GOVERNMENT OF ALBERTA

Health

Annual Report
2023-24

Health, Government of Alberta | Health 2023–2024 Annual Report

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Preface

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Sustainable Fiscal Planning and Reporting Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each ministry.

The 2023-24 Annual Report reflects the 2023-26 Ministry Business Plans, the Government of Alberta Strategic Plan, as well as the ministry's activities and accomplishments during the 2023-24 fiscal year, which ended on March 31, 2024.

The Annual Report of the Government of Alberta contains Budget 2023 Key Results, the audited Consolidated Financial Statements and Performance Results, which compares actual performance results to desired results set out in the government's strategic plan.

This annual report of the Ministry of Health contains the Minister's Accountability Statement, the ministry's Financial Information and Results Analysis, a comparison of actual performance results to desired results set out in the Ministry Business Plan. This ministry annual report also includes:

- the financial statements of entities making up the ministry including Alberta Health Services and the Health Quality Council of Alberta, for which the minister is responsible; and
- other financial information as required by the *Financial Administration Act* and *Sustainable Fiscal Planning and Reporting Act*, as separate reports, to the extent that the ministry has anything to report.

All Ministry Annual Reports should be considered along with the Government of Alberta Annual Report to provide a complete overview of government's commitment to openness, accountability, and fiscal transparency.

Minister’s Accountability Statement

The ministry’s annual report for the year ended March 31, 2024, was prepared under my direction in accordance with the *Sustainable Fiscal Planning and Reporting Act* and the government’s accounting policies. All the government’s policy decisions as at June 5, 2024 with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original signed by]

Honourable Adriana LaGrange
Minister of Health

Message from the Minister

Albertans deserve reliable, accessible health care when and where they need it, and in 2023-24, our government launched an ambitious plan to refocus Alberta's health care system. Our refocusing initiative will prioritize acute care, primary care, assisted living, and mental health and addiction to improve patient outcomes, empower health care professionals and improve transparency and oversight.

The 2023-24 Alberta Health Annual Report highlights the significant work that has taken place over the past year to support the health care system across the province. Through Budget 2023, our government invested more than $24.5 billion to improve the delivery of health care services and advance the Health Care Action Plan. These funds were allocated across the health care system to boost access to surgeries, improve emergency medical services, and hire and train more staff. We also continued to expand and modernize hospitals and other facilities across the province to protect quality health care, grow system capacity and support the best front-line health care workers in the world.

Budget 2023 set the foundation to build a modern health care system that puts patients first. Over the past year, we have worked to achieve the priorities outlined in the Government of Alberta's strategic plan as well as the Ministry of Health's business plan. We have adapted to changing circumstances, found ways to support innovation and engaged in conversations with Albertans and health care professionals to help shape the future of health care in the province.

To support our refocusing initiative, we hosted in-person engagement sessions and virtual town halls and provided online engagement tools to ensure health care workers, patients, families, caregivers and community leaders across the province had an opportunity to participate in conversations about current health care challenges and to propose potential solutions. More than 2,500 people participated in the in-person sessions, with an additional 18,000 providing feedback online – a testament to the importance of this work to Albertans. Our refocusing work will continue throughout 2024-25.

Other highlights of 2023-24 include:

- Continuing to implement the Alberta Surgical Initiative and completing 305,000 surgeries – an increase of approximately four per cent from 2022-23.
- Reducing EMS response times in metro-urban communities, communities with more than 3,000 people and rural communities with fewer than 3,000 residents.
- Expanding access to MyHealth Records to allow Albertans to access more of their personal health information.
- Transitioning public laboratory services to Alberta Precision Laboratories, owned by Alberta Health Services, which has reduced wait times by 76 per cent since May 2023.
- Continuing to implement the Alberta Health Workforce Strategy, which sets out a framework to support current health care workers and to build a workforce that meets the needs of Albertans today and in the future.
- Signing of the Canada-Alberta bilateral agreement to invest $1.1 billion over three years to work together to improve health care for Canadians.

I'd like to thank the world-class health care professionals who work tirelessly to provide patients in every corner of the province with high-quality health care services. Together, we are building a more resilient and sustainable health care system, and I look forward to our continued collaboration over the coming year.

[Original signed by]

Honourable Adriana LaGrange
Minister of Health

Management's Responsibility for Reporting

The Ministry of Health includes the Department of Health, Alberta Health Services and the Health Quality Council of Alberta. The executives of the individual entities within the ministry have the primary responsibility and accountability for the respective entities. Collectively, the executives ensure the ministry complies with all relevant legislation, regulations and policies.

Ministry Business Plans, annual reports, performance results and the supporting management information are integral to the government's fiscal and strategic plan, annual report, quarterly reports, and other financial and performance reporting.

Responsibility for the integrity and objectivity of the accompanying ministry financial information and performance results for the ministry rests with the Minister of Health. Under the direction of the Minister, I oversee the preparation of the ministry's annual report, which includes the financial information, performance results on all objectives and initiatives identified in the Ministry Business Plan, and performance results for all ministry-supported commitments that were included in the 2023-26 Government of Alberta Strategic Plan. The financial information and performance results, out of necessity, include amounts that are based on estimates and judgments. The financial information is prepared using the government's stated accounting policies, which are based on Canadian public sector accounting standards. The performance measures are prepared in accordance with the following criteria:

- Reliable - Information used in applying performance measure methodologies agrees with the underlying source data for the current and prior years' results.
- Understandable - the performance measure methodologies and results are presented clearly.
- Comparable - the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- Complete - outcomes, performance measures and related targets match those included in the ministry's Budget 2023.

As Deputy Minister, in addition to program responsibilities, I am responsible for the ministry's financial administration and reporting functions. The ministry maintains systems of financial management and internal control which give consideration to costs, benefits, and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- provide information to manage and report on performance;
- safeguard the assets and properties of the province under ministry administration;
- provide Executive Council, the President of Treasury Board and Minister of Finance, and the Minister of Health the information needed to fulfill their responsibilities; and
- facilitate preparation of Ministry Business Plans and annual reports required under the *Sustainable Fiscal Planning and Reporting Act*.

In fulfilling my responsibilities for the ministry, I have relied, as necessary, on the executives of the individual entities within the ministry.

[Original signed by]

Andre Tremblay
Deputy Minister of Health
June 5, 2024

Results Analysis

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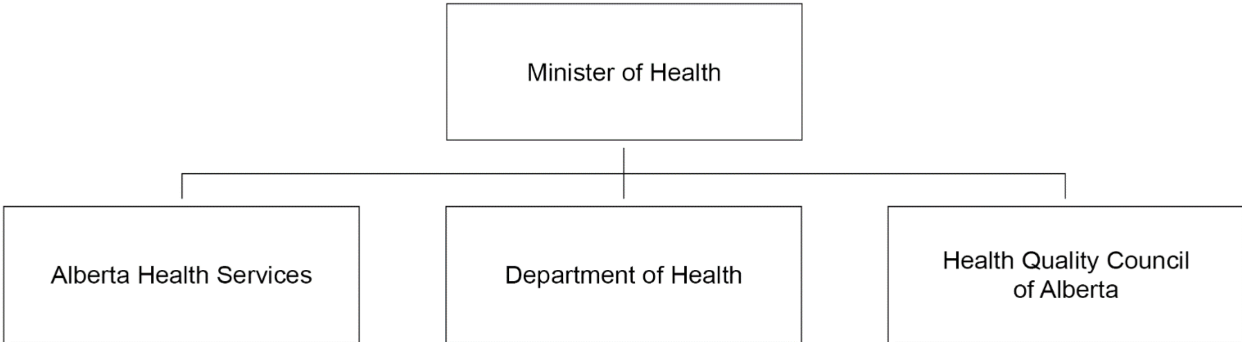
Ministry Overview

Organizational Structure

The Ministry of Health is refocusing Alberta's health care system to improve health outcomes for Albertans and empower health care workers to deliver quality care across the province. A refocused health care system will provide Albertans with the necessary care when and where they need it, enhance government's ability to provide system-wide oversight, set system priorities, and ensure accountability for those priorities on behalf of Albertans. The ministry supports Albertans' health and well-being throughout their lives by protecting public health and promoting wellness; coordinating and delivering safe, person-centered, quality health care services; planning capital infrastructure; supporting innovative information management and technologies; regulating health care; and, funding the health system.

The Ministry of Health currently consists of the Department of Health, Alberta Health Services (AHS), and the Health Quality Council of Alberta. In the refocused health care system, provincial sector-based health organizations will be created for acute care, continuing care, mental health and addiction, and primary care. AHS will continue to have a strong role as part of the refocused system as a hospital service provider. A separate integration council will be formed to ensure system alignment, identify efficiencies, remove barriers and make sure the system is delivering better health outcomes.

The Ministry of Health relies on collaboration with a range of health professionals; partners and organizations in the health and social sectors; academic and research institutions; First Nations, Metis Settlements, and the Métis Nation of Alberta; and other orders of government in delivering health services as well as maintaining and improving Alberta's health system. The Minister of Health is supported by parliamentary secretaries for rural health and health workforce engagement.



The Department of Health establishes the Government of Alberta's strategic direction for health, including advising government on health policy, legislation and standards, and public health concerns; monitoring and reporting health system performance; setting policies and priorities for the electronic/digital health environment; and providing oversight and ensuring accountability across the health system.

The provincial acute care organization will oversee the delivery of acute care including care delivered in all hospitals, urgent care centres, and chartered surgical facilities; emergency medical services; and, cancer care. The organization will work directly with acute care service delivery providers including AHS, Covenant Health and chartered surgical facilities to reduce wait times for

emergency departments, reduce wait times for surgeries, lower Emergency Medical Services (EMS) response times and improve quality of acute care across the province.

The provincial continuing care organization will provide provincial oversight and coordination of service delivery across the spectrum of continuing care, including continuing care homes and home and community care. The organization will focus on achieving equitable, consistent, and timely access to continuing care supports and services through a single, coordinated intake approach, increasing the number and geographic distribution of continuing care spaces to meet the needs of Albertans, and improving team-based, cross-sector care by leveraging other health and social services.

The provincial primary care organization will coordinate primary health care services and provide transparent provincial oversight. The organization will focus on ensuring all Albertans are attached to a family physician or a nurse practitioner, providing timely access to high-quality primary care services and supporting an integrated team of health professionals to provide comprehensive primary care with appropriate access to patient health information.

The Health Quality Council of Alberta (HQCA) works collaboratively with health system partners on a variety of topics and initiatives to improve the health system and patient safety, person-centred care and health service quality across the province. The HQCA's role will expand to support Alberta Health and the provincial health care organizations to set performance standards and performance indicators and to support audit and compliance functions.

The Office of the Alberta Health Advocates reports to the Minister of Health to improve patient care and the health system. The advocates support Albertans in navigating the health system and accessing the appropriate resolution services to address health care concerns, including those specific to the *Alberta Health Act*, seniors, their families, and service providers.

In the refocused health care system, the Ministry of Mental Health and Addiction will oversee the mental health and addiction organization.

Operational Overview

Department of Health

In 2023-24, the department reorganized its organizational structure. Four new divisions were established: Acute Care, Indigenous Health, Primary Care and System Refocusing, and changes were made to the existing divisions to better align with the refocused health system, ministry strategic objectives and to deliver on government's priorities.

With direction from the Minister, the Deputy Minister is responsible for the daily operations of the Department of Health, which is structured as follows:

Deputy Minister's Office – provides leadership to the health system to ensure quality health services, drives innovation, and builds and maintains collaborative relationships across government ministries, AHS, the HQCA, and partner organizations. The office provides policy coordination and issues management for the Minister and leadership in priority setting, decision-making, and operations of the ministry. The office is also responsible for ministry correspondence services.

Acute Care Division – leads the province's renewed focus on acute care services, including developing standards, monitoring and evaluating the acute care sector's performance, and working with partner divisions to oversee the delivery of hospital care, urgent care, cancer care, clinical operations, surgeries, and EMS. The division also supports strategic policy for acute care, working with partners to develop solutions for the acute care and EMS sectors, oversees the governance and legislative compliance of EMS delivery and is currently supporting the implementation of the new Alberta Standing Committee on EMS.

Continuing Care Division – develops provincial strategic policy and performance oversight for all streams of continuing care services (home care, supportive living and continuing care homes) and palliative and end-of-life care. The division works extensively with other government ministries, AHS, and other relevant stakeholders (e.g., community organizations, researchers, etc.) to achieve its mandate. This mandate includes directing continuing care policy through the development of relevant strategies, legislation, standards, initiatives (grant funded and otherwise) and evaluation frameworks to identify performance expectations and governance structures for monitoring system performance. The division also administers the licensing and regulatory compliance monitoring program for the continuing care sector. Over 1,000 continuing care sites throughout Alberta are licensed, and the division safeguards the safety, security, and quality of life of residents and continuing care clients through regular inspections and by investigating complaints and reportable incidents. Inspection results are posted in the facility, provided to residents and their families, and published on the Alberta Health website.

Finance and Capital Planning Division – develops and manages the ministry's budget and funds and monitors the financial activities of the department. It also provides financial advice and prepares annual financial statements, ensuring compliance with Government of Alberta financial legislation. The division oversees corporate planning and reporting; AHS accountability; systems planning; capital planning and coordination of infrastructure projects with the Ministry of Infrastructure and AHS. To enable the department to fulfill its mandate, the division coordinates the department's grant approval process and provides general administrative and contracting-based corporate services. The division also manages registration, designation and bed survey processes and reporting.

Health Information Systems Division – provides leadership and strategic direction for the development and implementation of policy, legislation and standards for the provincial eHealth environment, the *Health Information Act* and the department's information and technology

requirements. The division is responsible for Alberta Netcare (electronic health record) and MyHealth Records (personal health record), including health information policy and advice, stakeholder engagement, strategic planning and project and system delivery and operations.

Health Workforce Division – develops and implements health workforce and system policies related to insured health care provider compensation and health professions self-regulation. Working in collaboration with stakeholders, the division oversees the implementation of key health workforce planning and priorities such as the health workforce strategy and provides health workforce planning support to enable a fiscally sustainable and effective health workforce to support Albertans' needs. Together, these initiatives support the government's commitment to build a health care system that is sustainable and serves the needs of Albertans.

Indigenous Health Division – leads government efforts to improve the health and well-being of First Nations, Métis and Inuit Peoples in Alberta through culturally safe health care service delivery, policy development, health promotion, knowledge exchange, and partnerships. The division advances its critical work on First Nations, Métis and Inuit health by strengthening partnerships with First Nations, Métis and Inuit partners and working with them to develop and implement appropriate and meaningful healthcare for First Nations, Métis and Inuit Peoples in Alberta. The division leads key mandate priorities, such as enhancing Alberta Health's health policy and planning capacity and stakeholder relationships, advancing the implementation of the Indigenous Modernizing Alberta's Primary Health Care System (MAPS) initiative, and working collaboratively with First Nations, Métis, and Inuit partners, and health system providers to build a culturally safe health care system.

Pharmaceutical and Supplementary Benefits Division – oversees and provides governance to the Alberta Health Care Insurance Plan (AHCIP) and all government-sponsored supplementary health benefits programs (i.e., Coverage for Seniors, Non-Group Coverage, Assured Income for the Severely Handicapped, Income Support, Alberta Adult/Child Health Benefit programs, Ukrainian Evacuee Health Benefit, Alberta Aids to Daily Living, and Dental and Optical Assistance for Seniors programs) that provide Albertans with pharmaceutical, optical, dental and other medical supports (wheelchairs, prosthetics, oxygen, medical/surgical supplies, etc.). The division is also responsible for Alberta's participation in the National Blood Program and advising the Minister in their role as a corporate member of Canadian Blood Services.

Primary Care Division – responsible for developing policy and performance oversight of primary care, including establishing the new primary care organization and models (e.g., Regional Primary Health Care Networks) and developing related accountability mechanisms, such as standards and legislative tools. The division is also responsible for developing and implementing key policy initiatives aligned with the government renewed focus on primary care, such as the implementation of the Modernizing Alberta's Primary Care System (MAPS) initiative, supporting the administration and governance of Primary Care Networks (PCNs), and strengthening relationships with key stakeholders. The division will oversee primary and community health; chronic disease management; and the administration and governance of PCNs to meet the needs of Albertans. The division collaborates with stakeholders, such as physicians; nurse practitioners; registered nurses; licenced practical nurses; health professions' regulatory colleges; and health system leaders from academia and the community to support provision of quality primary health care services to Albertans. The mandate of the division is achieved through evidence-informed and value-oriented initiatives, promotion of the patient medical home initiative through PCNs and their governance structure; performance monitoring and evaluation; and, collaboration with health professions' regulatory colleges to support patient safety.

Public and Rural Health Division – provides strategic direction and leadership on emerging public health risks; communicable diseases; immunization; compliance monitoring; environmental public

health; newborn screening; health promotion; and, emergency preparedness, response and recovery, through the assessment, development and implementation of provincial policies, regulations, strategies, and standards. The division carries out these functions to support innovation and engagement with Albertans in wellness, health promotion, and injury and disease prevention. To support health system quality, the division collaborates with partners to perform compliance and monitoring activities and enforcement of the acts, regulations and standards administered by the division in the areas of physician billing, infection prevention and control oversight, and protection for persons in publicly funded care. The division is also responsible for the development of rural health-related policy.

Strategic Planning and Performance Division – responsible for providing leadership for health care research and innovation, including monitoring, assessing, and improving health system performance. The division is the primary source for Alberta's overall health system data standards and analytics, evaluating the health system's performance to support evidence-based policy decisions for all health sectors. The division is also responsible for the *Freedom of Information and Protection of Privacy Act* (FOIP), strategic policy and initiatives, governance of health agencies, and all Cabinet-related materials, as well as intergovernmental relations. The division leads the department's strategic policy development and works with other divisions on developing performance and reporting standards for the health care system.

System Refocusing Division – responsible for implementing the new direction for Alberta's health care system to improve health outcomes for Albertans and empower health care workers to deliver quality care across the province. This includes refocusing to support a unified health system with four sectors: primary care, acute care, continuing care, and mental health and addiction; supporting divisions, AHS, and system partners in achieving the new direction; and, engaging with health care workers and members of the public to understand the current system and support a smooth transition for the health care system.

Office of the Chief Medical Officer of Health – monitors and reports on the health of Albertans and advises on actions to protect and promote the health of the public under authority of the *Public Health Act*. This includes legislated responsibilities related to disease surveillance, communicable disease outbreaks, infection prevention and control measures, health risk assessments, and states of public health emergencies. The Office of the Chief Medical Officer of Health provides strategic leadership, oversight, support and clinical expertise on issues of public health importance to Albertans. The Office works closely with diverse partners within and beyond the health system, including the department's Public and Rural Health Division and Medical Officers of Health at AHS and Indigenous Services Canada, to facilitate policies, processes and programs to prevent chronic diseases, control the spread of communicable diseases, support health surveillance, and strengthen the public health system in Alberta.

Communications (Communications and Public Engagement-Health) – through Communications and Public Engagement (CPE), CPE-Health provides Albertans and health system partners with information about ministry policies, programs, and initiatives. The CPE-Health team works with department staff to develop and implement communication plans and offers communications support, such as media relations, issues management, writing and editing services, product development, and online communications services. CPE-Health also works closely with AHS and other reporting entities to coordinate ministry communications.

Health Law – through Alberta Justice, a team of lawyers support all aspects of the department's activities, ranging from grant agreements and contracting and procurement to developing and interpreting legislation and general legal advice to the ministry.

Human Resources – through the Public Service Commission, Human Resources is dedicated to supporting initiatives, delivering programs, and providing human resource expertise and services that attract, retain, and engage the department's workforce. The branch works in partnership with managers and employees to build and sustain workforce capacity to achieve business goals and create an environment where employees are respected, valued, engaged and resilient.

Procurement & System Optimization Secretariat – The Procurement and System Optimization Secretariat (Secretariat) supports system-wide optimization (i.e., cross-sector optimization projects, etc.) and leads development and negotiation of contracts and standing offers for system-wide ancillary services and to support system-wide optimization, where appropriate. The Secretariat establishes spending and urgency thresholds to support local procurement and decision making, as required. The overall goal is to maintain the benefits of a centralized procurement function, while at the same time adapting to local needs where required and where it makes sense.

Key Highlights

In 2023-24, the Ministry of Health focused on accomplishing three outcomes identified in the 2023-26 Ministry Business Plan:

- An effective and accessible health care system that provides Albertans with the necessary care when and where they need it.
- A modernized, safe, person-centered, high quality and resilient health system that provides the most effective care now and in the future for each tax dollar spent.
- The health and well-being of all Albertans is protected, supported and improved, and health inequities among population groups are reduced.

The following table represents the key highlights and results achieved by the Ministry of Health in 2023-24. The content in this report is valid as of June 5, 2024; some information is still being assessed and therefore is not reflected.

Health Care Action Plan (HCAP)	Alberta Health continued to implement the HCAP, released November 2022, to ensure immediate improvements in key areas of health care and build a better health care system for Albertans. The HCAP focuses on four goals: reducing wait times for surgeries; decreasing emergency department wait times; improving EMS response times; and, empowering frontline workers to deliver health care.
Decreasing emergency department (ED) wait times	Work continues on several initiatives aimed at improving access to emergency care and reducing wait times. A primary focus is on improving patient flow through emergency rooms/acute inpatient wards and out to the community to increase patient safety and experience.
Improving emergency medical services (EMS) response time	Government remained committed to reducing EMS response times through the implementation of the HCAP. In 2023-24, a total of $663 million was spent on EMS. Further, as a result of the EMS Return to Service initiative that was launched in March 2023 to support paramedics in the safe handover of patient care to ED staff within a 45-minute target, there was an overall decrease in the amount of time paramedics spent in hospital from an average of 3.0 hours in in 2022-23 to 1.6 hours as of March 31, 2024.
Reducing wait times for surgeries as part of the Alberta Surgical Initiative (ASI)	Work continued on prioritizing surgeries and allocating operating room time according to the greatest need; streamlining referrals from primary care to specialists; increasing surgeries at underutilized operating rooms, mainly in rural areas; and, providing less complex surgeries through chartered surgical facilities.
Building health workforce capacity	In 2023-24, Alberta Health continued to implement actions and initiatives to address Alberta's health care workforce needs and ensure the health care system has sufficient workforce to support Albertans' health needs now, and in the future. Efforts include working with the Ministry of Advanced Education and Alberta's post-secondary institutions to expand the number of nursing student seats, undergraduate medicine seats and post-graduate medical residency seats in Alberta's medical schools. In 2023-24, $158 million was invested for initiatives to train, recruit and retain more health care professionals for Alberta, with a focus on rural areas.

Modernizing Alberta's primary care system	The government continued to implement the Modernizing Alberta's Primary Health Care System (MAPS) initiative that was launched in September 2022 to address urgent pressures, help stabilize the primary health care system, and increase access to the health care Albertans need. On October 18, 2023, the MAPS final reports for the Strategic Advisory Panel and the Indigenous Primary Health Care Advisory Panel were released, which identified immediate, medium- and long-term improvements to strengthen Alberta's primary health care system, with a targeted stream for Indigenous peoples across the province. *Budget 2023* invested $243 million to develop new models of care and stabilize the primary care system to improve primary health care for Albertans, which included almost 51 per cent, or $125 million, being invested over three years to implement recommendations from both MAPS final reports.
Health Care System Refocusing Initiatives	The Government of Alberta is refocusing the health care system to prioritize patient care and empower frontline health care workers, including those serving rural, remote and Indigenous communities, to deliver the highest quality health care. The refocused system will improve patient outcomes and access through the creation of dedicated sector-based health organizations for acute care, continuing care, mental health and addiction, and primary care within a unified provincial health care system.
Continuing care transformation	Alberta Health continued to reshape the continuing care system based on the recommendations from the Facility-Based Continuing Care review, the Palliative and End-of-Life Care engagement, and learnings from COVID-19. The new *Continuing Care Act* came into effect on April 1, 2024, setting the conditions for change in the continuing care sector to support more Albertans to age at home; improve workforce flexibility; and, enhance service quality and oversight to assist Albertans transitioning between care types and settings, including home and community care, supportive living accommodations, and continuing care homes.
Innovation and modernizing digital health services	Government continued to provide digital access to health information to empower Albertans on their health journey within a person-centered health care model. In 2023-24, the ministry made progress on key innovations such as the expansion of information available through the MyHealth Records (MHR) portal, and linking community primary care information into Alberta's Electronic Health Record (Alberta Netcare) to support patients and their care teams in making better clinical decisions. As of March 31, 2024, there were over 1.7 million MHRs users, with an average daily login of 25,000 users. In addition, over 2,780 community clinics and 1,670 community pharmacies were using Alberta Netcare.
Canada Health Transfer	In 2023-24, Alberta received $6 billion from the Government of Canada through the Canada Health Transfer (CHT); this included a one-time CHT top up of $233 million during 2023-24 to address immediate pressure on the health care system. In December 2023, Alberta's government also signed a bi-lateral agreement with the federal government on shared health care priorities to improve access to high-quality family health services, including in rural and remote areas, and for underserved communities. The agreement included $285 million over the next three fiscal years (2023-24 to 2025-26). This funding will support actions and prorities to improve and strengthen

	primary health care in Alberta, including support for First Nations, Métis and Inuit Peoples through the Indigenous MAPS initiative. In addition, Alberta executed the Aging with Dignity bi-lateral agreement in March 2024 for $627 million to be funded over the period from 2023-24 to 2027-28.
Strengthening rural health capacity	Making sure Alberta's rural and remote communities have the doctors and nurses it needs to support the health care system was a priority for the government. In 2023-24, the ministry invested $158 million on initiatives to educate, recruit, and retain health care professionals, particularly for rural areas. These initiatives included: rural physician education programs; financial incentives for rural physicians such as the Rural Remote Northern Program; the Rural Health Professions Action Plan (RhPAP); targeted recruitment of internationally educated nurses; and, implementation of the Alberta Medical Association Agreement.
Protecting population and public health	In 2023-24, over $1 billion was spent to support population and public health initiatives to maintain and improve the health of Albertans. Alberta Health continues to protect Albertans through injury prevention; environmental public health and food safety; immunization; and, primary prevention, testing and treatment of chronic diseases such as diabetes and cancer, as well as communicable diseases, sexually transmitted and blood borne illnesses and respiratory viruses.
Alberta Ukrainian Evacuees Health Benefit Program	In 2023-24, Alberta Health continued to support the Ukrainian Evacuee Alberta Health Benefit. As of March 2024, the benefit has provided supplementary health benefits coverage to over 43,000 Ukrainian evacuees. In addition, Ukrainian evacuees have benefited from the Ukrainian Evacuee Temporary Health Benefits Program, which was established in March 2022 to provide publicly funded health insurance coverage to Ukrainian evacuees. As of March 26, 2024, 52,819 Ukrainian evacuees were receiving public health insurance coverage through the benefit program.
Improving health care access for underserved populations and for First Nations, Métis, and Inuit peoples	As part of the MAPS Indigenous Primary Health Care Advisory Panel's Final Report, which was released on October 18, 2023 and contained 22 recommendations to address immediate challenges facing Indigenous patients, communities, and organizations, the ministry has established the Indigenous Primary Health Care Innovation Fund and Indigenous Patient Navigator grant programs. Through these programs, government will invest in Indigenous health care service providers and agencies to deliver comprehensive primary health care services closer to home. Further, *Budget 2023* provided approximately $1 million over three years (2023-24 to 2025-26) to each of the two Indigenous post-secondary institutions to support delivery of the Health Care Aide (HCA) program in an Indigenous learning environment.

The Ministry of Health remains committed to regulatory approaches and program delivery that reduces unnecessary government oversight and emphasizes outcomes, to improve access to government services, attract investment, support innovation and competitiveness, and grow Alberta businesses.

Discussion and Analysis of Results

Actions that support the priorities of the Government of Alberta Strategic Plan

Key Priority Two:

Standing up for Albertans

Objective Four: Ensuring an accessible and modernized health care system

- Improving access for underserved populations and for First Nations, Métis, and Inuit peoples to quality health services that support improved health outcomes by promoting and exploring novel, innovative, and creative strategies.

  Detailed reporting found on page 47 – 48 (Key Objective 3.3)

- Implementing actions identified by the Health Care Action Plan to improve Emergency Medical Services system response times, reduce emergency department and surgical wait times to ensure patients are receiving the appropriate level of care, and empowering frontline workers to better deliver health care services.

  Detailed reporting found on page 21 – 28 (Key Objective 1.1)

- Modernizing continuing care, primary health care, and digital health systems to increase choice, enhance access, and improve the quality of care for Albertans.

  Detailed reporting found on page 50 – 54 (Key Objective 3.5)

- Addressing health care staffing challenges by investing $158 million in 2023-24 towards initiatives to train, recruit, and retain more health care professionals for Alberta. This work is supported by Alberta's Health Workforce Strategy and the Rural Health Professions Action Plan, addressing specific challenges in remote and rural communities, as well as creating additional seats for physician training at Alberta's medical schools.

  Detailed reporting found on page 28 -29 (Key Objective 1.2)

- Addressing the province's critical nursing shortage by making it easier for credentialed nurses from the Philippines to bring their skills to Alberta patients. Government is attracting internationally educated nurses by addressing barriers faced by many internationally trained nurses, including the navigation of complex regulatory requirements, assessment and licensing processes, and having access to clinical placements.

  Detailed reporting found on page 28 -29 (Key Objective 1.2)

- Investing $4.2 billion over three years in capital funding to maintain or expand health care facilities across the province. This includes funding for the redevelopment and expansion of the Red Deer Regional Hospital, which will increase critical services and add capacity to one of the largest hospitals in the province.

  Detailed reporting found on page 34 – 36 (Key Objective 2.2)

Objective Six: Partnering with Indigenous communities

- Working with the federal government to improve access for Indigenous Peoples to key services such as education and health care, and advocating for on-reserve services for persons with developmental disabilities, addiction and/or mental health issues.

  Detailed reporting found on page 47 – 48 (Key Objective 3.3)

Objective Eight: Building better communities

- Assisting Ukrainian evacuees fleeing the Russian invasion through the provision of supports and services to help them settle and integrate into communities across the province, including initiatives to address recommendations from the Premier's Advisory Task Force on Ukraine.

  Detailed reporting found on page 34 (Key Objective 2.2)

Outcome One: An effective and accessible health care system that provides Albertans with the necessary care when and where they need it

Key Objectives

1.1 Implement the Health Care Action Plan to strengthen the Emergency Medical Services (EMS) system, reduce surgical wait times, decrease emergency department wait times, and empower frontline workers to provide improved services to Albertans with immediate health care needs.

Alberta is committed to creating an effective and accessible health care system that provides Albertans with the necessary care when and where they need it. The Government continues to prioritize building health system capacity to have a high-quality health system that meets patients' needs and provides access to the most appropriate care in the most suitable setting. This includes building surgical, emergency medical services (EMS) and Intensive Care Unit (ICU) capacities, as well as the health workforce. Several initiatives are underway to expand the capacity of Alberta's publicly funded health care system and minimize disruptions to patient care. This includes preparing to respond more effectively to any future health crises and reduce wait times across the health care system. A resilient, sustainable health system will allow the system to operate at full capacity for longer periods before needing to adjust health care resources. This policy has overall goals of improving access to scheduled health services, improving wait times and reporting, and ensuring timely communication for patients.

The ministry remains unwavering in its focus on increasing surgical capacity to keep pace with demand and reduce the length of time Albertans are waiting for scheduled surgeries. Efforts are geared towards improving patient navigation of the health care system through enhanced care coordination and surgical pathways and resources; improving specialist advice and collaboration with family physicians before consultation; and, centralizing referrals for distribution to the most appropriate surgeon with a shorter wait list.

Alberta Health continued to implement the Health Care Action Plan (HCAP), released in November 2022, to ensure immediate improvements in key areas of health care and build a better health care system for Albertans. The HCAP has four goals: decreasing emergency department wait times; improving EMS response times; reducing wait times for surgeries; and, empowering frontline workers to deliver health care.

As part of HCAP, a key priority for the ministry in 2023-24 was to continue with the implementation of the Alberta Surgical Initiative (ASI), a surgical access improvement plan with a patient-first focus to reduce surgery wait lists and wait times, and strengthen surgical services in Alberta. This will ensure that Albertans are receiving surgeries within clinically recommended wait times. Through the ASI, Alberta Health continued to work with Alberta Health Services (AHS) to improve and standardize the entire surgical journey through:

- prioritizing surgeries and allocating operating room time according to the greatest need;
- streamlining referrals from primary care to specialists;
- increasing surgeries at underutilized operating rooms, mainly in rural areas; and,
- providing less complex surgeries through accredited Chartered Surgical Facilities (CSFs) to help provide publicly funded insured services and extend existing capacity in hospitals.

CSFs continue to be an integral part of the ASI implementation to enable increased volume of publicly funded surgeries at no cost to patients. In 2023-24, there were 39 existing CSFs, which included one new CSF contract that was implemented to expand publicly funded surgical capacity in these facilities. CSFs are an extension of existing capacity in hospitals and are used in many other Canadian health systems. Under the *Health Facilities Act*, CSFs providing publicly funded insured services must be accredited by the College of Physicians and Surgeons of Alberta, and have a signed service contract with AHS.

In 2023-24, accredited CSFs in Alberta provided over 62,400 surgeries, up from a total of 47, 400 surgeries provided in previous year. This is approximately 20.5 per cent of all publicly funded scheduled surgeries being performed in CSFs in 2023-24, a significant increase from the 16.2 per cent of surgeries that were performed in CSFs in 2022-23. One agreement was added with a CSF to provide up to 800 otolaryngology (ear, nose and throat) surgeries and another was amended to increase the volume by 400 surgeries annually. In 2023-24, AHS also entered into agreements with CSFs in Edmonton and Calgary for up to 6,000 orthopedic surgeries annually. The volume of surgeries performed at CSFs is expected to continue to increase over the coming years as more CSFs become operational.

In 2023-24, a total of over 304,500 surgeries were completed, which was over 10,200 or approximately four per cent more than the 294,300 surgeries in 2022-23. As of March 31, 2024, there were over 5,000 fewer surgery cases waiting longer than clinically recommended than at the start of the fiscal year (i.e., 27,159 surgery cases compared to 32,200 surgery cases in April 2023). This was almost a 16 per cent improvement compared to 2022-23.

Wait times for surgical procedures are an indicator of access to the health care system and a reflection of efficient use of resources. This indicator tracks the proportion of the three common surgical procedures completed within the national wait time benchmarks. In 2023-24, more Albertans received knee and hip replacements procedures within the national wait time benchmarks compared to 2022-23. Hip replacements, at 62.4 per cent, improved by 19 per cent compared to the prior year. The proportion of knee replacements that met national wait time benchmarks increased to 53.3 per cent, an improvement of 21 per cent when compared to last year. These improvements were due to continued expansion of surgical capacity as more chartered surgical facilities (CSFs) become fully operational and the optimization of surgical capacity across the province, especially in rural communities. However, 59.7 per cent of cataract surgical procedures met national wait time benchmarks in 2023-24, a decline of 5 per cent when compared to last year. This metric is influenced by the level of demand for cataract surgery and the continued efforts to prioritize patients who have waited longest for surgeries. These patients are often individuals who have waited longer than the national benchmark for clinical recommended timelines.

The improvements in surgical procedures reflect progress towards expanding surgical capacity as per the Alberta Surgical Initiatives and Health Care Action Plan led by the Ministry of Health, which contributes to lower wait times. Ongoing actions include ministry initiatives to streamline the surgery referrals system, prioritize surgeries to the greatest need, and provide less-complex surgeries through CSFs. However, wait times for surgical procedures continue to be impacted by delayed surgeries due to the pandemic, an aging population and health system capacity.

Performance Indicator 1.c
Percentage of surgical procedures that met national wait time benchmarks

Surgery (national benchmark)	Prior Years' Results				2023-24 Actual
	2019-20	2020-21	2021-22	2022-23[3]	
Hip replacement[1] (benchmark 182 days)	65.5%	51.6%	51.2%	43.0%	62.4%
Knee replacement[2] (benchmark 182 days)	61.5%	43.3%	39.7%	32.5%	53.3%
Cataract surgery (benchmark 112 days)	45.1%	45.3%	64.7%	64.7%	59.7%

Source: Alberta Health Services
Notes: [1] Hip replacement data include totals, partials, resurfacings, primaries and revisions for scheduled/elective cases.
[2] Knee replacement data include totals, partials, unicondylars, primaries and revisions for scheduled/elective cases.
[3] The percentages of all the three surgeries performed within national benchmark for 2022-23 have been updated to reflect additional data received after publication.

The ministry also worked on additional actions as part of the ASI to improve access and wait times for surgery. AHS partnered with the Institute for Healthcare Optimization, through a grant provided by Alberta Health, to implement surgical smoothing techniques (e.g., performing scheduled and urgent surgeries in different operating rooms) to improve the flow of surgical patients through AHS' busiest facilities. A progress report on this initiative is expected later in 2024. Alberta Health provided AHS with grants to implement projects and additional measures to improve access and wait times for surgery, which included approximately $1.4 million for Rapid Access Clinics, over $1.5 million for prehabilitation, over $1.4 million for the Virtual Health Hospital, almost $577,000 for the Regional Surgical & Obstetrical Network of Alberta and approximately $20 million for ASI Capital Equipment.

In October 2023, AHS launched a prehabilitation pilot in Edmonton to provide patients with the information they need to prepare for surgery to improve surgical outcomes. Also, in February 2024, AHS initiated a pilot with three Rapid Access Clinics to expedite musculoskeletal assessments for individuals referred for orthopedic services. These clinics will determine if patients require surgery or non-surgical treatment. These actions are expected to reduce referrals to orthopedic surgeons and allow patients to start non-surgical treatment in a more timely fashion.

Addressing surgical workforce challenges to support continued expansion of surgical capacity was also a key priority in 2023-24. As of December 31, 2023, there were 456 Anesthesiologists registered in Alberta, up from 441 from December 31, 2022 - a 3.4 per cent increase. AHS continued to work on increasing operating room hours across the province, including upgrades and work on new surgical suites in 15 communities across Alberta. Further, *Budget 2023* invested $237 million in capital funding over three years to add and expand operating rooms in hospitals across the province. This investment will boost surgery capacity in Brooks, Calgary, Camrose, Crowsnest Pass, Edmonton, Fort Saskatchewan, Grande Prairie, Innisfail, Olds, Pincher Creek, Ponoka, Red Deer, St. Albert, Stettler, Taber, Edson, Lethbridge, Medicine Hat and Rocky Mountain House. In 2023-24, AHS was provided a grant of $20 million to support implementing the capital program.

The government also recognized that Medical Device Reprocessing (MDR) is an essential clinical support service and is especially important in supporting government's efforts to reduce surgical backlogs and increase surgical capacity. This was why *Budget 2023* invested $104.7 million over three years to renovate MDR departments in five hospitals, including Foothills Medical Centre in

Calgary, the Westlock Health Centre, the Northern Lights Regional Hospital Centre in Fort McMurray, the Sturgeon Community Hospital in St. Albert, and the Royal Alexandra Hospital in Edmonton. This will allow for planning to begin on these priority MDR departments.

The performance measure on the ED wait times tracks the time to see a physician after being triaged on arrival 90 per cent of the time in the 16 largest hospitals. The lower the number the better, as it demonstrates patients are receiving timely assessment and treatment at EDs. In 2023-24, the wait time to see a physician in the ED was 6.7 hours compared to 6.2 hours in 2022-23. The trend showed that patients were waiting 0.5 hours longer in the ED to see a physician in 2023-24 compared to last year. The longer ED wait times was due to an increase in ED visits and the number of patients with the highest level of acuity that require aggressive interventions such as patients with cardiac arrest or major trauma. In 2023-24, there was approximately a 2 per cent increase in total visits to EDs across Alberta, including a 13 per cent increase in the number of patients with the highest level of acuity. In addition, high hospital occupancy and patients waiting in hospital for placement in continuing care contribute to longer ED wait times. The ministry continued to work on initiatives to improve ED wait times by expanding care delivery options in the community to support care outside the ED, improving access to continuing care, expanding hospital capacity, and implementing strategies in hospitals to streamline patient treatment and discharge.

Several initiatives are underway across the province to reduce emergency department (ED) wait times through increased staff recruitment and retention, and efficient patient movement through the ED. These include expanding Health Link Virtual MD hours of operation, and expanding the EMS/811 Shared Response Line to include direct referral to the Health Link RN team and the Addiction and Mental Health Helpline. AHS increased staffing by adding 114 full-time equivalent (FTEs) nurses to ED teams in Alberta's 16 largest hospitals (including the Alberta Children's Hospital and the Stollery Children's Hospital) and some of Alberta's suburban hospitals to ensure a safe and faster patient transfer of care from paramedics to ED staff. AHS added 127 FTEs to allied health staff (social workers, physiotherapists, and occupational therapists) and pharmacies to boost ED resources. Patients are now spending less time at the ED before being admitted, with 90 per cent of patients admitted within 39 hours as of January 2024, down from 42 hours in November 2022.

Performance Measure 1.a
Emergency department wait times: 90th percentile time to initial physician assessment in the 16 largest sites (hours)

	2020-21	2021-22	2022-23	2023-24 Target	2023-24 Actual
Emergency department wait times: 90th percentile time to initial physician assessment in the 16 largest sites (hours)	3.4	4.5*	6.2*	Below 2022-23	6.7

* The methodology was revised to exclude data for patients that 'Left Without Being Seen' and results were updated from 4.6 to 4.5 hours in 2021-22 and 6.3 to 6.2 hours in 2022-23.

On November 21, 2023, a new ED opened at the Misericordia Community Hospital in Edmonton. The new ED includes 5,500 square meters of spaces (an increase from 1,700 square meters), six ambulance bays (increased from four), 64 treatment rooms (an increase from 26 rooms), two radiology rooms, five isolation rooms (an increase from one), 18 acute care spaces (increased from 12) and a decontamination suite. The new ED is three times larger than the old one and has the

capacity to handle up to 60,000 visits per year which will help reduce wait times and strain on other EDs in the Edmonton region.

In addition, over $24 million was spent in 2023-24 on completion of Phase 1 of the Peter Lougheed Centre ED redevelopment, which includes a larger, upgraded triage area, modern care spaces and an improved resusciation and trauma space. The construction of the next phase of the redevelopment has started that will include 25 additional care spaces. AHS also launched 36 beds at the Bridge Healing Transitional Accommodation Program in Edmonton to support the transition of patients experiencing homelessness discharged from the ED.

To improve patient flow throughout the acute care system, government is working with AHS to reduce the number of Albertans who have finished their required hospital care and are waiting in hospital beds until they can be moved to a more appropriate setting, such as a continuing care space or community care services. Between November 2023 and March 2024, an additional 150 temporary continuing care spaces were created in the province to help free up hospital beds to reduce ED and surgical wait times.

Improving emergency medical services (EMS) response times is a top priority for government. Alberta Health continues to work with AHS to improve EMS by implementing the HCAP and recommendations from the Alberta EMS Provincial Advisory Committee (AEPAC) and EMS Dispatch Review. The AEPAC recommendations focused on accountability, capacity, efficiencies, operations, performance, and workforce support for EMS. Changes are being made to improve EMS response times and get paramedics out of hospital waiting rooms and back into their communities. In November 2023, a Ministerial Directive was issued to AHS to ensure the continued improvement of the EMS system and response times, including the creation of the Alberta EMS Standing Committee and the shared coordination of Alberta Health and AHS on EMS-related initiatives and decisions such as the implementation of the AEPAC and EMS Dispatch Review recommendations.

The performance measure on EMS response times helps evaluate the timeliness of ambulance services. The shorter the time demonstrates system responsiveness and the ability to provide timely medical care to patients in the community. The EMS response times for which 90 per cent of the most urgent calls were responded to in metro/urban communities, communities with over 3,000 residents and rural communities with under 3,000 residents all met or exceeded their performance targets in 2023-24. For metro/urban communities, the EMS response time decreased to 13.8 minutes, an improvement of 21 per cent from the prior year, while communities with over 3,000 residents saw a 14 per cent improvement in their EMS response time to 16.3 minutes from 18.9 minutes from 2022-23. EMS response times for rural communities with under 3,000 residents, at 33.3 minutes, improved by five per cent from 2022-23. In contrast, EMS response times for the most urgent calls in remote communities increased slightly to 64.9 minutes from 61.8 minutes due to staffing challenges and seasonal changes in staff availability. Staffing continues to be impacted by vacancies, sick time, and worker compensation claims. Also, seasonal changes in the number of overtime and casual shifts that staff are willing to pick-up impacts staffing levels, which typically decreases during the summer months.

The ministry understands there is more to do to improve response times and EMS coverage in rural and remote communities through the implementation of the AEPAC and Dispatch Review recommendations. The ministry continued to take actions to keep paramedics out of hospital waiting rooms and in communities, which have contributed to decreased EMS response times and red alerts, improved community coverage, and quicker access to EMS. The EMS Return to Service initiative, launched in 2023 to support paramedics to safely hand over patient care to ED staff within a 45-minute target, is now fully operational in all major hospitals. The time paramedics spent in hospital before being able to respond to another call decreased from 3.0 hours in 2022-23 to 1.6 hours as of March 31, 2024. This was an improvement of almost 49 percent compared to

2022-23. Additional actions included the continued implementation of the EMS/811 Shared Response to allow calls that have been assessed as not experiencing a medical emergency that requires an ambulance to be transferred to Health Link 811, ensuring that patients get the care they need and reducing unnecessary ambulance responses.

Performance Measure 1.b
EMS 90th percentile response times (minutes) for the most urgent (life threatening) calls

	EMS Response Time for the Most Urgent Calls (minutes) [1]				
	2020-21	**2021-22**	**2022-23**	**2023-24 Target**	**2023-24 Actual**
Metro/urban communities	11.7	14.6	17.5	Below 2022-23	13.8
Communities with over 3,000 residents	15.7	18.6	18.9	Below 2022-23	16.3
Rural communities with under 3000 residents	31.6	33.8	33.9	Below 2022-23	33.3
Remote communities	55.1	55.4	61.8	Below 2022-23	64.9

Source: Alberta Health Services as of March 31, 2024.
Notes: [1] Measures 90th percentile, meaning these are the response times for 90 per cent of activity.

In 2023-24, implementation of the AEPAC report recommendations and other actions continued to help several key strategic initiatives and other pressures identified through HCAP. In 2023-24, Calgary and Edmonton saw 19 twelve-hour shifts and an additional 20 twelve-hour shifts added respectively to manage peak volumes during the busiest times of the day. AHS also added more ambulance coverage in Chestermere, Lethbridge, Okotoks and Red Deer. For calendar year 2023, EMS hired 470 new staff members including 362 paramedics. In January 2024, EMS hired 32 new staff members including 20 paramedics. There has been a 16.9 per cent increase in EMS staff employed by AHS between December 2019 and January, 2024.

As of March 31, 2024, 50 out of 53 recommendations from the AEPAC report have been completed or are in progress, while 44 of the 45 recommendations from the Dispatch Review have been completed or are in progress. Examples of projects completed inlude:

- Allowing the use of Emergency Medical Responders (EMRs) on class 1 and 2 ambulances and an EMR in place of primary care paramedic when required on class 4 ambulances under the Ground Ambulance Regulation.
- Enabling firefighters functioning as Medical First Responders (MFRs), who are also registered paramedics, the ability to cancel incoming EMS resources.
- Enabling registered paramedics working as MFRs in Alberta's seven integrated fire-EMS services to log onto spare ambulances and transport as necessary and if possible.

Other examples of projects executed by Alberta Health in conjuction with AHS to address the AEPAC report and the Dispatch Review recommendations and strengthen the EMS system across the province include:

- Implemented alternative transport methods for non-medical patient transfers to patients' homes from a facility or acute care, such as community shuttles, wheelchair accessible taxis, and other local options. AHS expects that 15 per cent of transports will be diverted from EMS, allowing paramedics to respond to approximately 70 more events per day.
- Issued a request for expressions of interest and qualifications for dedicated services to provide lower acuity inter-facility transfers in the Calgary and Edmonton areas and drafted contracts with two successful proponents.
- Completed an independent review and analysis of air ambulance landing sites in Alberta that included an assessment of landing site impacts on overall EMS performance, landing site prioritization based on needs, and recommendations for operational policy and protocols to better support landing site operators. Alberta Health developed a landing sites grant program and rolled it out to support impacted municipalities.
- Created the Alberta EMS Standing Committee to coordinate EMS-related initiatives and decisions such as the implementation of the AEPAC and Dispatch Review recommendations.
- Completed an external review of EMS resource allocation to evaluate ambulance placement in the province. The ministry is now reviewing the report of the external review.
- Began development of a comprehensive performance framework for the EMS system.

The Government of Alberta continues to prioritize actions to improve access and reduce wait times for medically necessary diagnostic tests. Each year, Alberta spends about $1 billion on diagnostic imaging, which includes ultrasounds, X-rays, mammography, MRI scans and CT scans. Of this, 46 per cent is allocated to AHS and 54 per cent is allocated to community diagnostic imaging providers. About one-third of all CT and MRI scans are emergency scans and are completed within clinically appropriate timelines (under 24 hours). In 2023-24, the Government made an additional investment to deliver more medical imaging services, which resulted in a total of over 595,800 CT scans and over 255,200 MRI scans, an improvement of over 75,300 CT scans and 24,200 MRI compared to 2022-23.

The ministry continued to implement a number of projects to manage costs, wait times, and demand for CT and MRI scans across the province through the Diagnostic Imaging Action Plan. AHS reached a five-year agreement with radiologist groups in Edmonton and Calgary to reduce wait times and signed a Memorandum of Understanding with the three largest radiology providers in Alberta's North, Central, and South Zones to reduce wait times. The bilateral agreement on shared health priorities also invested a $45 million in federal funding to increase the volume of MRI scans and CT scans conducted so Albertans could get these important tests as part of their health care. In August 2023, an agreement was reached between AHS and DynaLIFE to transfer staff, equipment, and property in all regions of the province to AHS. Transition of remaining leases and contracts is progressing as planned and is on track. All community laboratory operations and DynaLIFE unionized employees transitioned to AHS-owned Alberta Public Laboratories (APL) on December 18, 2023. APL continues to add more workers and provides laboratory testing in all regions of Alberta. Since the APL transition, patient wait times have consistently met or exceeded targets, representing a 76 per cent reduction in wait times since the peak in May 2023. Access to available appointments continues to improve with the average next available appointment in 5.4 days, with no site over 18 days.

Increasing ICU capacity to ensure that Albertans receive care when they need it most remains a major priority for the government. By adding more ICU capacity, Alberta's health care system is able to treat those who come into hospitals in a timely manner and respond to surges and pressures caused by unforeseen events. In 2023-24, approximately $72 million was provided by the ministry to continue supporting the 50 ICU beds created as part of the ICU Baseline Capacity Grant in 2022-

23. The provincial total ICU capacity sits at 223. Since April 2023, 221 new, permanent non-ICU beds were added by AHS, with an additional temporary surge beds open as needed to support demand such as during respiratory season. As of September 2023, the overall permanent acute care capacity increased to approximately 8,753 beds, up from 8,470 beds in 2019. Work will continue to build flexibility in the health care system to ensure a resilient, sustainable, and accessible health care system that meets the needs of Albertans.

1.2 Attract, recruit and retain health care professionals in order to build health system capacity and sustainability.

Government is working to address workforce challenges that impact Alberta's health system capacity. Alberta Health is now updating the Alberta Health Workforce Strategy, which sets out a framework for supporting Alberta's current health care workers and building a workforce to support Albertans' health needs now, and in the future. In 2023-24, Alberta Health continued to implement the strategy; efforts included working with the Ministry of Advanced Education and Alberta's post-secondary institutions to explore options to expand the number of nursing student seats, undergraduate medicine seats and post-graduate medical residency seats in Alberta's medical schools. In 2023-24, $158 million was invested for initiatives to train, recruit and retain more health care professionals for Alberta, particularly for rural, remote and Indigenous areas.

In addition, Alberta Health collaborated with Advanced Education to increase post-secondary training seats and the number of nursing student seats and expand capacity at medical schools to educate and train more physicians. In 2023-24, Advanced Education began increasing nurse bridging programs so internationally educated nurses (IENs) will have access to an additional 1,221 spaces at post-secondary institutions and can complete necessary programs for certification in Alberta. In 2023-24, the number of undergraduate medical seats increased by 20: 10 additional seats at the University of Alberta and 10 at the University of Calgary.

As part of initiatives to improve continuing care staffing capacity, the government continues to prioritize actions to increase the number of students enrolled in Health Care Aide (HCA) programs at various post-secondary institutions. Nearly $13 million was provided to post-secondary institutions to support HCA students' bursaries over three years (2023-2026). Demand for the HCA bursaries is high, with over 1,500 students applying for the bursaries since implementation. In 2023-24, approximately 860 students were approved to receive a bursary. These bursaries remove barriers for students and pay for schooling and other expenses while they complete the HCA education program.

In April 2023, the College of Registered Nurses of Alberta (CRNA) streamlined licensure requirements and processes for IENs and out-of-province nurses to help them join Alberta's health workforce faster. By streamlining the registration process, over 3,000 new IENs have been licensed to work in Alberta. Alberta Health is now focused on supporting the newly licensed nurses by working with the CRNA to understand the challenges they face and develop potential solutions, including Alberta's Nurse Navigator program that provides employment supports to affected nurses. Further, Alberta Health is funding the Alberta Association of Nurses to implement the Nurse Navigator program to support IENs with licensure and employment in Alberta; the program has supported about 139 IENs as of March 31, 2024.

Alberta continued to support the Primary Care Network (PCN) Nurse Practitioner (NP) Support Program, created to enable NPs to work to the full scope of their skills. The program increases access to primary health care, including after hours, weekends, and in rural and remote areas and underserved populations; supports chronic disease management; and helps meet unmet demand

for primary health care services using NPs. As of March 31, 2024, there were over 60 NP FTEs funded through the PCN NP Support Program to improve access to primary health care in rural and remote areas and for underserved populations to help meet unmet demand for services. In 2023-24, the ministry focused on important priority areas for the program, including NP compensation, recruitment and retention, and the desire of NPs for an independent practice model. On November 22, 2023, government announced a new NP Primary Care Program to provide public funding for primary care services provided by NPs, adding much-needed capacity to Alberta's primary care system. As of March 31, 2024, a draft primary care compensation framework and program parameters for the new NP primary care program were under development for a targeted announcement in April 2024, which will provide compensation to NPs so that they can set up an independent practice or partner with an existing clinic.

In 2023-24, Alberta Health signed an agreement with the Nurse Practitioner Association of Alberta (NPAA) to provide grant funding of $2 million to support the adoption of the new NP program and provide NPs the support needed for successful transition to independent practice. This support will allow the NPAA to implement the NP program, recruit NPs, and provide supports as they work to set up their own practice. Alberta Health will continue to collaborate with NPAA and the Alberta Medical Association (AMA) to successfully launch the program.

The ministry is working with regulatory colleges to streamline the assessment and registration processes for international medical graduates (IMGs) coming to Alberta. Alberta Health continued to work with the College of Physicians and Surgeons of Alberta on a 5-year pilot that started in January 2023 for an alternate pathway for licensing IMGs trained in the United States, South Africa, Australia, New Zealand, Hong Kong, Singapore, Switzerland, Ireland and the United Kingdom. Through this pilot, Alberta will attract more IMGs by accelerating the licensure process for IMGs whose education and training are comparable to the Canadian standard. Since the pilot started, 176 physicians are in the registration process, with 19 already in practice. In 2023, the College initiated the highest number of assessments of IMGs since 2017.

More physicians are now registered to practice in Alberta compared to previous years. As of December 31, 2023, there were 11,738 physicians registered in Alberta, which was a net gain of 331 physicians, or a 2.9 per cent increase compared to the same period last year. There were 4,379 family medicine specialists and 1,277 non-specialists, for a total of 5,656 as well as 6,082 specialists in Alberta. This represents an additional 135 family physicians (2.4 per cent increase) and 196 specialists (3.3 per cent increase) compared to December 31, 2022.

Performance Indicator 1.d
Number of registered physicians in Alberta

	2019[1]	2020	2021	2022	2023
Number of registered physicians in Alberta	10,948	11,120	11,153	11,407	11,738

Source: College of Physicians and Surgeons of Alberta [1]Results based on calendar year

1.3 Strengthen and modernize Alberta's primary health care system and implement innovations to ensure all Albertans have access to timely and appropriate primary health care services in the community.

A strong primary health care system is foundational for better health care for Albertans. Alberta's government is stabilizing and strengthening primary health care across the province so that Albertans can access care no matter where they live. Alberta continues to take actions to improve and strengthen access and quality of the primary health care system. In September 2022, the Government of Alberta launched the Modernizing Alberta's Primary Health Care System (MAPS) initiative with health care leaders, Indigenous stakeholders and experts from across Canada and around the world coming together to form the Strategic Advisory Panel and the Indigenous Advisory Panel as part of the MAPS initiative.

On October 18, 2023, the MAPS Strategic Advisory Panel and Indigenous Advisory Panel final reports were released to serve as guideposts for actions to strengthen primary health care and improve access to timely, appropriate primary health care services across the province. The reports identified immediate, medium- and long-term improvements to strengthen Alberta's primary health care system. The Strategic Advisory Panel's final report contains 11 recommendations to improve primary health care, with an emphasis on access to team-based care, integration between primary health care and community care, and the foundation of a coordinated and accountable primary health care system. The MAPS Indigenous Advisory Panel's final report contains 22 recommendations under five themes: providing culturally safe and appropriate care; improving access to timely, appropriate primary care; ensuring primary care services are integrated and seamless; ensuring high quality services are available from an accountable, innovative and sustainable primary health care system; and including First Nations, Métis and Inuit Peoples as partners to achieve health and wellness goals.

Alberta's government has begun implementation of the MAPS Strategic Advisory Panel's recommendations on immediate actions to address urgent pressures, help stabilize the primary health care system, and increase access to the health care Albertans need. Budget 2023 invested $243 million to develop new models of care and stabilize the primary care system to improve primary health care for Albertans. This included early MAPS investments, the development of a new NP program, PCN enrollee growth and PCN stabilization. More than half of the $243 million (51 per cent or $125 million) is being invested over three years to implement recommendations from MAPS. The recommendations are being implemented through a phased approach, with several moving forward immediately, followed by medium- and longer-term improvements that will enhance community-based primary health care across Alberta. The ministry also initiated immediate actions identified in the Indigenous MAPS final report to improve access to culturally safe primary health care programs and services. On December 20, 2023, an Indigenous Primary Health Care Innovation Fund provided $20 million over two years to support primary health care services designed and delivered by Indigenous communities.

A Comprehensive Care Task Force was struck to recommend a new payment model for family physicians, supports for family physicians, ways to reduce the administrative workload for providers, and other short-term stabilization measures. This includes the new NP program and compensation model, which was announced in April 2024. A three-year, $57 million grant agreement was also established with the AMA to support physician patient panel management. This funding is being distributed to primary care physicians throughout the province to help address the impact of administrative burdens by offsetting the cost of panel management and practice improvement activities. It will also support family doctors and NPs to help manage costs related to their increasing number of patients.

Finally, in December 2023, Alberta Health signed a bi-lateral agreement with the federal government on shared health care priorities to improve access to high-quality family health services, including in rural and remote areas, and for underserved communities. The agreement will support team-based care for underserved populations, which will help to support implementation of MAPS recommendations. The agreement included $2 million over the next three fiscal years for a total of $6 million dollars (2023-24 to 2025-26) to support First Nations, Métis and Inuit Peoples through the Indigenous MAPS initiative. Alberta Health will initiate the programs to use this funding in 2024-25.

Outcome Two: A modernized, safe, person-centered, high quality and resilient health system that provides the most effective care now and in the future for each tax dollar spent

Key Objectives

2.1 Implement strategies that ensure the sustainability of publicly funded pharmaceutical benefits.

Albertans want and deserve a health care system that meets their needs, while also recognizing the system needs to be sustainable. Government's focus on ensuring value for money spent on health care supports this vision through actions and initiatives that make the most of taxpayer dollars. *Budget 2023* invested $24.5 billion in Health's operating budget to keep Albertans safe and healthy.

Alberta signed a one-time Canada Health Transfer (CHT) top up agreement in principle in February 2023, and received $233 million in funding from the federal government during 2023-24, as part of the $6 billion CHT from the Government of Canada. Alberta signed an additional bi-lateral agreement in December 2023 with the federal government to work together to improve health care for Canadians with funding of $285 million over the next three fiscal years (2023-24 to 2025-26). In addition, Alberta signed the Aging with Dignity bi-lateral agreement in March 2024 for $627 million to be funded over a five-year period (2023-24 to 2027-28) to support the shared priority of helping people in Canada age with dignity close to home, with access to home care or with quality care in continuing care homes.

The ministry continued to closely monitor provincial per capita spending on health care to assess progress on government's broader commitment to get the most value for each dollar spent on health care services. The Government of Alberta collaborated with health system partners to manage the biggest cost drivers in the health system – namely hospital services, labour and physician compensation, and publicly funded drug benefit programs. In 2023-24, the Government of Alberta spent $5.0 billion on hospital services (i.e., acute care), $6.4 billion on physician compensation and development, and $2.8 billion on drugs and supplemental health benefits.

The performance indicator on the Alberta health care spending per capita versus comparator provinces is used to monitor the financial resources used for health care for each person covered by Alberta's publicly funded health care system. This is a gauge of the fiscal sustainability and efficiency of Alberta's health system versus comparator provinces. Alberta's provincial per capita spending on health care in 2022-23 was estimated to be $5,476, which was lower than Canadian average of $5,749. Further, Alberta's per capita healthcare expenditures was lower than the average of British Columbia, Ontario and Quebec ($5,748). Over the past five years, Alberta has tempered the growth of spending, with average annual per capita spending growth lower than all comparator provinces (British Columbia, Ontario and Quebec) as well as the national average (as measured by the compounded annual growth rate). Improving the efficiency of health care delivery will improve health outcomes and support the fiscal sustainability of the health system.

Performance Indicator 2.a
Alberta health care spending per capita vs comparator provinces (2022-23)

	Alberta	British Columbia (BC)	Ontario (ON)	Quebec (QC)	Average (BC, ON, QC)
Health spending per capita (2022-23)	$5,476	$ 5,808	$ 5,330	$ 6,107	$5,748
Difference (versus average)	$ (272)	$ 60	$ (418)	$ 358	
Population (in millions)	4.6	5.4	15.3	8.7	
Total health spending difference versus average (in billions)	$ (1.24)	$ 0.32	$ (6.39)	$ 3.13	

Source: Statistics Canada

Prescription drugs provide benefit for improving quality of life, managing illnesses, and, in some cases, precluding the need for more extensive treatments. With this in mind, Alberta's government continued to build on its existing drug benefit programs to address gaps in drug coverage and the sustainability of public drug programs in a way that works for Albertans. The province continued to improve existing drug benefit programs and add innovative and effective therapies through the addition of 372 new products. Of the new products added, 59 were brand name drug products and 313 were generic products.

Alberta continued to work on approaches to reduce prescription drug costs, including expanding access to life-saving drugs, leveraging price negotiations for all new drugs, implementing the new pan-Canadian Pharmaceutical Alliance (pCPA) generics agreement and extending the Retina Anti-Vascular Endothelial Growth Factor Program for Intraocular Disease (RAPID) program:

- As of December 2023, Alberta expanded access to Trikafta to children aged two to five years. With this expansion, Alberta was among the first of the provinces in Canada to provide access to this life-saving drug for patients with cystic fibrosis aged two years and older.
- Alberta implemented the new agreement between the pCPA and the Canadian Generic Pharmaceutical Association for a three-year pricing initiative for generic drugs that took effect on October 1, 2023. The agreement allows the price of new single-source generic drugs to automatically drop to 55 per cent of the name brand reference price after three months from the start of public funding in a participating jurisdiction. This is estimated to save Alberta more than $100 million over three years.
- The government continued to leverage price negotiations between the pCPA and drug manufacturers for all new drugs, with rebates increased to an estimated $432 million in 2023-24 from $327 million in 2022-23, demonstrating the ongoing success of the pCPA and Alberta's commitment as a member to push health jurisdictions for more value and budgetary protection.
- Alberta also extended the RAPID program, which is estimated to save approximately $100 million per year.

Alberta continued to support the biosimilars initiative to replace biologic drugs with their clinically proven, lower-cost alternatives whenever possible so patients in Alberta continued to receive safe and effective treatment at a lower price. In 2023-24, savings from this initiative were estimated at approximately $34.5 million. While no new biosimilars were added in 2023-24, the existing 15 biosimilar products under the initiative were added to the Alberta Drug Benefit List, thus expanding coverage options for patients. Alberta Health is also currently working with other

provinces and territories on an approach that best leverages federal funding as part of a national strategy for drugs for rare diseases.

The Government of Alberta continues to support initiatives aimed at expanding access to pharmacy services, including access to convenient and accessible pharmacy services through community-based pharmacy care clinics. Alberta Health engaged the Alberta Pharmacists' Association - RxA and Alberta Blue Cross to identify pharmacies that self-identified as pharmacist-led clinics and engaged researchers at the University of Alberta to understand the types of services and patient needs addressed at pharmacist-led clinics. This work is expected to support a better understanding of how to improve access to community pharmacy services for Albertans.

The ministry also made strategic capital investments to renovate pharmacies and consolidated and centralized drug production in the province to meet current standards. In 2023-24, almost $36.5 million was spent on the construction of a 63,000 square-foot Provincial Pharmacy Central Drug Production and Distribution Centre. Located in northwest Edmonton, the facility will be responsible for mixing and packaging medication for local health centres. The project is on time and on budget, with the design development report and full construction plan completed in September 2023. *Budget 2023* also invested $54 million over three years to support the National Association of Pharmacy Regulatory Authorities' program to renovate and upgrade 33 pharmacies operating in 20 Alberta Health Services (AHS) facilities in 11 communities across the province. As of March 31, 2024, AHS has been provided with grant funding of $14 million to implement these improvements.

As part of the transition of COVID-19 to an endemic state and to align with the fees for other publicly funded vaccines, the fee for pharmacist administration of the COVID-19 vaccine decreased from $25 to $17 per dose as of January 1, 2024, and subsequently to $13 per dose on April 1, 2024. The government also removed the COVID-19 assessment fee on October 1, 2023, as this service was no longer needed outside of a public health emergency.

As of March 2024, the Ukrainian Evacuee Alberta Health Benefit has provided supplementary health benefits coverage to over 43,000 Ukrainian evacuees. The Health Benefit program provides premium- and co-payment-free coverage for supplementary benefits including prescription and non-prescription drugs, essential diabetic supplies, eye exams and glasses, dental care, and emergency ambulance services. In addition, Ukrainian evacuees have benefited from the Ukrainian Evacuee Temporary Health Benefits Program, established in March 2022, which provides publicly funded health insurance coverage for medically necessary physician and hospital services, as well as some dental and oral surgical health services in Alberta. As of March 26, 2024, 52,819 Ukrainian evacuees were receiving public health insurance coverage through the Temporary Benefits Program.

2.2 Assess the effectiveness of health care institutions including the HQCA and AHS to improve health care delivery and health care outcomes while managing costs.

The Government of Alberta remains committed to controlling the rising costs of health care while providing Albertans with the health care services they expect and deserve. The ministry continued to work collaboratively with health system partners to strike a balance between fiscal restraint and the investment required to support economic growth and a world-class health care system, with the capacity to respond to emerging public health challenges.

On November 8, 2023, the government announced efforts to refocus Alberta's health care system to prioritize patient care and empower frontline health care workers, including those serving rural, remote and Indigenous communities, to deliver the highest quality health care. The refocused health care system will improve patient outcomes and access through the creation of sector-based health organizations for acute care, continuing care, mental health and addiction and primary care

within a single, unified provincial health care system. The provincial acute care organization will oversee the delivery of acute care including care delivered in all hospitals, urgent care centres, and chartered surgical facilities; emergency medical services; and cancer care. The provincial continuing care organization will provide provincial oversight and coordination of service delivery across the spectrum of continuing care, including continuing care homes and home and community care. The provincial primary care organization will coordinate primary health care services and provide transparent provincial oversight. The Ministry of Mental Health and Addiction will oversee the mental health and addiction organization.

As part of the refocused health care system, an integration council will be formed to ensure system alignment, identify efficiencies, remove barriers and make sure the system is delivering seamless patient care. Alberta Health Services (AHS) will continue to have a strong role in the refocused system by concentrating on delivering acute care services. There will also be 12 regional advisory councils and a new Indigenous Advisory Council to enable greater emphasis on local decision-making.

In 2023-24, over $13.3 million was spent on health care system refocusing efforts. The ministry launched a comprehensive engagement process that included telephone and virtual town halls, online feedback forms and one of the largest in-person public engagement projects in government history. As of March 31, 2024, 55 engagement sessions were completed, with a total of 2,658 participants providing feedback. Approximately 18,000 responses were submitted through an online feedback portal as of March 31, 2024. Ten additional sessions are scheduled in April 2024 and information gathering sessions with Indigenous communities began in April 2024.

As part of the refocusing initiative, in fall 2023 Alberta Health conducted an initial assessment of the current operating models for each health sector and what functions are needed to support the new health sector organizations. This included a detailed review of AHS' key functions, accountabilities, and expenditures in order to determine its most appropriate alignment in the refocused system, including the transfer of some current AHS functions to the new sector-based health organizations. Alberta Health also initiated preliminary work to support the creation of the primary care, continuing care and acute care organizations with efforts accelerating in the next fiscal year. Work is also ongoing to implement legislative amendments to support the refocused health care system. Efforts to launch the primary care, continuing care, and acute care organizations will continue in 2024-25.

As of March 31, 2024, Alberta Health has initiated work to support the creation of the new advisory councils and Indigenous Advisory Council to be established in 2024-25. This included engaging with the existing health advisory councils under AHS, led by the Parliamentary Secretary for Rural Health, to understand current challenges. Ten of 12 sessions were completed as of March 31, 2024.

Establishing a framework for performance monitoring and assessment will be an important component of enhanced accountability and oversight for the refocused health care system. Alberta Health engaged with the Health Quality Council of Alberta (HQCA) to initiate the development of a Health System Framework that will define a common vision for quality and guide the selection of indicators, standards, and targets for system performance. When completed, the framework will serve as a foundation to enhance accountability for monitoring and improving quality, performance and value across a refocused health care system.

Health care infrastructure plays an important role in providing access to quality health care services and improving health outcomes. Protecting Alberta's health care system requires investments in health care infrastructure to improve efficiency, reduce wait-times, and provide additional surgical capacity to improve patient outcomes. Alberta Health continues to expand and modernize hospitals and other facilities to ensure an accessible and modernized health care system.

In 2023-24, approximately $735 million was spent on health-related capital projects across the province to expand and modernize hospitals and other facilities to protect quality health care and grow system capacity, including technology and information systems maintenance and enhancements to existing facilities.

Almost $20 million was spent on the Red Deer Regional Hospital Centre (RDRHC) redevelopment project to improve critical services and capacity at one of the province's busiest hospitals. The schematic design for the new inpatient tower and renovation of the RDRHC's main building was released March 14, 2023. The hospital redevelopment is on schedule and on budget. The next stage of the project, design development, is now underway and construction is anticipated to start in 2024. The procurement process has started with a Request for Qualifications released in January 2024 for the ambulatory care building, which will be constructed through a public-private partnership (P3) approach and will be located adjacent to the surface parkade. Once complete, the expansion of RDRHC will add 200 beds to the existing facility, bringing the total number of beds to 570 from 370; and will add new operating rooms, Medical Device Reprocessing department, cardiac catheterization labs; and renovations to areas in the main building, including the emergency department.

The ministry is resetting the capital planning priorities for the Edmonton region, including building smaller, purpose-built facilities that can be developed quickly. Several planning projects are underway in Edmonton and surrounding areas, including the redevelopment of the Royal Alexandra Hospital and expansion of the Strathcona Community Hospital. Alberta's government is steadfast in its commitment to build a new, stand-alone Stollery Children's Hospital in Edmonton. A new facility would provide more beds, larger clinical spaces, more private rooms, and dedicated areas for children and their families and ensure that as the province's population continues to grow, children in Edmonton and northern Alberta would have access to the specialized care they need.

In December 2022, the Arthur J.E. Child Comprehensive Cancer Centre (Calgary Cancer Centre) was turned over to AHS for operational commissioning. In 2023-24, operational commissioning activities, including installing equipment and furniture, and training staff, continued to prepare the hospital for clinical services and begin treating patients later in 2024. The hospital has 160 inpatient beds, 100 patient exam rooms, 100 chemotherapy chairs, increased space for clinical trials, 12 radiation vaults and outpatient cancer clinics. There are also designated areas for clinical and operational support services and research laboratories. Once operational, the facility will increase cancer care capacity in Calgary by consolidating and expanding existing services to support integrated and comprehensive cancer care.

Budget 2023 invested $56 million over three years for a Cyclotron Facility in Calgary. In 2023-24, the schematic design for the Cyclotron facility in Calgary was completed. The project remains on budget and on schedule.

The ministry continued working with the Alberta Medical Association (AMA) to manage spending growth and modernize physician funding models through the implementation of the AMA Agreement. A key focus in 2023-24 was to fully implement the recently negotiated agreement with increased funding provided to physicians in rural communities, increased funding for physician recruitment and retention and a review of rural physician compensation. Several items outlined within the agreement have been successfully implemented, including retroactive payments for physicians providing rural service. Virtual care mental health service code enhancements that allow physicians to provide additional virtual care went live on January 24, 2024, with over 242,200 claims and approximately $28.3 million spent. Eligible physicians can now bill the new and updated health service codes in the Schedule of Medical Benefits. An updated "Good Faith" billing policy also went live on February 6, 2024, which supports physician claims processes for situations where patients may not be able to provide conventional proof of residency or registration under

the Alberta Health Care Insurance Plan. Approximately $16 million annually - or about $4 million over the last quarter of 2023-24 - has been provided for this initiative through the bi-lateral agreement with the federal government to improve health care for Canadians.

2.3 Modernizing the digital health system for Albertans and health care providers.

Alberta's health care system is shifting from a provider- to patient-centric model and more Albertans now rely on accessing on-demand virtual government services. To enable this shift towards a patient-centered health system, the Government of Alberta is making considerable investments to modernize Alberta's digital health system. This will simplify how patients and citizens interact with the health care system, enable patients to access their health information, empower the patient's care team with on-demand information and decision support tools and, enrich Alberta Netcare (Alberta's Electronic Health Record) with robust, meaningful patient information. Part of Alberta's digital health initiatives include efforts to integrate the Electronic Medical Record (EMR) systems of community providers with AHS' Connect Care and other provincial assets.

MyHealth Records (MHR), a portal that allows Albertans to access their health information, is one of the important elements of the digital modernization of the health care system, along with Alberta Netcare and Connect Care. Alberta Netcare is available to health care professionals in the community and AHS facilities. Connect Care is an integrated system with Alberta Netcare that serves as a common platform for clinical information and stores all medical records, prescriptions and care history collected from AHS facilities, including doctor's notes.

In 2023-24, the government expanded access to MHR to allow Albertans to access their health information included with Alberta Netcare. This means Albertans now have access to more of their health information, which enables them to be active participants with their care team in the management of their health. MHR further enhances individuals' access to their personal health information through inclusion of some laboratory test results. As of March 31, 2024, there were over 1.7 million MHR users, with an average daily login of 25,000 users. MHR will continue to empower Albertans on their health journey within a person-centred health care model.

The ministry also made progress on a phased roll out of Connect Care within all AHS facilities to support digital modernization of the health system. In 2023-24, two planned launches for the Connect Care project were completed (for a total of seven out of nine), which improves integration of health information in AHS to support the care of AHS patients. Connect Care provides a single source of information within AHS to support team-based, integrated care, with a focus on the patient and the efficient and effective provision of health care services. In 2023-24, $159.4 million (operating and capital) was spent on Connect Care. The total cost of Connect Care when completed is expected to be approximately $1.47 billion. A full implementation of Connect Care is expected in 2024-25, with the final two launches scheduled for May and November 2024. Once fully launched, Connect Care will serve as a key information technology asset in the delivery of care in the province's refocused health system.

The ministry also made significant progress toward the implementation of the Alberta Digital Strategy and Alberta Health's eHealth Strategy, which was developed in 2022 to modernize digital service delivery, increase productivity, save tax dollars, and improve user experience by better integrating technologies into the delivery of government services. Alberta Health continued to deploy Alberta Netcare access to community providers. As of March 31, 2024, over 2,780 community clinics and 1,670 community pharmacies were using Alberta Netcare, resulting in more clinical information available at point of care leading to better clinical decision-making. In 2023-24, Alberta enhanced the Alberta Netcare clinician experience by enabling additional features, such as the Alberta Netcare Patient Event History. This provided value to over 44,000 clinician

users of Alberta Netcare by allowing easier access to clinical information to inform decision-making.

As part of digital modernization efforts and to facilitate better integration and improve productivity, 69 new data sources were added to Alberta Netcare from clinics across the province in 2023-24 using the provincial Health Information Exchange. This included new clinics sharing clinical reports such as diagnostic images and reports, cardiology, pulmonary function, lab results, community patient encounters, and consult reports. This has increased integration between the primary care systems and Alberta Netcare.

In addition, work continued on the Community Information Integration (CII) project to improve Albertans' access to primary care and community health information. Patient data from physician offices and other community-based clinics is made available to other health care providers through Alberta Netcare. The CII project expanded sharing of identified patient health information from community EMRs to Alberta Netcare. As of March 31, 2024, over 600 clinics and 2,671 physician practitioners provided patient data gathered in the community to Alberta Netcare. Approximately 2 million residents have a Clinical Encounter Digest (a report summarizing care the patient has received over the past 12 months from all community-based clinics participating in CII) in their Alberta Netcare Record and about 16 million patient encounters have been submitted to Alberta Netcare. This increases the integration between primary care systems and Alberta Netcare, thereby expanding the availability of clinical data.

In 2023-24, Alberta also expanded the use of the Central Patient Attachment Registry (CPAR), which captures the confirmed relationship of a primary provider and their paneled patients (patients who have seen the provider in the past 18 months). As of March 2024, over 1.8 million Albertans were confirmed to have seen their primary health care provider through CPAR. As of March 31, 2024, approximately $6 million in grant funding has been provided to the AMA through the CII and CPAR Acceleration Program to provide financial incentives to clinicians to participate in the CII Program. Alberta has also integrated an initial three First Nations clinics with CII/CPAR to capture patient panels, with the clinics starting to submit automated panels.

The ministry is also supporting the Alberta Vaccine Booking System (AVBS) as part of its digital modernization, allowing Albertans to book vaccine appointments more effectively. To date, 1.78 million Albertans have registered and almost 2.3 million appointments have been booked through the system. In 2023-24, over 261,343 appointments were booked, and 41,253 new registrations were added in AVBS. The ministry also supported the modernization of Alberta Health's provincial drug information system (DIS) in 2023-24. Enabling 932 community pharmacies to be connected to the DIS in real-time contributed over 40 million dispense records to Alberta Netcare. This enhancement allows for the immediate communication of medication information for clinical care by authorized clinicians.

Alberta Health continued to update and enhance its legacy health information systems as there are increasingly more complex data demands. Alberta Health successfully completed a project enabling the province of Quebec to use a secure file transfer account for electronic submission of claim adjustment requests and reports related to out of province health services, allowing for more efficient public health benefits management between Alberta and Quebec. This project replaces the existing paper-based exchange system, leading to a reduction in associated issues while streamlining the process. Additional data integrated into claim files from the Workers' Compensation Board (WCB) to Alberta Health enables the Claims Management team to efficiently and effectively identify duplicate claims submitted by health practitioners. This enhancement provides quicker identification of claims for work-related injuries paid by Alberta Health and increases the recovery of public funds mistakenly paid to practitioners for claims covered by WCB.

2.4 Ensure processes for resolving patient concerns are effective, streamlined, and consistent across the province.

The ministry is committed to ensuring that the patient complaints process is fair, responsive and accessible and that processes are in place to review and respond to feedback from patients and families. AHS continues to make targeted improvements to its patient complaint management process.

The ministry continued to expand the mandate and role of the Health Advocate to guide Albertans through the complaints resolution process and provide clear and accessible public information and education supports. In 2023-24, 14 new FTEs were approved and hired for the Office of the Alberta Health Advocate (OAHA) and Mental Health Patient Advocate (MHPA) to expand the complaints and concerns triage and navigation support for patients, and to prepare to implement patient-centred improvements to the patient complaints process.

The ministry also made progress on the implementation of the recommendations of the HQCA review to improve patient-centred accountability and public reporting, including standardized follow-up for patient complaints and mandatory information exchange requirements. Alberta Health collaborated with the OAHA and MHPA to engage key stakeholders in assessing the feasibility of the HQCA recommendations for improving patient complaints. The engagement identified critical success factors, including technology requirements, for implementing a new model for patient complaints and mandatory information exchange in alignment with the refocusing of the health system. This work will continue in 2024-25.

Work is underway to better address patient complaints from Indigenous Peoples through the creation of an Indigenous Patient Complaints Investigator and Elders Roster. The Investigator will act as a conduit to support Indigenous patients and their families in addressing negative experiences when accessing health care in Alberta. The Elders Roster, which will be comprised of Elders selected by the Indigenous Patient Navigators, will work with Indigenous patients and families to seek the appropriate cultural and social supports required during their health care journey. The ministry initiated recruitment of the Indigenous Patient Complaints Investigator within the Office of the Alberta Health Advocate to provide support to Indigenous patients who experience perceived harm or racism when accessing health care services.

2.5 Work with the Ministry of Technology and Innovation to create health spending accounts for non-publicly funded or non-insured expenses.

Alberta Health continues to work closely with the Ministry of Technology and Innovation, who is the lead Ministry on this project, to explore the feasibility of establishing Health Spending Accounts (HSA). Ongoing work includes the exploration of program feasibility, viability, the scope of services, program eligibility, program benefits and financial implications.

If implemented, the new Alberta HSA will provide additional funding to Albertans to help pay for goods and services not covered by the Alberta Health Care Insurance Plan and will contribute to a system-wide shift towards patient-centred, preventative care to empower Albertans with their own health and wellness with the goal of increasing quality of life and improving health outcomes for all Albertans. HSAs can help bridge gaps in current health system performance and enable Albertans to take a more active and participatory role in prioritizing and funding the health services of their choosing.

Alberta's government will provide Albertans with more information about the HSA, once further details become available.

2.6 Increase oversight to improve safety while reducing red tape within the health system by streamlining processes and reducing duplication.

Government continues to implement measures to reduce red tape, where appropriate, in the health care system, while ensuring the health and safety of Albertans. This includes restructuring and modernizing health legislation by removing unnecessary requirements to improve service accessibility and better support the health care needs of Albertans. In 2023-24, the ministry continued to streamline health delivery processes, where appropriate, to improve efficiency and save time and resources.

As of March 31, 2024, the ministry, including Alberta Health and AHS, achieved an over 36 per cent reduction in its regulatory and administrative requirements. The ongoing launches of Connect Care by AHS across the organization continued to drive the reduction in burdensome administrative requirements in 2023-24.

In 2023-24, two planned launches for the Connect Care project were completed (for a total of seven out of nine), which improves integration of health information in AHS to support care of AHS patients. Connect Care supports digital modernization of more complete central access to patient information related to AHS services. It provides resources, including medication alerts; evidence-based order sets; test and treatment suggestions; and, care paths and best practice advisories, which result in fewer repeated tests and consistent information across the province where care is being provided at AHS facilities. This system also reduces the number of forms used by AHS and helps to eliminate data entry duplication.

Connect Care also facilitates direct communication between patients and AHS health care providers through a patient portal, MyAHS Connect, which helps patients better manage their health with online access to their health information, including reports and test results. It also allows for online interaction with their care team, an ability to review and manage appointments and after visit care summaries, and less repeating of their health histories or the need to remember complex histories or medication lists.

On December 7, 2023, the *Public Health Act* received Royal Assent and came into force. The Act clarifies decision-making processes during a public health emergency, outlining the roles and accountabilities of Cabinet and medical officers of health in any future declared state of public health emergency.

Further, Alberta Health changed the listing status for three medications: dapagliflozin, apixaban and rivaroxaban, used for diabetes or cardiovascular disease, from step therapy/special authorization to regular (open) benefit. This change removed the requirement for physicians to submit special authorization forms and expedited access for patients for these important therapies. The renewal criteria period for biosimilars and multiple sclerosis drugs was changed from one to two years. This change reduces burden on physicians and patients and provides more time for follow-ups and testing while maintaining treatment.

As part of the MAPS initiative, a Comprehensive Primary Care Task Force was created and included an Administrative Burden Working Group, jointly led by the AMA and the Alberta College of Family Physicians. The Working Group developed an interim report titled "*Decreasing Administrative Burden*" that identifies several recommendations to streamline requirements and reduce

duplication for health professionals and service providers. These recommendations will be reviewed as part of the MAPS implementation plan in 2024-25.

Outcome Three: The health and well-being of all Albertans is protected, supported and improved, and health inequities among population groups are reduced

Key Objectives

3.1 Safeguard Albertans from communicable diseases that can cause severe outcomes.

Alberta remains committed to safeguarding the health and well-being of its residents through proactive measures to prevent the spread of communicable diseases. The ministry works to protect Albertans from a number of communicable diseases, such as influenza, measles, and sexually transmitted and blood borne infections (STBBI). Immunization programs for vaccine-preventable diseases continued to be a primary strategy in preventing disease, disease transmission and severe health outcomes. They are key to the health of a population and to decreasing the strain on the acute care system.

The ministry collaborated with AHS to increase childhood immunization rates as well as pharmacists and physicians to promote initiatives that aim to improve access to influenza vaccine and adult immunization rates. Alberta offered annual influenza immunizations to Albertans six months of age and older free of charge, as well as the COVID-19 vaccine, which continues to be available.

The Alberta Outreach Program started the week of October 2, 2023, to immunize Albertans at highest risk of severe outcomes from influenza and COVID-19. The 2023-24 Influenza Immunization Program for the public began on October 16, 2023, and ended on March 31, 2024. Albertans had access to influenza and COVID-19 vaccines at more than 2,000 sites across the province, including AHS clinics, Indigenous Services Canada clinics, community pharmacies, community medical clinics, and post-secondary institutions. Influenza vaccine and COVID-19 appointments continued to be made accessible by Albertans through the Alberta Vaccine Booking System. The overall influenza immunization rate in 2023-24 was 25 per cent, which was three per cent lower than in 2022-23. As of March 31, 2024, 25 per cent of all Albertans had received the influenza vaccine, with the highest rate (65 per cent) in those 75 years of age and older. Similarly, as of March 31, 2024, 17 per cent of all Albertans had received a COVID-19 vaccine, with the highest rate (56 per cent) in those 75 years of age and older. As of March 31, 2024, approximately 59 per cent of Albertans 65 years of age and older, and 72 per cent of Albertans 90 years of age and older received a high-dose influenza vaccine.

Alberta's immunization programs for childhood diseases continue to be a primary strategy in preventing disease, disease transmission and severe health outcomes. The ministry prioritized immunization to prevent vaccine preventable diseases such as measles, mumps, rubella, chicken pox, diphtheria, tetanus, pertussis (whooping cough), polio, human papillomavirus, meningococcal and pneumococcal. Alberta continued to offer provincially funded vaccines to support the administration of routine infant, preschool, and school immunization programs.

In 2023, by age two, 71 per cent of Albertans had received immunization with the diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (DTaP-IPV-Hib) vaccine and 82 per cent had received immunization with the measles, mumps, rubella (MMR) vaccine. These immunization rates are both lower than the national target of 95 per cent for these vaccines. Overall, childhood immunization rates in Alberta have been declining over the last three years partly due to the COVID-19 response, vaccine misinformation and vaccine fatigue between 2021 and 2023. AHS implemented a catch-up program to increase childhood immunization rates, including reminder calls for booked appointments, monitoring wait times, adding appointments as needed, and

following up using a recall process. AHS also hired additional staff to address the school immunization backlog, ensuring the immunization rates for school-aged children were nearing pre-pandemic coverage levels. Funding for these additional staff was in place until March 2024.

In July 2023, the Public Health Agency of Canada (PHAC) initiated enhanced surveillance and screening of Dadaab refugees arriving in Canada due to an outbreak of circulating vaccine-derived poliovirus type 2 (cVDPV2) in the Dadaab refugee complex in Kenya. As of March 31, 2024, more than 79 refugees arrived in Alberta and AHS implemented the PHAC risk assessment protocols. No cases of polio were identified in Canada. PHAC reassessed the risk in January 2024 and subsequently recommended a phased approach to scale down the national response starting in March 2024, with the goal of discontinuing the measures in November 2024.

A significant increase in measles outbreak activity was reported worldwide in 2023 and continues into 2024 due in part to a decline in measles immunizations during the pandemic. Alberta Health collaborated with key public health stakeholders to update the ministry's Public Health Disease Management Guideline for measles and developed a measles framework to guide the provincial response for public health management of cases, contacts, and outbreaks. One case of measles was reported in Alberta in 2023 in an unimmunized person who had travelled to an area where measles was circulating. AHS conducted a robust public health investigation, and no secondary cases were identified.

An outbreak of pertussis was declared in January 2023 in the South Zone (southern Alberta). Since then, cases of pertussis have been reported in all AHS zones and all zones have declared an outbreak at some point in the last 12 months. The provincial incidence rate of pertussis has increased from 0.29 per 100,000 population in 2022 to 19.3 per 100 000 population in 2023, with the number of reported cases varying from a high of 288 cases in the South Zone to a low of four cases in the Edmonton Zone. The reported cases were predominantly individuals who were under or unimmunized, with about 65.8 per cent of the cases in the under 10 years of age group. There were 28 cases hospitalized between January 2023 and February 2024; however, no deaths have been reported during this outbreak. In August 2023, AHS established the Provincial Pertussis Coordinating Committee (PPCC) to respond to the increase in reported pertussis cases and ensured collaboration and coordination to limit further spread. The PPCC consists of representatives from the ministry, First Nations and Inuit Health Branch and the Alberta Provincial Laboratories and will continue to work on a communications plan to raise pertussis awareness across the province.

In fall 2023, Alberta faced its most significant *E. coli 0157*:H7 outbreak to date, impacting 18 daycares in the AHS Calgary Zone. As of November 22, 2023, a total of 1,604 children were impacted by the outbreak, with 358 laboratory confirmed cases and 90 probable cases. Alberta Health worked closely with other federal and provincial government ministries, including the Canadian Food Inspection Agency, Alberta Agriculture and Irrigation, and AHS in the management and investigation of the outbreak. In response to the outbreak, the Government of Alberta appointed an external panel, the Food Safety and Licensed Facility-Based Child Care Review Panel, to review respective legislation, regulation and inspection policies for areas that could be strengthened to protect the health and safety of Alberta's children in licensed child care facilities. The Panel will submit a final report to the Ministers of Health and Jobs, Economy, and Trade in late spring 2024 with recommendations to enhance food safety in Alberta's licensed child care facilities and licensed food service establishments that supply food for children in those facilities. The Panel's final report will be supported by information collected from formal public and targeted stakeholder engagement conducted by Alberta Health and a third-party vendor between March 22 and April 25, 2024. Engagement activities included a public engagement survey, virtual and in-person round table discussions with affected childcare providers and affected families, and invited written submissions from subject matter experts including the Canadian Institute of Public Health

Inspectors, the Canadian Society of Nutrition Management and the O'Brien Institute of Public Health.

A Shigella outbreak was officially declared in Edmonton on September 8, 2022, and initially ended on February 16, 2023, following two weeks of no new cases. However, due to the number of cases confirmed shortly thereafter, the outbreak was reopened in March 2023. As of March 31, 2024, a total of 382 cases have been reported since the outbreak started in September 2022, which included the 167 cases reported in 2023-24. There have been 261 hospitalizations and no deaths reported since the outbreak began. Alberta Health continues to participate on the Shigella Outbreak Task Force, which includes cross-sector representation from Alberta Health, AHS, shelters, inner-city agencies, the City of Edmonton, local family physicians and Alberta Precision Laboratories (APL) to coordinate resources and discuss options to limit the spread of Shigella. Also, in collaboration with federal, provincial and territorial partners, PHAC has incorporated culture-independent diagnostic tests into case definitions for some enteric (gastrointestinal) diseases as part of routine surveillance and reporting. These tests can rapidly detect organisms such as shigellosis and shiga toxin-producing E. coli to facilitate prompt and timely identification and management of cases and contacts. Alberta Health and APL actively participated in developing the updated national case definitions that were published in January 2024.

Alberta's goal remains to decrease the number of syphilis cases and eliminate congenital syphilis. By monitoring rates of syphilis and congenital syphilis, Alberta is able to support program planning and resource allocation, including improving access to testing, treatment and better prenatal care for vulnerable pregnant women. In 2023, the rate of infectious syphilis per 100,000 population was 57.9 and the rate of congenital syphilis per 100,000 live births in Alberta was 122.1, which were lower than the rates in 2022. This decrease may be attributed to a number of factors including, more general awareness of the outbreak, focused work done by AHS to support testing and treatment, and the efforts of community-based organizations. The ministry continued to work with several service providers to enhance testing, treatment and prevention strategies to reduce barriers to testing and treatment of STBBIs, increase access to prenatal syphilis screening and support prevention strategies.

Alberta Health announced the Syphilis Outbreak Action Response grant program to fund community-based organizations for initiatives that focus on the prevention, testing and treatment of syphilis. In 2023-24, eight projects were approved, and seven of them received a total of $1.8 million in funding to support increased awareness of syphilis and sexual well-being, increase testing for syphilis, improve access to culturally safe care and management for syphilis, and address congenital syphilis. The eighth project is awaiting approval later in 2024. Alberta Health also updated the Interim Sexually Transmitted Infections Outbreak Screening Guidelines in December 2023 to clarify guidance for health practitioners when assessing risk and ordering appropriate laboratory tests for sexually transmitted infections, including syphilis. AHS has been working on initiatives to increase syphilis awareness, including a provincial webinar for primary care providers. In addition, syphilis and congenital syphilis information, as well as testing and treatment, was incorporated into a variety of public health centres, birth control clinics, sexual and reproductive health programs, and maternal and child health programs. Alberta Health continued to support the roll out of novel Point-of-Care Testing for syphilis/HIV to facilitate more rapid diagnosis and treatment.

Further, in 2023-24, Alberta Health provided $9.7 million to organizations for community-based prevention, identification and treatment of STBBIs and wrap-around supports for people living with those infections, including almost $3 million specifically for responding to the syphilis outbreak. In the first six months of 2023-24, STBBIs programs provided services to over 50,000 unique individuals and provided intensive wrap around supports to approximately 517 individuals living with a STBBI. More than 10,000 STBBI tests conducted resulted in approximately five per

cent of those individuals tested being supported through treatment services. Approximately 2,600 referrals were provided to mental health and addiction recovery oriented supports, and over 1,500 individuals were supported with access other health services. In addition, 1,950 community members received STBBI awareness and prevention education, and a total of 64 training initiatives were provided to over 1,152 health professionals and service providers including sessions on working with vulnerable populations, addressing stigma, the syphilis outbreak and HIV.

3.2 Improve access to health services in remote and rural communities by attracting, recruiting and retaining health professionals in these communities and modernizing critical capabilities in the delivery of health care services.

The Government of Alberta understands the unique health workforce challenges that impact the delivery of safe, high-quality and sustainable health care services in rural and remote communities. Making sure Alberta's rural and remote communities have the doctors and nurses they need to support the health care system is a priority for the government. In 2023-24, the Government of Alberta spent $158 million on initiatives to educate, recruit, and retain health care professionals, particularly for rural areas. These initiatives included rural physician education programs; financial incentives for rural physicians such as the Rural Remote Northern Program and the Rural Health Professions Action Plan (RhPAP); targeted recruitment of internationally educated nurses; and, initiatives under the Alberta Medical Association (AMA) Agreement.

Alberta Health worked with the College of Registered Nurses of Alberta (CRNA) to streamline registration processes for internationally educated nurses (IENs) and developed a grant agreement with the Alberta Association of Nurses for nurse navigators to support IENs going through the assessment, education, and registration processes. As of March 31, 2024, CRNA has licensed an additional 1,669 IENs educated in the Philippines to support the Memorandum of Understanding between the Government of Alberta and the Philippine Government. In 2023-24, Alberta Health provided AHS with approximately $7 million in grants for global recruitment of nurses. AHS has hired more than 360 nurses, over 40 of whom have arrived in Alberta and are joining our nursing workforce, with the majority recruited to rural sites. The remaining IENs are in various stages of immigration and are expected to arrive in Alberta in 2024. These nurses are employed in hard-to-recruit sites, thereby increasing access to health care in rural and remote areas of the province. A major challenge was the lack of accommodation in most communities. AHS has begun to provide temporary accommodation for some of these IENs in hotels until housing becomes available. Further, Alberta Health is now funding Alberta Association of Nurses to implement the Nurse Navigator program to support IENs with licensure and employment in Alberta. As of March 31, 2024, the program has supported a total of 139 IENs.

In 2023-24, over $26 million was spent to support capital initiatives under the Rural Health Facilities Revitalization Program. The program:

- provides capital funding for revitalizing rural health facilities throughout the province;
- focuses on smaller, strategic rural health capital initiatives to underserved rural areas; and,
- supports progress in improving access to emergency departments, urgent care centres and emergency medical services (EMS), and treatment services for targeted conditions.

Budget 2023 allocated $64 million over three years to continue the La Crete Maternity and Community Health Centre capital project to provide increased access to maternity health services. Design is well underway to provide an integrated health facility for existing services in the community as well as low-risk, midwife-led birthing services, 24/7 ambulatory care services and

expanded EMS capacity. Alberta Health worked with the project team and the community to refine the project scope to meet anticipated needs in the community and enable progress on the design.

With support from Alberta's government, the Town of Beaverlodge partnered with Landrex Inc. to build the Mountview Health Complex to replace the current Beaverlodge hospital. In November 2023, AHS signed a lease agreement to lease space in the Mountview Health Complex. The construction of the new facility will begin in 2024 and will meet current health facility standards and better support local delivery of more innovative and effective health services.

Alberta Health made progress on increasing capacity and access to surgeries in rural communities through the ongoing implementation of the Alberta Surgical Initiative (ASI). In 2023-24, the department continued to implement capital infrastructure investments to support opening, upgrading, and renovating operating rooms in rural Alberta. For instance, the expansion of Rocky Mountain House Health Centre, which includes a new operating room, six additional recovery beds, a patient support area and an updated MDR department, is now complete.

Alberta is creating more rural medical training opportunities and exploring how post-secondary institutions can help deliver medical education with regional training. The ministry is working with post-secondary institutions to develop ways to educate and graduate more nurses, especially in rural areas of the province where there is a shortage. AHS and the University of Calgary launched a registered nurse education program that allows students to live, learn and work in their home communities. As of March 31, 2024, there were students in St. Paul in their second year with expected completion in December 2025; students in Cold lake in the third year of the program with an expected completion date of December 2024; students at Siksika First Nation in year 1 and year 2 of the program with expected completion dates of April 2026-27; and, students in Wainwright in year 1, 2 and 3 of the programs with expected completion dates of April 2025-27.

In 2023-24, the government provided over $4 million in funding for the RhPAP to support rural health education, rural health workforce recognition and the attraction and retention of rural health professionals. The program supported physician locums to maintain services when rural physicians need time away from their practice; offered continuing medical education; provided accommodations for 891 medical learners and 70 allied health learners for rural placements so that they can train and choose to practice in rural communities; and, supported 50 attraction and retention committees so that rural communities can attract and retain health professionals. Further, the Rural Education Supplement and Integrated Doctor Experience (RESIDE) program administered through the RhPAP signed eight return of service contracts for a total commitment of $680,000 over three years. This will increase access to physician services in seven rural communities (High Level, Fox Creek, Bonnyville, Blairmore, Taber, Cardston and Hinton) for up to three years.

Through *Budget 2023,* the Government of Alberta provided $15 million to implement the Bursary for Internationally Educated Nurses (IENs) under the RhPAP. The bursary provides funding to IENs in Alberta as they complete the bridging training required to practice as a licensed practical nurse or registered nurse. In exchange for the funding, applicants commit to a return-in-service period spent working in rural Alberta following completion of their bridging program. Each learner under this program is offered a bursary of up to $30,000, which includes a fixed incentive to cover associated fees, along with funding to support living expenses, and a portion of tuition based on the training program's length.

The Rural Capacity Investment Fund (RCIF) was implemented in 2023-24 as part of the collective agreement between AHS, Covenant Health and its unions including the United Nurses of Alberta, Health Sciences Association of Alberta, and the Alberta Union of Provincial Employees. In 2023-24, the RCIF invested over $17 million to assist nearly 900 employees who chose to relocate to rural

Alberta and pay out retention payments to over 17,390 rural health professionals. The benefit to rural Albertans will be realized through improved staff retention rates and fewer vacancies. Between April 1, 2022, and March 31, 2024, the RCIF has invested about $35 million to support retention, and recruitment and grow capacity at sites within the South, Central and North Zones. The RCIF supports recruitment and retention strategies in rural and remote areas of the province, including relocation assistance.

3.3 Improve access for underserved populations and for First Nations, Métis, and Inuit peoples to quality health services that support improved health outcomes.

Alberta's government continues to prioritize the healthcare needs of First Nations, Métis, and Inuit Peoples residing in Alberta. Alberta Health works with health and community partners including First Nations and Métis leaders and the Government of Canada to ensure that health services are accessible and culturally appropriate. This commitment entails working with Indigenous leaders, the Government of Canada, and other stakeholders in a way that respects the unique and complex needs of First Nations, Métis and Inuit Peoples living in Alberta, with several initiatives underway to improve health outcomes.

Under the Indigenous Modernizing Alberta's Primary Health Care System (MAPS) initiative, a separate Indigenous Stream and panel was established to reflect unique challenges and identify ways to improve the primary health care delivery system for First Nations, Métis and Inuit Peoples in the province. As part of the Indigenous MAPS final report announced on October 18, 2023, the Indigenous Primary Health Care Advisory Panel provided 22 recommendations that focused on the five themes to help improve primary health care services for Indigenous peoples in Alberta:

- Culturally Safe and Appropriate Care: First Nations, Métis and Inuit Peoples have access to high quality, culturally safe care that is free of racism, and designed and delivered in a manner that respects their unique health care needs.
- Access: First Nations, Métis and Inuit Peoples in Alberta have access to timely, appropriate primary health care services from a regular provider or team. Care options are flexible and reflect individual and population health needs.
- Integration: First Nations, Métis and Inuit Peoples in Alberta have a health home that provides primary health care services and seamless transitions to other health, social and community services. Coordination and communication between First Nations and Métis communities, health service providers, and organizations are promoted and facilitated by service planning and the provincial governance structure.
- Quality: First Nations, Métis and Inuit Peoples receive high quality services from an accountable, innovative and sustainable primary health care system. Health service delivery is evidence informed, follows best practices, and uses resources efficiently.
- Indigenous Peoples as Partners: First Nations, Métis and Inuit Peoples and their social support networks are meaningful partners in achieving their health and wellness goals. Health services are proactive, recognize and address underlying influences on health outcomes, and respect individual needs and preferences.

These five strategic outcomes guided the work of the panel and continue to support in the ongoing effort to implementation. To assist with the implementation of the panel's recommendations, an Indigenous Primary Health Care Implementation Advisory Panel was created in December 2023 with representation from First Nation, Métis and Inuit health care practitioners, administrators, and technicians, as well as federal and provincial representatives.

Alberta Health issued a call for proposals for the Indigenous Patient Navigator grant program on December 20, 2023, to provide Indigenous communities, groups, and organizations with funding to improve Indigenous patient access and experience through the provision of cultural and community-specific assistance and support, as well as facilitating individualized planning for Indigenous patients to assist with access to and navigation throughout their health care journey. The application deadline was February 2, 2024, and successful applicants will be announced later in 2024.

Budget 2023 also provided approximately $1 million over three years (2023-24 to 2025-26) to each of the two Indigenous post-secondary institutions, Blue Quills University and Red Crow Community College, to support the delivery of the Health Care Aide (HCA) program in an Indigenous learning environment to approximately 16 students per institution in each year. This funding supports delivery of a culturally infused HCA program that will aid students in better understanding the delivery of culturally appropriate care while addressing the needs of their communities. These programs help to address the health care provider labour and skill shortages experienced on and off reserves by First Nations, Métis and Inuit Peoples and their communities.

In 2023-24, Alberta Health provided $10.8 million, which was equivalent to over 35 FTEs of physician funding, to the Indigenous Wellness Program (IWP) clinical Alternative Relationship Plan (ARP). The IWP clinical ARP provided program services for 16 communities (an increase from 11 communities for 2022-23) in 25 facilities, in addition to virtual services through the Alberta Indigenous Virtual Care Clinic. This program continues to improve access to physician services for Indigenous people in communities throughout Alberta, including those living on reserve and in Metis Settlements, with the additional benefit overcoming geographical, economic, political, cultural, and socio-historical barriers faced by First Nation, Métis and Inuit Peoples when accessing health care services. The ministry will continue to engage stakeholders on program scope and expansion.

Alberta remains committed to implementing Jordan's Principle commitments. Alberta Health continues to work with the First Nations Health Consortium and ministry partners to ensure that First Nations children in Alberta experience no denials, delays, or disruptions in publicly funded health, education, or social services due to jurisdictional disputes because of their First Nations status. For example, the Jordan's Principle Cross-Ministry Technical Working Group is working in collaborating with First Nations partners to ensure Jordan's Principle is meeting the needs of First Nations children.

Alberta Health also continues to work with Indigenous Services Canada's First Nations and Inuit Health Branch (FNIHB). In 2023-24, a representative from FNIHB was appointed as a member of the MAPS Indigenous Advisory Panel, as well as a member of the MAPS Indigenous Implementation Advisory Panel, tasked with providing advice on how jurisdictional barriers could be addressed through the implementation of the recommendations outlined in the Indigenous Primary Health Care Advisory Panel's final report.

3.4 Prevent injuries and manage chronic diseases and conditions through policy development, health and wellness promotion, screening, strengthening primary health care delivery, and initiatives that facilitate individual and community wellbeing in healthy environments

The government is actively supporting a range of policies and public health initiatives aimed at enhancing the well-being of Albertans. These efforts focused on promoting health, preventing

injuries, and combatting diseases. The government provides a leadership role in safeguarding the health and safety of Albertans, setting forth public policies across various domains. This included maternal, infant, and early child development, as well as initiatives targeting injury prevention, cannabis usage, tobacco and vaping control, and the advancement of population wellness and health equity.

In September 2023, the ministry launched a call for proposals for the third Health Innovation Implementation and Spread Fund. As of March 2024, three projects were approved for funding, which included over $467,000 for extending the endovascular therapy treatment window for stroke from six hours to 24 hours from the time of onset; almost $1.5 million for streamlining gastrointestinal cancer diagnoses by expanding a proven model for use by all Albertans; and, more than $340,000 for sustaining and spreading the Contrast Reducing Injuries Sustained by Kidneys Initiative across Alberta's cardiac catheterization centres.

Government continues to support cancer screening programs to return screening rates to pre-pandemic levels. Alberta Health continued the annual competitive Cancer Research for Screening and Prevention (CRSP) funding program, which launched in September 2022 to build capacity and excellence in cancer research, collaboration and innovation. The program provides three-year grants of up to $1 million each to fund research, education and initiatives that promote cancer prevention, early detection, and screening, and improve the journey of care for cancer patients and their families. In 2023-24, over $3.5 million was committed to successful recipients, which enabled the five inaugural CRSP projects, including four Indigenous-led initiatives, to continue work started in 2022. The five new projects span various areas to address gaps in screening and prevention, including: supporting nurse navigators to lead cancer screening and prevention clinics, and facilitate follow-up with patients including those in rural settings; assessing artificial intelligence tools to improve capacity for lung cancer screening; enhancing lung cancer risk reduction for non-tobacco lung cancers; establishing screening and prevention guidelines for individuals with a genetic predisposition to cancer; and, supporting Métis Peoples in Alberta who must travel long distances to access cancer screening.

As part of the government's three-phase plan to improve diabetes care, insulin pump benefits will be transferred from the Insulin Pump Therapy Program to government-sponsored health benefit plans. This transition will provide access to newer, more advanced models of insulin pumps. In 2022, Alberta Health set up the Diabetes Working Group (DWG) to review Alberta's diabetes care pathway and develop a comprehensive diabetes strategy, identify and address gaps in care, and improve diabetes prevention, diagnosis, treatment and management. On March 31, 2024, the DWG provided its final report and recommendations to the minister.

Alberta Health has made several targeted investments to support a variety of initiatives and programs related to women's health. In the first six months of 2023-24, programs supporting vulnerable women, including the H.E.R. (Healthy, Empowered, Resilient) Pregnancy Program in Edmonton and the Prenatal Outreach Support Team in Calgary provided intensive wrap-around supports to a total of 205 vulnerable women who were pregnant or of child-bearing age, and an additional 158 women of childbearing age were provided one-time or short-term assistance. Approximately 60 per cent of women accessing these programs identify as Indigenous, with over half of the women currently or having recently experienced domestic violence and facing barriers to accessing health services. Of women enrolled in the programs, 73 per cent indicated improvements in accessing healthcare, 50 per cent improved their mental health and wellbeing and 49 per cent had improved safety for themselves and their infants. About 74 per cent of infants born to women in the program were born at a healthy birthweight. Alberta Health also provided funding to support the University of Alberta's Cultural Safety for Indigenous Mothers Program, which supports pregnant Indigenous women in Maskwacis with increased access to high quality, culturally safe and competent pre- and post-natal care to improve maternal-infant health outcomes.

Alberta's previous tobacco reduction strategies have proven successful in reducing overall smoking rates. The government is committed to preventing and reducing the health harms of smoking, secondhand smoke, and vaping. A new, five-year, Tobacco and Vaping Strategy was released on January 22, 2024. It builds upon the successes of Alberta's previous tobacco reduction strategies, dating back to 2002. The strategy will seek to drive further reductions in tobacco use, and for the first time, vaping product use, particularly among youth. The objectives of the strategy are to: acknowledge the negative health and financial impacts of commercial tobacco and vaping on Albertans and affirm a commitment to reducing their use; identify strategic directions as a framework for collective and collaborative action with stakeholders and key partners; and, facilitate the development of a collective body of key partners with a mandate to assess provincial tobacco and vaping reduction, prevention and cessation efforts and provide recommendations for future action.

The ministry also continues to support Communities Choose Well (CCW), a free provincial program that fosters the wellbeing of Albertans by engaging and supporting communities to transform local practices, places, policies and partnerships so that healthy eating and active living are easy choices for everyone. From April 1, 2023, to September 30, 2023, over $350,000 was spent on building healthier environments. The program supported healthy eating and active living champions through learning opportunities, funding and recognition programs to build healthier environments within their communities. The CCW program engaged 1,032 unique champions, 313 of whom worked directly with Indigenous populations. The champions represent 257 unique municipalities and 83 Indigenous communities and organizations across Alberta. Eight community organizations were funded through the Healthy Community Seed Grants. The majority of the 2023-24 seed grant recipients focused on healthy eating and active living initiatives for children and youth.

Alberta continues to demonstrate an ongoing commitment to tackling the global threat of antimicrobial resistance (AMR). The department continued to work with Alberta Agriculture and Irrigation and Alberta Environment and Protected Areas on a One Health AMR Framework for Action to help guide collective efforts to address the growing threat of AMR in Alberta. In 2023-24, Alberta's One Health AMR Framework for Action was finalized and approved for public release by the Ministries of Health, Agriculture and Irrigation and Environment and Protected Areas. The AMR Framework identifies 15 Alberta-specific areas for action within the three pillars of Stewardship, Surveillance, and Infection Prevention and Control. Antimicrobial stewardship activities were identified, and implementation plans were developed to immediately target both the human and animal health sectors. Further, funding for AMR was approved to support targeted activities in antimicrobial stewardship and surveillance. Alberta also endorsed the Pan-Canadian Action Plan on AMR.

3.5 Modernize and transform the continuing care system to improve access and shift to more care in the community.

The new *Continuing Care Act* came into effect on April 1, 2024. The Act establishes consistent authority and oversight for Alberta Health regarding licensing and compliance monitoring of continuing care accommodations and the delivery of continuing care services in Alberta to ensure consistency and accountability. The new legislation established one overarching legislative framework for the full spectrum of continuing care services and settings in Alberta (i.e., home and community care, supportive living and continuing care homes). It sets the conditions for change in the continuing care sector and supports more Albertans to age at home, enables flexibility in the workforce, and improves oversight and quality of services. Ultimately, the new legislative framework will support a high-quality, accountable, and flexible continuing care system.

The Government of Alberta continues to invest in continuing care transformation to provide a sustainable way to meet both the increasing demands for continuing care and the needs and desires

of Albertans. *Budget 2023* invested $1 billion over three years (2023-24 to 2025-26) to begin transformation in the continuing care system to meet the growing needs of an aging population, including supporting initiatives that will enable a shift to more care in the community, enhance workforce capacity, increase choice and innovation, and improve the quality of care within the continuing care sector.

Continuing care transformation will enable better care for seniors and those requiring continuing care services by implementing recommendations from the Facility-Based Continuing Care Review (FBCC), the Palliative and End-of-Life Care Report, and the Office of the Auditor General Reports. As of March 31, 2024, of the 42 recommendations resulting from the FBCC, three have been addressed, two are partially addressed, 29 are in progress and eight are planned for a future response.

Alberta Health signed the Canada-Alberta Aging with Dignity Funding Agreement with the Government of Canada that provides Alberta with $139.4 million per year over four years, beginning in 2023-24, plus $69.4 million in 2027-28, to help Albertans age with dignity close to home, with improved access to home care, and with quality care in continuing care homes.

The performance measure 3.a monitors the number of patients waiting in hospital approved and ready for placement to Designated Supportive Living or Long-Term Care in the 14 largest acute care sites (excluding the Alberta Children's Hospital and the Stollery Children's Hospital). As of March 31, 2024, 205 patients were waiting in the 14 largest hospitals for continuing care placement compared to 240 on March 31, 2023, which represented almost a 15 per cent improvement. During 2023-24, AHS experienced significant hospital capacity pressures across the province due to higher demand for services from a growing and aging population as well as surges in demand due to respiratory illness. In response to a higher demand for services, AHS introduced a number of strategies to reduce the number of people waiting in hospital for placement (i.e., Alternative Level of Care reduction strategies) that were aimed at relieving hospital capacity pressures. These included adding net new and temporary community and continuing care capacity, facilitating additional discharges from hospital with admissions to continuing care homes on weekends, and enabling earlier discharges from hospital with additional home care supports until a designated living option became available.

Performance Measure 3.a
Number of patients waiting in hospital for continuing care placement

	2020-21	2021-22	2022-23	2023-24 Target	2023-24 Actual
Number of patients waiting in hospital for continuing care placement	190	216	240	Below 2022-23	205

Between December 2023 and March 2024, 235 new continuing care spaces were added with a temporary call out to operators. The number of patients specifically waiting for transfer to a continuing or community care facility after finishing their required hospital care has been reduced by almost 30 per cent. In addition, from November 2023 to March 2024, an additional 150 temporary continuing care spaces were created to help free up hospital beds to reduce emergency department and surgical wait times. Further, in 2023-24, the government provided $24.7 million to continuing care operators to partially offset inflationary increases to accommodation charges for continuing care residents. This support made accommodation charges

more affordable for residents and shielded them from the full cost of living pressures associated with higher-than-average inflation.

A key focus in 2023-24 was to enable a shift from facility to home-based care, where safe and appropriate. The ministry strives to provide Albertans with care where they want it most: in their homes and communities. By providing home care services that are responsive to changing needs, Albertans are supported to safely manage their own care while reducing reliance on acute and emergency services.

The performance indicator on the number of home care hours provided (millions hours) and number of individual/unique clients monitors shifting reliance from facility to home-based care, where safe and appropriate to do so. There was overall improvement in the total number of home care clients served and hours provided in 2023-24. AHS served over 130,111 unique home care clients, representing over a 2.8 per cent increase compared to 126,539 in 2022-23. In addition, AHS provided more than 12.71 million home care hours in 2023-24, which was over 40,000 hours more than 2022-23 (12.67 million). In addition, there was an increase in Alberta's home care service capacity to support Albertans to safely manage their own care and reduce reliance on acute and emergency services. The average hours of direct care provided to residents of continuing care homes increased in 2023-24 to improve resident care experience and health outcomes. The number of hours per resident per day increased from 2.8 to almost 3.0 hours and about 3.4 to 3.6 hours for Designated Supported Living Level 4 and long-term care, respectively.

In addition, the percentage of medical patients with an unplanned hospital readmission within 30 days of discharge from hospital was 12.7 per cent in 2023-24. This is 0.2 percentage points lower than last year (2022-23). A lower percentage means fewer patients have been readmitted to hospital within one month of discharge. A high rate of readmissions increases costs and may mean the health system is not performing as well as it could be. Although readmission may involve many factors, lower readmission rates may show that Albertans are supported by discharge planning and continuity of care. Continuity of care refers to the provision of coordinated, seamless, and person-centered health care services to improve the health outcomes and experiences of Albertans. Rates may also be impacted by the nature of the population served by a hospital facility, such as elderly patients or patients with complex health needs, or by the accessibility of post-discharge health care services or social supports in the community.

Performance Indicator 3.b

Number of home care hours provided (millions hours) and number of individual/unique clients

	2019-20	2020-21	2021-22	2022-23	2023-24
Number of home care hours provided	12.52	11.46	11.95	12.67	12.71
Number of unique home care clients[1]	124,779	117,502	122,084	126,539	130,111

[1]Results from 2019-20 to 2022-23 have been revised to reflect additional data received after publication.

Alberta continues to invest in community-based services and supports as part of the transformation of Alberta's continuing care system to ensure Albertans are getting the care they need, when and where they need it. Alberta Health worked with Alberta Blue Cross and AHS to successfully expand the Client-Directed Home Care Invoicing model to rural areas of the province. This program provides Albertans with increased choice and flexibility in selecting their home care service provider and increases their ability to influence and direct how their care is provided. The program grew from 644 clients on April 1, 2023, to 1,637 in March 2024.

Government invested over $10 million to expand home and community-based palliative and end-of-life services and supports through grant funded projects. Examples of these projects include:

- $1.4 million to support caregivers (people caring for family members or friends) to strengthen caregiver-centred care and build community and connections between caregivers across Alberta;
- $2.4 million investment in community projects to support seniors who are at risk of hospitalization or moving to a continuing care home, to age well at home through the provision of community-based, non-medical supports such as transportation, food security, housekeeping and snow removal; and
- $2.5 million innovation grant to Pilgrims Hospice Society's Roozen Family Hospice Centre in Edmonton to implement and study the unique wrap-around hospice model used at the Pilgrims Hospice Society, to inform hospice funding model work to be undertaken in 2024-25.

Additionally, government initiated four innovative home and community care pilot projects that are enabling transitions home from acute care (Calgary and Central Zones), supporting clients and caregivers with extended or overnight hours at adult day programs (Calgary and Central Zones); and, supporting vulnerable, hard to house individuals with medication management (Edmonton Zone). Overall, these actions will help seniors and adults with disabilities stay in their homes and communities longer with additional supports and appropriate home and community care.

The Government of Alberta is strengthening workforce capacity and attracting and retaining the continuing care workforce through transformation initiatives. In 2023-24, Alberta maintained the $2 per hour increase to health care aide (HCAs) wages that was introduced for contracted operators during the pandemic. In addition, the government increased funded rates for home care agencies to increase HCA and licensed practical nurse wages in home care to help reduce the gap in pay between continuing care home settings and home and community care. In 2023-24, the government also invested in innovative opportunities to attract and train more HCAs, including:

- $666,000 spent to support Indigenous post-secondary institutions to provide HCA programming that will train more HCAs to be able to deliver culturally appropriate care; and
- $1.5 million to support the College of Licensed Practical Nurses of Alberta to review the HCA curriculum to ensure that the program continues to meet the needs of students and supports them to be able to work within the continuing care system, and to begin preparations for HCA regulation.

Supporting staff mental health and wellness is a key priority for continuing care transformation. That is why, in 2023-24, government provided $2.5 million to the Alberta Continuing Care Association to support eligible operators to initiate innovative, staff-informed projects to increase staff mental health and wellness in continuing care homes and home and community care. Additionally, government provided $150,000 to the Continuing Care Safety Association of Alberta in 2023-24 to reduce stigma related to mental health in the workplace. Further, government invested

almost $900,000 in Translating Research in Elder Care in 2023-24 to develop evidence-based workforce strategies and tools to improve workplace conditions and quality of work life for staff and management.

Budget 2023 invested almost $90.6 million over three years to complete work required at the Gene Zwozdesky Centre at Norwood. The Norwood West building at the Gene Zwozdesky Centre opened its doors on October 31, 2023, and increased continuing care capacity by 29 beds for a total of 234 beds. In addition to the increased capacity, the 38,000 square metre centre features a fully accessible green roof, dental clinic, and new ambulatory clinics that provide greater access to complex, post-acute and continuing care. Work will begin on the Angus McGugan Pavilion in 2024-25, which is expected to increase the total number of beds to 350.

In 2023-24, additional investments were made in the Continuing Care Capital Program (CCCP), which supports four program streams that will modernize continuing care homes; develop innovative small care homes; provide culturally appropriate care for Indigenous peoples; and, add new spaces in priority communities having the greatest need. Ten not-for-profit and for-profit applicants were conditionally approved to modernize outdated publicly funded continuing care homes under the inaugural CCCP - Modernization stream. Modernization includes replacement, renovation and/or upgrades to current standards to improve the quality, life safety and accessibility of existing continuing care homes. The inaugural 2023-24 CCCP Small Care Home stream launched on April 25, 2023, and closed on November 30, 2023. Evaluation and approval of the applications is expected to conclude in early summer 2024. In addition, the second request for grant process for the CCCP Indigenous stream and a request for grant process for the CCCP Priority Communities stream are being prepared for launch in 2024-25. The Continuing Care Design Standards and Best Practices were published in March 2024 that outline the requirements and best practices for designing continuing care homes. The Design Standards were updated based on emerging research, COVID-19 learnings, and recommendations from Facility Based Continuing Care review and Auditor General Report.

Performance Measure and Indicator Methodology

Performance Measure 1.a:

Emergency department wait times: 90th percentile time to initial physician assessment in the 16 largest sites (hours)

Methodology

The ED wait times are calculated based on the total time from the first documented time after arrival at an ED to the time the patient leaves the ED for an inpatient hospital bed.
• Inclusions: Top 16 largest sites and emergency department visits
• Exclusions:
  ○ Both registration and triage date/time are unknown, missing or invalid
  ○ Visits where physician initial assessment time is missing or invalid
  ○ Any visit that is not face to face visits
  ○ Any visit where the most responsible provider services is not a physician
  ○ Visits where patient left without triage
  ○ Visits where patient left without being seen by a service provider
  ○ Visits where patient was dead on arrival (DOA)

Step 1. For each record with valid start and end times, calculate wait time in minutes as: (physician initial assessment time)−minimum (registration time, triage time) Step 2. Calculate summary measure as 90th percentile (in hours).
Source
Emergency Department Visit Data Repository Alberta Health Services

Performance Measure 1.b:

EMS 90th percentile response times (minutes) for the most urgent (life threatening) calls

Methodology

Response time is calculated based on events thought to be life threatening at the time of the 911 call and includes Delta and Echo events. These events are a subset of the total number of Emergency Events
• Inclusion: Event level response interval for all 911 generated events with a Delta or Echo determinant categorized by geographical type (Metro/Urban, Communities > 3,000, Rural or Remote).
• Exclusions:
  ○ Event level response interval for all 911 generated events with an Alpha, Bravo or Charlie determinant.
  ○ Inter-Facility Transfers.
  ○ EMS responses with missing timestamps (such as arrive on scene) related to interval calculation are excluded

The 90th percentile response interval is calculated for all 911 generated Delta and Echo determinant events within a specified geographical type
Source

The data for this measure is extracted from the EMS Computer Aided Dispatch (CAD) data

Performance Indicator 1.c:
Percentage of surgical procedures that met national wait time benchmarks

Methodology

Ready-to-treat (RTT) wait time (in days) is calculated for each relevant record meeting specified inclusion/exclusion criteria.

- Inclusion Criteria: All elective hip, knee replacement and cataract surgeries based on surgery procedure catalogue descriptions. All urgency levels.
- Exclusion Criteria: persons who received emergency surgical care. Cases with an invalid RTT date. When cataract surgery is required for both of a patient's eyes, only the wait time for surgery on the first eye is included in the wait time calculations.

RTT Date = The date that the surgeon determines the patient is ready for the surgical intervention. The RTT Date excludes patient delays or voluntary waits.
Treatment Date = The date the treatment (surgical procedure) took place.
RTT Wait time = Treatment (surgical procedure) Date minus RTT Date
National RTT wait time benchmarks:

- Hip replacement national benchmark is 182 days
- Knee replacement national benchmark is 182 days
- Cataract surgery national benchmark (for first eye) is 112 days.

$$\text{Percentage} = \frac{\text{\# of cases completed with a RTT wait time less than or equal to the national RTT wait time benchmark}}{\text{\# of completed cases with valid RTT dates}} \times 100$$

Source

Local Operating Room (OR) Information Systems, AHS and OR Data Repository, Alberta health Services.

Performance Indicator 1.d:
Number of registered physicians in Alberta

Methodology

Counts are as of December 31 of each year as reported by the College of Physicians and Surgeons of Alberta (CPSA). CPSA's year end is December 31 of each year and reports the number of physicians as of this date. Note that physician registration counts are cyclical throughout the year Counts decrease in the first quarter as physicians that do not renew their registration are removed and increase throughout the year, particularly in the third quarter when the majority of new physicians register after completing residency programs.

Source

College of Physicians and Surgeons of Alberta https://cpsa.ca/wp-content/uploads/2024/02/Registration-Statistics-2023-2019.pdf

Performance Indicator 2.a:
Alberta health care spending per capita vs comparator provinces (2022-23)

Methodology
Health expenditure data is extracted from Government Finance Statistics (Canadian Classification of Functions of Government (CCOFOG) by consolidated provincial/territorial and local government component on Health) available from Statistics Canada. The most recently released data (November 28, 2023) provides revised actuals for 2021-22 and preliminary estimates for 2022-23. 2020-21 was the first year of CCOFOG data to include COVID-19 expenditure estimates in the health component. Population estimates (release date: December 19, 2023). The population estimates for Q4 2022 are used in the calculation. The data is presented for consolidated governments. Provincial-territorial and local governments' data can be compared across provinces and territories because consolidation considers differences in administrative structure and government service delivery by removing the effects of internal public sector transactions within each jurisdiction. The Canadian Classification of Functions of Government (CCOFOG) is a detailed classification of the functions, or socioeconomic objectives, that general government units aim to achieve through various kinds of outlays. Therefore, by definition, Government Business Enterprises (GBE's) are excluded from this data.
Per capita provincial government health expenditure = provincial government health expenditure / population estimates

$$\text{Per capita provincial government health expenditure} = \frac{\text{provincial government health expenditure}}{\text{population estimates}}$$

Source
Government Finance Statistics (Canadian Classification of Functions of Government (CCOFOG) by consolidated provincial/territorial and local government component) data on health, Statistics Canada. . https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1010000501 Population estimates, quarterly, Statistics Canada. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901

Performance Measure 3.a:
Number of patients waiting in hospital for continuing care placement

Methodology

Count of the number of individual persons assessed and approved for a publicly funded continuing care home who are waiting in hospital acute care or sub-acute care beds in the 14 largest acute care sites at the end of a specified month, quarter, or fiscal year.

- **Inclusions:** People who have been assessed and approved for admissions to a CCH, and who are waiting in: acute care spaces, sub-acute spaces (including palliative end-of-life care spaces, restorative care, and transition unit) that are legislated under the *Hospitals Act*.

  14 Largest Hospitals:
  - Chinook Regional Hospital
  - Foothills Medical Centre
  - Glenrose Rehabilitation Hospital
  - Grande Prairie Regional Hospital

- Grey Nuns Community Hospital
- Medicine Hat Regional Hospital
- Misericordia Community Hospital
- Northern Lights Regional Health Care Centre
- Peter Lougheed Centre
- Red Deer Regional Hospital
- Rockyview General Hospital
- Royal Alexandra Hospital
- South Health Campus
- University of Alberta Hospital

- Exclusions:
  - People who are waitlisted but who are categorized as a Process Delay for the following reasons: medically unstable or care type under review.

This measure is calculated as the *arithmetic sum*, at a specific point in time, of the total number of individual persons assessed and approved for admission to a publicly funded continuing care home who are waiting in an acute care, or a sub-acute care hospital bed in the 14 largest acute care sites, for any of the following types of continuing care:

- CCH type A
- CCH type B

The specific point in time when the number of people waiting for a CCH space is to be calculated is the last day of the month of each quarter in a fiscal year; that is, the last day of June, September, December, and March in a given fiscal year. The last day of March (March 31) in a given fiscal year is the date to be used in calculation of the result to be reported in the annual reports of the Government of Alberta, Alberta Health, and Alberta Health Services.

Source

Alberta Health Services

Performance Indicator 3.b:

Number of home care hours provided (millions hours) and number of individual/unique clients

Methodology

Home Care Hours

Hours provided by both AHS staff and agency contracts that are reported under the Home Care Financial Directive. AHS hours are a calculated metric based on eManager statistical hours. Agency hours are based on authorised and billed hours paid.

- Inclusion and exclusion:
  AHS:
  - AHS hours includes worked hours including relief and overtime
  - Include hours related to management, administration, and clinical supports
  - Excludes non-worked hours

  Agency:
  - Agency contracted hours are based on the amounts paid to contracted operators. Hours paid are based on authorised billed hours and reconciled by zones.
  - Includes: added care and congregate living environments; authorised and billed travel hours for congregate living environments and supplemental rural travel; and non-delivered paid hours. These are hours that can be billed due to: short notice cancellation, client not home or safety issue at the residence.
  - Excludes client directed care, self-managed care, and day programs and cancelled or missed visits/missed hours. These are not billable.

Number of individual/unique clients

The total number of unique individuals with an active registration in the Home Care Program (HCP).

- Inclusions: Individuals of all age groups are eligible for and receive Home Care Services.Home Care clients with an active registration at least one day during the reporting period.
- Exclusions: Clients who are discharged prior to the specified reporting period. Clients who are discharged prior to the specified reporting period. Clients who are served only by Hospital Transition Services in Calgary and Edmonton. Clients who are served only by Community Aids to Independent Living. Clients who have not yet been discharged but are considered “inactive” or “stale”.
  a)

Arithmetic sum of the number of unique home care clients considering inclusion and exclusion criteria

Source

AHS/Agency Hours:

- HomeFirst application for authorisation of care and billing system, Meditech, Connect Care and Oracle/eManager

Number of individual/unique clients

- Meditech: South Zone, Central Zone, Edmonton Zone, North Zone
- PARIS: Calgary Zone

Additional Performance Metrics not included in Health Business Plan 2023-26

Performance Indicator (Outcome 1, Key Objective 1.1):
Annual number of surgeries provided

Methodology
Data is provided by Alberta Health Services and obtained from local Operating Room (OR) Information Systems (and other sources) and combined in an OR data repository, from which Main OR cases are identified. The total surgeries includes the number of surgeries performed in main OR and CSF sites only. It excludes procedures performed in the minor procedure rooms, endoscopy suites, emergency departments, labour & delivery, etc. Some data validation is ongoing and as such, future reported numbers might vary. Current estimate is results adjustment will be less than 1% overall.
Source
Local Operating Room (OR) Information Systems, Alberta Health Services (AHS), and OR Data Repository, AHS.

Performance Indicator (Outcome 1, Key Objective 1.1):
Percentage scheduled surgeries performed in chartered surgical facilities (CSFs)

Methodology		
Main operating room activity is used as representative of "surgeries" in the province. Based on identified main operating cases, those which are non-emergency are identified and the percentage where the site of delivery was a CSF is reported. ○ Numerator: Non-Emergency Main Operating Room cases completed in CSFs ○ Denominator: Non-Emergency Main Operating Room cases.		
Percentage =	# surgeries performed in chartered surgical facilities under contract with AHS ――――――――――――― total # surgeries in chartered surgical facilities and hospitals from April 1 to Mar 31	X 100
Source		
Alberta Health Services Main Operating Room (OR) information system sources as extracted to OR data repository as of March 31, 2022. Sites that do not have OR information systems were not included.		

Performance Indicator (Outcome 3, Key Objective 3.1):
Children by age two immunized for diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza type b) (DTaP-IPV-Hib) and for measles, mumps, rubella (MMR)

Methodology
Using data from the Alberta Health Care Insurance Plan population registries, children in Alberta are followed through time (i.e., from date of birth to study end date). Exclusions include individuals leaving Alberta, individuals who died, individuals who do not belong to the study period, First Nations individuals, and residents of Lloydminster. Coverage rates are based on a birth cohort and reported at age two. Once established, the population-based birth cohort is linked to Imm/ARI using the Unique Lifetime Identifier to get immunization information.
Calculation: Childhood immunization coverage is calculated using a survival analysis (time-to-immunization) method based on the specified population-based birth cohort. The analysis measures the probability that the child will receive required vaccines by age two. The data is calculated for 2022 calendar year.
Source
Alberta Health Care Insurance Plan (AHCIP) Quarterly Population Registries; Immunization/Adverse Reactions to Immunization (Imm/ARI), Alberta Vital Statistics, Birth Files.

Performance Indicator (Outcome 3, Key Objective 3.5):
Unplanned medical readmission from hospital within 30 days of discharge

Methodology

Numerator: Total number of medical patients with unplanned readmission to hospital within 30 days of discharge.

- Inclusion Criteria: Residents of Alberta covered by the Alberta Health Care Insurance Plan. Admission day of subsequent readmission is less than or equal to 30 days of initial discharge date from an acute care hospital.
- Exclusion Criteria: Transfers (admitted within 6 hours of discharge from another hospital, or 6-12 hours after transfer from or to an acute care facility); newborn, still birth, cadaver admissions; non-acute care admissions; pediatric (less than 20 years of age), surgery, obstetrics, palliative care, mental health admissions; hospital admissions for cancer therapy; non-urgent, planned admissions.

$$\text{Hospital Readmission Percentage (unadjusted)} = \frac{\text{Number of hospital inpatient discharges where a patient was readmitted to hospital within 30 days of index discharge}}{\text{Number of hospital inpatients discharged}} \times 100$$

Risk Adjustment: Accounts for differences in patient characteristics that may vary over years. Based on the list of risk factors (e.g., age, sex, case mixing grouping, Charlson comorbidity score) published by the Canadian Institute for Health Information (CIHI), and the Alberta-built, provincial specific logistic regression model using data from the past five years to estimate the Alberta average and expected readmissions based on patients' risk profile. The risk-adjusted rate is calculated using the following formula:

Financial Information

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Reporting Entity and Method Consolidation

The consolidated ministry financial information is prepared in accordance with government's stated accounting policies, which are based on Canadian Public Sector Accounting Standards.

The reporting entity is the Ministry of Health for which the Minister of Health is accountable. The accounts of the Ministry of Health, which includes the Department of Health, Alberta Health Services (AHS), and Health Quality Council of Alberta (HQCA), are consolidated using the line-by-line method.

The audited financial statements of AHS and HQCA are included in the annual report. Accounts of entities that are consolidated by AHS are listed in note 2a (i) and (ii) of AHS consolidated financial statements.

Under the line-by-line method, accounting policies of the consolidated entities are adjusted to conform to those of the government and the results of each line item in their financial statements (revenue, expense, assets, and liabilities) are included in government's results. Revenue and expense, capital, investing and financing transactions, and related asset and liability balances between the consolidated entities have been eliminated.

A list of the individual entities making up the ministry are shown on the "Management's Responsibility for Reporting" statement included in this annual report.

Ministry Financial Highlights

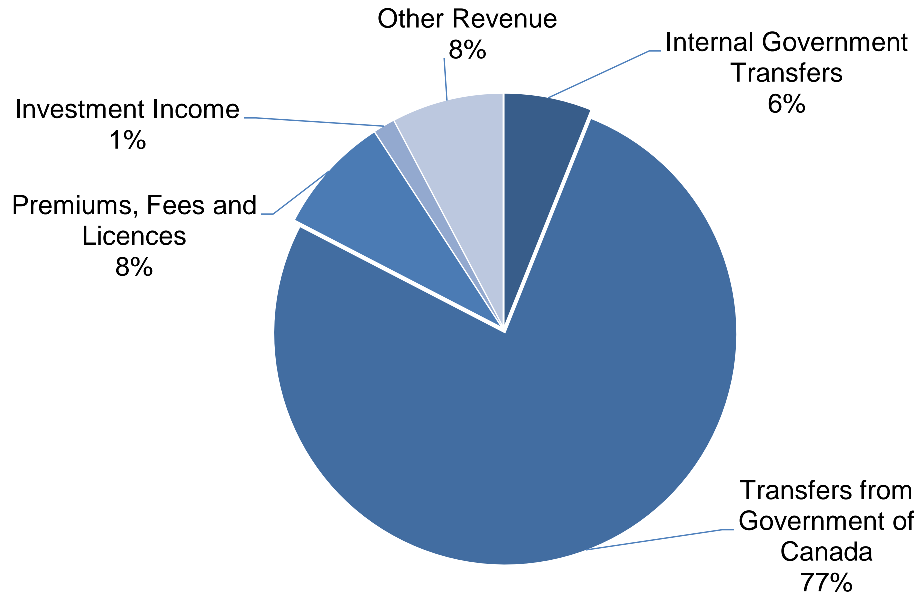
Consolidated Statement of Revenues and Expenses (unaudited)

Year ended March 31, 2024
(in thousands)

	2024		2023	Change from	
	Budget	Actual	Actual	Budget	2023 Actual
Revenues					
Internal Government Transfers	$ 468,138	$ 493,054	$ 433,814	$ 24,916	$ 59,240
Transfers from Government of Canada	6,242,219	6,232,244	5,844,404	(9,975)	387,840
Premiums, Fees and Licences	632,001	667,751	577,448	35,750	90,303
Investment Income	54,020	118,359	39,716	64,339	78,643
Other Revenue	522,475	630,162	657,969	107,687	(27,807)
Ministry Total	7,918,853	8,141,570	7,553,351	222,717	588,219
Inter-Ministry Consolidation Adjustments	(493,962)	(527,932)	(470,245)	(33,970)	(57,687)
Adjusted Ministry Total	7,424,891	7,613,638	7,083,106	188,747	530,532
Expenses - Directly Incurred					
Ministry Support Services	69,599	79,719	65,805	10,120	13,914
Physician Compensation and Development	6,178,296	6,420,869	6,019,667	242,573	401,202
Acute Care	4,661,667	4,970,478	4,273,300	308,811	697,178
Diagnostic, Therapeutic, and Other Patient Service	2,903,157	2,955,802	2,601,729	52,645	354,073
Drugs and Supplemental Health Benefits	2,768,842	2,798,801	2,495,107	29,959	303,694
Community Care	2,021,800	1,933,551	1,684,057	(88,249)	249,494
Continuing Care	1,405,031	1,419,320	1,234,839	14,289	184,481
Home Care	902,800	843,510	715,119	(59,290)	128,391
Population and Public Health	827,904	1,019,529	649,310	191,625	370,219
Emergency Medical Services	739,569	663,029	591,807	(76,540)	71,222
Support Services	2,531,200	2,780,825	2,473,388	249,625	307,437
Information Technology	907,385	887,716	863,787	(19,669)	23,929
Administration	541,300	574,058	484,506	32,758	89,552
Research and Education	133,492	128,173	117,003	(5,319)	11,170
Infrastructure Support	89,452	1,162	11,311	(88,290)	(10,149)
Debt Servicing	15,000	15,788	16,959	788	(1,171)
Cancer Research and Prevention Investment	10,380	10,328	9,184	(52)	1,144
COVID-19 Pandemic Response	-	-	1,210,533	-	(1,210,533)
Ministry Total	26,706,874	27,502,658	25,517,411	795,784	1,985,247
Inter-Ministry Consolidation Adjustments	(250,375)	(287,755)	(293,385)	(37,380)	5,630
Adjusted Ministry Total	26,456,499	27,214,903	25,224,026	758,404	1,990,877
Adjusted Annual Deficit	$ (19,031,608)	$ (19,601,265)	$ (18,140,920)	$ (569,657)	$ (1,460,345)

Revenue and Expense Highlights

Consolidated Revenues (prior to inter-ministry consolidation adjustments)



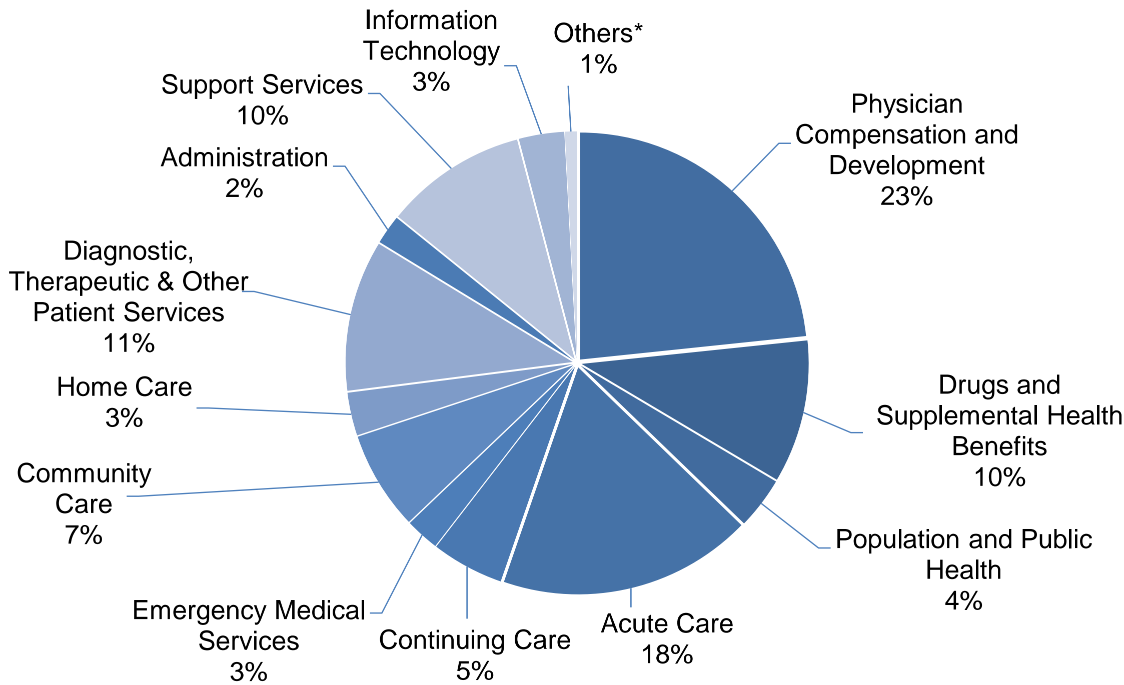
Total revenue for the year was $8.1 billion, which was $223 million higher than budget mainly due to:

- Transfers from Government of Canada as result of unbudgeted new funding for Working Together to improve health care for Canadians and in-kind receipt of COVID-19 drugs and supplies ($106 million);
- Premiums, Fees and Licenses as a result of higher volume of healthcare services billable to other Canadian jurisdictions and non-residents of Canada;
- Investment Income as a result of increased interest and dividend due to favourable market conditions and higher than anticipated net realized gains from active portfolio management; and
- Other Revenue as a result of increased recoveries from external entities.
- This was partially offset by lower than expected Canada Health Transfer ($116 million) due to adjustment for prior years and a downward revision to the Alberta's estimated population which reduced Alberta's entitlement.

Actual revenue increased by $588 million over prior year mainly due to:

- Internal Government Transfers due to increased activity in addiction and mental health programs and tangible capital asset additions resulting in higher recognition of externally funded capital revenue;
- Transfers from Government of Canada mainly as a result of higher national entitlement and a stronger national population share for Alberta ($457 million) and new funding for Working Together to improve health care for Canadians ($93 million);
- Premiums, Fees and Licenses as a result of increased billing rates and higher volume of healthcare services billable to other Canadian jurisdictions and non-residents of Canada; and
- Investment Income as a result of increased interest and dividend due to favourable market conditions.
- This was partially offset by in-kind contribution of rapid test kits and other supplies received from Government of Canada in prior year to support the COVID-19 pandemic response.

Consolidated Expenses (prior to inter-ministry consolidation adjustments)



* includes Ministry Support, Research and Education, Debt Servicing, Infrastructure Support, and Cancer Research and Prevention Investment.

Total expense for the year was $27.5 billion, which was $796 million higher than budget mainly due to:

- Physician Compensation and Development primarily due to higher than anticipated claims and Clinical Alternative Relationship Plan expansions;
- Acute Care due to increased use of agency nursing, overtime, and relief due to ongoing vacancies, recruitment challenges, and increased sick leave;
- Population and Public Health due to valuation adjustment of in-kind contributed COVID-19 rapid tests resulting from reduced demand for the tests;
- Administration due to higher liability insurance costs for greater required reserves and timing of claim settlements, and additional finance and human resource costs related to the transition of lab services from DynaLIFEDX to AHS;
- Support Services due to higher utility costs resulting from inflation and carbon tax, valuation adjustment of personal protective equipment and other supplies inventory, and procurement and capital management costs due to transitioning lab services from DynaLIFEDX to AHS.

This was partially offset by lower than budgeted expenses in:

- Community Care due to staggered timing of contract rate increases, less than expected designative supportive living bed openings, and recovery of prior year surplus COVID-19 funds from community care providers;
- Home Care due to delays in implementing home care innovations and palliative home care initiatives resulting from delayed operational planning, deferral of integrated funding model implementation, and delays in implementing rural home care travel and congregate living initiatives;

- Emergency Medical Services due to delays in implementing certain initiatives resulting from ongoing vacancies and delays related to contract negotiations; and
- Infrastructure Support due to delayed program implementation as a result of resequencing of Continuing Care Capital grants.

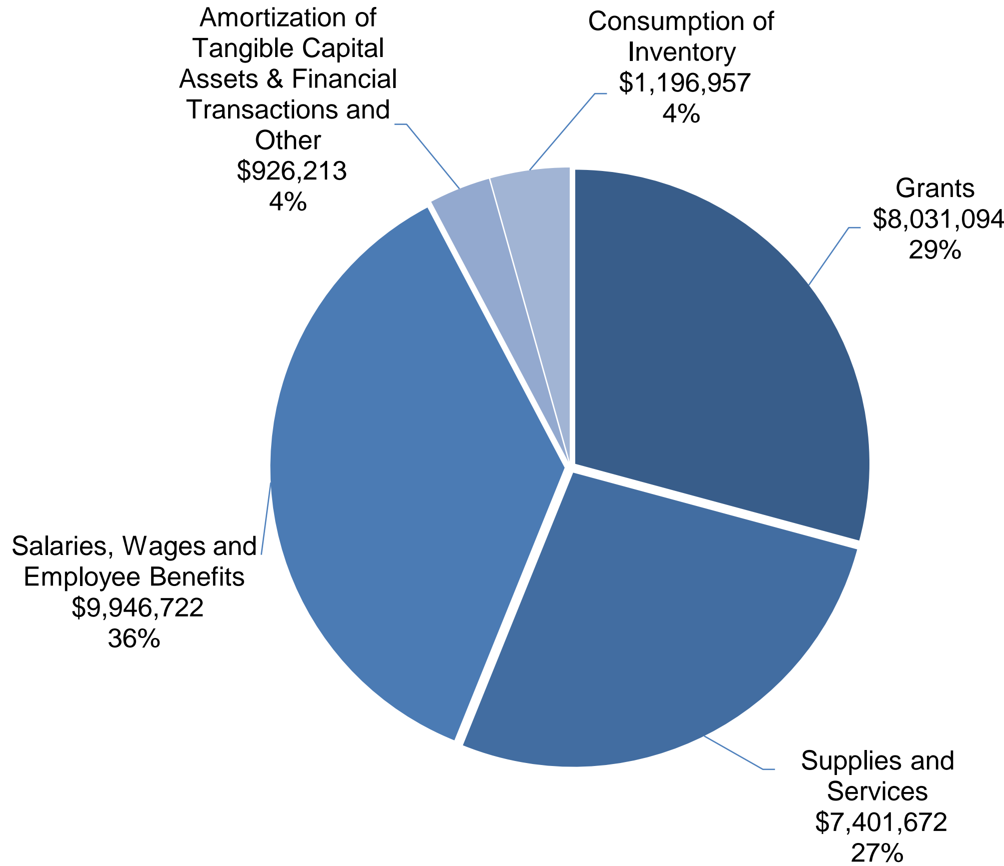
Certain program expenses indicate a significant increase compared to prior year due to COVID-19 expenses being allocated within the programs while in prior year they were reported as a separate line item.

Actual expenses increased by $2.0 billion from prior year mainly due to:

- Physician Compensation and Development due to increased claims, Clinical Alternative Relationship Plan expansions, and additional compensation costs due to transitioning of lab services from DynaLIFEDX to AHS;
- Acute Care due to increased activities including utilization of oncology drugs, increases in inpatient days, emergency room visits, and surgeries performed related to the Alberta Surgical Initiative resulting in increased compensation costs, utilization of agency nursing staff, and overtime;
- Diagnostic, Therapeutic & Other Patient Services due to costs associated with the acquisition of DynaLIFEDX, increased lab testing, and CT and MRI testing. Higher amortization expense for equipment additions due to Arthur J.E. Child Comprehensive Cancer Centre and DynaLIFEDX further contributed to the increase;
- Drugs and Supplemental Health Benefits due to volume growth in various benefit programs and increased claims in Pharmaceutical Innovation and Management program. Increased utilization of high-cost oncology and rare disease drugs, and valuation adjustment related to children’s pain medication inventory further contributed to the increase;
- Community Care due to increased funding provided to supportive living providers and other community health providers under Continuing Care Transformation initiatives, and opening supportive-living and community mental health beds;
- Continuing Care primarily due to increased funding for the Aging With Dignity Grant from the federal bilateral agreement;
- Home Care due to contracted rate increases to agency home care providers, increased home care activity due to increased hours of care, and new client directed home care services;
- Population and Public Health primarily due to valuation adjustment of rapid tests and implementation of Modernizing Alberta's Primary Health Care System recommendations;
- Support Services due to increased utility costs resulting from inflation and carbon tax, higher food supplies costs, compensation increases, increased Connect Care education and training costs, increased costs related to building commissioning and operational readiness of the Arthur J.E. Child Comprehensive Cancer Centre, and additional procurement and capital management costs resulting from the transition of lab services from DynaLIFEDX to AHS;
- Administration due to higher liability insurance costs as a result of greater required reserves and timing of claim settlements, increased compensation costs, and administration costs for contracted health service providers.

Expenses – Directly Incurred Detailed by Object (unaudited)

(*in thousands)*

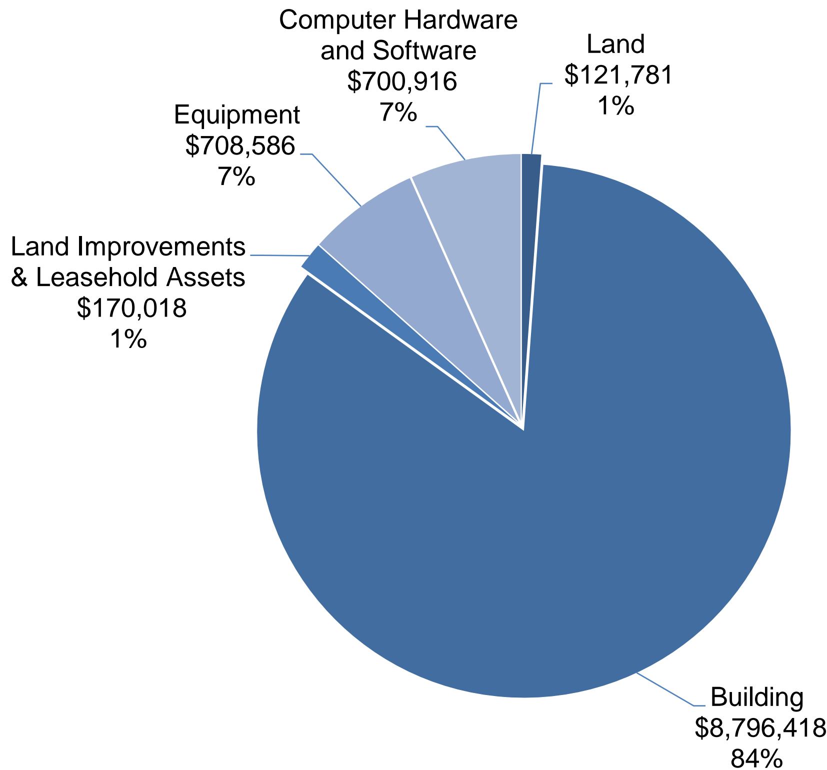


- Ministry's expenses were primarily for grants, salaries, wages and employee benefits, and supplies and services which combined accounted for 92 per cent of the total expense.
- Salaries, wages and employee benefits were $9.9 billion or 36 per cent of total expense, supporting delivery of health services across the province.
- Grants were $8 billion or 29 per cent of total expense, primarily for Physician Compensation and Development, and Drugs and Supplemental Health Benefit programs. Other grant expenses included restricted funding to support organizations and communities through various programs or initiatives, and funding for out-of-province health services.
- Supplies and services were $7.4 billion or 27 per cent of total expense, mainly attributed to contracts with voluntary and private health service providers, and various purchased supplies and services.
- Amortization of tangible capital assets ($561 million), consumption of inventory ($1.2 billion), and financial transactions and other expenses ($365 million) comprised the balance of ministry's total expense.

Supplemental Financial Information

Tangible Capital Assets (unaudited)

Year ended March 31, 2024
(in thousands)



- Total net book value of tangible capital assets was $10.5 billion.
- Buildings are the largest component and account for $8.8 billion or 84 per cent of the ministry's total tangible capital assets.
- The remainder of the ministry's tangible capital assets comprises of computer hardware and software, equipment, land, land improvements, and leasehold assets.
- Tangible capital assets of the Ministry are recognized at historical cost and are amortized, excluding land, on a straight-line basis over the estimated useful lives of the assets.
- Buildings and Equipment include $179 million (net of amortization) for obligations associated with retirement of tangible capital assets.

Portfolio Investments (unaudited)

Year ended March 31, 2024
(in thousands)

	2024		2023	
	Cost	Fair Value	Cost	Fair Value
Interest bearing securities:				
Deposits and short-term securities	$ 746,326	$ 746,331	$ 490,715	$ 490,755
Bonds and mortgages	1,326,783	1,304,133	1,228,624	1,194,576
	2,073,109	2,050,464	1,719,339	1,685,331
Equities:				
Canadian equities	181,927	199,709	171,926	177,151
Global equities	224,040	299,807	228,896	273,522
	405,967	499,516	400,822	450,673
Real estate	30,926	37,712	40,371	48,690
Total Portfolio Investments	$ 2,510,002	$ 2,587,692	$ 2,160,532	$ 2,184,694

The following is a breakdown of portfolio investments:

	2024		2023	
	Cost	Fair Value	Cost	Fair Value
Operating	$ 2,404,729	$ 2,482,419	$ 2,083,040	$ 2,107,202
Endowments	105,273	105,273	77,492	77,492
Total Portfolio Investments	$ 2,510,002	$ 2,587,692	$ 2,160,532	$ 2,184,694

Financial Statements of Other Reporting Entities

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Management Responsibility for Financial Reporting

The accompanying consolidated financial statements for the year ended March 31, 2024 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and include certain disclosures required by the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains systems of financial management and internal control which give consideration to costs, benefits and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public funds;
- safeguard the assets and properties of the "Province of Alberta" that are the responsibility of Alberta Health Services.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Finance, Audit and Risk Committee (the Committee). The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by]

Athana Mentzelopoulos
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Michael Lam, CPA, CA, CHE
Interim Vice President, Corporate Services and Chief Financial Officer
Alberta Health Services

Independent Auditor’s Report

To the Members of the Alberta Health Services Board and the Minister of Health

Report on the Consolidated Financial Statements

Opinion

I have audited the consolidated financial statements of Alberta Health Services (the Group), which comprise the consolidated statement of financial position as at March 31, 2024, and the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and notes to the consolidated financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Group as at March 31, 2024, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

I conducted my audit in accordance with Canadian generally accepted auditing standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Consolidated Financial Statements* section of my report. I am independent of the Group in accordance with the ethical requirements that are relevant to my audit of the consolidated financial statements in Canada, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Emphasis of matter

I draw attention to Note 29 of the consolidated financial statements, which describes the subsequent events and restructuring/refocusing of the Group. My opinion is not modified in respect of this matter.

Other information

Management is responsible for the other information. The other information comprises the information included in the *Annual Report*, but does not include the consolidated financial statements and my auditor’s report thereon. The *Annual Report* is expected to be made available to me after the date of this auditor’s report.

My opinion on the consolidated financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

In connection with my audit of the consolidated financial statements, my responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the consolidated financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work I will perform on this other information, I conclude that there is a material misstatement of this other information, I am required to communicate the matter to those charged with governance.

Responsibilities of management and those charged with governance for the consolidated financial statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of the consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is responsible for assessing the Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless an intention exists to liquidate or to cease operations, or there is no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Group's financial reporting process.

Auditor's responsibilities for the audit of the consolidated financial statements

My objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these consolidated financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, I exercise professional judgment and maintain professional skepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Group's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the consolidated financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit

evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the consolidated financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

[Original signed by W. Doug Wylie FCPA, FCMA, ICD.D]
Auditor General

June 3, 2024
Edmonton, Alberta

Consolidated Statement of Operations

Year ended March 31

(in thousands)

	2024		2023
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 15,137,611	$ 15,138,434	$ 13,446,558
One-time base operating	-	286,083	185,146
Other operating	1,655,938	1,712,435	2,467,695
Recognition of expended deferred capital revenue	113,400	106,297	104,165
Other government transfers (Note 4)	470,718	527,925	475,512
Fees and charges	586,000	625,668	536,774
Ancillary operations	110,000	87,178	103,324
Donations and non-government contributions (Note 5)	182,000	213,382	189,244
Investment and other income (Note 6)	214,800	330,376	240,285
TOTAL REVENUES	**18,470,467**	**19,027,778**	**17,748,703**
Expenses:			
Continuing care	1,373,300	1,375,360	1,381,494
Community care	2,073,700	1,983,628	1,888,404
Home care	902,800	843,709	740,152
Acute care	5,788,067	6,084,875	5,594,950
Emergency medical services	741,400	665,954	599,476
Diagnostic and therapeutic services	2,872,000	2,932,784	2,645,702
Population and public health	500,200	439,173	589,216
Research and education	363,500	352,707	341,797
Information technology	775,000	793,775	749,085
Support services (Note 7)	2,539,200	2,798,372	2,639,431
Administration (Note 8)	541,300	573,810	495,326
TOTAL EXPENSES (Schedules 1 and 3)	**18,470,467**	**18,844,147**	**17,665,033**
ANNUAL OPERATING SURPLUS	**-**	**183,631**	**83,670**
Accumulated surplus, beginning of year	1,120,827	1,120,827	1,037,157
Accumulated surplus, end of year (Note 21)	**$ 1,120,827**	**$ 1,304,458**	**$ 1,120,827**

The accompanying notes and schedules are part of these consolidated financial statements.

Consolidated Statement of Financial Position

Year ended March 31

(in thousands)

	2024 Actual	2023 Actual
Financial Assets:		
Cash and cash equivalents	$ 243,462	$ 334,649
Portfolio investments (Note 10)	2,587,692	2,184,694
Accounts receivable (Note 11)	755,525	750,083
	3,586,679	3,269,426
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,855,955	1,773,424
Employee future benefits (Note 13)	818,539	787,643
Unexpended deferred operating revenue (Note 14)	697,922	572,628
Unexpended deferred capital revenue (Note 15)	214,072	177,901
Debt (Note 17)	415,813	434,088
Asset retirement obligations (Note 18)	539,421	583,172
	4,541,722	4,328,856
NET DEBT	**(955,043)**	**(1,059,430)**
Non-Financial Assets:		
Tangible capital assets (Note 19)	10,467,655	10,303,649
Inventories of supplies (Note 20)	197,169	307,725
Prepaid expenses, deposits, and other non-financial assets	355,181	231,254
	11,020,005	10,842,628
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	10,064,962	9,783,198
Expended deferred revenue (Note 16)	8,696,431	8,642,101
NET ASSETS	**1,368,531**	**1,141,097**
Net Assets is comprised of:		
Accumulated surplus (Note 21)	1,304,458	1,120,827
Accumulated remeasurement gains	64,073	20,270
	$ 1,368,531	**$ 1,141,097**

Contractual Obligations and Contingent Liabilities (Note 22)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by:

[Original signed by]

Dr. Lyle Oberg
Executive Board Chair
Alberta Health Services

[Original signed by]

Paul George Haggis
Finance, Audit & Risk Committee Chair
Alberta Health Services

Consolidated Statement of Change in Net Debt

Year ended March 31

(in thousands)

	2024		2023
	Budget (Note 3)	Actual	Actual
Annual operating surplus	$ -	$ 183,631	$ 83,670
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets:			
Purchased	(530,000)	(452,501)	(497,852)
Purchased as part of DynaLIFEDX asset purchase	-	(71,760)	-
Leased	(10,000)	(37,753)	(19,031)
Constructed by Alberta Infrastructure on behalf of AHS	(457,000)	(198,774)	(262,429)
Contributed by others	-	(24)	(35)
Revision to asset retirement cost estimates	-	41,773	(41,164)
Amortization and loss on disposals/write-downs of tangible capital assets	527,500	555,033	514,897
Effect of other changes:			
Net increase in expended deferred capital revenue	485,600	170,966	246,496
Net decrease in expended deferred operating revenue	(161,000)	(116,636)	(220,336)
Net decrease (increase) in inventories of supplies	(123,000)	118,442	205,294
Net increase in prepaid expenses, deposits and other non-financial assets	(19,000)	(118,968)	(54,684)
Net increase in non-financial assets due to DynaLIFEDX acquisition	-	(12,845)	-
Net remeasurement gains (losses) for the year	(7,000)	43,803	(4,616)
Decrease (increase) in net debt for the year	**(293,900)**	**104,387**	**(49,790)**
Net debt, beginning of year	(1,059,430)	(1,059,430)	(1,009,640)
Net debt, end of year	**$ (1,353,330)**	**$ (955,043)**	**$ (1,059,430)**

The accompanying notes and schedules are part of these consolidated financial statements.

Consolidated Statement of Remeasurement Gains and Losses

Year ended March 31

(in thousands)

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31		
	2024 Actual	**2023 Actual**
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ 586	$ 2,572
Portfolio investments		
Quoted in an active market	6,600	(3,208)
Designated at fair value	35,815	(36,392)
Amounts reclassified to the Consolidated Statement of Operations:		
Derivatives	(998)	(1,710)
Portfolio investments		
Quoted in an active market	-	-
Designated at fair value	1,800	34,122
Net remeasurement gains (losses) for the year	**43,803**	**(4,616)**
Accumulated remeasurement gains, beginning of year	20,270	24,886
Accumulated remeasurement gains, end of year (Note 10)	**$ 64,073**	**$ 20,270**

The accompanying notes and schedules are part of these consolidated financial statements.

Consolidated Statement of Cash Flows

Year ended March 31

(in thousands)

	2024 Actual	2023 Actual
Operating transactions:		
Annual operating surplus	$ 183,631	$ 83,670
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	555,033	514,897
Revenue recognized for acquisition of land	-	(3,934)
Recognition of expended deferred capital revenue	(355,407)	(328,651)
Recognition of expended deferred operating revenue	(116,636)	(289,853)
(Gain) loss on disposal of portfolio investments	(13,736)	32,218
Change in employee future benefits	24,268	9,765
(Increase) decrease in:		
Accounts receivable related to operating transactions	(14,564)	(155,654)
Inventories of supplies	118,442	205,294
Prepaid expenses, deposits, and other non-financial assets	(118,968)	(54,684)
Increase (decrease) in:		
Accounts payable and accrued liabilities	23,669	(171,577)
Unexpended deferred operating revenue	115,570	59,541
Asset retirement obligations	(1,978)	(2,409)
Cash provided by (applied to) operating transactions	399,324	(101,377)
Capital transactions:		
Purchased tangible capital assets	(452,501)	(497,852)
DynaLIFEDX purchase consideration net of cash acquired	(29,388)	-
Cash applied to capital transactions	(481,889)	(497,852)
Investing transactions:		
Purchase of portfolio investments	(5,284,617)	(4,110,544)
Proceeds on disposals of portfolio investments	4,948,882	4,476,003
Cash (applied to) provided by investing transactions	(335,735)	365,459
Financing transactions:		
Restricted operating contributions received	-	69,517
Restricted capital contributions received	367,372	345,074
Unexpended deferred capital revenue returned	(3,626)	(73)
Proceeds from debt	20,000	11,500
Principal payments on debt	(38,275)	(32,405)
Payments on obligations under capital leases	(17,745)	(25,639)
Net repayment of life lease deposits	(613)	(246)
Cash provided by financing transactions	327,113	367,728
(Decrease) increase in cash and cash equivalents	**(91,187)**	**133,958**
Cash and cash equivalents, beginning of year	334,649	200,691
Cash and cash equivalents, end of year	**$ 243,462**	**$ 334,649**

The accompanying notes and schedules are part of these consolidated financial statements.

Notes to the Consolidated Financial Statements

Year ended March 31

(in thousands)

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the merger of 12 formerly separate health entities in Alberta.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided and;
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the assets, liabilities, revenues and expenses associated with its responsibilities.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards. In addition, the consolidated financial statements include certain disclosures required by the financial directives issued by Alberta Health (AH).

These consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the reporting entity, which is comprised of the organizations controlled by AHS as noted below:

(i) Controlled Entities

AHS controls the following three wholly owned subsidiaries:

- Alberta Precision Laboratories Ltd. - provides medical diagnostic services throughout Alberta.
- CapitalCare Group Inc. - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

AHS has majority representation on, or the right to appoint, the governance boards, indicating control of the following entities:

- Foundations:

  The largest foundations controlled by AHS are the Alberta Cancer Foundation and the Calgary Health Foundation. AHS also controls 33 other foundations that facilitate fundraising for various initiatives including enhancements to healthcare delivery (including equipment), programs, renovations, and research and education.

- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP):

  The LPIP's main purpose is to share the risks of general and professional liability to lessen the impact on any one healthcare subscriber. Effective April 1, 2020, the LPIP ceased providing new liability coverage and continues in operation for the limited purpose of winding up its affairs.

  The LPIP has a fiscal year end of December 31, 2023. Significant transactions occurring between this date and March 31, 2024 have been recorded in these consolidated financial statements.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

All inter-entity accounts and transactions between these organizations and AHS are eliminated upon consolidation.

(ii) Government Partnerships

AHS proportionately consolidates its 50% ownership interests in 39 (2023 – 40) Primary Care Network (PCN) partnerships with physician groups, its 50% ownership interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% ownership interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 24).

AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services to achieve the PCN plan objectives, and to contract and hold property interests required in the delivery of PCN services.

All inter-entity accounts and transactions between these organizations and AHS are eliminated upon consolidation.

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 25).

(iv) Other

AHS is responsible for the delivery and operation of the public health system in Alberta (Note 1) and contracts with various voluntary and private health service providers to provide health services throughout Alberta. The largest of these service providers is Covenant Health, a denominational health care organization, providing a full spectrum of care including operating several hospitals and long-term care facilities. Covenant Health is an independent, separate legal entity with a separate Board of Directors and accordingly, these consolidated financial statements do not include their assets, liabilities or results of operations. However, the payments for contracts with health service providers such as Covenant Health are recorded as expenses in the Consolidated Statement of Operations.

In addition, AHS provides administrative services to certain foundations and contracted health care providers not included in these consolidated financial statements.

(b) Revenue Recognition

All revenues are recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable. Revenues from transactions with performance obligations are recognized when AHS provides the promised goods and/or services to a payor. Revenue from transactions with no performance obligations are recognized at their realizable value when AHS has the authority to claim or retain an inflow of economic resources and identifies a past transaction or event that gives rise to an asset. Unallocated costs comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

(i) Government Transfers

Transfers from AH, other Province of Alberta ministries and agencies, and other government entities are referred to as government transfers.

Government transfers and, if applicable, the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for the use of the transfer, or the stipulations together with AHS' actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, AHS complies with the communicated use of the transfer.

All other government transfers, without stipulations for the use of the transfer, are recorded as revenue when the transfer is authorized and AHS meets the eligibility criteria.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Deferred revenue consists of unexpended deferred operating revenue (Note 14), unexpended deferred capital revenue (Note 15), expended deferred capital revenue (Note 16(a)) and expended deferred operating revenue (Note 16(b)). The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

(ii) Donations and Non-Government Contributions

Donations and non-government contributions are received from individuals, corporations, registered charities, and other not-for-profit organizations. Donations and non-government contributions may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, and non-government contributions are recorded as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, non-government contributions, and the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with AHS' actions and communications as to their use create a liability. These resources are recognized as revenue as the terms are met and, when applicable, AHS complies with the communicated use.

In-kind contributions of services and materials from non-related parties are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

Endowment contributions are recognized in the Consolidated Statement of Operations in the period in which they are received or receivable.

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recorded as deferred revenue when received and as revenue when the land is purchased. In-kind donations of land from non-related entities are recorded as revenue at the fair value of the land. When AHS cannot determine the fair value, it records such donations at nominal value. In-kind donations of land from related entities are recorded as revenue at the net book value of the transferring entity.

(iv) Fees and Charges, Ancillary Operations, and Other Income

Fees and charges, ancillary operations, and other income are considered revenue arising from exchange transactions with performance obligations. These are recognized in the year that goods are delivered or services are provided by AHS. Amounts received for which goods or services have not been provided by year end are recorded as deferred revenue.

(v) Investment Income

Investment income includes dividend income, interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments (excluding gains or losses from restricted transfers, endowments, or donations) are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related portfolio investments are sold. When realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses from restricted transfers including endowments or donations are deferred until recognized according to the provisions within the individual funding agreements.

(c) Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed. Interest expense includes debt servicing costs.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

Financial instruments comprise financial assets and financial liabilities. Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial liabilities are contractual obligations to deliver cash or another financial asset to another entity or to exchange financial instruments with another entity under conditions that are potentially unfavourable to AHS.

All of AHS' financial assets and financial liabilities are initially recorded at their fair value. The following table identifies AHS' financial assets and financial liabilities and identifies how they are subsequently measured:

Financial Assets and Financial Liabilities	Subsequent Measurement and Recognition
Portfolio investments	Measured at fair value with unrealized changes in fair values recognized in the Consolidated Statement of Remeasurement Gains and Losses or deferred revenue until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Cash and cash equivalents, accounts receivable, payroll payable and related accrued liabilities, trade accounts payable and accrued liabilities, other liabilities and debt	Measured at cost or amortized cost.

Amortized cost is the amount at which a financial instrument asset or a financial instrument liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization using the effective interest method of any difference between that initial amount and the maturity amount, and minus any reduction (directly or through the use of an allowance account) for impairment or uncollectibility.

AHS records equity investments quoted in an active market at fair value and may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record all portfolio investments at fair value. The three levels of information that are used to measure fair value are disclosed in Note 10.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to portfolio investments respectively. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses until realized, at which time the gains or losses are recognized in the Consolidated Statement of Operations.

Contractual obligations are evaluated for the existence of embedded derivatives. AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and when the entire contract is not measured at fair value. An election can be made to either measure the entire contract at fair value or measure the value of the derivative component separately when characteristics of the derivative are not closely related to the economic characteristics and risks of the contract itself. Contracts to buy or sell non-financial items for AHS' normal course of business are not recognized as financial assets or liabilities. AHS does not have any embedded derivatives.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations. A write-down of a portfolio investment to reflect a loss in value is not reversed for a subsequent increase in value.

A financial liability or a part thereof is derecognized when it is extinguished.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Transaction costs associated with the acquisition and disposal of portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and disposition of portfolio investments are recognized on the trade date.

(e) Cash and Cash Equivalents

Cash is comprised of cash on hand and demand deposits. Cash equivalents include amounts in interest bearing accounts and are subject to an insignificant risk of change in value. Cash and cash equivalents are held for the purpose of meeting short-term commitments rather than for investment purposes.

(f) Accounts receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. A valuation allowance is recognized when recovery is uncertain.

(g) Inventories of Supplies

Purchased inventories of supplies are valued at lower of cost (defined as moving average cost) and replacement cost. Contributed inventories of supplies are recorded at fair value when such value can reasonably be determined.

(h) Tangible Capital Assets

Tangible capital assets are recorded at cost less accumulated amortization, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset, and asset retirement cost. Costs incurred by Alberta Infrastructure (AI) to construct tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

Contributed tangible capital assets from non-related entities are recognized at their fair value at the date of the contribution when fair value can be reasonably determined. When AHS cannot determine the fair value, it records such contributions at nominal value.

The costs less residual values of tangible capital assets, excluding land, are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-70 years
Equipment	3-20 years
Information systems	3-15 years
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facility and improvement projects and development of information systems, is not amortized until after a project is substantially complete and the tangible capital assets are available for use.

Leases of tangible capital assets which transfer substantially all benefits and risks of ownership to AHS are accounted for as leased tangible capital assets and leasehold improvements and are amortized over the shorter of the term of the lease or their estimated useful lives. Obligations under capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.). The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing and the interest rate implicit in the lease.

Tangible capital assets are written down to their net recoverable amount when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. Write-downs are recorded as part of amortization and loss on disposals / write-downs of tangible capital assets.

Intangibles and other assets inherited by right and that have not been purchased are not recognized in these consolidated financial statements. Similarly, works of art, historical treasures, and collections are not recognized as tangible capital assets.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) Employee Future Benefits

(i) Defined Benefit Pension Plans

Local Authorities Pension Plan (LAPP) and Management Employees Pension Plan (MEPP)

AHS participates in the LAPP and MEPP which are multi-employer registered defined benefit pension plans. AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year. LAPP and MEPP set the employer contribution rates on an annual basis based on actuarially pre-determined amounts that are expected to provide the plans' future benefits.

Supplemental Executive Retirement Plan (SERP)

The SERP covers certain employees and supplements the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). The SERP has been closed to new entrants since April 1, 2009. The SERP provides future pension benefits to participants based on years of service and earnings.

As required under the *Income Tax Act* (Canada), approximately half of the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERP are invested in a combination of Canadian equities and Canadian fixed income securities.

(ii) Defined Contribution Pension Plans

Group Registered Retirement Savings Plans (GRRSPs)

AHS sponsors GRRSPs for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff that would have otherwise been eligible for SERP have been enrolled in a defined contribution SPP. The SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). The SPP provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

(iii) Other Benefit Plans

Accumulating Non-Vesting Sick Leave

Sick leave benefits accumulate with employees' service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS recognizes a liability and expense for accumulating non-vesting sick leave benefits using an actuarial cost method as the employees render services to earn the benefits. The liability and expense is determined using the projected benefit method pro-rated for service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement dates, sick leave accumulation and utilization, and mortality. Actuarial gains and losses are amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

AHS does not record a liability for sick leave benefits that do not accumulate beyond the current reporting year as these are renewed annually.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental, and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

(j) Asset Retirement Obligations

Asset retirement obligations are legal obligations associated with the retirement of tangible capital assets. A liability for an asset retirement obligation is recognized when, as at the financial reporting date:

(i) there is a legal obligation to incur retirement costs in relation to a tangible capital asset;
(ii) the past transaction or event giving rise to the liability has occurred;
(iii) it is expected that future economic benefits will be given up; and
(iv) a reasonable estimate of the amount can be made.

Asset retirement obligations are initially measured as of the date the legal obligation was incurred, based on management's best estimate of the amount required to retire tangible capital assets.

When a liability for asset retirement obligation is recognized, asset retirement costs related to recognized tangible capital assets in productive use are capitalized by increasing the carrying amount of the related asset and are amortized on a straight- line basis over the estimated useful life of the underlying tangible capital asset (Note 2(h)). Asset retirement costs related to unrecognized tangible capital assets and those not in productive use are expensed. Revisions in estimates are recognized as a change to both the liability and related tangible capital asset in the Consolidated Statement of Financial Position.

(k) Foreign Currency Translation

Transaction amounts denominated in foreign currencies are translated into their Canadian dollar equivalents at exchange rates prevailing at the transaction dates. Carrying values of monetary assets and liabilities and non-monetary items denominated in foreign currencies included in the fair value category reflect the exchange rates at the Consolidated Statement of Financial Position date. Unrealized foreign exchange gains and losses are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

In the year of settlement, foreign exchange gains and losses are reclassified to the Consolidated Statement of Operations, and the cumulative amount of remeasurement gains and losses are reversed in the Consolidated Statement of Remeasurement Gains and Losses.

(l) Reserves

Certain amounts, as approved by the AHS Board, may be set aside in accumulated surplus for use by AHS for future purposes. Transfers to, or from, are recorded to the respective reserve account when approved. Reserves include Invested in Tangible Capital Assets and Internally Restricted Surplus for Insurance Equity Requirements and Foundations.

(m) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences could require adjustment in subsequent reporting years.

Measurement uncertainty exists in the fair values reported for portfolio investments designated to the fair value category (see Note 10). The fair values of these investments are based on estimates. Estimated fair values may not reflect amounts that could be recognized upon immediate sale or amounts that ultimately may be recognized.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for accumulating non-vesting sick leave are based on various assumptions including the estimated service life of employees, drawdown rate of sick leave banks and rate of salary escalation. The establishment of the provision for unpaid claims relies on judgment and estimates including historical precedent and trends, prevailing legal, economic, social, and regulatory trends; and expectation as to future developments.

There is measurement uncertainty related to asset retirement obligations as it involves estimates in determining settlement amount and timing of settlement. Changes to any of these estimates and assumptions may result in change to the obligation.

(n) Changes in Accounting Policy

AHS has adopted on a prospective basis the following accounting standards and guideline as of April 1, 2023:

- **PS 3400 – Revenue**
  PS 3400 provides guidance on how to account for and report revenue, and specifically, it differentiates between revenue arising from exchange and non-exchange transactions. The adoption of this standard did not have any significant impact on AHS' consolidated financial statements.

- **PSG-8 – Purchased Intangibles**
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets. The adoption of this standard did not have any impact on AHS' consolidated financial statements.

- **PS 3160 – Public Private Partnerships**
  PS 3160 provides guidance on how to account for public private partnerships between public and private sector entities, where the public sector entity procures infrastructure using a private sector partner. The adoption of this standard did not have any impact on AHS' consolidated financial statements.

(o) Future Accounting Changes

On April 1, 2026, AHS will adopt the following new conceptual framework and accounting standard approved by the Public Sector Accounting Board:

- **The Conceptual Framework for Financial Reporting in the Public Sector**
  The Conceptual Framework is the foundation for public sector financial reporting standard setting. It replaces the conceptual aspects of Section PS 1000 Financial Statement Concepts and Section PS 1100 Financial Statement Objectives. The conceptual framework highlights considerations fundamental for the consistent application of accounting issues in the absence of specific standards.

- **PS 1202 Financial Statement Presentation**
  Section PS 1202 sets out general and specific requirements for the presentation of information in general purpose financial statements. The financial statement presentation principles are based on the concepts within the Conceptual Framework.

Management is currently assessing the impact of the conceptual framework and the standard on the AHS consolidated financial statements.

Note 3 Budget

The 2023-24 annual budget was approved by the Official Administrator on March 23, 2023 for submission to the Minister who approved it on April 28, 2023.

Note 4 Other Government Transfers

	Budget	2024	2023
Recognition of expended deferred capital revenue (Note 16 (a))	$ 216,200	$ 214,858	$ 192,079
Restricted operating (Note 14(a))	224,318	251,255	218,460
Unrestricted operating	30,200	61,812	64,973
	$ 470,718	**$ 527,925**	**$ 475,512**

Other government transfers include $492,963 (2023 – $433,722) (Note 23) transferred from the Province of Alberta, $34,962 (2023 – $41,790) from government entities outside the Province of Alberta and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations and Non-Government Contributions

	Budget	2024	2023
Recognition of expended deferred capital revenue (Note 16 (a))	$ 36,800	$ 34,252	$ 32,407
Restricted operating (Note 14(a))	144,000	139,182	150,190
Unrestricted operating	1,200	12,167	6,537
Endowment contributions (Note 21)	-	27,781	110
	$ 182,000	**$ 213,382**	**$ 189,244**

Note 6 Investment and Other Income

	Budget	2024	2023
Investment income	$ 54,000	$ 118,227	$ 39,658
Other income:			
AH	10,525	11,507	12,883
Other Province of Alberta Ministries (Note 23)	23,800	29,791	31,307
Other [(i)]	126,475	170,851	156,437
	$ 214,800	**$ 330,376**	**$ 240,285**

[(i)] Other mainly relates to recoveries for services provided to third parties.

Note 7 Support Services

	Budget	2024	2023
Facilities operations	$ 1,006,700	$ 1,070,364	$ 994,103
Patient health records, food services, and transportation	416,600	513,793	492,530
Housekeeping, laundry, and linen	273,700	264,093	260,404
Materials management [(i)]	189,600	233,350	243,399
Support services expense of full-spectrum contracted health service providers	162,700	182,462	166,462
Ancillary operations	86,600	61,412	73,236
Fundraising expenses and grants awarded	47,200	53,310	51,705
Other [(i)]	356,100	419,588	357,592
	$ 2,539,200	**$ 2,798,372**	**$ 2,639,431**

[(i)] Materials management and other include inventory valuation adjustments of $78,997 (2023 – $71,419) (Note 20).

Note 8 Administration

	Budget	2024	2023
General administration	$ 233,500	$ 276,775	$ 219,583
Human resources	146,700	143,236	127,969
Finance	87,100	80,422	80,565
Communications	26,500	28,038	26,496
Administration expense of full-spectrum contracted health service providers	47,500	45,339	40,713
	$ 541,300	**$ 573,810**	**$ 495,326**

Note 9 Financial Risk Management

AHS is exposed to a variety of financial risks associated with its financial instruments. These financial risks include market risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in market prices. Market risk is comprised of three types of risk: price risk, interest rate risk, and foreign currency risk.

In accordance with the AHS investment bylaw and policy, AHS manages market risk by maintaining a conservative and diversified portfolio, and engages Alberta Investment Management Corporation, a related party, to manage the portfolio. Compliance with the bylaw and policy is monitored and reported to the AHS Board on a quarterly basis.

In order to earn financial returns at an acceptable level of market risk, the consolidated investment portfolio is governed by investment bylaws and policies with clearly established target asset mixes. The target assets range between 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities and 0% to 70% for equity holdings.

Risk is reduced through asset class diversification, diversification within each asset class, and portfolio quality constraints governing the quality of portfolio holdings.

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. Volatility is determined using a ten-year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 3.70% (2023 – 3.79%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in unrealized net gains and losses of $95,745 (2023 – $82,800).

(i) Price Risk

Price risk relates to the possibility that equity portfolio investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity portfolio investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $53,723 or 2.06% of total portfolio investments (2023 – $49,936 or 2.27%).

(ii) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. AHS manages the interest rate risk exposure of its fixed income securities by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in fixed income securities with both fixed and floating interest rates. AHS has fixed interest rate loans for all debt, thereby mitigating interest rate risk from rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

Note 9 Financial Risk Management (continued)

In general, investment returns for fixed income securities are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter term bonds and money market instruments.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $62,499 (2023 – $62,550).

Interest bearing securities have the following average maturity structure:

	2024	2023
Less than one year	33%	27%
1 – 5 years	49%	52%
6 – 10 years	10%	8%
Over 10 years	8%	13%

	Average Effective Market Yield	
Asset Class	2024	2023
Money market instruments	5.06%	4.45%
Fixed income securities	4.41%	4.21%

(iii) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. Cash and cash equivalents and portfolio investments denominated in foreign currencies are translated into Canadian dollars on a daily basis using the reporting date exchange rate. Both the realized gain/loss and remeasurement gain/loss comprise actual gains or losses on the underlying instrument as well as changes in foreign exchange rates at the time of the valuation. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. AHS is also exposed to changes in the valuation on its global equity funds attributable to fluctuations in foreign currency.

Foreign currency risk is managed by the investment policies which limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2024, investments in non-Canadian equities represented 11.6% (March 31, 2023 – 12.5%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. AHS holds US dollar forward contracts to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2024, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2023 – $18,000). The fair value of these forward contracts as at March 31, 2024 was $434 (2023 – $846) and is included in portfolio investments (Note 10).

(b) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its contractual obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. The investment policies restrict the types and proportions of eligible investments, thus mitigating AHS' exposure to credit risk.

Accounts receivable primarily consists of amounts receivable from AH, other Alberta government reporting entities, patients, other provinces and territories, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

The carrying amounts of financial assets represent the maximum credit exposure.

Under the investment bylaws and policies governing the consolidated investment portfolio, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total investment portfolio. Not more than 20% of the investment portfolio may be BBB or equivalent rated bonds. AHS holds unrated mortgage fund investments which are classified as part of AHS' fixed income securities.

Note 9 Financial Risk Management (continued)

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31.
The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2024	2023
AAA	58%	51%
AA	10%	19%
A	17%	14%
BBB	11%	12%
Unrated	4%	4%
	100%	**100%**

(a) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty under both normal and stressed conditions in meeting obligations associated with financial liabilities that are settled by delivery of cash and cash equivalents or another financial asset. Liquidity requirements of AHS are met through funding provided by AH, income generated from portfolio investments, and by investing in liquid assets, such as money market securities, fixed income securities and equities traded in an active market that are easily sold and converted to cash. Short-term borrowing to meet financial obligations would be available through established credit facilities, which have not been drawn upon, as described in Note 17(b).

AHS issued debentures and the committed repayments with respect to these debentures are described in Note 17(c). The following are contractual maturities of the remaining financial liabilities as at March 31, 2024, based on expected undiscounted cash flows.

	Due in less than 1 year	Due in 1-5 years	Due after 5 years
Payroll payable and related accrued liabilities	$ 816,482	$ -	$ -
Trade accounts payable and accrued liabilities	692,594	-	-
Other liabilities	6,930	13,056	5,961
	$ 1,516,006	**$ 13,056**	**$ 5,961**

Note 10 Portfolio Investments

	2024		2023	
	Fair Value	**Cost**	**Fair Value**	**Cost**
Cash held for investing purposes	**$ 131,690**	**$ 131,690**	**$ 122,940**	**$ 122,940**
Interest bearing securities:				
Money market securities	614,641	614,636	367,815	367,775
Fixed income securities	1,304,133	1,326,783	1,194,576	1,228,624
	1,918,774	**1,941,419**	**1,562,391**	**1,596,399**
Equities:				
Canadian equity investments and funds	199,709	181,927	177,151	171,926
Global equity investments and funds	299,807	224,040	273,522	228,896
	499,516	**405,967**	**450,673**	**400,822**
Real estate pooled funds	**37,712**	**30,926**	**48,690**	**40,371**
	$ 2,587,692	**$ 2,510,002**	**$ 2,184,694**	**$ 2,160,532**

	2024	2023
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,509,350	$ 2,121,012
Portfolio investments in equity instruments that are quoted in an active market	77,908	62,836
Derivative asset, net	434	846
	$ 2,587,692	**$ 2,184,694**

As at March 31, 2024, included in portfolio investments is $188,142 (2023 – $187,959) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* (Alberta). Endowment principal included in portfolio investments amounts to $105,273 (2023 – $77,492).

The following are the total net remeasurement gains on portfolio investments:

	2024	2023
Accumulated remeasurement gains	$ 64,073	$ 20,270
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	13,617	3,892
	$ 77,690	**$ 24,162**

Note 10 Portfolio Investments (continued)

Fair Value Hierarchy

The three levels of information that are used to measure fair value are:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 – Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

	2024			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ -	$ 131,690	$ -	$ 131,690
Interest bearing securities:				
Money market securities	-	614,641	-	614,641
Fixed income securities	-	1,252,966	51,167	1,304,133
Equities:				
Canadian equity investments and funds	77,908	121,801	-	199,709
Global equity investments and funds	-	299,807	-	299,807
Real estate pooled funds	-	-	37,712	37,712
	$ 77,908	**$ 2,420,905**	**$ 88,879**	**$ 2,587,692**
Percent of total	3%	94%	3%	100%

	2023			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ -	$ 122,940	$ -	$ 122,940
Interest bearing securities:				
Money market securities	-	367,815	-	367,815
Fixed income securities	-	1,143,251	51,325	1,194,576
Equities:				
Canadian equity investments and funds	62,836	114,315	-	177,151
Global equity investments and funds	-	273,522	-	273,522
Real estate pooled funds	-	-	48,690	48,690
	$ 62,836	**$ 2,021,843**	**$ 100,015**	**$ 2,184,694**
Percent of total	3%	93%	4%	100%

Reconciliation of Investments classified as level 3

	2024		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,325	$ 48,690	$ 100,015
Purchases	2,015	-	2,015
Sales	(333)	(11,129)	(11,462)
Realized (loss) gain	(21)	1,684	1,663
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	595	(1,533)	(938)
Transfers out[i]	(2,414)	-	(2,414)
End of year	**$ 51,167**	**$ 37,712**	**$ 88,879**

Note 10 Portfolio Investments (continued)

	2023		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,053	$ 45,027	$ 96,080
Purchases	2,266	-	2,266
Sales	(857)	-	(857)
Realized loss	(68)	-	(68)
(Loss) gain included in the Consolidated Statement of Remeasurement Gains and Losses	(1,999)	3,663	1,664
Transfers in[(i)]	930	-	930
End of year	**$ 51,325**	**$ 48,690**	**$ 100,015**

[(i)] Transfers are attributable to changes in the observability of market data.

Note 11 Accounts Receivable

	2024			2023
	Gross	Allowance for Doubtful Accounts	Net	Net
AH operating transfers receivable	$ 168,549	$ -	$ 168,549	$ 324,146
Other capital transfers receivable	105,534	-	105,534	108,535
Patient accounts receivable	160,934	44,350	116,584	86,584
Drugs rebates receivable	105,960	-	105,960	87,031
AH capital transfers receivable	20,497	-	20,497	10,922
Other operating transfers receivable	50,050	-	50,050	38,117
Other accounts receivable	198,011	9,660	188,351	94,748
	$ 809,535	**$ 54,010**	**$ 755,525**	**$ 750,083**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2023, the total allowance for doubtful accounts was $57,791 of which $48,229 related to patient accounts receivable.

Note 12 Accounts Payable and Accrued Liabilities

	2024	2023
Payroll payable and related accrued liabilities	$ 816,482	$ 697,925
Trade accounts payable and accrued liabilities	692,594	749,089
Provision for unpaid claims[(a)]	167,598	164,312
Obligations under capital leases[(b)]	142,882	122,977
Other liabilities	36,399	39,121
	$ 1,855,955	**$ 1,773,424**

As at March 31, 2024, accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $237,885 (2023 – $237,507). Of these amounts, $9,166 (2023 – $9,779) comprise life lease deposits received from tenants of certain AHS' long term care facilities, and obligations under capital leases of $142,882 (2023 – $122,977).

(a) Provision for unpaid claims is an actuarial estimate of liability claims against AHS. It is influenced by factors such as historical trends involving claim payment patterns, loss payments, number of unpaid claims, claims severity and claim frequency patterns.

The provision has been actuarially estimated using the discounted value of claim liabilities using a discount rate of 4.37% (2023 – 3.80%).

Note 12 Accounts Payable and Accrued Liabilities (continued)

(b) Obligations under capital leases include site leases with the University of Calgary, vehicle and equipment leases, site leases for ambulance services and a community care service facility.

The obligations will be settled between 2025 and 2041 and have an implicit interest rate payable ranging from 2.53% to 5.41% (2023 – 2.53% to 5.07%).

AHS is committed to making payments for obligations under capital leases as follows:

Year ended March 31	Minimum Contract Payments
2025	$ 24,071
2026	22,366
2027	19,928
2028	15,794
2029	11,076
Thereafter	71,055
	164,290
Less: interest	(21,408)
	$ 142,882

Note 13 Employee Future Benefits

	2024	2023
Accrued vacation pay	$ 680,804	$ 646,664
Accumulating non-vesting sick leave[(a)]	137,552	140,592
SERP pension plans	183	387
	$ 818,539	**$ 787,643**

(a) Accumulating Non-Vesting Sick Leave

Sick leave benefits are paid by AHS; there are no employee contributions and no assets set aside to support the obligation.

	2024	2023
Funded status – deficit	$ 99,365	$ 91,650
Unamortized net actuarial gain	38,187	48,942
Accrued benefit liability	**$ 137,552**	**$ 140,592**

Key assumptions used in the determination of the accumulating non-vesting sick leave liability are:

	2024	2023
Estimated average remaining service life	10 years	10 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	18.30%
Discount rate – beginning of year	5.60%	2.50%
Discount rate – end of year	5.00%	5.60%
Rate of compensation increase per year	2023-24 2.25% 2024-25 2.00% 2025-26 2.00% Thereafter 2.75%	2022-23 1.60% 2023-24 2.25% 2024-25 2.00% Thereafter 2.75%

Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 46% (2023 - 47%) of the total membership in LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

(ii) LAPP Surplus

The LAPP carried out an actuarial valuation as at December 31, 2022 and these results were then extrapolated to December 31, 2023.

	December 31, 2023	December 31, 2022
LAPP net assets available for benefits	$ 63,337,859	$ 58,747,000
LAPP pension obligation	48,281,339	46,076,000
LAPP surplus	**$ 15,056,520**	**$ 12,671,000**

The 2024 and 2023 LAPP contribution rates are as follows:

Calendar 2024		Calendar 2023	
Employer	Employees	Employer	Employees
8.45% of pensionable earnings up to the YMPE and 11.65% of the excess	7.45% of pensionable earnings up to the YMPE and 10.65% of the excess	8.45% of pensionable earnings up to the YMPE and 12.23% of the excess	7.45% of pensionable earnings up to the YMPE and 11.23% of the excess

(c) Pension Expense

	2024	2023
Local Authorities Pension Plan	$ 521,199	$ 462,649
Defined contribution pension plans and group RRSPs	41,331	39,651
Other pension plans	1,727	(253)
	$ 564,257	**$ 502,047**

Note 14 Unexpended Deferred Operating Revenue

(a) Changes in the unexpended deferred operating revenue balance are as follows:

	2024				2023
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 190,243	$ 98,730	$ 283,655	$ 572,628	$ 529,707
Received or receivable during the year	1,641,288	169,270	205,588	2,016,146	2,596,362
Unexpended deferred operating revenue returned	(7,288)	(2,630)	(404)	(10,322)	(4,585)
Restricted investment income	1,700	1,586	13,574	16,860	2,463
Transferred from unexpended deferred capital revenue [ii]	9,197	95,149	712	105,058	83,435
Transferred to expended deferred operating revenue	-	-	-	-	(69,517)
Recognized as revenue	(1,605,994)	(251,255)	(139,182)	(1,996,431)	(2,546,492)
Miscellaneous other revenue recognized	(1,701)	(923)	(13,118)	(15,742)	(2,125)
	227,445	**109,927**	**350,825**	**688,197**	**589,248**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(1,677)	1,332	10,070	9,725	(16,620)
Balance, end of year	**$ 225,768**	**$ 111,259**	**$ 360,895**	**$ 697,922**	**$ 572,628**

(i) The balance for other government includes $1,879 (2023 – $2,512) of unexpended deferred operating revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta (Note 23).

(ii) The transfer is mainly comprised of restricted capital funding that was used for approved expenditures that did not meet the definition of a tangible capital asset.

Note 14 Unexpended Deferred Operating Revenue (continued)

(a) The unexpended deferred operating revenue balance at the end of the year is externally restricted for the following purposes:

	2024				2023
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 4,222	$ 2,741	$ 255,047	$ 262,010	$ 200,129
Cancer prevention, screening and treatment	83,490	197	3,814	87,501	74,806
Addiction and mental health	-	60,278	1,868	62,146	55,053
Acute care	8,369	1,413	41,720	51,502	51,902
Support services	6,756	5,513	32,939	45,208	40,270
Physician revenue and alternate relationship plans	42,527	2,181	-	44,708	49,196
Primary Care Networks	29,240	-	-	29,240	23,150
Diagnostic and therapeutic services	21,639	594	847	23,080	22,694
Emergency medical services	19,936	1,053	255	21,244	200
Long term care partnerships	-	20,171	-	20,171	19,508
Population and public heath	1,941	14,926	1,163	18,030	21,859
Others individually less than $10,000	8,845	40	10,580	19,465	9,969
	226,965	**109,107**	**348,233**	**684,305**	**568,736**
Unrealized net (loss) gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	(1,197)	2,152	12,662	13,617	3,892
	$ 225,768	**$ 111,259**	**$ 360,895**	**$ 697,922**	**$ 572,628**

Note 15 Unexpended Deferred Capital Revenue

(a) Changes in the unexpended deferred capital revenue balance are as follows:

	2024				2023
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 70,973	$ 8,442	$ 98,486	$ 177,901	$ 149,516
Received or receivable during the year	143,304	279,166	51,072	473,542	429,670
Used for the acquisition of land	-	-	-	-	(3,934)
Unexpended deferred capital revenue returned	(1,174)	(2,452)	-	(3,626)	(73)
Transferred to expended deferred capital revenue	(92,938)	(186,853)	(47,784)	(327,575)	(312,683)
Transferred to unexpended deferred operating revenue[(ii)]	(9,197)	(95,149)	(712)	(105,058)	(83,435)
Revenue recognized on settlement of asset retirement obligations (Note 18)	(168)	(630)	(314)	(1,112)	(1,160)
Balance, end of year	**$ 110,800**	**$ 2,524**	**$ 100,748**	**$ 214,072**	**$ 177,901**

(i) The balance for other government all relates to the Province of Alberta (Note 23).

(ii) The transfer is mainly comprised of restricted capital funding of approved expenditures that did not meet the definition of a tangible capital asset.

(b) The unexpended deferred capital revenue balance at the end of the year is externally restricted for the following purposes:

	2024	2023
AH		
Continuing Care Beds	$ 4,150	$ 12,714
Information systems	828	5,505
Medical Equipment Replacement Upgrade Program	9,771	2,367
Diagnostic equipment	2,436	3,612
Alberta Surgical Initiative Capital Program	44,229	15,560
Rural Health Facilities Revitalization Program	31,214	22,119
National Association of Pharmacy Regulatory Authorities	13,687	-
Other equipment	4,485	9,096
Total AH	**110,800**	**70,973**
Other government		
Facilities and improvements	482	2,489
Equipment	2,042	5,953
Total other government	**2,524**	**8,442**
Donors and non-government		
Equipment	89,371	88,792
Facilities and improvements	11,377	9,694
Total donors and non-government	**100,748**	**98,486**
	$ 214,072	**$ 177,901**

Note 16 Expended Deferred Revenue

	2024	2023
Expended deferred capital revenue[a]	$ 8,696,431	$ 8,525,465
Expended deferred operating revenue[b]	-	116,636
	$ 8,696,431	**$ 8,642,101**

(a) Expended deferred capital revenue

Changes in the expended deferred capital revenue balance are as follows:

	2024				2023
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 591,868	$ 7,705,605	$ 227,992	$ 8,525,465	$ 8,278,969
Transferred from unexpended deferred capital revenue	92,938	186,853	47,784	327,575	312,683
Constructed tangible capital assets on behalf of AHS	-	198,774	-	198,774	262,429
Contributed tangible capital assets	-	-	24	24	35
Recognized as revenue	(106,297)	(214,858)	(34,252)	(355,407)	(328,651)
Balance, end of year	**$ 578,509**	**$ 7,876,374**	**$ 241,548**	**$ 8,696,431**	**$ 8,525,465**

[i] The balance includes $228 (2023 - $nil) of expended deferred capital revenue received from government entities outside of the Province of Alberta. The remaining balance in other government relates to the Province of Alberta (Note 23).

(b) Expended deferred operating revenue

Changes in the expended deferred operating revenue balance are as follows:

	2024	2023
	Total	Total
Balance, beginning of year	$ 116,636	$ 336,972
Transferred from unexpended deferred operating revenue	-	69,517
Recognized as unrestricted revenue	(10,195)	-
Recognized as restricted revenue	(106,441)	(289,853)
Balance, end of year	**$ -**	**$ 116,636**

The balance of expended deferred operating revenue in 2023 pertains to unused COVID-19 supplies purchased with AH funding.

Note 17 Debt

	2024	2023
Debentures [(a)]:		
Parkade loan #1	$ 9,811	$ 13,446
Parkade loan #2	11,658	14,677
Parkade loan #3	19,081	22,372
Parkade loan #4	88,956	98,549
Parkade loan #5	22,331	24,473
Parkade loan #6	17,279	18,411
Parkade loan #7	38,774	41,037
Parkade loan #8	149,397	151,400
Parkade loan #9	20,000	-
Energy savings initiative loan	14,887	16,817
EMS support vehicle loan	23,639	32,906
	$ 415,813	**$ 434,088**

(a) Alberta Treasury Board and Finance (TBF) is responsible for the administration of the Province's lending program.

AHS issued debentures to TBF, a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being constructed, renovated, owned, and operated by AHS as security for these debentures.

AHS issued a debenture to TBF relating to an energy savings initiative. AHS has pledged the mortgage on the Royal Alexandra Hospital Lands and Alberta Hospital Lands as security for this debenture.

AHS issued a debenture to TBF relating to EMS support vehicles. AHS has pledged the vehicles as security for this debenture.

AHS is in compliance with all performance requirements relating to its debentures as at March 31, 2024.

The maturity dates and interest rates for the outstanding debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Parkade loan #8	December 2059	3.6010%
Parkade loan #9	March 2044	5.1200%
Energy savings initiative loan	December 2030	2.4160%
EMS support vehicle loan	September 2026	1.1500%

(b) As at March 31, 2024, AHS has access to a $220,000 (2023 – $220,000) revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2024, AHS has $nil (2023 – $nil) drawn against this facility.

AHS also has access to a $33,000 (2023 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2024, AHS has $3,316 (2023 – $3,353) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit as at March 31, 2024.

Note 17 Debt (continued)

(c) AHS is committed to making principal and interest payments with respect to its outstanding debt as follows:

Year Ended March 31	Principal	Interest	Total
2025	$ 40,226	$ 15,535	$ 55,761
2026	41,671	14,090	55,761
2027	36,274	12,584	48,858
2028	28,904	11,236	40,140
2029	28,302	10,023	38,325
Thereafter	240,436	108,280	348,716
	$ 415,813	**$ 171,748**	**$ 587,561**

During the year, the total interest related to debt was $15,788 (2023 – $16,960), comprised of capitalized interest of $nil (2023 – $3,631) (Note 19(a)) and interest expense of $15,788 (2023 – $13,329). Accrued interest at March 31, 2024 amounted to $2,679 (2023 – $2,767).

Note 18 Asset Retirement Obligations

	2024	2023
Asset retirement obligations, beginning of year	$ 583,172	$ 544,416
Liability incurred	-	1,144
Liability settled	(1,978)	(2,780)
Revision in estimates (Note 19)	(41,773)	40,392
Asset retirement obligations, end of year	**$ 539,421**	**$ 583,172**

AHS has asset retirement obligations to remove hazardous asbestos fibre containing materials from its buildings. Regulations require AHS to handle and dispose of the asbestos in a prescribed manner when it is disturbed, such as when the building undergoes renovations or is demolished. Although timing of the asbestos removal is conditional on the building undergoing renovations or being demolished, regulations create an existing obligation for AHS to remove the asbestos when asset retirement activities occur.

The estimate of the liability is based primarily on asbestos abatement rates calculated using the current costs incurred as part of AHS renovation and demolition projects. Third party engineering reports, building schematics, and professional judgments were used in determining the square meters containing asbestos. A funding source for this obligation has not been determined.

The timing of settlement of asset retirement obligations is currently unknown. For the year ended March 31, 2024, a recovery of $1,112 (2023 - $1,160) was recognized (Note 15(a)).

Note 19 Tangible Capital Assets

Cost	2023	Additions[a]	Transfers/ Adjustments[i]	Disposals/ Write-downs	2024
Facilities and improvements	$ 12,717,651	$ -	$ 267,024	$ (1,222)	$ 12,983,453
Work in progress	665,094	506,115	(509,307)	(411)	661,491
Equipment	2,974,510	207,650	(2,001)	(40,277)	3,139,882
Information systems	2,268,704	14,038	108,723	(7,067)	2,384,398
Building service equipment	1,025,874	-	64,883	(13)	1,090,744
Land[b]	121,749	32	-	-	121,781
Leased facilities and improvements	317,743	33,000	22,431	-	373,174
Land improvements	107,568	-	6,474	-	114,042
	$ 20,198,893	**$ 760,835**	**$ (41,773)**	**$ (48,990)**	**$ 20,868,965**

Accumulated Amortization	2023	Amortization Expense	Effect of Transfers/ Adjustments	Disposals/ Write-downs	2024
Facilities and improvements	$ 4,994,290	$ 158,195	$ -	$ (1,120)	$ 5,151,365
Work in progress	-	-	-	-	-
Equipment	2,298,163	172,250	-	(38,919)	2,431,494
Information systems	1,682,243	150,060	-	(6,994)	1,825,309
Building service equipment	626,105	49,801	-	(14)	675,892
Land[b]	-	-	-	-	-
Leased facilities and improvements	214,316	19,714	-	-	234,030
Land improvements	80,127	3,093	-	-	83,220
	$ 9,895,244	**$ 553,113**	**$ -**	**$ (47,047)**	**$ 10,401,310**

Cost	2022	Additions	Transfers/ Adjustments	Disposals/ Write-downs	2023
Facilities and improvements	$ 11,129,930	$ 772	$ 1,604,903	$ (17,954)	$ 12,717,651
Work in progress	1,934,048	557,785	(1,822,697)	(4,042)	665,094
Equipment	2,823,434	208,700	(2,107)	(55,517)	2,974,510
Information systems	2,106,767	10,124	165,939	(14,126)	2,268,704
Building service equipment	978,574	-	47,300	-	1,025,874
Land[b]	117,804	3,966	-	(21)	121,749
Leased facilities and improvements	262,878	-	55,496	(631)	317,743
Land improvements	116,010	-	(8,442)	-	107,568
	$ 19,469,445	**$ 781,347**	**$ 40,392**	**$ (92,291)**	**$ 20,198,893**

Accumulated Amortization	2022	Amortization Expense	Effect of Transfers/ Adjustments	Disposals/ Write-downs	2023
Facilities and improvements	$ 4,866,614	$ 142,844	$ -	$ (15,168)	$ 4,994,290
Work in progress	-	-	-	-	-
Equipment	2,190,700	160,272	-	(52,809)	2,298,163
Information systems	1,556,079	140,274	-	(14,110)	1,682,243
Building service equipment	574,139	51,966	-	-	626,105
Land[b]	-	-	-	-	-
Leased facilities and improvements	205,500	9,123	-	(307)	214,316
Land improvements	78,378	1,749	-	-	80,127
	$ 9,471,410	**$ 506,228**	**$ -**	**$ (82,394)**	**$ 9,895,244**

[i] Transfers and adjustments relate to reclassifications between capital asset categories and revisions to asset retirement costs of $41,773 (2023 - $40,392) (Note 18).

Note 19 Tangible Capital Assets (continued)

	Net Book Value	
	2024	2023
Facilities and improvements	$ 7,832,088	$ 7,723,361
Work in progress	661,491	665,094
Equipment	708,388	676,347
Information systems	559,089	586,461
Building service equipment	414,852	399,769
Land[(b)]	121,781	121,749
Leased facilities and improvements	139,144	103,427
Land improvements	30,822	27,441
	$ 10,467,655	**$ 10,303,649**

(a) Additions

Additions include tangible capital assets constructed by AI on behalf of AHS of $198,774 (2023 – $262,429) (Note 23) and $24 (2023 – $35) contributed from other sources. During the year, AHS capitalized interest of $nil (2023 – $3,631) (Note 17(c)) within work in progress. Capital lease additions amounted to $37,753 (2023 – $19,031).

(b) Leased Land

Land at the following sites have been leased to AHS at nominal values:

Site	Leased from	Lease Expiry
Evansburg Community Health Centre	Yellowhead County	April 2031
Bethany Care Centre	Red Deer College	April 2034
Myrnam Land	Eagle Hill Foundation	May 2038
Helipad Land at Two Hills	Stella Stefiuk	August 2041
McConnell Place North	City of Edmonton	September 2044
Northeast Community Health Centre	City of Edmonton	February 2047
Jasper Healthcare Centre	Parks Canada	March 2049
Foothills Medical Centre Parkade	University of Calgary	July 2054
Alberta Children's Hospital	University of Calgary	December 2103
Kaye Edmonton Clinic (Parcel H)	The University of Alberta	February 2109
Laneway adjacent to Queen Elizabeth II Hospital	City of Grande Prairie	Under negotiation

(c) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes vehicle leases, equipment, information systems and facilities with a cost of $579,537 (2023 – $487,324) and accumulated amortization of $286,709 (2023 – $269,475).

(d) Asset Retirement Costs

Facilities and improvements and Building service equipment, include $538,304 (2023 - $581,299) of asset retirement costs and $359,135 (2023 - $348,944) of related accumulated amortization.

Note 20 Inventories of Supplies

	2024	2023
Pharmaceuticals	$ 106,759	$ 114,334
Medical and surgical supplies	47,395	95,817
Other[(i)]	43,015	97,574
	$ 197,169	**$ 307,725**

(i) Other is mainly related to staff wearing apparel such as gowns and masks, housekeeping, and other supplies not included under pharmaceuticals and medical and surgical supplies.

Demand has reduced for inventories purchased to support public health emergencies in prior years, resulting in a valuation adjustment of $78,997 (2023 – $71,419) in the current year.

AHS holds and distributes COVID-19 rapid test kits, provided at no cost by the Federal Government, on behalf of AH. These inventories are excluded from these consolidated financial statements. AHS is holding $1,459 (2023 – $223,542) on behalf of AH as at March 31, 2024.

Note 21 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2024					2023
	Unrestricted Surplus	Invested in Tangible Capital Assets [(a)]	Endowments[(b)]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[(c)]	Total	Total
Balance, beginning of year	$ 262,491	$ 649,167	$ 77,492	$ 131,677	$ 1,120,827	$ 1,037,157
Annual operating surplus	183,631	-	-	-	183,631	83,670
Net investment in tangible capital assets	(56,615)	56,615	-	-	-	-
Transfer of insurance equity requirements and foundations deficits	8,182	-	-	(8,182)	-	-
Transfer of net deficits related to asset retirement obligations	9,435	(9,435)	-	-	-	-
Transfer of endowment contributions (Note 5)	(27,781)	-	27,781	-	-	-
Balance, end of year	**$ 379,343**	**$ 696,347**	**$ 105,273**	**$ 123,495**	**$ 1,304,458**	**$ 1,120,827**

Note 21 Accumulated Surplus (continued)

(a) Invested in Tangible Capital Assets

Invested in tangible capital assets represents the portion of accumulated surpluses that has been invested in the acquisition or construction of AHS' assets. The balance is offset by asset retirement costs recognized to date in accumulated surplus net of related liability settlements.

Reconciliation of invested in tangible capital assets:

	2024	2023
Tangible capital assets (Note 19)	$ 10,467,655	$ 10,303,649
Net Book Value of Asset Retirement Costs capitalized (Note 19(d))	(179,169)	(232,355)
Less funded by:		
Expended deferred capital revenue (Note 16(a))	(8,696,431)	(8,525,465)
Debt (Note 17)	(415,813)	(434,088)
Unexpended debt	32,405	20,999
Obligations under capital leases (Note 12)	(142,882)	(122,977)
Life lease deposits (Note 12)	(9,166)	(9,779)
	$ 1,056,599	**$ 999,984**
Asset retirement costs recognized net of related liability settlements	(360,252)	(350,817)
	$ 696,347	**$ 649,167**

(b) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity. Transfers of endowment contributions from unrestricted surplus include $27,781 (2023 – $110) of net contributions received in the year (Note 5).

(c) Internally Restricted Surplus for Insurance Equity Requirements and Foundations

Insurance equity requirements comprise surpluses of $21,042 (2023 – $39,359) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $102,453 (2023 – $92,318) related to donations received by AHS' Controlled Foundations without external restrictions attached.

Note 22 Contractual Obligations and Contingent Liabilities

(a) Contractual Obligations

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of those contracts or agreements are met.

The estimated aggregate amount payable for the unexpired terms of these contractual obligations are as follows:

Year ended March 31	Services[i]	Other[ii]	Operating Lease	Capital Projects	Total
2025	$ 3,533,626	$ 440,411	$ 67,744	$ 315,700	$ 4,357,481
2026	1,890,785	275,754	56,726	63,945	2,287,210
2027	1,360,101	188,217	51,335	16,016	1,615,669
2028	1,138,489	113,045	44,196	17,268	1,312,998
2029	985,707	31,911	33,754	21,905	1,073,277
Thereafter	7,147,609	21,696	119,086	13,644	7,302,035
March 31, 2024	**$ 16,056,317**	**$ 1,071,034**	**$ 372,841**	**$ 448,478**	**$ 17,948,670**
March 31, 2023	$ 20,121,744	$ 1,126,267	$ 312,835	$ 268,567	$ 21,829,413

(i) Service obligations mainly relate to contracts with third parties for the provision of long-term care services, home care services, and community laboratory services (Note 22(b)).

(ii) Other obligations mainly relate to contracts with third parties for maintenance, information technology services, software, equipment, and procurement of medical supplies and food.

(b) Transition of Community Laboratory Services

On December 5, 2022, community laboratory services were transferred from AHS to DynaLIFEDX (DLDX). The agreement included an estimated commitment of $4.8 billion over an initial term of 14 years and four months. On August 18, 2023, the government announced that AHS, through Alberta Precision Laboratories, would be the sole provider of community laboratory services in Alberta, to improve service delivery to Albertans (Note 27). The previous agreements with DLDX, including the related commitment, was cancelled effective August 31, 2023.

(c) Contingent Liabilities

(i) Legal Claims

AHS is subject to legal claims during its normal course of business. AHS recognizes a liability when the assessment of a claim indicates that a future event is likely to confirm that a liability has been incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2024, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

Note 22 Contractual Obligations and Contingent Liabilities (continued)

AHS has been named in 234 legal claims (2023 – 292 claims) related to conditions in existence at March 31, 2024 where the likelihood of the occurrence of a future event confirming a contingent loss is not determinable. Of these, 201 claims have $706,650 in specified amounts and 33 have no specified amounts (2023 – 256 claims with $777,051 of specified claims and 36 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

(ii) Collective Agreements

AHS currently has 1 (2023 – 7) collective agreement that has expired as at March 31, 2024. Given that negotiations are ongoing or have not commenced, no additional disclosures have been made.

Note 23 Related Parties

Transactions with related parties are included within these consolidated financial statements, unless otherwise stated.

The Minister appoints all members of the AHS Board. The viability of AHS' operations depends on transfers from AH. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the tables below.

Related parties also include key management personnel of AHS. AHS has defined key management personnel to include those disclosed in Schedules 2A and 2B of these consolidated financial statements, except management reporting to CEO direct reports. Related party transactions with key management personnel primarily consist of compensation related payments and are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is a related party with respect to those entities consolidated or included on a modified equity basis in the consolidated financial statements of the Province of Alberta. Entities consolidated or included on a modified equity basis have been grouped with their respective ministry and transactions between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenues[a]		Expenses	
	2024	2023	2024	2023
Alberta Advanced Education[b]	$ 57,875	$ 59,994	$ 184,077	$ 181,312
Alberta Infrastructure[c]	312,158	289,460	12,064	17,310
Alberta Mental Health and Addiction[d]	121,779	90,695	-	-
Other ministries[e]	33,157	29,113	31,749	33,112
Total for the year	**$ 524,969**	**$ 469,262**	**$ 227,890**	**$ 231,734**

	Receivable from		Payable to	
	2024	2023	2024	2023
Alberta Advanced Education[b]	$ 11,435	$ 7,597	$ 33,399	$ 45,006
Alberta Infrastructure[c]	69,725	67,236	6,144	1,000
Alberta Mental Health and Addiction[d]	28,419	22,641	1,288	-
Other ministries[e]	8,928	3,635	419,112	437,593
Balance, end of year	**$ 118,507**	**$ 101,109**	**$ 459,943**	**$ 483,599**

Note 23 Related Parties (continued)

(a) Revenues with Province of Alberta ministries include other government transfers of $492,963 (2023 – $433,722), (Note 4), other income of $29,791 (2023 – $31,307) (Note 6), and fees and charges of $2,214 (2023 – $4,233).

(b) The majority of AHS' transactions with Alberta Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The transactions reported are a result of funding provided from one to the other and recoveries of shared costs.

(c) The transactions with AI relate to the construction of tangible capital assets on behalf of AHS. These transactions include operating transfers of $98,110 (2023 – $99,542) and recognition of expended deferred capital revenue of $214,048 (2023 – $189,918) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Not included in the table above but included in total amounts disclosed in Note 19(a) is tangible capital assets constructed by AI on behalf of AHS of $198,774 (2023 – $262,429).

(d) The transactions with Alberta Mental Health and Addiction relate to initiatives to support Albertans experiencing addiction and mental health challenges.

(e) The payable transactions with other ministries include the debt payable to TBF (Note 17(a)).

At March 31, 2024, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $109,380 (2023 – $96,218) related to unexpended deferred operating revenue (Note 14(a)), $2,524 (2023 – $8,442) related to unexpended deferred capital revenue (Note 15(a)) and $7,876,146 (2023 – $7,705,605) related to expended deferred capital revenue (Note 16(a)).

Contingent liabilities in which AHS has been jointly named with other government entities within the Province of Alberta are disclosed in Note 22.

Note 24 Government Partnerships

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC and 33.33% of the results in iRSM. The following is 100% of the financial position and results of operations for AHS' government partnerships.

	2024	2023
Financial assets (portfolio investments, accounts receivable, other assets)	$ 83,417	$ 67,995
Liabilities (trade accounts payable, unexpended deferred operating revenue)	83,417	67,995
Accumulated surplus	**$ -**	**$ -**
Total revenues	$ 279,160	$ 263,082
Total expenses	279,160	263,082
Annual surplus	**$ -**	**$ -**

Note 25 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority representation on the HBTA governance board. The HBTA is a formal employee life and health trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement.

The HBTA's balances as at March 31 are as follows:

	2024	2023
Financial assets	$ 232,932	$ 125,630
Liabilities	23,983	34,644
Net financial assets	208,949	90,986
Non-financial assets	-	5
Net assets	**$ 208,949**	**$ 90,991**

AHS has included in prepaid expenses $142,539 (2023 – $59,712) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2024, AHS paid premiums of $632,746 (2023 – $552,232) which is approximately 98% (2023 – 98%) of the total premiums received by the HBTA.

(b) Other Trust Funds

AHS holds funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2024, the balance of funds held in trust by AHS for research and development is $100 (2023 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2024, the balance of these funds is $2,185 (2023 – $1,855). These amounts are not included in the consolidated financial statements.

AHS and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. As at March 31, 2024, there are $25,176 in plan assets (2023 – $26,547). These amounts are not included in the consolidated financial statements.

Note 26 Segment Disclosure

The Consolidated Schedule of Segment Disclosures – *Schedule 3* is intended to enable users to better understand the reporting entity and identify the resources allocated to the major activities of AHS.

AHS' revenues, as reported on the Consolidated Statement of Operations, are most informatively presented by source and are not reasonably assignable to the reportable segments. For each reported segment, the expenses are directly or reasonably attributable to the segment.

The segments have been selected based on the presentation that is adopted for the financial reporting, planning and budget processes, and represent the major distinguishable activities of AHS.

Segments include:

(a) Continuing care

Continuing care is comprised of long-term care including chronic, palliative, and psychiatric care in facilities operated by AHS and contracted providers.

(b) Community care

Community care includes supportive living, palliative and hospice care, and community programs including Primary Care Networks, Family Care Clinics, urgent care centres, community paramedic program and mental health. This segment excludes community-based dialysis, oncology, and surgical services.

Note 26 Segment Disclosure (continued)

(c) Home care

Home care is comprised of home nursing and support.

(d) Acute care

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

(e) Emergency medical services

Emergency medical services is comprised of ground ambulance, air ambulance, patient transport, and central dispatch. AHS also supports community paramedic programs, as well as other programs that support the learning, development, quality and safety of emergency medical services professionals.

(f) Diagnostic and therapeutic services

Diagnostic and therapeutic services support and provide care for patients through clinical lab (both in the community and acute settings), diagnostic imaging, pharmacy, rehabilitation services such as physiotherapy, occupational therapy, respiratory therapy, and speech language pathology.

(g) Population and public health

Population and public health is comprised primarily of health promotion, disease and injury prevention, and health protection. This segment also includes immunizations, traveler’s health clinics, outbreaks, screening programs, and disease surveillance. This segment excludes activities associated with treatment of communicable diseases.

(h) Research and education

Research and education is comprised primarily of costs pertaining to formally organized health research and graduate medical education, primarily funded by donations, and third party contributions.

(i) Information technology

Information technology is comprised of costs pertaining to the provision of service and consultation in the design, development, implementation of technology services and systems.

(j) Support services

Support services is comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution, and sterilization), housekeeping, patient registration, health records, infection control, food services, and emergency preparedness.

(k) Administration

Administration is comprised of human resources, finance, communications, and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executives and many functions such as planning and development, quality assurance, patient safety, insurance, privacy, public relations, risk management, internal audit, and legal.

Note 27 Acquisition of DynaLIFEDX

On August 18, 2023, the government announced that AHS, through Alberta Precision Laboratories, would be the sole provider of community laboratory services in Alberta, to improve service delivery to Albertans. This was accomplished by AHS' acquisition of the operations, including specific assets, liabilities, and workforce of DynaLIFEDX (DLDX) through the Asset Purchase and Transition Agreements executed on August 31, 2023. The previous Services Agreement and Ancillary Agreements with DLDX including the related commitment, was cancelled effective August 31, 2023 (Note 22(b)).

The purchase price allocation of assets and liabilities on the basis of fair value was as follows:

		August 31, 2023
Financial assets:		
Cash	$	2,112
Accounts receivable		7,173
		9,285
Liabilities:		
Accounts payable and accrued liabilities		39,468
Employee future benefits		10,421
		49,889
Non-financial assets:		
Tangible capital assets		71,760
Inventories of supplies		7,886
Prepaid expenses		4,959
		84,605
Purchase price before settlement of balances due from DLDX		(47,795)
Net balances due from DLDX settled at acquisition		16,295
Cash purchase consideration paid		**(31,500)**
Purchase premium before transaction costs		**(3,794)**
Transaction costs		(912)
Purchase premium	**$**	**(4,706)**

Note 28 Corresponding Amounts

Certain corresponding amounts have been reclassified to conform with 2024 presentation.

Note 29 Subsequent Events and Restructuring/Refocusing of AHS

On November 8, 2023, the Premier of Alberta announced that AHS will shift its primary focus from being the regional health authority in Alberta to focusing on acute care. Implementation of these changes will be introduced in a staged approach, resulting in the restructuring of AHS and the creation of four new agencies focusing on primary care, acute care, continuing care, and mental health and addiction.

On April 2, 2024, the Premier of Alberta announced that Recovery Alberta will be the new provincial health agency responsible for the delivery and oversight of mental health and addiction services. The annual budget for these services is estimated at approximately $1 billion and is expected to be transitioned from Alberta Health to the ministry of Mental Health and Addiction.

On May 30, 2024, the *Health Statutes Amendment Act*, 2024, received Royal Assent, enabling the transition from one regional health authority, AHS, to an integrated system of four sector-based provincial health agencies. The *Regional Health Authorities Act*, now renamed the *Provincial Health Agencies Act*, clarifies the Minister of Health's authority, the roles and responsibilities of the provincial health agencies, and enables the transfer of staff from AHS to the new agencies.

Recovery Alberta will begin operating in the summer of 2024, while the remaining three provincial health agencies are expected to be established in the fall of 2024. The full financial effect of the restructuring, including the impact on AHS' assets, liabilities and operations is currently unknown.

Note 30 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 3, 2024 and submitted to the Ministry of Health.

Schedule 1 – Consolidated Schedule of Expenses by Object

Year ended March 31

(in thousands)

	2024		2023
	Budget (Note 3)	Actual	Actual
Salaries and benefits	$ 9,408,967	$ 9,839,465	$ 9,155,665
Contracts with health service providers	3,790,600	3,466,333	3,328,374
Contracts under the Health Facilities Act	59,300	55,824	28,587
Drugs and gases[(i)]	827,300	738,881	679,210
Medical supplies[(i)]	707,000	815,353	828,438
Other contracted services	1,559,300	1,688,175	1,533,975
Other[(a)]	1,590,500	1,685,083	1,595,887
Amortization and loss on disposals/write-downs of tangible capital assets (Note 19)	527,500	555,033	514,897
	$ 18,470,467	**$ 18,844,147**	**$ 17,665,033**
(a) Significant amounts included in Other are:			
Equipment expense	$ 320,900	$ 295,346	$ 272,979
Utilities	180,400	230,705	209,283
Building and ground expenses	163,300	174,780	164,886
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[(i) (ii)]	159,300	163,538	222,813
Building rent	133,500	125,766	128,547
Minor equipment purchases	75,000	103,351	75,540
Food and dietary supplies	88,800	86,029	86,604
Fundraising and grants awarded	52,000	65,734	56,600
Office supplies and courier	54,400	64,347	68,685
Insurance and liability claims	51,500	58,656	35,860
Travel	30,000	46,165	35,486
Telecommunications	36,400	34,250	30,936
Licenses, fees and memberships	30,630	26,139	27,390
Education	12,000	14,994	11,802
Other	202,370	195,283	168,476
	$ 1,590,500	**$ 1,685,083**	**$ 1,595,887**

[(i)] Demand has reduced for inventories purchased to support public health emergencies in prior years, resulting in a valuation adjustment of $78,997 (2023 – $71,419) (Note 20).

[(ii)] Includes personal protective equipment, such as procedural masks, N95s, gowns, face shields and goggles, as well as other supplies such as hand sanitizers, disinfecting wipes and other cleaning supplies

Schedule 2 – Schedules of Remuneration and Benefits

Schedule 2A – Board Remuneration

Year ended March 31, 2024
(in thousands)

	Term	2024 Committees	2024 Remuneration	2023 Remuneration
Board Chair[f]				
Dr. Lyle Oberg	Since Nov 8, 2023	FARC, FC, GCHRC	$ 155	$ -
Board Members				
Sandy Edmonstone (Vice Chair)	Since Nov 8, 2023	FC (Chair), GCHRC	14	-
Cynthia Farmer [g]	Since Nov 8, 2023	-	-	-
Angela Fong	Since Nov 21, 2023	GCHRC (Chair)	12	-
Paul George Haggis	Since Nov 8, 2023	FARC (Chair), FC	14	-
Evan Romanow[g]	Since Nov 8, 2023	FC	-	-
Andre Tremblay[g]	Since Nov 8, 2023	FARC, FC, GCHRC	-	-
Total Board			**$ 195**	**$ -**

The Board chair and Board members were remunerated with monthly honoraria. In addition, Board members received remuneration for attendance at Board and committee meetings.

Board committees were established by the Board to assist in governing AHS and overseeing the management of AHS' business and affairs.

Committee legend: FARC = Finance, Audit and Risk Committee, FC = Foundations Committee, GCHRC = Governance, Compliance and Human Resources Committee

Schedule 2B – Former Official Administrator/Former Official Administrator Committee Remuneration

	Term	2024 Committees	2024 Remuneration	2023 Remuneration
Former Official Administrator				
Dr. John Cowell	Nov 17, 2022 to Nov 8, 2023	OAAC	$ 436	$ 267
Former Official Administrator Committee Participants[h]				
Tara Lockyer	Nov 24, 2022 to Nov 8, 2023	OAAC	2	4
Gregory Turnbull	Nov 24, 2022 to Nov 8, 2023	OAAC	3	4
Tyler White	Jul 12, 2023 to Nov 8, 2023	OAAC	1	-
Gord Winkel	Nov 24, 2022 to Nov 8, 2023	OAAC	3	4
Total Former Official Administrator / Former Official Administrator Committee			**$ 445**	**$ 279**

The tenure of the Official Administrator was in lieu of a Board at AHS.

Dr. John Cowell was appointed to the position of Official Administrator effective November 17, 2022 per Ministerial Order 319/2022 for a six month term. The incumbent was reappointed to the position of Official Administrator effective May 17, 2023 as per Ministerial Order 305/2023 with a term to end on June 30, 2023, and then subsequently reappointed effective July 1, 2023 as per Ministerial Order 307/2023 with a term to end on December 31, 2023. The incumbent's term ended November 8, 2023 when Ministerial Order 307/2023 was repealed by Ministerial Order 314/2023.

Official Administrator committees were established by the Official Administrator to aid in governing AHS and overseeing the management of AHS' business and affairs. Official Administrator committee participants were eligible to receive honoraria for meetings attended.

Committee legend: OAAC = Official Administrator Advisory Committee

Schedule 2C – Former Board Remuneration

Year ended March 31, 2023

(in thousands)

	Term	2023 Remuneration
Former Board Chair		
Gregory Turnbull	Dec 8, 2021 to Nov 17, 2022	$ 43
Former Board Members		
Dr. Sayeh Zielke (Vice Chair)	Sep 28, 2020 to Nov 17, 2022	31
Deborah Apps	Jan 19, 2021 to Oct 7, 2022	18
Tony Dagnone	Jan 19, 2021 to Nov 17, 2022	21
Sherri Fountain	Jan 19, 2021 to Nov 17, 2022	23
Hartley Harris	Aug 9, 2021 to Nov 17, 2022	21
Tara Lockyer	Aug 17, 2022 to Nov 17, 2022	7
Jack Mintz	Jun 3, 2021 to Nov 17, 2022	17
Heidi Overguard	Sep 25, 2019 to Nov 17, 2022	23
Natalia Reiman	Jan 19, 2021 to Nov 17, 2022	18
Brian Vaasjo	Aug 20, 2019 to Nov 17, 2022	19
Vicki Yellow Old Woman	Sep 28, 2020 to Nov 17, 2022	19
Former Board Committee Participants		
Dr. William Ghali	Oct 1, 2021 to Nov 17, 2022	1
Stephen Livergant	Apr 9, 2021 to Sep 15, 2022	-
Gord Winkel	Nov 27, 2015 to Nov 17, 2022	1
Total Former Board		**$ 262**

Former Board members were remunerated with monthly honoraria. In addition, they received remuneration for attendance at Board and committee meetings. Former Board members did not serve however in the fiscal year ended March 31, 2024, having been dismissed effective November 17, 2022.

Schedule 2D – Executive Remuneration and Benefits

Year ended March 31, 2024

(in thousands)

	2024						
For the Current Fiscal Year	FTE [a]	Base Salary [b, i]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board / Former Official Administrator Direct Reports							
Athana Mentzelopoulos – President and Chief Executive Officer[j, dd]	0.31	$ 179	$ -	$ 88	$ 267	$ -	$ 267
Sean Chilton – Interim President and Chief Executive Officer[k, ee]	0.06	35	-	6	41	-	41
Mauro Chies – President and Chief Executive Officer[l]	0.63	374	-	85	459	1,386	1,845
Ronda White – Chief Audit Executive[m, ff]	1.00	313	2	73	388	-	388
Athana Mentzelopoulos – Official Administrator Advisor/ Provisional Lead, Emergency Medical Services[j, dd]	0.33	119	-	44	163	-	163
CEO Direct Reports							
Sean Chilton – Interim VP and Chief Operating Officer, Clinical Operations/VP, People, Health Professions and Information Technology[k, ee]	0.94	410	19	102	531	-	531
Lori Anderson – Acting VP and Chief Operating Officer, Clinical Operations[n]	0.03	10	3	2	15	-	15
Deb Gordon – VP and Chief Operating Officer, Clinical Operations[o, hh]	0.52	212	-	7	219	970	1,189
Dr. Sid Viner – VP and Medical Director, Clinical Operations[ff]	0.90	436	22	102	560	-	560
Dr. Peter Jamieson – Interim VP, Quality and Chief Medical Officer[p, gg]	0.33	177	-	-	177	-	177
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[q, hh]	0.63	316	-	85	401	1,071	1,472
Susan McGillivray – Interim VP, People and Health Professions[r, ee]	0.60	229	-	61	290	-	290
Karen Horon – VP, Cancer Care Alberta and Clinical Support Services[s, ff]	1.00	331	1	96	428	-	428
Natalie McMurtry – Interim VP, Provincial Clinical Excellence[t, ff]	0.81	219	-	48	267	-	267
Dr. Braden Manns – Interim VP, Provincial Clinical Excellence[u]	0.19	107	2	7	116	-	116
Kerry Bales – Chief Program Officer, Addiction and Mental Health and Correctional Health Services[ff]	1.00	328	-	99	427	-	427
Holly Budd – Acting Senior Program Officer, Community Engagement and Communications[v, ff]	0.33	60	12	18	90	-	90
Gail Fredrickson – Interim VP, Community Engagement and Communications[w]	0.07	18	2	3	23	-	23
Colleen Turner – VP, Community Engagement and Communications[x, hh]	0.60	233	-	103	336	792	1,128
Michael Lam – Interim VP, Corporate Services and Chief Financial Officer[y, ff]	0.33	97	12	29	138	-	138
Colleen Purdy – VP, Corporate Services and Chief Financial Officer[z, hh]	0.63	273	-	57	330	504	834
Andrea Beckwith-Ferraton – Interim General Counsel and Corporate Secretary[aa, ff]	0.37	86	10	23	119	-	119
Tina Giesbrecht – General Counsel[bb, hh]	0.63	165	5	49	219	356	575
Geoffrey Pradella – Chief Strategy Officer[cc]	0.35	105	-	26	131	144	275
Total Executive	**12.59**	**$ 4,832**	**$ 90**	**$ 1,213**	**$ 6,135**	**$ 5,223**	**$ 11,358**
Management Reporting to CEO Direct Reports	**59.68**	**$ 14,938**	**$ 468**	**$ 2,844**	**$ 18,250**	**$ 388**	**$ 18,638**

Schedule 2D – Executive Remuneration and Benefits (continued)

Year ended March 31

(in thousands)

For the Prior Fiscal Year	2023						
	FTE [(a)]	Base Salary [(b, i)]	Other Cash Benefits [(c)]	Other Non-Cash Benefits [(d)]	Subtotal	Severance [(e)]	Total
Official Administrator / Former Board Direct Reports							
Mauro Chies – President and Chief Executive Officer	0.99	$ 490	$ 13	$ 143	$ 646	$ -	$ 646
Dr. Verna Yiu – President and Chief Executive Officer	0.01	4	-	4	8	660	668
Ronda White – Chief Audit Executive	1.00	291	1	45	337	-	337
Athana Mentzelopoulos – Official Administrator Advisor/ Provisional Lead, Emergency Medical Services	0.37	139	-	57	196	-	196
CEO Direct Reports							
Deb Gordon – VP and Chief Operating Officer, Clinical Operations	1.00	389	-	51	440	-	440
Dr. Sid Viner – VP and Medical Director, Clinical Operations	0.90	415	22	110	547	-	547
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	477	-	59	536	-	536
Sean Chilton – VP, People, Health Professions and Information Technology	1.00	365	1	81	447	-	447
Karen Horon – Interim VP, Cancer Care Alberta and Clinical Support Services	0.98	255	3	63	321	-	321
Mauro Chies – VP, Cancer Care Alberta and Clinical Support Services	0.01	4	-	1	5	-	5
Dr. Braden Manns – Interim VP, Provincial Clinical Excellence	0.83	454	6	34	494	-	494
Kathryn Todd – VP, Provincial Clinical Excellence	0.08	24	5	5	34	-	34
Dr. Mark Joffe – VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence	0.62	288	20	29	337	-	337
Kerry Bales – Chief Program Officer, Addiction and Mental Health and Correctional Health Services	0.79	242	-	57	299	-	299
Colleen Turner – VP, Community Engagement and Communications	1.00	356	-	88	444	-	444
Colleen Purdy – VP, Corporate Services and Chief Financial Officer	1.00	412	3	78	493	-	493
Tina Giesbrecht – General Counsel	1.00	257	3	41	301	-	301
Total Executive	**12.58**	**$ 4,862**	**$ 77**	**$ 946**	**$ 5,885**	**$ 660**	**$ 6,545**
Management Reporting to CEO Direct Reports	**56.91**	**$ 13,828**	**$ 459**	**$ 1,608**	**$ 15,895**	**$ 457**	**$ 16,352**

Schedule 2E – Executive Supplemental Pension Plan and Supplemental Executive Retirement Plan

Year ended March 31

(in thousands)

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Schedule 2D are prorated for the period of time the individual was in their position directly reporting to the Board / former Official Administrator or directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to the Board / former Official Administrator or President and Chief Executive Officer during the current fiscal year are disclosed.

	2024			2023			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2023	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2024
Athana Mentzelopoulos - President and Chief Executive Officer	$ 14	$ -	$ 14	$ -	$ -	$ 14	$ 14
Sean Chilton - Interim President and Chief Executive Officer/Interim VP and Chief Operating Officer, Clinical Operations/VP, People, Health Professions and Information Technology	30	-	30	21	265	60	325
Mauro Chies - President and Chief Executive Officer	49	-	49	36	217	73	290
Ronda White - Chief Audit Executive	14	-	14	12	159	32	191
Lori Anderson - Acting VP and Chief Operating Officer, Clinical Operations	17	-	17	15	135	32	167
Deb Gordon - VP and Chief Operating Officer, Clinical Operations							
SERP	-	(4)	(4)	(42)	560	(560)	-
SPP	13	-	13	23	307	(307)	-
Dr. Sid Viner - VP and Medical Director, Clinical Operations	31	-	31	29	152	51	203
Dr. Peter Jamieson - Interim VP, Quality and Chief Medical Officer [5]	-	-	-	-	-	-	-
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	23	-	23	34	469	(469)	-
Susan McGillivray - Interim VP, People and Health Professions							
SERP	-	(1)	(1)	(9)	147	2	149
SPP	18	-	18	12	148	20	168
Karen Horon - VP, Cancer Care Alberta and Clinical Support Services	16	-	16	8	48	20	68
Natalie McMurtry - Interim VP, Provincial Clinical Excellence	7	-	7	1	5	8	13
Dr. Braden Manns - Interim VP, Provincial Clinical Excellence [5]	-	-	-	-	-	-	-
Kerry Bales - Chief Program Officer, Addiction and Mental Health and Correctional Health Services	16	-	16	13	211	40	251
Holly Budd – Acting Senior Program Officer, Community Engagement and Communications [6]	-	-	-	-	-	-	-
Gail Fredrickson - Interim VP, Community Engagement and Communications	6	-	6	7	34	(34)	-

Schedule 2E – Executive Supplemental Pension Plan and Supplemental Executive Retirement Plan (continued)

Year ended March 31

(in thousands)

	2024			2023			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2023	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2024
Colleen Turner - VP, Community Engagement and Communications	14	-	14	20	220	(220)	-
Michael Lam - Interim VP, Corporate Services and Chief Financial Officer	12	-	12	9	79	22	101
Colleen Purdy - VP, Corporate Services and Chief Financial Officer	18	-	18	26	74	(74)	-
Andrea Beckwith-Ferraton - Interim General Counsel and Corporate Secretary	4	-	4	3	39	9	48
Tina Giesbrecht - General Counsel	5	-	5	8	91	(91)	-
Geoffrey Pradella - Chief Strategy Officer [7]	-	-	-	-	-	-	-

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plan's assets. AHS uses the straight-line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.
(5) The incumbent is not an employee of AHS, and therefore not eligible for enrollment in the SPP.
(6) The incumbent's pensionable earnings were below the threshold for enrollment in the SPP.
(7) The SPP had not fully vested at the time of the incumbent's departure, and as a result no current period benefit costs were incurred.

Footnotes to the Schedules of Remuneration and Benefits

Year ended March 31, 2024

(in thousands)

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,030.50 annual base hours (2023 – 2,022.75 hours).

b. Base salary is regular salary and includes all payments earned related to actual hours earned other than those reported as other cash benefits.

c. Other cash benefits include, as applicable, honoraria, acting pay, membership fees, and lump sum payments. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation unless related to severance. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

d. Other non-cash benefits include:
   - Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Schedule 2E
   - Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans
   - Vacation accruals, and
   - Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination which are not included in other cash benefits or other non-cash benefits.

Board

f. The Board Chair is an Ex-Officio member on all Board committees.

g. These individuals did not claim honoraria.

Former Official Administrator and Former Official Administrator Committee Participants

h. These individuals were participants of Official Administrator committees but are not AHS employees.

Executive

i. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2024, the number of work days at AHS was 260 (2023 – 261 work days).

j. Athana Mentzelopoulos held management positions as both Official Administrator Advisor and Provisional Lead, Emergency Medical Services until July 28, 2023 at which time she left AHS. During this tenure, the incumbent was on temporary secondment from the Government of Alberta, and AHS reimbursed the Government of Alberta for the incumbent's base salary and benefits. The incumbent was subsequently appointed to the position of President and Chief Executive Officer effective December 11, 2023.

k. Sean Chilton held the position of Vice President, People, Health Professions and Information Technology until August 28, 2023 at which time he was appointed to Interim Vice President and Chief Operating Officer, Clinical Operations. The incumbent held the position of Interim Vice President and Chief Operating Officer, Clinical Operations until November 16, 2023 at which time the incumbent was appointed to Interim President and Chief Executive Officer and became a direct report to the Board. The incumbent held the position of Interim President and Chief Executive Officer until December 11, 2023 at which time the incumbent resumed the role of Interim Vice President and Chief Operating Officer, Clinical Operations and resumed being a direct report to the President and Chief Executive Officer.

l. Mauro Chies held the position of President and Chief Executive Officer until November 16, 2023 at which time he left AHS from a leadership capacity. The incumbent's severance is to be paid by way of salary continuance which will terminate, without a requirement of further notice or compensation from AHS, effective November 15, 2025. The reported severance includes 24 months base salary plus accrued entitlements to pension and other benefits, as well as $21 in lieu of the loss of employee benefits. In addition, the incumbent received a vacation payout of $174 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. Ronda White received a vacation payout of $18 for unused accrued vacation earned in prior periods; accrued vacation has been recorded in the compensation as a non-cash benefit in the period it was earned.

n. Lori Anderson held the position of Chief Zone Officer, Calgary Zone until November 30, 2023 at which time she was appointed

to Acting Vice President and Chief Operating Officer, Clinical Operations and became a direct report to the President and Chief Executive Officer. The incumbent held the position of Acting Vice President and Chief Operating Officer, Clinical Operations until December 11, 2023 at which time the incumbent resumed the role of Chief Zone Officer, Calgary Zone and was no longer a direct report to the President and Chief Executive Officer.

o. Deb Gordon held the position of Vice President and Chief Operating Officer, Clinical Operations until October 6, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure, as well as the reported severance. In addition, the incumbent received a vacation payout of $164 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

p. Dr. Peter Jamieson held the position of Interim Associate Medical Director, Clinical Operations until November 21, 2023 at which time he was appointed to Interim Vice President, Quality and Chief Medical Officer and became a direct report to the President and Chief Executive Officer. The incumbent's remuneration is as per the terms of a Medical Administrative Services Agreement.

q. Dr. Francois Belanger held the position of Vice President, Quality and Chief Medical Officer until November 16, 2023 at which time he left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 22 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $106 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

r. Susan McGillivray held the position of Senior Program Officer, HR Talent and Workforce Strategies until August 28, 2023 at which time she was appointed to Interim Vice President, People and Health Professions and became a direct report to the President and Chief Executive Officer.

s. Karen Horon held the position of Interim Vice President, Cancer Care Alberta and Clinical Support Services until October 2, 2023 at which time she was appointed to Vice President, Cancer Care Alberta and Clinical Support Services.

t. Natalie McMurtry held the position of Senior Program Officer, Sustainability Program Office until June 12, 2023 at which time she was appointed to Interim Vice President, Provincial Clinical Excellence and became a direct report to the President and Chief Executive Officer. Effective November 30, 2023, the incumbent took on the additional responsibilities as AHS Transition Lead. In addition, the incumbent received a vacation payout of $13 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

u. Dr. Braden Manns held the position of Interim Vice President, Provincial Clinical Excellence until June 9, 2023 at which time he left AHS from a leadership capacity. The incumbent is a participant in the Alberta Academic Medicine and Health Services Program (South Sector), and their remuneration is as per the terms of that agreement. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary, and AHS reimburses the University for the incumbent's base salary and benefits.

v. Holly Budd held the position of Executive Director, Communications until November 30, 2023 at which time she was appointed to Acting Senior Program Officer, Community Engagement and Communications and became a direct report to the President and Chief Executive Officer.

w. Gail Fredrickson held the position of Senior Program Officer, Communications until November 6, 2023 at which time she was appointed to Interim Vice President, Community Engagement and Communications and became a direct report to the President and Chief Executive Officer. The incumbent held the position of Interim Vice President, Community Engagement and Communications until November 30, 2023 at which time the incumbent resumed the role of Senior Program Officer, Communications and was no longer a direct report to the President and Chief Executive Officer.

x. Colleen Turner held the position of Vice President, Community Engagement and Communications until November 3, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure, as well as the reported severance. In addition, the incumbent received a vacation payout of $183 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

y. Michael Lam held the position of Chief Program Officer, Financial Operations until November 30, 2023 at which time he was appointed to Interim Vice President, Corporate Services and Chief Financial Officer and became a direct report to the President and Chief Executive Officer.

z. Colleen Purdy held the position of Vice President, Corporate Services and Chief Financial Officer until November 16, 2023 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 12 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $73 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

aa. Andrea Beckwith-Ferraton held the position of Chief Ethics and Compliance Officer until November 17, 2023 at which time she was appointed to Interim General Counsel and Corporate Secretary and became a direct report to the President and Chief Executive Officer.

bb. Tina Giesbrecht held the position of General Counsel until November 16, 2023 at which time she left AHS. The incumbent

received salary and other accrued entitlements to the date of departure. The reported severance included 14 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $111 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

cc. Geoffrey Pradella was appointed to the position of Chief Strategy Officer effective July 12, 2023. The incumbent held the position until November 16, 2023 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 5 months base salary at the rate in effect at the date of departure, and 15% of the severance in lieu of benefits. In addition, the incumbent received a vacation payout of $8 for unused accrued vacation at the time of departure.

Termination Obligations

dd. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month base salary for each completed month of service during the first year of the term or, after completion of one year of service of the term, 12 months base salary. Such severance will be paid in equal monthly instalments. There was no severance associated with the temporary position.

ee. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 24 months' salary and benefits.

ff. The incumbent's termination benefits have not been predetermined.

gg. There is no severance associated with the Medical Administrative Services Agreement.

hh. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2023-24 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2023 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. For participants of SERP, the benefit includes the accrued benefit obligation as at March 31, 2023, the current period benefit cost, interest accruing on the obligations, the amortization of any actuarial gains or losses in the period, and gains or losses due to curtailment that were incurred during the current year as identified in Schedule 2E. The AHS obligations are paid through either a monthly, annual, or lump sum payment:

Incumbent (1)	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Deb Gordon - VP and Chief Operating Officer, Clinical Operations (SERP)	January 4, 2005	$4,156	Monthly	For a fixed term of 10 years from November 1, 2023 to October 1, 2033
Deb Gordon - VP and Chief Operating Officer, Clinical Operations (SPP)	November 1, 2012	$42,872 increasing annually to $43,300	Annually	For a fixed term of 8 years from November 2023 to January 2030
Dr. Francois Belanger - VP, Quality and Chief Medical Officer (SPP)	May 1, 2012	$136,699 increasing annually to $138,066	Annually	For a fixed term of 4 years from December 2023 to January 2026
Colleen Turner - VP, Community Engagement and Communications (SPP)	March 1, 2010	$247,986	Once	December 2023
Colleen Purdy - VP, Corporate Services and Chief Financial Officer (SPP)	July 1, 2020	$33,014 increasing annually to $33,345	Annually	For a fixed term of 3 years from December 2023 to January 2025
Tina Giesbrecht - General Counsel (SPP)	September 17, 2012	$104,072	Once	December 2023

(1) Pertains only to those individuals for which the applicable SPP was fully vested at the time their employment with AHS ended, and in a position directly reporting to the Board / former Official Administrator or President and Chief Executive Officer at the time of departure.

Schedule 3 – Consolidated Schedule of Segment Disclosures

Year ended March 31

(in thousands)

	2024								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 340,236	$ 951,304	$ -	$ 7,566	$ 7,657	$ 42,481	$ 23,068	$ 3,048	$ 1,375,360
Community care	927,558	945,293	-	9,574	5,428	53,219	41,622	934	1,983,628
Home care	370,243	358,439	-	199	11,593	83,992	18,683	560	843,709
Acute care	3,427,032	462,215	55,824	654,905	472,626	744,026	202,602	65,645	6,084,875
Emergency medical services	357,098	230,011	-	2,800	5,952	3,869	49,822	16,402	665,954
Diagnostic and therapeutic services	1,820,366	264,783	-	35,072	256,841	368,902	120,658	66,162	2,932,784
Population and public health	351,956	24,052	-	5,634	23,861	9,609	23,448	613	439,173
Research and education	194,329	3,229	-	108	453	119,400	35,066	122	352,707
Information technology	358,249	1,951	-	-	(32)	42,702	242,264	148,641	793,775
Support services	1,279,425	185,744	-	22,996	30,828	164,998	864,210	250,171	2,798,372
Administration	412,973	39,312	-	27	146	54,977	63,640	2,735	573, 810
Total	$ **9,839,465**	**$ 3,466,333**	**$ 55,824**	**$ 738,881**	**$ 815,353**	**$ 1,688,175**	**$ 1,685,083**	**$ 555,033**	**$ 18,844,147**

Schedule 3 – Consolidate Schedule of Segment Disclosures (continued)

Year ended March 31
(in thousands)

	2023								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets[a]	Total
Continuing care	$ 328,893	$ 975,288	$ -	$ 7,711	$ 9,567	$ 35,968	$ 21,563	$ 2,504	$ 1,381,494
Community care	851,905	925,158	-	15,238	5,156	47,831	42,667	449	1,888,404
Home care	350,859	275,690	-	198	11,290	81,146	20,920	49	740,152
Acute care	3,169,349	427,606	28,587	617,230	427,485	657,759	197,273	69,661	5,594,950
Emergency medical services	325,073	207,542	-	2,855	5,570	3,032	42,150	13,254	599,476
Diagnostic and therapeutic services	1,617,433	288,896	-	24,932	229,445	325,160	105,588	54,248	2,645,702
Population and public health	393,365	21,732	-	6,898	90,858	17,126	58,913	324	589,216
Research and education	190,860	3,182	-	91	1,097	121,689	24,812	66	341,797
Information technology	350,583	1,644	-	-	(31)	43,605	214,845	138,439	749,085
Support services[a]	1,208,134	166,678	-	4,037	47,215	156,836	828,509	228,022	2,639,431
Administration	369,211	34,958	-	20	786	43,823	38,647	7,881	495,326
Total	$ 9,155,665	**$** 3,328,374	**$** 28,587	**$** 679,210	**$** 828,438	**$** 1,533,975	**$** 1,595,887	**$** 514,897	**$** 17,665,033

Health Quality Council of Alberta

Financial Statements

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Management's Responsibility for Financial Reporting

The accompanying financial statements are the responsibility of management and have been reviewed and approved by Senior Management. The financial statements were prepared in accordance with Canadian Public Sector Accounting Standards, and of necessity, include some amounts that are based on estimates and judgement.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

The Health Quality Council of Alberta's Board of Directors carries out their responsibility for the financial statements through the Audit and Finance Committee. The Committee meets with management and the Auditor General of Alberta to review financial matters and recommends the financial statements to the Health Quality Council of Alberta Board of Directors for approval upon finalization of the audit. The Auditor General of Alberta has open and complete access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures, which allow him to report on the fairness of the financial statements prepared by management.

On behalf of the Health Quality Council of Alberta.

[Original signed by]

Chief Executive Officer
Charlene McBrien-Morrison
May 30, 2024

[Original signed by]

Director, Financial Services
Jessica Wing
May 30, 2024

Independent Auditor's Report

To the Board of Directors of the Health Quality Council of Alberta

Report on the Financial Statements

Opinion

I have audited the financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2024, and the statements of operations, change in net financial assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2024, and the results of its operations, its changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

I conducted my audit in accordance with Canadian generally accepted auditing standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Health Quality Council of Alberta in accordance with the ethical requirements that are relevant to my audit of the financial statements in Canada, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other information

Management is responsible for the other information. The other information comprises the information included in the *Annual Report*, but does not include the financial statements and my auditor's report thereon. The *Annual Report* is expected to be made available to me after the date of this auditor's report.

My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work I will perform on this other information, I conclude that there is a material misstatement of this other information, I am required to communicate the matter to those charged with governance.

Responsibilities of management and those charged with governance for the financial statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Health Quality Council of Alberta's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless an intention exists to liquidate or to cease operations, or there is no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Health Quality Council of Alberta's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, I exercise professional judgment and maintain professional skepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Quality Council of Alberta's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Health Quality Council of Alberta's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Health Quality Council of Alberta to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

[Original signed by W. Doug Wylie FCPA, FCMA, ICD.D]
Auditor General

May 30, 2024
Edmonton, Alberta

Statement of Operations

Year ended March 31
(thousands of dollars)

	2024		2023
	Budget	**Actual**	**Actual**
	(Note 5)		
Revenues			
Alberta Health transfers			
Base operating	$ 7,559	$ 7,672	$ 7,559
Restricted operating (Note 8)	-	1,053	-
Other government transfer (Note 8)	1,231	125	92
Interest income	27	132	58
Other revenue	-	25	94
	8,817	9,007	7,803
Expenses (Schedule 1)			
Administration	1,588	1,544	1,834
Health system analytics	3,323	3,010	3,385
Health system improvement	1,817	1,629	1,724
Communications and engagement	1,801	1,391	1,619
Ministerial assessment/study (Note 8)	1,231	1,178	92
Other assessment/study	-	-	94
	9,760	8,752	8,748
Annual operating (deficit) surplus	(943)	255	(945)
Accumulated operating surplus, beginning of year	1,484	1,951	2,896
Accumulated operating surplus, end of year	$ 541	$ 2,206	$ 1,951

The accompanying notes and schedules are part of these financial statements.

Statement of Financial Position

Year ended March 31
(thousands of dollars)

	2024	2023
Financial Assets		
Cash	$ 4,346	$ 2,600
Accounts receivable (Note 7)	37	709
	4,383	3,309
Liabilities		
Accounts payable and other accrued liabilities	1,069	691
Unspent deferred contributions (Note 8)	1,609	1,387
Employee future benefits (Note 9)	43	35
Deferred lease inducements (Note 10)	16	-
	2,737	2,113
Net Financial Assets	1,646	1,196
Non-Financial Assets		
Tangible capital assets (Note 11)	463	657
Purchased intangibles	12	-
Prepaid expenses	85	98
	560	755
Net Assets	2,206	1,951
Net Assets		
Accumulated operating surplus (Note 13)	$ 2,206	$ 1,951

Contractual obligations (Note 12)

The accompanying notes and schedules are part of these financial statements.

Statement of Change in Net Financial Assets

Year ended March 31
(thousands of dollars)

	2024		2023
	Budget (Note 5)	**Actual**	**Actual**
Annual operating (deficit) surplus	$ (943)	$ 255	$ (945)
Acquisition of tangible capital assets (Note 11)	(8)	(16)	(572)
Purchase of intangible assets	-	(12)	
Amortization of tangible capital assets (Note 11)	217	210	389
Loss on disposal and write down of tangible capital assets (Note 11)	-	-	33
Decrease in prepaid expenses	-	13	28
(Decrease) / Increase in net financial assets in the year	(734)	450	(1,067)
Net financial assets, beginning of year	1,196	1,196	2,263
Net financial assets, end of year	$ 462	$ 1,646	$ 1,196

The accompanying notes and schedules are part of these financial statements.

Statement of Cash Flows

Year ended March 31
(thousands of dollars)

	2024	2023
Operating Transactions		
Annual operating surplus (deficit)	$ 255	$ (945)
Non-cash items:		
Amortization of tangible capital assets (Note 11)	210	389
Loss on disposal and write down of tangible capital assets (Note 11)	-	33
Amortization of deferred lease inducements (Note 10)	(2)	(37)
Increase in employee future benefits (Note 9)	8	8
	471	(552)
Decrease (Increase) in accounts receivable (Note 7)	672	(388)
Decrease in prepaid expenses	13	28
Increase (Decrease) in accounts payable and other accrued liabilities	378	(17)
Increase in unspent deferred contributions (Note 8)	222	1,108
Increase in deferred lease inducement (Note 10)	18	-
Cash provided by operating transactions	1,774	179
Capital Transactions		
Acquisition of tangible capital assets (Note 11)	(16)	(572)
Purchase of intangible assets	(12)	-
Cash applied to capital transactions	(28)	(572)
Increase (Decrease) in cash	1,746	(393)
Cash at beginning of year	2,600	2,993
Cash at end of year	$ 4,346	$ 2,600

The accompanying notes and schedules are part of these financial statements.

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 1 AUTHORITY

The Health Quality Council of Alberta (HQCA) is a government not-for-profit organization formed under the *Health Quality Council of Alberta Act*.

Pursuant to the Act, the HQCA has a mandate to promote and improve patient safety, person-centered care and health service quality on a province-wide basis.

The HQCA is exempt from income taxes under the *Income Tax Act*.

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES

These financial statements are prepared in accordance with Canadian public sector accounting standards (PSAS).

(a) Reporting Entity

The financial statements reflect the assets, liabilities, revenues and expenses of the HQCA.

(b) Basis of Financial Reporting

Revenues

All revenues are reported on the accrual basis of accounting.

Revenues from transactions with performance obligations are recognized when HQCA provides the promised services to the payors. Course fees are recognized in the year that courses are delivered.

Cash received for which services have not been provided by year end is recognized as unearned revenue.

Revenues from transactions with no performance obligations are recognized at their realizable value when HQCA has the authority to claim or retain an inflow of economic resources and identifies a past transaction or event that gives rise to an asset.

Government transfers

Transfers from all governments are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recognized as deferred contributions if the eligibility criteria for use of the transfer, or the stipulations together with the HQCA's actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, the HQCA complies with its communicated use of these transfers.

All other government transfers, without stipulations for the use of the transfer, are recognized as revenue when the transfer is authorized and the HQCA meets the eligibility criteria (if any).

Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed.

Grants and transfers are recognized as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Valuation of Financial Assets and Liabilities

The HQCA's financial assets and liabilities are generally measured as follows:

Financial Statement Component	Measurement
Cash	Cost
Accounts receivable	Lower of cost or net recoverable value
Accounts payable and other accrued liabilities	Cost

The HQCA does not hold equities traded in an active market, nor engage in derivative contracts or foreign currency transactions. The HQCA is not exposed to remeasurement gains or losses and, consequently, a statement of remeasurement gains and losses is not presented.

Financial Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations.

Financial assets are the HQCA's financial claims on external organizations and individuals at the year end.

Cash

Cash comprises cash on hand and demand deposits.

Accounts Receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. A valuation allowance is recognized when recovery is uncertain.

Liabilities

Liabilities represent present obligations of the HQCA to external organizations and individuals arising from past transactions or events occurring before the year end, the settlement of which is expected to result in the future sacrifice of economic benefits. They are recognized when there is an appropriate basis of measurement and management can reasonably estimate the amounts.

Deferred Lease Inducements

Deferred lease inducements represent amounts received for leasehold improvements and the value of a rent-free period. Lease inducements are deferred and amortized on a straight-line basis over

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

the term of the related lease and the amortization is recognized as a reduction of rent expense for the year.

Employee Future Benefits

The HQCA Board has approved a defined contribution Supplementary Executive Retirement Plan (SERP) for certain members of its executive staff. The SERP supplements the benefit under the HQCA registered plan that is limited by the *Income Tax Act* (Canada). The HQCA contributes a certain percentage of an eligible employee's pensionable earnings in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participants.

Non-Financial Assets

Non-financial assets are acquired, constructed, or developed assets that do not normally provide resources to discharge existing liabilities, but instead:

(a) are normally employed to deliver government services;
(b) may be consumed in the normal course of operations; and
(c) are not for sale in the normal course of operations.

Non-financial assets are limited to tangible capital assets, purchased intangibles and prepaid expenses.

Tangible Capital Assets

Tangible capital assets are recognized at cost less amortization, which includes amounts that are directly related to the acquisition, design, construction, development, improvement or betterment of the assets. Cost includes overhead directly attributable to construction and development, as well as interest costs that are directly attributable to the acquisition or construction of the asset.

The cost, less residual value, of the tangible capital assets, excluding work-in-progress, is amortized on a straight-line basis over their estimated useful lives as follows:

Computer hardware and software	5 years
Office equipment	10 years
Leasehold improvements	Over term of the lease

Tangible capital assets are written down when conditions indicate that they no longer contribute to the HQCA's ability to provide services, or when the value of future economic benefits associated with the tangible capital assets are less than their book value. The net write-downs are accounted for as expenses in the Statement of Operations.

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Purchased Intangible Assets

Purchased intangibles are recognized at cost less amortization, and tested regularly for impairment. The cost, less any residual value, of purchased intangible assets is amortized on a straight-line basis over its useful life in a manner appropriate to its nature and use, which is normally the shortest of the technological, commercial, and legal life.

Prepaid Expenses

Prepaid expenses are recognized at cost and amortized based on the terms of the agreement.

Funds and Reserves

Certain amounts, as approved by the Board of Directors, are set aside in accumulated operating surplus for future operating and capital purposes. Transfers to/from funds and reserves are an adjustment to the respective fund when approved.

Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recognized for amortization of tangible capital assets are based on estimates of the useful life of the related assets. Actual results could differ from estimates.

Note 3 CHANGES IN ACCOUNTING STANDARDS

On April 1, 2023, HQCA adopted PS 3400 Revenue. There were no changes to the measurement of revenues on adoption of the new standard.

At the beginning of the same fiscal reporting period, the HQCA also adopted the PSG-8 Purchased Intangibles Guideline. The financial statements now include purchased intangibles recognized as assets when they meet the asset definition and general recognition criteria. Prior to adoption, purchased intangibles were expensed.

HQCA used prospective application to adopt the new standard. As a result, 2023 comparatives are not restated.

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 4 FUTURE CHANGES IN ACCOUNTING STANDARDS

On April 1, 2026, HQCA will adopt the following new conceptual framework and accounting standard approved by the Public Sector Accounting Board:

The Conceptual Framework for Financial Reporting in the Public Sector

The Conceptual Framework is the foundation for public sector financial reporting standard setting. It replaces the conceptual aspects of Section PS 1000 Financial Statement Concepts and Section PS 1100 Financial Statement Objectives. The conceptual framework highlights considerations fundamental for the consistent application of accounting issues in the absence of specific standards.

PS 1202 Financial Statement Presentation

Section PS 1202 sets out general and specific requirements for the presentation of information in general purpose financial statements. The financial statement presentation principles are based on the concepts within the Conceptual Framework.

Management is currently assessing the impact of the conceptual framework and the standard on the financial statements.

Note 5 BUDGET

The HQCA's 2023-2024 operating budget was approved by the Board of Directors on January 26, 2023 and submitted to the Ministry of Health.

Note 6 FINANCIAL RISK MANAGEMENT

The HQCA has the following financial instruments: cash, accounts receivable, accounts payable and other accrued liabilities.

The HQCA has exposure to the following risks from its use of financial instruments: interest rate risk, liquidity risk, price risk and credit risk.

(a) Interest rate risk

The HQCA is exposed to the interest rate associated with cash held in the bank. The interest rate risk is minimal.

(b) Liquidity risk

Liquidity risk is the risk that the HQCA will encounter difficulty in meeting obligations associated with financial liabilities. The HQCA enters into transactions to purchase goods and services on credit. Liquidity risk is measured by reviewing the HQCA's future net cash flows for the possibility of negative net cash flow. The HQCA manages the liquidity risk resulting from its accounts payable obligations by maintaining adequate cash resources.

(c) Credit risk

The HQCA is exposed to credit risk from potential non-payment of accounts receivable. During the fiscal year most of the HQCA's receivables are from provincial agencies; therefore the credit risk is minimized.

Notes to the Financial Statements

Year ended March 31, 2024
(thousands of dollars)

Note 7 ACCOUNTS RECEIVABLE

	2024	2023
Accounts receivable	$ 37	$ 109
Restricted operating grant receivable (Note 8)	-	600
	$ 37	$ 709

Note 8 UNSPENT DEFERRED CONTRIBUTIONS

	2024			2023
	Alberta Health	Other	Total	Total
Balance at beginning of the year	$ -	$ 1,387	$ 1,387	$ 279
Cash received or receivable during the year	2,000	(600)	1,400	1,200
Recognized as revenue	(1,053)	(125)	(1,178)	(92)
Balance at end of year	$ 947	$ 662	$ 1,609	$ 1,387

The unspent deferred contribution from Alberta Health at the end of the year is externally restricted to support a task force to provide recommendations to the Minister. The balance in other relates to an externally restricted grant from the Ministry of Mental Health and Addictions (MHA). HQCA will not receive $600 from MHA that was recorded in prior year as a receivable.

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 9 EMPLOYEE FUTURE BENEFITS

The HQCA participates in the Local Authorities Pension Plan (LAPP), a multi-employer defined benefit pension plan.

The HQCA accounts for this multi-employer pension plan on a defined contribution basis. The HQCA is not responsible for future funding of the plan deficit other than through contribution increases. Pension expense recorded in the financial statements is equivalent to HQCA's annual contributions of $388 for the year ended March 31, 2024 (2023 - $374).

At December 31, 2023, the Local Authorities Pension Plan reported a surplus of $15,056,520 (2022 – surplus of $12,671,000).

The Supplementary Executive Retirement Plan (SERP) payable at year ended March 31, 2024 is $43 (2023 - $35). The current year contribution related to this plan is $8 (2023 - $8). No payment has been made to plan member at retirement in the current year.

Note 10 DEFERRED LEASE INDUCEMENTS

The HQCA received a lease inducement in the form of free rent relating to a lease renewal of the premises effective April 1, 2024. This amount will be amortized on a straight-line basis over the term of the related lease and the amortization is recognized as a reduction of rent expense.

	2024	2023
Lease inducements - rent free periods	$ 18	$ 209
Less accumulated amortization	(2)	(209)
	$ 16	$ -

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 11 TANGIBLE CAPITAL ASSETS

	2024				2023
	Office Equipment	**Computer Hardware & Software**	**Leasehold improvements**	**Total**	**Total**
Estimated useful life	10 years	5 years	Over term of the lease		
Historical Cost					
Beginning of year	$ 403	$ 1,387	$ 1,013	$ 2,803	$ 2,378
Additions	-	16	-	16	572
Disposals, including write-downs	(1)	(54)	-	(55)	(147)
	402	1,349	1,013	2,764	2,803
Accumulated Amortization					
Beginning of year	336	797	1,013	2,146	1,871
Amortization expense	28	182	-	210	389
Effect of disposals, including write-downs	(1)	(54)	-	(55)	(114)
	363	925	1,013	2,301	2,146
Net book value at March 31, 2024	$ 39	$ 424	$ -	$ 463	
Net book value at March 31, 2023	$ 67	$ 590	$ -		$ 657

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 12 CONTRACTUAL OBLIGATIONS

Contractual obligations are obligations of the HQCA to others that will become liabilities in the future when the terms of those contracts or agreements are met.

Estimated payment requirements for each of the next five years and thereafter are as follows:

Year ended March 31	Operating Lease
2024 – 25	$ 324
2025 – 26	335
2026 – 27	335
2027 – 28	347
2028 – 29	358
Thereafter	1,557
	$ 3,256

Note 13 ACCUMULATED OPERATING SURPLUS

Accumulated operating surplus is comprised of the following:

	2024				2023
	Investment in Tangible Capital Assets and intangible assets[(a)]	Internally Restricted Surplus[(b)]	Unrestricted Surplus (Deficit)	Total	Total
Balance, April 1, 2023	$ 657	$ 1,294	$ -	$ 1,951	$ 2,896
Annual operating surplus (deficit)	-	-	255	255	(945)
Net investments in capital assets and intangible assets	(182)	-	182	-	-
Transfers, prior year restricted	-	(1,294)	1,294	-	-
Transfers, current year restricted	-	1,731	(1,731)	-	-

Balance, March 31, 2024	$ 475	$ 1,731	$ -	$ 2,206	$ 1,951

Notes to the Financial Statements

Year ended March 31, 2024

(thousands of dollars)

Note 13 ACCUMULATED OPERATING SURPLUS (CONT'D)

(a) Investment in tangible capital assets and intangible assets represents the net book value of internally funded tangible capital assets and intangibles assets. These assets are restricted and are not available for any other purpose.

(b) The internally restricted surplus represents amounts set aside by the Board for future purposes. Those amounts are not available for other purposes without the approval of the Board. Internally restricted surplus based on the annual work plan is summarized as follows:

	2024	2023
Measure/monitor	$ 300	$ 152
Engage	1,253	732
Improve	178	410
	$ 1,731	$ 1,294

Note 14 COMPARATIVE FIGURES

Certain 2023 figures have been reclassified, where necessary, to conform to the 2024 presentation.

Note 15 APPROVAL OF THE FINANCIAL STATEMENTS

The financial statements were approved by the HQCA Board of Directors on May 30, 2024.

Schedule 1 – Expenses – Detailed by Object

Year ended March 31

(thousands of dollars)

	2024		2023
	Budget	**Actual**	**Actual**
Salaries and benefits	$ 6,140	$ 5,104	$ 4,807
Supplies, services and other	3,403	3,438	3,552
Amortization of tangible capital assets (Note 11)	217	210	389
	$ 9,760	$ 8,752	$ 8,748

Schedule 2 – Salary and Benefits Disclosure

Year ended March 31

(thousands of dollars)

	2024				2023
	Base Salary [(1)]	Other Cash Benefits [(2)]	Other Non-Cash Benefits [(3)]	Total	Total
Board of Directors-Chair	$ -	$ 20	$ -	$ 20	$ 19
Board of Directors-Members	-	28	-	28	34
Chief Executive Officer	255	16	27	298	276
	$ 255	$ 64	$ 27	$ 346	$ 329

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include honoraria for board members, vehicle allowance, and vacation payout. There were no bonuses paid in 2024.

(3) Other non-cash benefits include: employer's portion of all employee benefits and contributions or payments made on behalf of employees, including pension, Supplementary Executive Retirement Plan, health care benefits, dental coverage, vision coverage, out of country medical benefits, group life insurance, accidental disability and dismemberment insurance, employee assistance program, Canadian Pension Plan, Employment Insurance and fair market value parking.

Schedule 3 – Related Party Transactions

Year ended March 31

(thousands of dollars)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Government of Alberta's Consolidated Financial Statements. Related parties also include key management personnel and close family members of those individuals in the HQCA. The HQCA and its employees paid or collected certain taxes and fees set by regulation for premiums, licenses, and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The HQCA had the following transactions with related parties recorded in the Statement of Operations and the Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2024	2023
Revenues		
Grants	$ 8,850	$ 7,651
Other	26	94
	$ 8,876	$ 7,745
Expenses		
Other services	$ 207	$ 117
Amount due from related parties	$ -	$ 694
Amount due to related parties	$ 1,614	$ 33

Other Financial Information

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Department of Health

Statement of Credit or Recovery (unaudited)

Year ended March 31, 2024
(in thousands)

	2024				
	Authorized Spending	Actual Revenue Recognized	Unearned Revenue	Total Amount Received / Receivable	(Shortfall) / Excess [1]
Expense Amounts					
Ministry Support Services					
Strategic Corporate Support [a]	$ 2,024	$ 2,024	$ -	$ 2,024	$ -
Population and Public Health					
Research and Support Programs [b]	1,000	-	-	-	(1,000)
	$ 3,024	$ 2,024	$ -	$ 2,024	$ (1,000)

(a) The Department receives revenue from the Department of Mental Health and Addiction to recover the cost of providing shared corporate services.

(b) The Department receives revenue from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection.

(1) Shortfall is deducted from current year's corresponding funding authority.

Department of Health

Lapse/Encumbrance (unaudited)

Year ended March 31, 2024
(in thousands)

Expense Vote by Program Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Over Expended/ (Unexpended)
1 Ministry Support Services						
1.1 Minister's Office	$ 1,016	$ -	$ -	$ 1,016	$ 1,207	$ 191
1.2 Deputy Minister's Office	1,534	-	-	1,534	1,542	8
1.3 Strategic Corporate Support	42,159	-	-	42,159	45,464	3,305
1.4 Policy Development and Strategic Support	21,095	-	-	21,095	28,162	7,067
1.5 Health Advocates' Office	3,545	-	-	3,545	2,215	(1,330)
	69,349	-	-	69,349	78,590	9,241
2 Alberta Health Services						
2.1 Continuing Care	1,230,000	-	-	1,230,000	1,271,792	41,792
2.2 Community Care	1,782,961	-	-	1,782,961	1,779,873	(3,088)
2.3 Home Care	845,000	-	-	845,000	599,207	(245,793)
2.4 Acute Care	4,200,000	-	-	4,200,000	4,402,013	202,013
2.5 Emergency Medical Services	547,000	-	-	547,000	508,957	(38,043)
2.6 Diagnostic and Therapeutic Services	2,420,000	-	-	2,420,000	2,445,940	25,940
2.7 Population and Public Health	408,000	-	-	408,000	409,213	1,213
2.8 Health Workforce Education and Research	100,000	-	-	100,000	97,133	(2,867)
2.9 Information Technology	450,000	-	-	450,000	485,838	35,838
2.10 Support Services	1,900,000	-	-	1,900,000	1,979,113	79,113
2.11 Administration	503,000	-	-	503,000	510,970	7,970
2.12 Drugs and Gases	751,650	-	-	751,650	738,969	(12,681)
	15,137,611	-	-	15,137,611	15,229,018	91,407
3 Health System Capacity	75,000	-	-	75,000	61,814	(13,186)
4 Physician Compensation and Development						
4.1 Program Support	8,137	-	-	8,137	7,869	(268)
4.2 Physician Services	5,278,815	-	(4,458)	5,274,357	5,354,626	80,269
4.3 Physician Education and Recruitment	438,725	-	-	438,725	358,109	(80,616)
	5,725,677	-	(4,458)	5,721,219	5,720,604	(615)

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2024
(in thousands)

Expense Vote by Program Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Over Expended/ (Unexpended)
5 Drugs and Supplemental Health Benefits						
5.1 Program Support	$ 54,949	$ -	$ -	$ 54,949	$ 58,979	$ 4,030
5.2 Outpatient Cancer Therapy Drugs	351,000	-	-	351,000	347,300	(3,700)
5.3 Outpatient Specialized High Cost Drugs	142,449	-	-	142,449	141,700	(749)
5.4 Seniors Drug Benefits	692,690	-	-	692,690	735,916	43,226
5.5 Seniors Dental, Optical and Supplemental Health Benefits	149,800	-	-	149,800	150,205	405
5.6 Non-Group Drug Benefits	200,000	-	-	200,000	217,629	17,629
5.7 Non-Group Supplemental Health Benefits	975	-	-	975	2,651	1,676
5.8 Assured Income for the Severely Handicapped Health Benefit	251,908	-	-	251,908	264,040	12,132
5.9 Child Health Benefit	24,810	-	-	24,810	24,079	(731)
5.10 Adult Health Benefit	214,098	-	-	214,098	226,620	12,522
5.11 Alberta Aids to Daily Living	207,354	-	-	207,354	197,562	(9,792)
5.12 Pharmaceutical Innovation and Management	140,371	-	-	140,371	197,812	57,441
	2,430,404	-	-	2,430,404	2,564,493	134,089
6 Emergency Medical Services						
6.1 Program Support	1,469	-	-	1,469	1,192	(277)
6.2 Emergency Medical Services Initiatives	89,600	-	-	89,600	59,346	(30,254)
	91,069	-	-	91,069	60,538	(30,531)
7 Primary Health Care						
7.1 Program Support	3,594	-	-	3,594	3,964	370
7.2 Primary Health Care	319,048	63,700	-	382,748	284,082	(98,666)
	322,642	63,700	-	386,342	288,046	(98,296)

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2024
(in thousands)

Expense Vote by Program Operating Expense	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Over Expended/ (Unexpended)
8 Population and Public Health						
8.1 Program Support	$ 21,215	$ -	$ -	$ 21,215	$ 18,695	$ (2,520)
8.2 Immunization Support	4,121	-	-	4,121	2,170	(1,951)
8.3 Community-Based Health Services	122,467	-	-	122,467	107,748	(14,719)
8.4 Research and Support Programs	18,848	-	-	18,848	17,411	(1,437)
8.5 Palliative Care	5,000	-	-	5,000	6,250	1,250
8.6 Children's Health Supports	15,000	-	-	15,000	15,000	-
8.7 Health Innovation	17,500	-	-	17,500	7,500	(10,000)
8.8 Health System Projects	1,900	-	-	1,900	407	(1,493)
8.9 Health Quality Council of Alberta	7,672	-	-	7,672	7,672	-
	213,723	-	-	213,723	182,853	(30,870)
9 Allied Health Services	153,226	-	-	153,226	162,502	9,276
10 Human Tissue and Blood Services	254,522	-	-	254,522	256,925	2,403
11 Continuing Care						
11.1 Program Support	9,672	-	-	9,672	7,219	(2,453)
11.2 Continuing Care Programs	26,402	69,400	-	95,802	81,387	(14,415)
11.3 Accomodation Standards and Licensing	5,757	-	-	5,757	4,334	(1,423)
	41,831	69,400	-	111,231	92,940	(18,291)
12 Out-of-Province Health Care Services						
12.1 Program Support	16,614	-	-	16,614	8,008	(8,606)
12.2 Out-of-Province Health Care Services	139,986	-	-	139,986	143,335	3,349
	156,600	-	-	156,600	151,343	(5,257)
13 Information Technology						
13.1 Program Support	7,149	-	-	7,149	7,029	(120)
13.2 Development and Operations	125,036	-	-	125,036	97,188	(27,848)
	132,185	-	-	132,185	104,217	(27,968)
14 Cancer Research and Prevention Investment	25,850	-	-	25,850	26,848	998

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2024
(*in thousands)*

Expense Vote by Program	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Over Expended/ (Unexpended)
Capital Grants						
8 Population and Public Health						
8.1 Program Support	$ -	$ -	$ -	$ -	$ 83	$ 83
15 Infrastructure Support						
15.1 Continuing Care Beds	89,452	-	-	89,452	1,162	(88,290)
	89,452	-	-	89,452	1,245	(88,207)
Capital Payments to Related Parties						
3 Health System Capacity	10,730	-	-	10,730	10,730	-
8 Population and Public Health						
8.3 Community-Based Health Services	-	-	-	-	20,064	20,064
15 Infrastructure Support						
15.2 External Information Systems Development	5,748	-	-	5,748	3,005	(2,743)
15.3 Medical Equipment Replacement and Upgrade Program	30,000	-	-	30,000	30,000	-
15.4 Alberta Surgical Initiative Capital Program	12,072	-	-	12,072	20,072	8,000
15.5 Rural Alberta Health Facilities Capital Program	40,000	-	-	40,000	40,000	-
15.6 National Association of Pharmacy Regulatory Authorities Capital Program	15,069	-	-	15,069	14,000	(1,069)
15.7 Emergency Medical Services Vehicles Capital Program	5,000	-	-	5,000	5,000	-
15.8 Beaverlodge Health Centre Replacement	-	-	-	-	1,000	1,000
	118,619	-	-	118,619	143,871	25,252
Total	$ 25,037,760	$ 133,100	$ (4,458)	$ 25,166,402	$ 25,125,847	$ (40,555)
Credit or Recovery (Shortfall)	-	-	(1,000)	(1,000)	-	1,000
	$ 25,037,760	$ 133,100	$ (5,458)	$ 25,165,402	$ 25,125,847	$ (39,555)
(Lapse)/Encumbrance						$ (39,555)

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2024
(*in thousands)*

Expense Vote by Program	Voted Estimate [1]	Supplementary Estimate [2]	Adjustments [3]	Adjusted Voted Estimate	Voted Actuals [4]	Over Expended/ (Unexpended)
Capital Investment Vote by Program						
Department Capital Acquisitions						
1 Ministry Support Services						
1.3 Strategic Corporate Support	$ -	$ -	$ -	$ -	$ 446	$ 446
8 Population and Public Health						
8.8 Health System Projects	-	-	-	-	579	579
11 Continuing Care						
11 Program Support	585	-	-	585	-	(585)
13 Information Technology						
13 Development and Operations	27,280	-	-	27,280	13,483	(13,797)
15 Infrastructure Support						
15.8 Beaverlodge Health Centre Replacement	1,000	-	-	1,000	-	(1,000)
Total	$ 28,865	$ -	$ -	$ 28,865	$ 14,508	$ (14,357)
(Lapse)/Encumbrance						$ (14,357)
Financial Transactions Vote by Program						
Inventory Acquisition						
5 Drugs and Supplemental Health Benefits						
5.3 Outpatient Specialized High Cost Drugs	$ 9,000	$ -	$ -	$ 9,000	$ 6,652	$ (2,348)
8 Population and Public Health						
8.2 Immunization Support	79,876	-	-	79,876	77,871	(2,005)
Total	$ 88,876	$ -	$ -	$ 88,876	$ 84,523	$ (4,353)
(Lapse)/Encumbrance						$ (4,353)
Contingency Vote by Program						
2 Alberta Health Services						
2.4 Acute Care	$ -	$ -	$ 183,491	$ 183,491	$ 183,491	$ -
4 Physician Compensation and Development						
4.2 Physician Services	-	-	232,000	232,000	232,000	-
Total	$ -	$ -	$ 415,491	$ 415,491	$ 415,491	$ -
(Lapse)/Encumbrance						$ -

[1] As per "Expense Vote by Program", "Capital Investment Vote by Program" and "Financial Transactions Vote by Program" page 110 to 114 of 2023-2024 Government Estimates.

[2] Per the Supplementary Supply Estimates approved on March 21, 2024.

[3] Adjustments include encumbrances, capital carry over amounts, transfers between votes, credit or recovery increases approved by Treasury Board, and credit or recovery shortfalls. An encumbrance is incurred when, on a vote by vote basis, the total of actual disbursements in the prior year exceed the total adjusted estimate. All calculated encumbrances from the prior year are reflected as an adjustment to reduce the corresponding voted estimate in the current year.

[4] Actuals exclude non-voted amounts such as amortization, inventory consumption, and valuation adjustments as no cash disbursement is required (non-cash amounts), or because the Legislative Assembly has already provided the funding authority pursuant to a statute other than an appropriation act.

Department of Health

Statement of Remissions, Compromises and Write-offs (unaudited)

Year ended March 31, 2024
(in thousands)

	2024	2023
Write-Offs		
Medical Claim Recoveries	$ 2,900	$ 2,294
Pharmaceuticals and Health Benefits	3,220	-
Other Receivables	498	3,346
Total Write-offs [1]	$ 6,618	$ 5,640

[1] There were no remissions or compromises during the year.

The above statement has been prepared pursuant to Section 23 of the *Financial Administration Act*. The statement includes all remissions, compromises and write-offs made or approved during the fiscal year.

Payments Based on Agreements (unaudited)

The following has been prepared pursuant to Section 25(3) of the Financial Administration Act.

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments to provide health services on their behalf. The Department pays service providers for services rendered under the agreements and recovers the amount paid. Service providers include Alberta Health Services and physicians. The Department merely provides a service for another party and assumes no liability beyond that of completely discharging the role of being a conduit for funding. Costs based on these agreements are incurred by the Department under authority in Section 25 of the *Financial Administration Act.* Accounts receivable includes $56,750 (2023 - $50,032) relating to payments based on agreements.

Amounts paid based on agreements are as follows:

	2024	2023
Other Provincial and Territorial Governments	$ 344,034	$ 301,047

Ministry of Health

Year ended March 31, 2024
(in thousands)

Trust Funds under Administration (unaudited)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements.

As at March 31, 2024, the balance reported for Health Benefit Trust of Alberta was $208,949 (2023 - $90,991) and other trust funds for research and development, education, and other programs was $2,185 (2023 - $1,955).

The Ministry and a third-party trustee administer the Supplemental Executive Retirement Plan in accordance with a retirement compensation arrangement trust agreement. As at March 31, 2024, there are $25,176 in plan assets (2023 - $26,547).

Annual Report Extracts and Other Statutory Reports

Public Interest Disclosure (Whistleblower Protection) Act

Section 32 of the *Public Interest Disclosure (Whistleblower Protection) Act* reads:

32(1) Every chief officer must prepare a report annually on all disclosures that have been made to the designated officer of the department, public entity or office of the Legislature for which the chief officer is responsible.

(2) The report under subsection (1) must include the following information:

(a) the number of disclosures received by the designated officer, the number of disclosures acted on and the number of disclosures not acted on by the designated officer;

(b) the number of investigations commenced by the designated officer as a result of disclosures;

(c) in the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations made or corrective measures taken in relation to the wrongdoing or the reasons why no corrective measure was taken.

(3) The report under subsection (1) must be included in the annual report of the department, public entity or office of the Legislature if the annual report is made publicly available.

There were no disclosures of wrongdoing filed with my office for your department between April 1, 2023 and March 31, 2024.

Note: Alberta Health Services and the Health Quality Council of Alberta are considered separate entities for the purposes of the Act, and therefore have individual reporting obligations.