clinical surgical assistants are recruited through the Alberta Clinical and Surgical Assistant Program (ACSAP), which specifically targets the recruitment of IMGs seeking to practice medicine in Canada (Alberta International Medical Graduate Program, 2025). These clinical surgical assistants have restrictions on the number of hours they can work (Alberta Medical Association, 2024). Without sufficient clinical surgical assistants, the capacity of operating rooms is significantly diminished. Surgical nurse shortages are also rampant throughout Alberta, which directly influences the number of operating rooms that are open and available, as well as the types of surgical procedures that can be performed (Alberta Medical Association, 2024). Shortages of housekeeping staff and non-medical support leads to significant delays in turning over operating rooms for use, which can take 50-70 minutes per procedure (Alberta Medical Association, 2024).

Surgical nursing shortages cannot be solved by simply increasing the number of seats in Alberta nursing programs, in part because Alberta Health Services preferentially hires graduate nurses who have had a final year of "focused experience" in the operating room, or extensive operating room experience (Alberta Health Services, 2023). Surgical nurses hired are then subject to a specialized 14-week training program before beginning independent practice (Alberta Health Services, 2023). Specialized areas of surgical practice (e.g., perioperative nursing) require nurses to complete a 38-week orientation program in addition to the 14-week training program before they can begin independent practice. While this extended training and orientation process is necessary for maintaining patient safety, it highlights how adding capacity for surgical nurses is complex and extends beyond simply expanding existing nursing programs

or available positions. We advocate for a comprehensive expansion of these programs as well as incentives to attract existing RNs to the perioperative nursing workforce.

- ***Action Item #2: Renew Compensation*** *- Modernize Alberta's Alternative Relationship Plan (ARP) rates to better align with fee-for-service (FFS) compensation, while enhancing incentives for after-hours care, on-call services, and complex case management.*

The AMA has proposed several strategies to stabilize acute care and retain physicians, including modernizing Alternative Relationship Plan (ARP) rates. Clinical ARPs offer a physician compensation model that serves as an alternative to the fee-for-service (FFS) payment method by reimbursing physicians for providing specific clinical services at defined facilities to targeted patient populations. Available ARP models include the annualized model, which calculates compensation based on the Provincial Base Payment Rate (PBPR) multiplied by the number of FTEs, and the sessional model, which provides hourly rates for part-time participation ($228.45 per hour for both GPs and specialists). Despite these options, ARP rates are outdated and lag behind FFS compensation, with Alberta having the lowest proportion of physicians paid through ARPs—only 14.1% in 2020–2021.

To address these disparities, adopting funding models like those in British Columbia, which include payroll and benefits, has been suggested. Incentives for after-hours care could be enhanced by improving remuneration systems such as 0.301AA, which currently provides compensation based on time frames and hourly rates, but excludes physicians working in non-AHS facilities. Additionally, improving rates for physicians on call through programs like the Physician On-Call Program (POCP) could address gaps in remuneration, as Alberta's current budget and hourly stipends for on-call services are substantially lower than those provided by British Columbia's Medical On-Call Availability Program (MOCAP).

Further reforms could involve reviewing AHS-paid stipends through the Stipend Working Group and addressing concerns surrounding Z-codes and AHS overhead charges, both of which have contributed to reduced physician involvement and emergency department congestion. Compensation structures should account for both stable, quick cases and complex, multi-comorbid surgeries to ensure equitable reimbursement for physicians handling varied patient needs. Additionally, case-based funding models, which allow for quick turnover while supporting complex procedures, could represent a more balanced approach to incentivizing acute care services.

Lastly, the Government of Alberta announced a shift to an Activity Based Funding model, where facilities' budgets are based on the volume and complexity of the patients they care for (CITE). As learners, we are inherently slower than our attending counterparts. This model would, as it stands, disincentivize teaching throughout our healthcare system. We advocate for guardrails on this model that would continue to make our healthcare facilities learner-friendly from a budgetary standpoint.

- ***Action Item #3: Appropriate chartered surgical facilities (CSF) investment*** *- Avoid over-investment in CSFs, prioritize investment in acute care beds and LTC capacity to free up inpatient beds for surgical patients needing overnight stays.*

Chartered Surgical Facilities (CSFs) have a role in Alberta's healthcare system to complement the hospital surgical capacity and rapidly reduce surgical wait times by efficiently completing "bread and butter" surgeries (cataracts, simple joint replacements, etc.). However, there must be caution with their adoption in order to avoid further draining our health and human resource capacity and exacerbate surgical waitlist issues. In Alberta, surgital waitlists are long and behind targets, due primarily to workforce constraints, not lack of operating facilities (Alberta Health Services, 2023). CSFs, which are excellent at quick, uncomplicated operations, pose a risk of exacerbating workforce shortages if over-adopted. Rather than overinvesting in CSFs, it is imperative that the Province continue investing in existing programs, including adding long-term care beds, to reduce hospital gridlocking to free-up space and personnel. For example, during the COVID-19 pandemic, hospital beds were filled with COVID-19 patients, leading to delayed and cancelled surgeries across the country (Canadian Institute for Health Information, 2024).

Furthermore, it is imperative that the government is transparent around their processes and data. Key statistics, such as: total related asset capacity - health workforce data, bed data, surgical supplies; as well as demographics by facility: on patients, procedures, complexity of cases, and cost so that CSFs, AHS, Covenant, and Lamont can be properly analyzed in terms of value and efficiency. As it stands, the case is not clear whether CSFs are beneficial to our system - as such, we advocate for comprehensive transparency by publicizing these metrics.

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