Health

Annual Report **2018–2019**

Alberta

Note to Readers:
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Ministry of Health

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Preface

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Fiscal Planning and Transparency Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 21 ministries.

The annual report of the Government of Alberta contains the consolidated financial statements of the province and *Measuring Up* report, 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 financial information of the ministry and 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 Department of Health, Alberta Health Services, and the Health Quality Council of Alberta, for which the minister is responsible;**
- **other financial information as required by the *Financial Administration Act* and *Fiscal Planning and Transparency Act*, as separate reports, to the extent that the ministry has anything to report.**

In December 2018, government announced changes to the 2018-19 ministry annual reports. Ministry and department audited financial statements previously included in the annual report of the Ministry of Health have been replaced with the financial information of the ministry on pages 47-56.

Key information previously contained in the annual reports of each of the 21 ministries is now included in the audited consolidated financial statements of the province.

Message from the Minister

Serving Albertans as the province's Minister of Health is an honour I was given this spring. My role will be to help ensure the overall design and strategic direction of Alberta's health system is responsive and sustainable for many years to come.

Since I took on this role on April 30, 2019, I have been learning about the results of the ministry for the 2018-19 fiscal year. Many of the achievements can be credited to the dedication of the health care professionals who work tirelessly to provide world-class care to Albertans.

As the Health Minister, I am committed to making the system even better by ensuring patients are at the centre of it. I look forward to working with Alberta Health Services to reduce wait times and ensure all Albertans have access to a publicly-funded, universal and reliable health care system.

Collaboration is essential to meeting the challenges of building a world-class health care system. I want to recognize the ongoing contributions of the many hard-working staff at the Ministry of Health and Alberta Health Services, as well as the work of our many partner organizations.

I look forward to our continued work together to build an outstanding health care system in Alberta.

[Original signed by]

Honourable Tyler Shandro
Minister of Health

Message from the Associate Minister

It is my pleasure to work with Minister Shandro and staff across the health system to improve mental health and addiction recovery outcomes for all Albertans. As Associate Minister for mental health and addiction, I am pleased to work toward improving access to a full continuum of high quality care.

Our Government is responding to the severity of the current addiction crisis. This response is bringing attention and resources to this important public health issue by helping to keep people alive and working with all parties and viewpoints to build a better, safer and more effective system for the future.

While we work hard to help the most at risk and keep communities safe, we must remind ourselves that success in helping people to achieve recovery is not only possible but is desirable and within reach.

Alberta is home to some of the best, most qualified counselling, treatment, harm reduction and recovery centres in Canada. It's time to cheer them on.

[Original signed by]

Honourable Jason Luan
Associate Minister of Mental Health and Addictions

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 consolidated financial statements and performance results for the ministry rests with the Minister of Health. Under the direction of the Minister, we oversee the preparation of the ministry's annual report, including consolidated financial statements and performance results. The consolidated financial statements and the performance results, 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:

- **Reliability** – Information used in applying performance measure methodologies agrees with the underlying source data for the current and prior years' results.
- **Understandability** – the performance measure methodologies and results are presented clearly.
- **Comparability** – the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- **Completeness** – outcomes, performance measures and related targets match those included in the ministry's *Budget 2018*.

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 *Fiscal Planning and Transparency 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]

Lorna Rosen
Deputy Minister of Health
June 7, 2019

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Ministry Overview

Organizational Structure

The Minister of Health is responsible for setting strategic policy, directing legislation and overseeing the health system to ensure the health of Albertans is protected, resources are aligned with the goals of the government, and public dollars are used appropriately. The ministry consists of:

- **Department of Health**
- **Alberta Health Services (AHS)** – which is the provincial health authority responsible for delivery of a substantial portion of health care services across the province
- **The Health Quality Council of Alberta (HQCA)** – which is a legislated council responsible for monitoring health service quality and patient safety

Department of Health

The Department of Health implements the Government of Alberta's vision and strategic direction for health and is responsible for the overall design, strategic policy direction, legislation, and monitoring of the health system's quality and performance. In this role the department ensures the health system is delivering quality in terms of health outcomes, including patient experience, and value for public investment. Core functions include advising the minister and government on health policy, assuring quality, supporting capital infrastructure, enabling policy implementation, funding the health system, and carrying out general health system oversight.

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, drive innovation, and continue to build and maintain collaborative relationships with partners across government ministries, AHS, and stakeholder organizations. The office provides policy coordination and issues management for the Minister as well as leadership in priority-setting, decision-making, and operations of the ministry.

Financial and Corporate Services Division – forecasts and manages the ministry's budget, funds and monitors the financial activities of the department, provides financial advice and prepares annual financial statements, ensuring compliance with Government of Alberta financial legislation. The division oversees capital planning, including health facilities planning and coordinates infrastructure projects with Ministry of Infrastructure and AHS. The division works with Health Service Delivery division to deliver continuing care capital grants and monitor the number of new continuing care spaces. The division also manages registration, designation and bed survey processes and reporting. The division coordinates the grant approval process for the department. The division also provides general administrative and contracting-based corporate services to enable the department to fulfil its mandate, as well as recovery of the cost of health services from liable third parties where appropriate.

Public Health and Compliance Division – provides strategic direction and leadership through the assessment, development and implementation of provincial policies, regulations, strategies, and standards in response to the opioid and other emerging public health crises, communicable diseases,

immunization, compliance monitoring, environmental public health, health promotion, and emergency preparedness, response and recovery. The division carries out these functions to support innovation and engagement with Albertans in wellness, health promotion, harm reduction, opioid use disorder treatment, as well as injury and disease prevention. To support health system quality, the division collaborates with partners in compliance and monitoring activities and enforcement of the acts, regulations and standards administered by the division regarding physician billing, continuing care accommodations and health services, infection prevention and control, and protection for persons in care.

Health Information Systems Division – manages the administration of Alberta's *Health Information Act*, including health information policy and advice, as well as the strategic planning and delivery of information management and technology systems. The division also provides provincial governance of health information management; develops and implements legislative requirements, policy and best practice information related to the secure exchange of health information; delivers information technology solutions to support ministry operations and the provincial e-health environment; and stewards the provincial programs of Alberta Netcare, the province's electronic health record and MyHealth Records, the online personal health record for Albertans.

Innovation and Strategic Operations Division – manages and facilitates the corporate processes that develop and deliver the ministry's strategic priorities and establishes evidence-informed, high-value innovation in policy and practice in the health care system. The division's responsibilities include leadership and coordination of the ministry's strategic policy, corporate planning and reporting, Indigenous health policy, strategic support on federal/provincial/territorial health issues, AHS accountability, governance of health sector public bodies, coordination and support of health care research and innovation, ministry correspondence services, and the ministry's response to applications under Alberta's *Freedom of Information and Protection of Privacy Act*.

Health Workforce Planning and Accountability Division – develops and implements health workforce policies, regulations, compensation strategies and governance models to enable a health workforce that meets Albertans' needs. The division collaborates with stakeholders, including physicians, professional colleges and associations, and other internal and external partners, to design and administer evidence-informed, value-oriented policies and health benefits that serve the needs of all Albertans.

Pharmaceutical and Supplementary Benefits Division – provides governance to, and oversees the administration of, the Alberta Health Care Insurance Plan, remuneration systems and claims processing for physicians and allied health professionals, and interprovincial reciprocal financial arrangements. The division designs and delivers community-based supplementary health benefit programs on behalf of Albertans requiring pharmaceutical, chiropractic, optical, dental, and other medical supports (wheelchairs, prosthetics, oxygen, medical/surgical supplies, etc.). These supplementary health benefit programs include premium-free prescribed drugs and other benefits to seniors as well as pharmacist-administered vaccinations. The division also provides leadership to national and provincial organizations to ensure accountable and appropriate delivery of blood, organ and tissue donation, dialysis and other provincial clinical services. Through leading engagement with cross-Canada working groups under the direction of the Interprovincial Health Insurance Agreements Coordinating Committee, the division examines the state of interprovincial health coverage to increase access and reduce barriers.

Health Standards, Quality and Performance Division – provides leadership for 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: primary health care, acute and emergency care, continuing

care, addiction and mental health, public health, and pharmaceuticals. It is the ministry's core strategic economic team developing and producing economic evaluations, predictive models, financial forecasts and value for money analyses.

The division is also responsible for ensuring acute and ambulatory care service planning, including transitions in models of care. Decisions are based on clinical evidence, integrate planning with other health care sectors, and ensure health delivery and capital investment are aligned with government policy direction. To improve existing acute and ambulatory care services, the division drives improvements through clinical appropriateness initiatives in collaboration with health care delivery partners, the Health Quality Council of Alberta and the College of Physicians and Surgeons, to ensure a safe and high quality health system.

Health Service Delivery Division – is responsible for providing leadership and strategic direction, including the development and implementation of policy, legislation and standards, as well as ongoing monitoring for continuing care, addiction and mental health, and emergency health services. The division is also responsible for working with government, service providers and community partners to promote a coordinated, integrated community-based health care system for Albertans. The division works closely with other social ministries, external organizations, partners, other Canadian provinces and the federal government to plan health service delivery.

Office of the Chief Medical Officer of Health – provides leadership and public health expertise on all issues of public health importance such as health surveillance, population health, injury or disease control initiatives and opioid emergency response. This includes taking necessary measures to respond to health crises and to new and emerging pathogens, control and intervention programs to limit the spread of communicable diseases, infection prevention and control measures, and health risk assessments. The Chief Medical Officer of Health has overarching legislated responsibilities for monitoring and reporting on the health of Albertans and intervening to protect and promote the health of the public under authority of the *Public Health Act*. This is accomplished by supporting and sometimes leading the development of healthy public policy and fulfilling the obligations of the Act.

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

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.

Corporate Counsel – through Alberta Justice and Solicitor General, Corporate Counsel leads a team of lawyers that supports all aspects of the department activities ranging from contracting and procurement, to developing and interpreting legislation and general legal advice to the ministry.

Office of the Alberta Health Advocates – includes the Health Advocate and the Mental Health Patient Advocate. The office supports Albertans in resolving their health-related concerns by helping them navigate the health care system; referring individuals to the appropriate complaints resolution services;

providing information about the Alberta Health Charter; requesting the inspection of provincial health care facilities; and, addressing patients' issues and concerns in relation to the *Mental Health Act*.

Key Factors Influencing Performance

Alberta's population continues to grow and change, placing increasing demands on provincial health services, health providers and physical infrastructure. Creative solutions, innovative partnerships, disciplined and integrated system planning, and strong fiscal stewardship are needed to help meet these demands.

Public expectations and lifestyle also play a key role in a high functioning health system. Governments, communities and individuals all have a part in addressing the social, economic and environmental determinants of health, which means a coordinated approach is needed to support Albertans in managing their health and making healthy lifestyle choices. This is even more important in the face of the province's growing and aging population.

Also important is having stable, secure information management and information technology systems and comprehensive data analysis, all of which are crucial to optimizing services, patient care, and health system outcomes. New technologies, including those in health information and biological and data science, will lead to new approaches and discoveries that could be significant for the future of more integrated and efficient health care.

Finally, one of the biggest key factors that influences success is health system cost drivers. These drivers, combined with external economic pressures that influence government revenue require active management of budget targets and innovative solutions to support long-term sustainability.

Discussion and Analysis of Results

In 2018-19 the Ministry of Health's four overarching outcomes were:

- **Outcome One:** Improved health outcomes for all Albertans
- **Outcome Two:** The well-being of Albertans is supported through population health initiatives
- **Outcome Three:** Albertans receive care from highly skilled health care providers and teams, working to their full scope of practice
- **Outcome Four:** A high quality, stable, accountable and sustainable health system

Outcome One: Improved health outcomes for all Albertans

Outcome statement |

Albertans' health and well-being is improved through an integrated health care system that is person-centred and structured around individuals, families, and communities. Seamless services across the continuum of care support individuals throughout their lives, ensuring every Albertan has access to appropriate services that are close to home.

Key Strategies

1.1 Expand home care services to increase access to health services, reduce reliance on acute care facilities, and enable Albertans to stay at home longer.

Home care services include professional health care, personal care and home supports to Albertans as well as respite for their caregivers. Clients may require services only for a short time or on an ongoing basis.

In 2018-19, rural home care staff and service hours were increased, as were supports for caregivers and the number of adult day program spaces. Additional resources strengthened management and in-home support for clients recently discharged from hospital. Team-based care for clients with complex needs, palliative and end-of-life care were also increased.

A bi-lateral transfer agreement was also signed with Health Canada for $703 million in federal funding over 10 years to support home care enhancements.

1.2 Develop a targeted approach for new continuing care spaces and upgrading or replacing existing sites, focusing on complex populations and communities in greatest need.

In 2018-19, Alberta Health Services (AHS) issued a Request for Proposal for continuing care spaces that do not need capital funding. The process will create almost 1,000 spaces. The ministry also commits to funding 37 Indigenous communities and organizations to help them identify the continuing care needs in their communities.

1.3 Enhance care for persons with dementia so they receive timely diagnosis and support in their communities with accessible, integrated and high-quality care and services.

As of April 1, 2018, there were more than 45,800 Albertans diagnosed and living with dementia – including 4,435 aged 40-65 years; 21,410 aged 65-84 years; and 19,960 aged 85 or older. This diagnosis has a significant impact on those living with dementia as well as on their families, friends, caregivers and communities.

In 2018-19, the ministry allocated $2.2 million to implement the Alberta Dementia Strategy and Action Plan. The plan addresses dementia as a larger societal issue, and one that government, communities and Albertans must work together to address. The $2.2 million investment is helping community partners develop programs and services that reduce stigma, change attitudes and behaviours, improve individuals' independence, and enhance quality of life and well-being. The First Link program delivered by the Alzheimer Society of Alberta and Northwest Territories is an example of the type of program needed to support individuals living with dementia and their caregivers. A progress report was released in March 2019, in which outcomes for supporting Albertans impacted by dementia were identified.

1.4 Implement the Valuing Mental Health: Next Steps to move toward a more coordinated and integrated addiction and mental health system.

In 2018-19, the ministry worked with health and community partners to strengthen addiction and mental health care for Albertans.

Low-income and homeless Calgarians seeking primary and mental health services from the Calgary Urban Partnership Society no longer face a wait list due to $1.4 million in ministry funding. Alberta Community and Social Services' funded addiction and mental health supports for homeless people through community-based organizations who implement the Housing First initiative in urban centres.

Mental Health First Aid training was delivered to 200 government staff working in disability services, as well as 250 seniors and their caregivers.

Schools hired staff to provide additional school-based community mental health supports, using ministry grant funding of $5 million. These additional staff will also act as links to additional mental health resources in the health care system.

1.5 Implement a system-wide response to chronic conditions and disease prevention and management by aligning and integrating work across the province.

With a growing number of Albertans living with chronic conditions and diseases such as cancer, health services and supports (including prevention initiatives) need to be integrated and coordinated within and beyond the health care system.

In 2018-19, the Alberta Cancer Prevention Legacy Fund provided approximately $10 million in funding for 14 projects, including 12 projects led by AHS and two projects led by community organizations. AHS projects included a Healthier Together Workplaces website, and nurse and oncology navigators to help cancer patients navigate through the health system.

The 41 Primary Care Networks (PCNs) in Alberta have each identified initiatives related to chronic conditions and disease prevention and management.

Performance Measures and Indicators

Performance Measure 1.a

Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed

Prior Years' Results				2018-19 Result	2018-19 Target
2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result		
60%	60%	56%	52%	58%	58%

Source: Alberta Health Services. Data are extracted from Meditech and Stratahealth Pathways.

This measure is used to monitor and report on access to continuing care living options (designated supportive living or long-term care) in Alberta, as indicated by the proportion of individuals waiting 30 days or less for a move into a continuing care option. Timely access to a continuing care facility as soon as possible after being assessed, supports the health and well-being of both the client and their family.

Results Analysis

The current result of 58 per cent shows that the increase in the number of facility-based continuing care spaces and the enhancements made to home care in the past few years are starting to achieve the planned improvement in the percentage of clients who are moved into facility-based continuing care within 30 days of being assessed. AHS tracks results on a monthly basis and there are indications that the results began to show improvement as early as late 2017 and have continued to improve across 2018-19, however there is need for the investments made in home and community care to mature and for the addition of facility-based spaces in continuing care to continue, as planned.

Performance Measure 1.b

Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital

Prior Years' Results				Current Result	2018-19 Target
2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result		
8.8%	8.6%	8.8%	8.8%	9.8%[1]	8.6%

Source: Canadian Institute for Health Information (CIHI); Alberta Health Services, Provincial Inpatient Database (DAD).
[1]Q3 year-to-date.

This measure represents the proportion of occurrences of a non-elective (unplanned) readmission to an acute care hospital for selected mental illness within 30 days of a patient being discharged from the hospital stay for their mental illness. The measure applies only to inpatients of acute care hospitals in Alberta. Visits to facilities and programs not designated as acute inpatient care facilities (e.g., hospital emergency departments, urgent care centres, community clinics) are not included. The selected mental

illnesses included are substance use disorders; schizophrenia, delusional, and non-organic psychotic disorders; mood/affective disorders; anxiety disorders; and disorders of adult personality and behavior.

Results Analysis

The preliminary result for 2018-19 of 9.8 per cent is above the target of 8.6 per cent. Alberta's results were rather consistent in the four years prior to this result, with continued efforts underway to achieve the target.

Although readmission may involve external factors, high rates of readmission act as a signal to hospital clinicians to look more carefully at their practices, including discharge planning and continuity of services after discharge. Rates may also be impacted due to the nature of the population served by a facility (e.g., patients with complex health needs) or by accessibility of mental health care in the community.

Performance Indicator 1.a
Emergency visits due to substance use (per 100,000 population)

Substance	Prior Years' Results[1]				2018 Result
	2014 Result	2015 Result	2016 Result	2017 Result	
Alcohol	945	957	961	946	935
Opioids	108	142	175	205	219

Sources: Alberta Ambulatory Care database; Alberta Health Care Insurance Plan, Mid-year adjusted Population Registry Files Statistics Canada; Canadian population, 2011.
[1]2014-2017 results have been updated.

This indicator provides the age-standardized rate of visits to emergency departments and urgent care centres related to use of alcohol and opioids.

Results Analysis

The results show that the number of emergency visits due to psychoactive substances has risen steadily over the past five years. The largest increase has been in visits due to opioid use. Substance use is a growing problem in Alberta, while alcohol use remains steady.

Steps taken by the ministry to reduce the harms associated with opioid use may increase emergency visits. For example, naloxone availability and increased awareness of how to respond to opioid overdoses may lead to an increase in individuals being brought to emergency departments for follow-up.

The ministry continues to be involved in supporting responsible alcohol consumption as co-chair of the National Alcohol Strategy Advisory Committee. This work supports the pan-Canadian sharing of best practices. AHS is working with municipalities to support and promote the development and implementation of municipal policies that support responsible alcohol use. The department, AHS, and the Alberta Gaming and Liquor Commission have all worked collaboratively to implement the Alcohol Strategy.

Performance Indicator 1.b

Prevalence of cigarette smoking among Albertans (per cent)

Age	Prior Years' Results				Current Result
	2014 Result	2015 Result	2016 Result	2017 Result	
12-24 years	14.7%[1]	9.8%	13.0%	15.1%	Not Available[2]
25 years and older	19.8%[1]	20.4%	19.1%	17.1%	Not Available[2]

Source: Canadian Community Health Survey, Statistics Canada.
[1] Statistics Canada has warned against making comparisons prior to 2014 with the Canadian Community Health Survey (CCHS) conducted 2015 onwards. The daily smoker used was defined slightly differently compared to pre-2014. Therefore comparing these estimates between 2013-2014 and 2015-2017 should be avoided or interpreted with caution.
[2] 2018 data is currently unavailable from Statistics Canada. Results expected to be available in the fall of 2019.

The cigarette-smoking indicator is a self-reported measure among Albertans who completed the Canadian Community Health Survey. Daily and occasional smokers are included in the estimate.

For 2015-2017, the cigarette-smoking indicator included the following self-reported responses: a) current daily smoker and b) current occasional smoker.

For 2013-2014, the cigarette-smoking indicator included the following self-reported responses: a) daily smoker, b) occasional smoker (former daily smoker), and c) always an occasional smoker.

Results Analysis

Cigarette smoking trends for Albertans 25 years and older have decreased (p-value<0.05) from 20.4 per cent (in 2015) to 17.1 per cent (in 2017). Among Albertans age 12-24, the smoking rate increased from 2015 to 2017 (p-value<0.05). Without additional information, it is unclear whether the rise in smoking rates for youth age 12-24 is a long-term trend that will require additional action to address or a short-term anomaly. A rise in smoking rates amongst this age group may be related to an increase in youth vaping and nicotine addiction over the same period of time.

The department continues to support AHS in offering tobacco cessation programs, tobacco prevention and health promotion activities, and the toll-free Tobacco Quitline (AlbertaQuits).

Performance Indicator 1.c

Ambulatory care sensitive conditions: Hospitalization rate (per 100,000) for patients under 75 years of age with conditions that could be prevented or reduced if they received appropriate care in an ambulatory setting

Prior Years' Results				2018 Result
2014 Result	2015 Result	2016 Result	2017 Result	
378[1]	361[1]	362[1]	349[1]	340[2]

Sources: Numerator: Alberta Health Services, Discharge Abstract Database (DAD); Denominator: Alberta Health Population Estimate.

[1]2014-2017 results have been updated. [2]2018 result is preliminary.

This indicator measures the number of people (under 75 years of age) per 100,000 population who were hospitalized for health conditions that could have been treated in an ambulatory care setting. Ambulatory care is provided outside of a hospital inpatient setting, such as in community clinics operated by AHS, urgent care centres, and emergency departments. The health conditions, known as ambulatory care sensitive conditions, include: grand mal status and other epileptic convulsions; chronic obstructive pulmonary diseases; asthma; heart failure and pulmonary edema; hypertension; angina; and, diabetes.

Hospitalization for an ambulatory care sensitive condition is considered an indicator of lack of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition.

Results Analysis

There has been consistent improvement in this indicator as shown by the declining hospitalization rate over the past five years for patients with ambulatory care sensitive conditions. This result suggests Albertans may be accessing more appropriate primary health care options, as opposed to hospitals, to address their needs.

Optimizing management of these health conditions in the community, including primary health care settings can contribute to both improved patient outcomes and reduced health care costs.
The Canadian Institute for Health Information (CIHI) ranked Alberta fifth out of 12 provinces and territories for this health indicator in 2016-17. While additional work is needed to further reduce this rate, Alberta's trend is decreasing each year and community options are increasing.

The ministry continued to focus on increasing access to care in the community and developing a coordinated approach across the continuum of care to help people prevent and manage chronic health conditions and diseases and improve their quality of life. The department and AHS are working collaboratively to coordinate the planning and delivery of supports and services with Albertans, patients, care providers and community partners.

Outcome Two: The well-being of Albertans is supported through population health initiatives

Outcome statement |

Healthy populations and communities are shaped through a range of social, economic, and physical environmental factors, also known as the determinants of health. The ministry works with its partners to address health inequities and to encourage Albertans to stay healthy by developing policies, programs and initiatives focused on prevention of injury and disease.

Key Strategies

2.1 Engage with community partners on wellness initiatives to enhance and support equitable approaches that enable Albertans to be active partners in the prevention and management of chronic disease.

Communities, schools and workplaces have a big impact on the health of Albertans. Strong partnerships with diverse stakeholders are essential when it comes to preventing and managing chronic disease.

The ministry worked with community partners to promote healthy living, including with Indigenous communities and other community partners to promote healthy eating and physical activity.

To help prevent negative health outcomes due to drug use, AHS launched a public awareness campaign focused on drugs. The website www.drugsafe.ca provides information on opioids, fentanyl, and cannabis.

The Injury Prevention Centre received $1.3 million in funding from the ministry to provide research, education, awareness and resources on topics like preventing falls, poisonings, concussions, and other injury hazards. Other injury prevention initiatives were targeted to seniors to increase awareness of injuries and to provide tools on strength and balance.

2.2 Engage with Indigenous communities and other organizations in the design and delivery of culturally appropriate health care services that address inequities in access and support improved health outcomes.

In 2018-19 the ministry continued to address health inequities and health service improvements for Indigenous Albertans by collaborating with Indigenous communities, AHS, the federal government and other partners to address heath priorities, and support culturally safe programs and services.

The ministry worked with AHS to adopt mandatory anti-racism and cultural sensitivity training for all staff and physicians with a goal to have all employees trained by 2021. As of March 31, 2019, 15,716 AHS employees completed the Awareness & Sensitivity program and 33,622 AHS employees completed the Indigenous People in Alberta: An Introduction training module.

Significant gaps continue in the overall health status of Indigenous Albertans compared to non-Indigenous Albertans. The ministry will continue to work with Indigenous communities to address these gaps through funding and program support, including suicide prevention, mental health, opioid response, and primary care. The ministry commits to funding 37 Indigenous communities and organizations to help determine continuing care needs for their community.

2.3 Lead an urgent response to reduce harms associated with opioid use and oversee the implementation of priority activities to address overdoses and deaths related to fentanyl and other opioids.

The opioid crisis is having an enormous impact on family, friends and communities. Opioid use disorder demands a public health response, which spans harm reduction services and treatment options.

Six new Supervised Consumption Services sites are now open, bringing the total to seven; and three temporary overdose prevention sites were established. To further support harm reduction efforts, the ministry also supported the distribution of more than 137,000 naloxone kits.

New opioid dependency treatment clinics were established in Fort McMurray, High Prairie and Bonnyville. Two specialized clinics were also established in Edmonton and Calgary as pilot projects to treat people with severe opioid use disorder, and $1.6 million in funding was provided to create up to 30 new intox spaces in Lethbridge. The Virtual Opioid Dependency Program was also expanded in Lethbridge.

A bilateral agreement was also signed between the Government of Canada and the province to provide $24 million from the federal Emergency Treatment Fund to create a program that covers the costs of opioid agonist therapy medications for Albertans without health benefits, as well as expand access to treatment in provincial correctional facilities.

2.4 Improve maternal, infant and child health by supporting initiatives that foster maternal-infant health and early childhood development.

Maternal-infant health initiatives foster healthy birth outcomes, including healthy birth weights, Fetal Alcohol Spectrum Disorder prevention, and support for overall maternal and infant health.

To support infant health, the ministry expanded newborn metabolic screening for more conditions including sickle cell disease and severe combined immunodeficiency. Screening for congenital hearing loss was also expanded. The dTAP vaccine was made available to expectant mothers without cost, which provides protection to newborns against pertussis (whooping cough).

2.5 Develop and implement evidence-based environmental public health policies and practices by addressing a range of public health protection issues in the natural and built environment

Environmental public health focuses on relationships between people and their environment, promotes human health and well-being, fosters healthy and safe communities.

In 2018-19 the ministry implemented recommendations from technical air quality, odour and human health assessments in the Peace and Fort McKay region. Work was completed in establishing emergency air quality triggers, exercising new protocols to determine the source of air quality concerns, and increased communication between key stakeholders.

Extensive collaboration with the Ministry of Environment and Parks and AHS to investigate contamination on the former Domtar Wood Preservation Facility site in northeast Edmonton occurred throughout the year. The ministry's focus was to protect the health of residents in the area and address public health questions.

The Alberta Rabies Prevention and Control Manual: Guidance for Public Health and Veterinary Professionals was published in 2019 and provided guidance on rabies prevention and control. Additionally, the ministry continued tick surveillance to assess the risk of Lyme disease in Alberta.

2.6 Safeguard Albertans from communicable disease through increased immunization and initiatives aimed at decreasing sexually transmitted infections.

There is a continuing outbreak of sexually transmitted infections (STI), and the ministry provided an additional $1 million in funding in 2018-19 to support enhanced STI outreach services by AHS. The HIV PrEP program was established in 2018 to support HIV prevention in higher risk individuals, and the Alberta Prenatal Screening Guidelines were updated to increase screening of all pregnant women for chlamydia and gonorrhea.

As of March 31, 2019, 1.3 million doses of influenza vaccine were administered, covering 30 per cent of the population. In 2018-2019, the influenza immunization program was expanded to allow pharmacists to offer provincially funded influenza vaccine to people aged five or older. Pharmacists were also able to offer provincially funded pneumococcal disease vaccine for Albertans over the age of 65.

The Education ministry and the Health ministry also began sharing information to support improvements to immunization rates and timely response to outbreaks in schools. During the 2018-2019 school year, AHS public health nurses started offering vaccines in the school setting to students in grades one to nine with incomplete immunizations.

Performance Measures and Indicators

Performance Measure 2.a

Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization

Population	Prior Years' Results				2018-19 Result	2018-19 Target
	2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result		
Seniors aged 65 or over	61%	63%	62%	60%	61%	64%
Residents of LTC[1] facilities	90%	90%	89%	89%	87%	91%

Sources: Numerator: Number of individuals immunized by age category: AHS zones; Alberta Health's weekly pharmacists data; First Nations and Inuit Health Branch, Indigenous Services Canada, Alberta Region.
Denominator: For seniors, the denominator is the ministry's population estimates, based on mid-year registration population estimates. For residents of long-term care facilities the denominator is the number of residents as of December 15, 2018 provided by AHS.
[1] Long-term care

This performance measure tracks efforts towards immunization among high risk groups, including seniors (aged 65 or over) and residents of long-term care facilities. Influenza immunization targets are set by the ministry and are based on national immunization targets as set by the National Immunization Strategy and agreed to by the Pan-Canadian Public Health Network Council. National targets are based on epidemiological evidence to decrease disease incidence and complications from disease.

Results Analysis

Influenza has a significant impact on the health of Albertans and tends to be most severe among older Albertans, residents of long-term care facilities, infants, young children, and those with certain chronic medical conditions. Rates of influenza immunization have remained relatively consistent over the last few years but are not meeting national targets. Alberta performance results measure progress year-over-year while maintaining the commitment to reach the national targets. Year-over-year target increases are more achievable and help with program planning and evaluation.

Challenges with achieving target immunization rates are as follows:

- There is a short window of opportunity to immunize the population before influenza disease begins to spread in the province.
- Every long-term care resident is offered the influenza vaccine, which explains the higher rate of coverage in this group. A lower rate of immunization is observed among seniors living in the community because this type of one-to-one service that is offered is not possible for all Albertans 65 years of age or older.
- There is a slight decrease from 89 per cent to 87 per cent in 2018-19; however this may be attributable to aggregate data collection methodology.
- Vaccine hesitancy has been increasing despite increased access to vaccine services and providing education about the benefits of annual influenza immunization.
- The belief that influenza is not a serious illness. Some people can be infected with the virus but have no symptoms, during this time, those people may still spread the virus to high-risk people.

The ministry continues to work with AHS, pharmacists, physicians and other stakeholders across Alberta to increase access to influenza immunization and to focus efforts on steadily improving influenza immunization rates and reporting over time. Pharmacist administration of publicly funded vaccines has expanded the reach of immunization services to Albertans. Influenza vaccine effectiveness ranges from 10 to 50 per cent (unlike other vaccines that are upwards of 95 per cent effective). The ministry and partners continue to communicate the importance and benefits of the annual influenza immunization.

Performance Indicator 2.a
Childhood immunization rates (by age two)

Immunization	Prior Years' Results				2018 Result
	2014 Result	2015 Result	2016 Result	2017 Result	
Diphtheria, tetanus, pertussis, polio, Hib	76%	76%	77%	77%	78%
Measles, mumps, rubella	88%	88%[1]	88%	88%[1]	87%

Source: Alberta Health Care Insurance Plan (AHCIP), Quarterly Population Registries; Immunization/Adverse Reactions to Immunization (Imm/ARI); Alberta Vital Statistics, Birth Files.
[1] Results have been updated.

This performance indicator shows efforts towards protecting children from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of immunization reduces the incidence of these diseases and serves to control outbreaks.

This indicator reports the percentage of children in Alberta who by two years of age have received the required immunization for specific childhood diseases (i.e. diphtheria, tetanus, pertussis, polio, Hib, measles, mumps, rubella).

Results Analysis

The department and AHS continue to work together to make progress towards national targets which have been revised to 95 per cent for both diphtheria, tetanus, pertussis, polio and haemophilus influenza type b (DTaP-IPV-Hib) and measles, mumps and rubella (MMR) vaccines.

Over the past five years, Alberta has achieved an immunization rate for these young Albertans of between 75 per cent and 77 per cent to prevent DTaP-IPV-Hib and between 86 per cent and 88 per cent to prevent MMR.

The provincial electronic immunization information repository captures all provincially-funded childhood immunization information in Alberta.

AHS has focused on increasing access and decreasing wait times at public health clinics for routine childhood immunization.

Performance Indicator 2.b
Life expectancy at birth (years)

Population	Prior Years' Results				Current Result
	2014 Result	2015 Result	2016 Result	2017 Result	
First Nations	68.7	69.9	69.1	67.7	67.9[1]
Non-First Nations	80.1	79.9	80.0	79.9	80.0[1]

Sources: Alberta Health Care Insurance Plan Adjusted Population; Alberta Health Postal Code Translation File; Alberta Vital Statistics Death File; First Nations Status Registry.
[1]Preliminary Data. Final Statistics expected to be available at the end of summer 2019.

This indicator compares the life expectancy of First Nations people to that of non-First Nations people in the province of Alberta. Life expectancy at birth is an indicator of the overall health status of a population and provides the number of years a given birth cohort would be expected to live if current age and sex mortality rates remained constant. Life expectancy at birth is determined by a number of factors that include genetic, social, and environmental conditions. It only takes into account the length of life and not quality of life.

Results Analysis

In 2018, the gap in life expectancy between First Nations and non-First Nations populations in Alberta was 12.1 years. Life expectancy among First Nations in Alberta is based on relatively small numbers that

result in annual fluctuations making trends over a short period of time difficult to interpret. However, there continues to be a large gap in life expectancy between First Nations and non-First Nations people in Alberta over time. This data clearly shows that more needs to be done to address health disparities for Indigenous peoples.

Globally, life expectancy at birth may be impacted by a host of factors that include access to and quality of health care. These include factors such as income, housing, education, and employment conditions. Importantly, for First Nations people, life expectancy may be influenced by a complex history that includes intergenerational trauma from residential schools, higher rates of poverty, and systemic racism.

The Ministry of Health works to address health service improvements and health priorities to improve health outcomes for Indigenous Albertans by collaborating with the province's Regional Indigenous Organizations, AHS, the Department of Indigenous Services Canada, and other partners. The Office of the Chief Medical Officer of Health and the Alberta First Nations Information Governance Centre are working together with an Advisory Committee to develop a report on the health status of First Nations people in Alberta. The report aims to highlight health inequities and identify initial areas for action to reduce identified gaps and improve the health of First Nations people in Alberta.

In addition, the ministry was involved with the Treaty 8 Protocol Agreement Health Table, Blackfoot Confederacy Protocol Agreement, Métis Nation of Alberta Framework Agreement, and the Metis Settlements General Council Long-Term Governance and Funding Arrangement. Progress is being made in several key areas including: strengthened immunization information sharing; coordination of actions through an Indigenous Integration Committee; and, collaboration with the Métis Nation of Alberta and Metis Settlements General Council to develop health status information to identify community health needs and future planning. Furthermore, work under the Protocol Agreements is focused on increasing collaboration across all government ministries to identify and address the gap in health outcomes of Alberta First Nations people and non-First Nations people.

Performance Indicator 2.c

Infant[1] mortality rate (per 1,000 live births)

Population	Prior Years' Results				2018 Result
	2014 Result	2015 Result	2016 Result	2017 Result	
First Nations	10.4	8.4	7.5	9.2	13.8
Non-First Nations	4.3	4.2	3.7	4.4	4.4

Sources: Alberta Vital Statistics Death File (infant deaths); Newborn Metabolic Screening Database (live births); First Nations Status Registry.

[1] Infants less than one year of age.

Infant mortality is an important indicator of population health. The infant mortality rate provides the rate of deaths for children less than one year of age, per 1,000 live births. Infant mortality is often used as an indicator to measure the health status of a general population, because factors affecting the health of entire populations can also impact the mortality rate of infants.

This indicator compares the infant mortality rate for the First Nations population to that of the non-First Nations population in Alberta.

Results Analysis

There is a significant gap in the infant mortality rate for the First Nations population in Alberta in comparison to the non-First Nations population. Infant mortality rates are based on relatively small numbers that result in annual fluctuations, making trends over time difficult to interpret. Compared to 2017, the infant mortality rate for First Nations people is higher in 2018 while the rate for non-First Nations people has remained relatively consistent.

Rates of death among infants under one year of age are associated with premature birth, lower birth weight, and injury. These outcomes may be impacted by maternal health, and may be driven by socio-environmental factors such as income, housing, education, and employment conditions. Importantly, for First Nations people, infant mortality rates may be influenced by a complex history that includes intergenerational trauma from residential schools, higher rates of poverty, and systemic racism.

To address the health status gaps between First Nations and non-First Nations populations in Alberta, the ministry is committed to respectfully engaging with Indigenous leadership, communities, and peoples in the design, delivery and stewardship of health services. Engagement and coordination processes with Regional Indigenous Organizations including Métis Nation of Alberta, Metis Settlements General Council, Confederacy of Treaty 6, Treaty 8 First Nations of Alberta, Blackfoot Confederacy and Stoney Nakoda Tsuut'ina Tribal Council, builds upon the foundation of reconciliation and relationships.

The ministry continues to work in partnership with Indigenous people, and federal and provincial partners to strengthen health services for Indigenous people in our province, and is supporting key initiatives aimed at reducing disparities between Indigenous and non-Indigenous Albertans including supporting expectant Indigenous mothers.

The Government of Alberta is committed to supporting midwifery as one option for women giving birth and to improving access to this health service, including for rural and underserved areas and for vulnerable populations.

Outcome Three: Albertans receive care from highly skilled health care providers and teams, working to their full scope of practice

Outcome statement |

Health care providers are vital to delivering high quality and safe care. This includes physicians, nurses, pharmacists, paramedics, psychologists, dieticians, dentists, counsellors, chiropractors, and social workers, among others. The right number, mix, and distribution of providers must align with health needs across the province.

Key Strategies

3.1 Enhance the delivery of primary health care services through patient attachment to providers and health care teams, increased integration of services, timely access, and improved quality and safety.

Shifting to a more person-centred and sustainable health system, while maintaining quality and safety, is dependent on the integration of efforts within the ministry and with health professions, post-secondary institutions, stakeholder organizations, and Albertans. Primary Care Networks (PCNs) are key to achieving this goal. In 2018-2019, the ministry made progress toward integration, including a PCN Governance Framework to better integrate PCNs with AHS' community-based services and other program areas, reduce the number of information systems used across the health system, and physician resource planning to better allocate physicians in accordance with needs.

In health information management, progress was made on the Central Patient Attachment Registry (CPAR), a centralized provincial information system that stores the confirmed relationships between patients and their primary provider. There are four PCNs currently participating in CPAR.

Changes to the Schedule of Medical Benefits became effective November 1, 2018 including provisions pertaining to Medical Assistance in Dying and transgender patients.

3.2 Develop sustainable physician resource plans and compensation models, which enable the provision of high quality care and support collaborative practice within an interdisciplinary team-based environment.

Rate increases are a key driver of physician expenditures. In 2018, the Alberta Medical Association (AMA) Amending Agreement was finalized and included no increases to physician rates and prices paid for insured medical services. As part of the AMA amending agreement, the ministry is working with the AMA to demonstrate the Blended Capitation Model, which is a form of alternative compensation for primary care physicians.

To achieve more cohesive provincial standards for funding and physician remuneration in academic medicine, as well as improved reporting and accountability, the Academic Medicine Health Service Program was implemented in 2018-19.

In addition, changes to the Schedule of Medical Benefits became effective November 1, 2018 and included expanding support for physicians working collaboratively with other health care providers in an interdisciplinary team-based environment.

3.3 Improve access to health care providers across the province and develop sustainable strategies that ensure the appropriate education, scope of practice, supply, mix and distribution of health care providers.

Highly skilled, well trained health care providers are central to the system's overall performance ensuring quality, safety and appropriateness in the provision of acute care services and community care.

The ministry made progress in 2018-19 to implement physician resource planning in Alberta. This included working with the Physician Resource Planning Advisory Committee to provide advice on the appropriate supply, distribution, and mix of physicians in Alberta. Emphasis was also placed on physician distribution to rural and remote communities, underserviced urban areas and Indigenous communities. Actions focused on recruitment tactics, education programs, labour market information, and international medical graduate placement.

Scopes of practice expanded for nurses and midwives in 2018-19 through amendments to the Midwives Profession Regulation and the Registered Nurse Profession Regulation. The ministry also completed a review of the podiatry program in Alberta.

3.4 Enhance accountability and promote practice excellence among regulated health care providers.

In 2018-19, the ministry completed a review of the College of Naturopathic Doctors of Alberta's code of ethics and standards of practice, which resulted in the development of over 30 standards of practice. New or revised standards of practice were also reviewed for the College of Podiatric Physicians of Alberta, the College of Physicians and Surgeons of Alberta, the College and Association of Registered Nurses of Alberta, the College of Dietitians of Alberta, and the Alberta College of Pharmacy.

3.5 Improve the effectiveness and efficiency of Alberta's emergency medical services system, and support the expanded role of paramedics in the delivery of patient care.

In 2018-19, support for emergency medical services was increased by more than $20 million (to $524 million), including support for the Community Paramedic Program, which allows paramedics to provide care to seniors and other vulnerable Albertans in their homes, and Community Response Teams, which facilitate local access to care for non-emergent patients by improving the ability for ambulances to respond to emergent patients. Ministry funding of $29 million was also announced to hire 100 additional paramedics and another $1 million to support the mental health of emergency medical services workers.

Performance Measures and Indicators

Performance Measure 3.a

Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network

Prior Years' Results				2018-19 Result	2018-19 Target
2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result		
77%	78%	80%	82%	82%	80%

Source: Department of Health, Alberta Health Care Insurance Plan Statistical Supplement, Claims Assessment System (CLASS).

This measure is defined as the percentage of Albertans informally enrolled in a Primary Care Network (PCN) as of March 31 of a given year. PCNs are the most common model of team-based primary health care delivery in Alberta. PCNs are groups of doctors working collaboratively with teams of health care professionals, such as nurses, dietitians and pharmacists, to meet primary health care needs in their communities.

The result is based on the total number of patients enrolled in a PCN as a proportion of the total population covered under the Alberta Health Care Insurance Plan in a given fiscal year. Determining the number of Albertans enrolled in a PCN will identify gaps in access.

Results Analysis

In 2018-19, 82 per cent of Albertans were enrolled in a PCN, this is two per cent higher than the target. Growth has been steady at slightly more than one per cent per year for the past five years. A steady growth in the number of physicians joining PCNs has had a positive impact on this measure. There is also growing awareness of the benefit patients receive when enrolled in a PCN. These results show that the focus on PCNs as the catalyst for a patient's medical and health home is working.

Alberta now has 41 PCNs involving more than 80 per cent of primary care physicians, the full-time equivalent of over 1,000 health care providers, providing services to close to 3.6 million Albertans. Non-PCN affiliated family physicians may also be providing team-based care; they may be part of another team model.

The enrollment calculation is based on visits over a rolling 36-month period, and which excludes healthy Albertans who may not have visited a family physician in the last three years. These Albertans may still have ready access and a relationship with a PCN-affiliated family physician but have not been counted in the statistic. In addition, a small percentage of Albertans receive team-based primary health care in non-family physician models such as nurse practitioner-led clinics.

The department is working with the PCN Physician Leads, Alberta Health Services (AHS), and primary health care partners to support the evolution of primary care delivery across the province. According to research conducted by the Canadian Institute for Health Information, access to a broad spectrum of services including health promotion and disease prevention (offered by PCNs), as well as comprehensive, multi-disciplinary and coordinated care, are markers of health care service delivery excellence.

Performance Indicator 3.a

Emergency department wait times: Median earliest patient time (minutes) to see an emergency doctor (17 busiest sites; patient level of urgency)

Patient Level of Urgency	Prior Years' Results				Current Result
	2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result	
CTAS 1	13	12	11	12	11[1]
CTAS 2	61	56	56	62	63[1]
CTAS 3, 4 and 5	90	84	84	92	92[1]

Source: National Ambulatory Care Reporting System format (NACRS).
[1] 2018-19 Preliminary data as of Dec 31, 2018. Data expected in the fall of 2019.

This indicator measures the time interval between the earliest of triage date/time or registration date/time and the date/time of physician initial assessment in the emergency department (ED). The indicator is measured in minutes, using the 50th percentile, which represents the maximum length of time that 50 per cent of patients stay in the ED until they are initially assessed by a physician.

Canadian Triage and Acuity Scale (CTAS) is one indicator of priority for treatment and an indirect estimator of the patient's symptom severity on arrival to the ED developed by Canadian Association of Emergency Physicians. The urgency or need for ED treatment decreases as CTAS scores increase. The CTAS levels used are 1) resuscitation required, 2) emergent care required, 3) urgent care required, 4) less-urgent care required and 5) non-urgent care required.

Results Analysis

In November 2018, the Canadian Institute for Health Information (CIHI) released data on two emergency department wait time indicators – time to initial physician assessment, and length of stay for admitted patients. The wait time trend for both indicators is on the rise nationally and provincially, but Alberta performs better than the national average for both and performs best among Canadian provinces for length of stay in emergency departments for admitted patients. AHS continues to monitor and report on the emergency department wait times indicator and is working to reduce ED wait times for admitted patients.

The reasons for the slow movement of patients from ED into inpatient care are multi-faceted and generally related to difficulties finding appropriate placement or services following hospital discharge. This is typically not a reflection of ED effectiveness but throughput of in-patients within the hospital. Many in-patients are waiting for discharge due to lack of available continuing care spaces or step-down beds in community to support rehabilitation.

The department is working with AHS to reduce pressures on EDs and hospitals by improving access to, and enhancing, primary health care, continuing care and home care services. Expansion of home and palliative care, opening of community-based Urgent Care Centres, specialized intensive home care programs, and implementation of Emergency Medical Services programs, including the expanded role of community paramedics may help reduce ED pressures. Flow through the acute care system will also be

improved by opening alternate level of care beds for patients who do not need acute care and improving access to continuing care options.

Outcome Four: A high quality, stable, accountable and sustainable health system

Outcome statement |

The design of Alberta's health system is based on access to safe, consistent, and readily available health care services where all health care stakeholders are accountable for health outcomes. Barriers to accessing care are reduced through innovative and evidence-informed best practices. Balancing physical and technological infrastructure to enable high quality, integrated care with alternative solutions focused on efficiency and cost effectiveness are necessary to ensure health system sustainability and reduce the ever-growing costs of care.

Key Strategies

4.1 Slow the rate of growth in health spending through increased efficiencies, while continuing to enhance the delivery of appropriate and high quality health care services and ensuring appropriate and reasonable access to pharmaceuticals and supplemental health benefits for Albertans.

Economic pressures, continued population growth with growing demand for health care services, coupled with the costs of delivering those services, are placing continued pressure on the publicly funded health system.

The ministry is working with other provinces and territories under the new pan-Canadian generics initiative to reduce generic drug prices, realizing more than $30 million in incremental savings for Alberta.

The department continually monitors, measures, and audits claims to contribute to accurate health system billing and recovery of duplicate billing, recovering nearly $5 million for claims erroneously billed to the ministry in 2018-2019.

In 2019, the ministry completed cost driver applications for physician, pharmacy and long-term care services. These tools help the ministry monitor the financial impact and pressures of policy and system changes.

4.2 Repair aging health infrastructure and build new health care facilities, where appropriate, to ensure such infrastructure meets current and future health care needs.

The ministry continued to work with AHS and the Ministry of Infrastructure to make investments in the province's health infrastructure. In 2018-19, a redeveloped maternity care unit at the Peter Lougheed Centre in Calgary and new wing at the Medicine Hat Regional Hospital were opened. A facility in Red Deer for detoxification and addiction treatment will be ready by September 2019. Progress continued on a number of infrastructure projects (planning and/or construction) including a new Edmonton hospital, Calgary Cancer Centre, Medicine Hat Regional Hospital renovations, Fort McMurray Residential Facility Based Care, and Chinook Regional Hospital redevelopment in Lethbridge.

4.3 Enhance data sharing, research, innovation, health technology assessment and knowledge translation to support evidence-informed policy, planning and practice.

The department made progress on number of ongoing initiatives that increase provincial capacity for making evidence-informed decisions to provide the best care for Albertans.

The ministry's Enabling New Models of Care initiative will support evolving physician payment models, better data collection for evidence-based decision making, and tracking performance on health system outcomes.

In 2018-19, the department and Alberta Health Services (AHS) each contributed $5 million to establish the Health Innovation Implementation and Spread Fund. This Fund supports the implementation of proven innovations in the health care system. An initial slate of five projects was selected in February 2019.

The Alberta Cancer Prevention Legacy Fund provided $9.2 million in funding to improve screening for breast and lung cancer, improve cancer screening for underrepresented populations, and continue to build the research resource developed by the Alberta Tomorrow Project.

4.4 Set health system expectations through a focus on appropriate access, patient safety, effectiveness, and patient experience, to reduce variations in clinical practice and health outcomes.

In 2018-19, the ministry engaged with key stakeholders across Alberta's health care system to create a shared understanding of health care quality and identify potential quality initiatives and priorities. This included a focus on evidence-based appropriateness, enhancing patient safety, reducing clinical variation, and enhancing quality across the health care spectrum.

The department and AHS continued to work to improve communications for referrals for consultation, advice and treatment between primary care providers and specialists to shorten wait times with initiatives such as eReferral and the Alberta Referral Directory.

4.5 Enhance a patient-centred, integrated health record to support decision-making by health providers and enable Albertans to take an active approach in managing their health by providing them with secure access to their own health information.

Netcare enhancements in 2018-19 enable physician offices and other care providers in the community to transfer select patient information to Alberta Netcare for the purpose of improving care coordination. As of March 15, 2019, there were 24 specialties participating in Alberta Netcare eReferral, where referrals can be managed electronically.

AHS is in the final stages of configuring and testing a new organizational-wide clinical information system – a single AHS electronic medical record for every patient receiving care in AHS.

The MyHealth Records portal launched in 2019, providing Albertans with online access to key personal health information (sub-set of labs, dispensed medications and immunizations). The protected portal was designed to meet industry-standard security practices. Since the launch of MyHealth Records 19,277 accounts have been created (as of March 31, 2019).

4.6 Develop an integrated plan for provincial laboratory services that will establish a centralized, single system for medical testing to meet growing demand.

The ministry established a new provincial laboratory services model and began work to consolidate diagnostic laboratory services in the Edmonton and Northern Zones into an Edmonton Clinical Hub Lab.

Performance Measures and Indicators

Performance Measure 4.a

Financial Sustainability: Annual rate of growth of Ministry of Health operational expenditures

Prior Year's Results				2018-19 Result	2018-19 Target
2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result		
5.8%	4.2%	3.1%	2.7%	3.3%	3%

Source: Ministry Consolidated Statement of Operations as presented in the Financial Statements in the Ministry of Health Annual Report.

This measure is used to monitor the trend of financial resources used for the Ministry of Health and is an indicator of fiscal sustainability and efficiency of the health system. This measure is defined as the percentage year-over-year change in the Ministry Consolidated Statement of Operations as presented in the Financial Statements in the Annual Report.

Results Analysis

In 2018-19, total expense for the Ministry of Health was nearly $22.2 billion (before inter-ministry consolidation adjustments), a $715 million or 3.3 per cent increase from 2017-18. The ministry continues to strive towards sustainability in health care spending while delivering effective and efficient health care that meets the needs of Albertans. Government and health system partners continue to work to control the three major cost drivers in the health care system – physician compensation, pharmaceuticals and hospital services.

- The current pharmacy agreement is expected to slow the growth of spending on government-sponsored drug programs.
- As a member of the pan-Canadian Pharmaceutical Alliance, Alberta works closely with provinces and territories to increase access to drug treatment options, achieve lower and consistent drug costs and improve consistency of coverage across Canada.
- Operational efficiency, effectiveness and financial constraint continue to be priorities for AHS.

Performance Measure 4.b

Access to the provincial Electronic Health Record (EHR): Number of health care professionals with access to Alberta Netcare

Previous Years' Results				2018-19 Result	2018-19 Target
2014-15 Result	2015-16 Result	2016-17 Result	2017-18 Result		
37,324	40,587	42,090	50,477	50,276	46,234

Source: Alberta Netcare Monthly Utilization Report.

Alberta Netcare is the common name for the provincial Electronic Health Record (EHR), a secure and confidential electronic system of Alberta patients' health information. The portal enables health care providers (registered users) to access available health information, with new content continually being added. Alberta Netcare, collects information from a variety of sources including hospitals, laboratories, testing facilities, pharmacies and physician clinics into a unified patient record.

Results Analysis

Information is foundational to support evidence-informed health care delivery, policy development and decision-making. Access to health information from providers, facilities and patients is needed to improve health service delivery and keep pace with the use of technology in our daily lives. The provincial electronic health record enables enhanced quality of care by providing better access to patient information at point of care through integrated care and reduced disjointed care, gaps, overlaps, errors and delays.

A total of 50,276 health professionals (physicians (including medical residents), nurses, pharmacists, allied health professionals, optometrists, chiropractors and dentists) now have access to patient records through Alberta Netcare, exceeding the 2018-2019 target of 46,234 by 8.7 per cent. While previous years showed a steady growth rate of five per cent year-over-year in the total number of health professionals with access to Alberta Netcare, in 2018-2019 there was a decrease of four per cent. This decrease is not viewed as an indicator that interest or use of Alberta Netcare has plateaued, but rather as a result of eliminating accounts that have been idle for more than 180 days. The gains made through the addition of new Alberta Netcare users throughout the year was offset by the deletion of these idle accounts. The 2018-2019 result shows continued strong endorsement from health care professionals for the value of information in the provincial EHR.

A number of initiatives may have positively influenced adoption of Netcare. The Real Time Integration project focused on connecting community pharmacies so that pharmacy updates were reflected in real time, may have contributed to the increase in the number of pharmacists accessing Alberta Netcare. Additionally, the eHealth Support Services team has actively contacted community clinics about access to Netcare, which may have contributed to the increase in physicians and other health professionals.

Developmental work has started on a new service that will electronically notify doctors when their patients are admitted or discharged from a hospital in Alberta, receive day surgery, or visit an emergency department.

Performance Indicator 4.a

Per capita provincial government health expenditures (nominal dollars)

Prior Years' Results				2018 Result
2014 Result	2015 Result	2016 Result	2017 Result	
$4,677	$4,813	$4,912	$5,004[1]	$5,097[1]

Source: Canadian Institute for Health Information (CIHI), National Health Expenditure Trends (NHEX), 1975 to 2018.
[1]Results for 2017 and 2018 are forecast as there is a two year lag in available actual results.

This indicator is used to monitor the trend of financial resources used for Alberta's health system and is an indicator of fiscal sustainability and efficiency of the health system. It includes spending by the ministry of Health, including AHS, and health-related spending by other government departments and agencies and is a gauge of the overall success of cost containment initiatives. The goal is to slow the growth of overall government health spending to help make the system sustainable.

Results Analysis

Based on the five-year (2014-2018) period, per capita provincial government health expenditures increased at an average of 2.2 per cent per year. This percentage is significantly lower compared to the previous five-year period (2009-2013) where per capita provincial government health expenditures increased at an average of four per cent per year. Alberta's per capita provincial government health expenditure growth rate between 2017 and 2018 is forecast to be 1.9 per cent which is lower than five provinces (British Columbia, Ontario, Quebec, New Brunswick, Newfoundland and Labrador) and the national average.

The Ministry of Health continues to strive towards keeping year-over-year expenses restrained while delivering effective and efficient care for Albertans. When comparing cost and outcome for other jurisdictions in Canada, it appears that there are opportunities to streamline cost via improving efficiency and effectiveness. To that end, government and health system partners are working to control the three biggest cost drivers in the health care system – physician compensation, pharmaceuticals and hospital services.

Curbing spending in these areas is expected to free up health dollars to invest in the shift to more community-based health care, including mental health and addiction services, primary health care, home care, continuing care, and improving health outcomes for Indigenous Albertans.

Performance Measure and Indicator Methodology

Performance Measure 1.a

Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed

Methodology

Percentage of clients admitted to a Continuing Care Living Option (Designated Supportive Living or Long-term Care) within 30 days of the assessed and approved date.

Assessed and Approved date refers to the date the client is placed on the waitlist for a Continuing Care Living Option following the completion of the assessment and approval process.

The data excludes clients who transferred from a continuing care living option to another continuing care living option; clients assessed and approved but not yet admitted during the reporting period; clients in the process of being approved for continuing care living options; clients admitted to another zone from the reporting zone to avoid double-counting; clients referred for home care services; clients admitted to a sub-acute unit or a rehabilitation unit; clients admitted to a hospice or palliative care unit; clients admitted to an acute care bed/service for another acute care bed/service (e.g., surgical bed to a medical bed); and clients transferred to a non-tertiary acute care hospital bed (e.g., repatriated to a community hospital). The wait time also excludes days when a client was unavailable for placement due to medical reasons.

$$\% = \frac{\text{\# of individuals admitted to a CCLO within 30 days of their assessed and approved date}}{\text{total \# of individuals admitted to a CCLO during the response period}} \times 100$$

Source

Alberta Health Services. Data are extracted from Meditech and Stratahealth Pathways.

Performance Measure 1.b

Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital

Methodology

The unit of analysis is an inpatient encounter within a single acute inpatient facility. Discharges to transfer between acute inpatient facilities are excluded, although the discharge from the final facility after transfers would be included. In this way, episodes of care are identified with the reporting facility identified as the final discharging facility.

Readmission rate reporting always lags by a quarter. Information is available once data from the Discharge Abstract Database (DAD) is collected by all facilities in the province and loaded into the provincial database. Enforced reporting lag is applied (90 days) to allow for completion of stay and load of the abstract record for the readmission stay.

Readmission rates are attributed to the quarter in which a patient is originally discharged from an acute care hospital. This requires that patients be tracked for 30 days after the end of the quarter to allow sufficient time from the date of initial discharge to determine whether a readmission will occur.

Since transfer is excluded from readmission and there are several non-standardized ways to determine whether a transfer has occurred, the readmission rates published elsewhere could differ. Since there is not a standard method to identify unplanned readmissions (e.g., admissions through emergency ambulatory care), readmission rates published elsewhere may differ. Unplanned admission is defined as admit category ‘U’ which is urgent/emergent admission. The data reliability is highly dependent on the accuracy of this field.

Crude Readmission Rate (CRR):

$$\text{CRR} = \frac{\text{\# discharged patients readmitted within 30 days of index discharge}}{\text{\# index hospital discharges with MRDx as selected mental illness}} \times 100$$

Risk Adjusted Rate (RAR):
The observed number of cases is the actual count of readmissions to a hospital. The expected number of cases is based on the sum of the probabilities of readmissions to a hospital. Coefficients from the Canadian Institute for Health Information used for calculating the probability of readmissions were from logistic regression models on the following independent variables – age, sex, multiple previous admissions for a selected mental illness (two or more) during the past 12 months, discharges against medical advice, substance abuse related disorder, schizophrenia, anxiety disorder, and personality disorder.

$$\text{RAR} = \frac{\text{\# of observed cases}}{\text{number of expected cases}} \times \text{the Canadian CRR}$$

Source

Canadian Institute for Health Information; Alberta Health Services, Provincial Inpatient Database (DAD).

Performance Indicator 1.a

Emergency visits due to substance use (per 100,000 population):

- **Alcohol**
- **Opioids**

Methodology

Emergency visits are any hospital discharges beginning with any of the following MIS codes: 71310 (Ambulatory Care Services described as emergency), 71513 (Community Urgent Care Centre), and 71514 (Community Advanced Ambulatory Care Centre).

A discharge or emergency visit occurs when a patient leaves the hospital – by death, transfer to another facility, discharge to home, or against medical advice.

Only Alberta residents are included in the numerator. Only the emergency visit rates based on the most responsible diagnosis fields are available.

The date of birth and sex on the mid-year population registry file is used to calculate the age and sex of the individual as of June 30 each year.

The population excludes members of the Armed Forces, RCMP, inmates in federal penitentiaries, or those who have opted out of the Alberta Health Care Insurance Plan.

Crude Visit Rate (CVR):

$$\text{CVR} = \frac{\text{\# of emergency visits due to substance use for a given age roup in a given year}}{\text{total population for a given age in a given year}} \times 100{,}000$$

The final result is the Age-standardized Rate: The crude rates by age group are converted to an age-standardized rate using the direct method of standardization with weights from the 2011 Canada Census.

Source

Alberta Ambulatory Care database; Alberta Health Care Insurance Plan, Mid-year adjusted Population Registry Files Statistics Canada; Canadian population, 2011.

Performance Indicator 1.b

Prevalence of cigarette smoking among Albertans (per cent):

- **12-24 years of age**
- **25 years of age or older**

Methodology

The Canadian Community Health Survey (CCHS) has been conducted annually since 2007 and is a cross-sectional survey that collects information related to health status, health care utilization, and health determinants for the Canadian population. The CCHS includes a wide range of questions about the health and health behaviours of residents in each province. The CCHS covers the population 12 years of age and over living in the 10 provinces and the three territories. Excluded from the survey's coverage are persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; and, the institutionalized population.

Statistics Canada provides a Provincial Share file to each provincial/territorial health ministry. This file contains detailed survey responses for those participants agreeing to disclose to the ministry. In Alberta, the share file represents between 92 per cent and 95 per cent of participants in each cycle of the master file.

For 2013-2014, the cigarette smoking indicator included the following self-reported responses: a) daily smoker, b) occasional smoker (former daily smoker), and c) always an occasional smoker.

For 2015-2017, the cigarette smoking indicator included the following self-reported responses: a) current daily smoker and b) current occasional smoker.

The percentage of cigarette smokers was estimated by tabulating a weighted proportion of those that responded as daily or occasional cigarette smokers. The standard errors were estimated from bootstrap weights provided by Statistics Canada.

$$\text{Rate} = \frac{\text{weighted total of daily or occasional cigarette smokers}}{\text{weighted total (all responses)}} \times 100$$

Source

Canadian Community Health Survey (CCHS), Statistics Canada.

Performance Indicator 1.c

Ambulatory care sensitive conditions: Hospitalization rate (per 100,000) for patients under 75 years of age with conditions that could be prevented or reduced if they received appropriate care in an ambulatory setting

Methodology

Numerator: Total number of acute care hospitalizations for patients under 75 years of age for ambulatory care sensitive conditions (ACSCs):

- Inclusion Criteria: Any most responsible diagnosis code of grand mal status and other epileptic convulsions, chronic obstructive pulmonary diseases, acute lower respiratory infection, asthma, diabetes, heart failure and pulmonary edema, hypertension, and angina.
- Exclusion Criteria: Individuals 75 years of age or older, death before discharge, admission category recorded as newborn or stillbirth.

Denominator: The total end-of-calendar year population younger than age 75.

The population is age-adjusted using the 2011 Canada Census. A more detailed technical definition for the indicator can be found at: https://open.alberta.ca/dataset/pmis-performance-measure-definitions

$$\text{Rate} = \frac{\text{total \# of acute care hospitalizations for ACSCs under age 75 years}}{\text{total end-of-calendar year population under age 75 years}} \times 100{,}000$$

Source

Numerator: Alberta Health Services, Discharge Abstract Database (DAD); Denominator: Alberta Health Population Estimate.

Performance Measure 2.a

Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization:

- **Seniors aged 65 or over**
- **Residents of long-term care facilities**

Methodology

Seniors aged 65 or over:

$$\text{Rate} = \frac{\text{\# of seniors aged 65 or over who received one dose of the influenza vaccine}}{\text{Mid-year population estimate of age category}} \times 100$$

Residents of long-term care (LTC) facilities:

$$\text{Rate} = \frac{\text{\# of LTC residents on Dec 15, 2018 who received one dose of influenza vaccine (Oct 1-Dec 15, 2018)}}{\text{\# of LTC residents on Dec 15, 2018}} \times 100$$

It is necessary to define the number of residents of long-term care facilities on December 15 each year, due to the high turnover in this population. Otherwise, the result would be an immunization rate over 100 per cent.

Source

Numerator: Number of individuals immunized by age category: Alberta Health Services zones; the ministry's weekly pharmacists data; First Nations and Inuit Health Branch, Indigenous Services Canada, Alberta Region.

Denominator: For seniors, the denominator is the ministry's population estimates, based on mid-year registration population estimates. For residents of long-term care facilities the denominator is the number of residents as of December 15, 2018 provided by Alberta Health Services.

Performance Indicator 2.a

Childhood immunization rates (by age two):

- **Diphtheria, tetanus, pertussis, polio, Hib**
- **Measles, mumps, rubella**

Methodology

Using data from the Alberta Health Care Insurance Plan (AHCIP) population registries, children born in Alberta are followed through time. 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. For example, the 2018 rates relate to the 2016 birth cohort which turned age two.

Once established the population-based birth cohort is linked to Imm/ARI using the Unique Lifetime Identifier and immunization dates.

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.

Source

Alberta Health Care Insurance Plan (AHCIP), Quarterly Population Registries. Immunization/Adverse Reactions to Immunization (Imm/ARI). Alberta Vital Statistics, Birth Files.

Performance Indicator 2.b

Life expectancy at birth (years):

- **First Nations**
- **Non-First Nations**

Methodology
Life expectancy is calculated using the commonly-used “period” life table methodology. A detailed description of the methodology used to convert age-sex specific death rates into life expectancy at birth can be found in Appendix 3 of the ministry’s Chronic Disease Projections Methodology, 2008. https://open.alberta.ca/publications/9780778566175.
Source
Alberta Health Care Insurance Plan Adjusted Population; Alberta Health Postal Code Translation File; Alberta Vital Statistics Death File; First Nations Status Registry.

Performance Indicator 2.c

Infant mortality rate (per 1,000 live births):

- **First Nations**
- **Non-First Nations**

Methodology
Infant deaths are identified from the Alberta Vital Statistics Death file, while live births are identified from the Newborn Metabolic Screening Database. Infants are defined as less than one year of age (birth to 364 days).
Infant Mortality Rate = $\frac{\text{\# of infant deaths during a calendar year}}{\text{\# of live births during a calendar year}}$ X 1,000
Source
Alberta Vital Statistics Death File (infant deaths); Newborn Metabolic Screening Database (live births); First Nations Status Registry.

Performance Measure 3.a

Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network

Methodology

The numerator is the total number of patients enrolled in a Primary Care Network (PCN) in a given year as reported in *Table 2.29 Primary Care Networks: Distribution of Primary Care Providers, Number of Patients, and Total Payments by Alberta Health Services Geographic Zone for the Service Year (April 1 to March 31)*, Alberta Health Care Insurance Plan Statistical Supplement.

Patients are considered to be enrolled in a PCN if they are assigned to a physician, nurse practitioner, or pediatrician registered to a PCN. There are four steps used to assign a patient to a physician (part of the four-cut methodology):

- Step 1: Patients who have seen one physician, nurse practitioner, or pediatrician only are assigned to that physician, nurse practitioner, or pediatrician.
- Step 2: Patients who have seen more than one physician, but one physician is predominant, are then assigned to that physician.
- Step 3: Patients who have seen multiple physicians the same number of times are assigned to the physician who did the physical examination last.
- Step 4: Patients who have seen multiple physicians the same number of times, and had no physical examination done, are assigned to the physician who saw the patient last.

The number of patients enrolled in a PCN is calculated by the payments issued to the program, which is associated with the providers within the PCN. The payments to the PCN are identified by the payments the providers receive through the Claims Assessment System (CLASS). CLASS is an application that collects and processes claims transactions for physicians of multiple disciplines, and provides information on compensation for physician services.

The denominator is the number of people with an Alberta Personal Health Number that are registered and covered under the Alberta Health Care Insurance Plan (AHCIP) as at March 31 of a given year.

This number is reported in Table 1.1 of the Alberta Health Care Insurance Plan Statistical Supplement.

$$\text{Percentage} = \frac{\text{total \# of Albertans informally enrolled in a PCN in a given year}}{\text{total population covered by the AHCIP as of March 31 in the same year}} \times 100$$

Source

Department of Health, Alberta Health Care Insurance Plan Statistical Supplement, Claims Assessment System (CLASS).

Performance Indicator 3.a

Emergency department wait times: Median earliest patient time (minutes) to see an emergency doctor (17 busiest sites; patient level of urgency):

- **CTAS 1**
- **CTAS 2**
- **CTAS 3, 4 and 5**

Methodology

Wait time is measured in minutes between Start Time and End Time, where the Start Time is the earliest of either the Emergency Department (ED) Triage Time or the ED Visit (Registration) Time and the End Time of the ED visit is recorded as the Date/Time of the Physician Initial Assessment when available. The indicator uses median earliest patient time, which represents the length of time that 50 per cent of patients stay in the ED until they are initially assessed by a physician.

Canadian Triage and Acuity Scale (CTAS) is one measure of a patient's priority for treatment and an indirect estimator of the symptom severity on arrival to the ED developed by Canadian Association of Emergency Physicians. The urgency or need for ED treatment decreases as CTAS scores increase. The CTAS levels used are 1) resuscitation required, 2) emergent care required, 3) urgent care required, 4) less-urgent care required and 5) non-urgent care required.

Valid records are defined by the inclusion and exclusion criteria below. Valid cases represents the eligible cases with a valid Start and End Time.

Inclusion Criteria:

- Emergency Visits: Unscheduled ED visit
- Visit Mode: Face to Face
- Service Provider: Most Responsible Provider to have service of Physician
- Data from Alberta's 17 busiest sites (i.e. high volume of Emergency Department visits) were used for these calculations: Chinook Regional Hospital, Medicine Hat Regional Hospital, Alberta Children's Hospital, Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, South Health Campus, Red Deer Regional Hospital Centre, Grey Nuns Community Hospital, Misericordia Community Hospital, Northeast Community Health Centre, Royal Alexandra Hospital, Stollery Children's Hospital, Sturgeon Community Hospital, University of Alberta Hospital, Northern Lights Regional Health Centre, and Queen Elizabeth II Hospital.

Exclusion Criteria:

- Visit Disposition: Left without being seen by physician; Left prior to registration; Dead upon Arrival; unclassified Visit Disposition

Wait time (minutes) = Date/time of Physician Initial Assessment minus Earliest of either ED Triage Date/Time or the ED Registration Date/Time

Source

National Ambulatory Care Reporting System format (NACRS).

Performance Measure 4.a

Financial Sustainability: Annual rate of growth of Ministry of Health operational expenditures

Methodology
Calculation of percentage growth in ministry operational expenses when compared to Operational Expenses in the previous fiscal year. Operational Expenses is defined at total expenses per published Statement of Operations less infrastructure support.
$\text{Growth \%} = \frac{\text{total 2018/19 operational expenses} - \text{total 2017/18 operational expenses}}{\text{total 2017/18 operational expenses}} \times 100$
Source
Ministry Consolidated Statement of Operations as presented in the Financial Statements in the Ministry of Health Annual Report.

Performance Measure 4.b

Access to the provincial Electronic Health Record (EHR): Number of health care professionals with access to Alberta Netcare

Methodology
Administration staff members who actively access Alberta Netcare are not included in the provided numbers in order to showcase the clinical evidence. Number of health care professionals with access to the provincial EHR (includes physicians, medical residents, nurses, pharmacists, optometrists, dentists, chiropractors and allied health professionals).
Sum of health professionals = 14,254 physicians (including medical residents) + 21,585 nurses + 7,079 pharmacists + 78 optometrists + 36 dentists + 27 chiropractors + 7,217 allied professionals
Source
Alberta Netcare Monthly Utilization Report.

Performance Indicator 4.a

Per capita provincial government health expenditures (nominal dollars)

Methodology

Data is extracted annually from provincial/territorial government public accounts. Programs and/or program items are classified into health expenditure categories according to accepted and standardized methods and definitions used in estimating national health expenditure. Data from the public accounts is supplemented with information from provincial/territorial government department annual reports and annual statistical reports when available, as well as information provided by provincial/territorial government department officials.

Adjustments for regional health authority and/or hospital deficits or surpluses are not made in National Health Expenditures Trends (NHEX) unless the provincial government assumes them. If deficits or surpluses are assumed by the provincial government, they are allocated to the years when the regional health authority and/or hospitals accumulated them.

As part of the preparation of the NHEX report, the Canadian Institute for Health Information (CIHI) estimates of provincial/territorial government health expenditures were submitted to provincial/territorial departments of health for review.

Provincial government health expenditure includes spending by the Ministry of Health and health-related spending by other government departments and agencies, as compiled by the CIHI.

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

Source

Canadian Institute for Health Information, National Health Expenditures Trends, 1975 to 2018.
Statistics Canada, Demography Division (population estimates).

Financial Information

Ministry Financial Highlights

Reporting Entity and Method of Consolidation

The consolidated financial information is prepared in accordance with 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 Department of Health are fully consolidated with Alberta Health Services and Health Quality Council of Alberta on a line-by-line basis.

Under the line-by-line method, accounting policies of the consolidated entities are adjusted to conform to government accounting policies 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.

Ministry of Health

Statement of Revenues and Expenses (unaudited)

Year ended March 31, 2019
(in thousands)

	2019		2018	Change from	
	Budget	Actual	Actual	Budget	2018 Actual
Revenues	(Restated)		(Restated)		
Government Transfers					
Government of Alberta Transfers	$ 442,000	$ 440,000	$ 441,981	$ 2,000	$ (1,981)
Federal Government Transfers	4,633,287	4,569,848	4,375,151	63,439	194,697
Premiums, Fees and Licences	534,001	580,542	562,542	(46,541)	18,000
Investment Income	68,006	68,544	67,999	(538)	545
Refunds of Expense	169,105	201,826	201,190	(32,721)	636
Other Revenue	407,278	457,080	480,007	(49,802)	(22,927)
Ministry Total	6,253,677	6,317,840	6,128,870	(64,163)	188,970
Inter-Ministry Consolidation Adjustments	(472,800)	(473,004)	(483,488)	204	10,484
Adjusted Ministry Total	5,780,877	5,844,836	5,645,382	(63,959)	199,454
Expenses - Directly Incurred					
Ministry Support Services	74,607	60,349	61,923	14,258	(1,574)
Physician Compensation and Development	5,296,164	5,406,137	5,164,360	(109,973)	241,777
Drugs and Supplemental Health Benefits	2,273,974	2,202,674	2,144,520	71,300	58,154
Population and Public Health	668,480	614,900	582,401	53,580	32,499
Acute Care	4,116,877	4,124,192	4,109,343	(7,315)	14,849
Continuing Care	1,107,000	1,125,904	1,062,999	(18,904)	62,905
Ambulance Services	524,000	525,530	500,801	(1,530)	24,729
Community Care	1,482,000	1,411,257	1,348,896	70,743	62,361
Home Care	691,000	688,040	609,579	2,960	78,461
Diagnostic, Therapeutic & Other Patient Services	2,458,648	2,475,531	2,430,818	(16,883)	44,713
Administration	559,504	571,800	522,481	(12,296)	49,319
Support Services	2,190,000	2,241,339	2,208,741	(51,339)	32,598
Information Technology	579,345	584,459	574,966	(5,114)	9,493
Research and Education	154,000	99,469	100,419	54,531	(950)
Debt Servicing	16,000	15,353	15,825	647	(472)
Infrastructure Support	48,990	44,360	44,521	4,630	(161)
Cancer Research and Prevention Investment	12,800	6,567	-	6,233	6,567
Ministry Total	22,253,389	22,197,861	21,482,593	55,528	715,268
Inter-Ministry Consolidation Adjustments	(183,360)	(277,663)	(258,216)	94,303	(19,447)
Adjusted Ministry Total	22,070,029	21,920,198	21,224,377	149,831	695,821
Annual Deficit	$ (16,289,152)	$ (16,075,362)	$ (15,578,995)	$ (213,790)	$ (496,367)

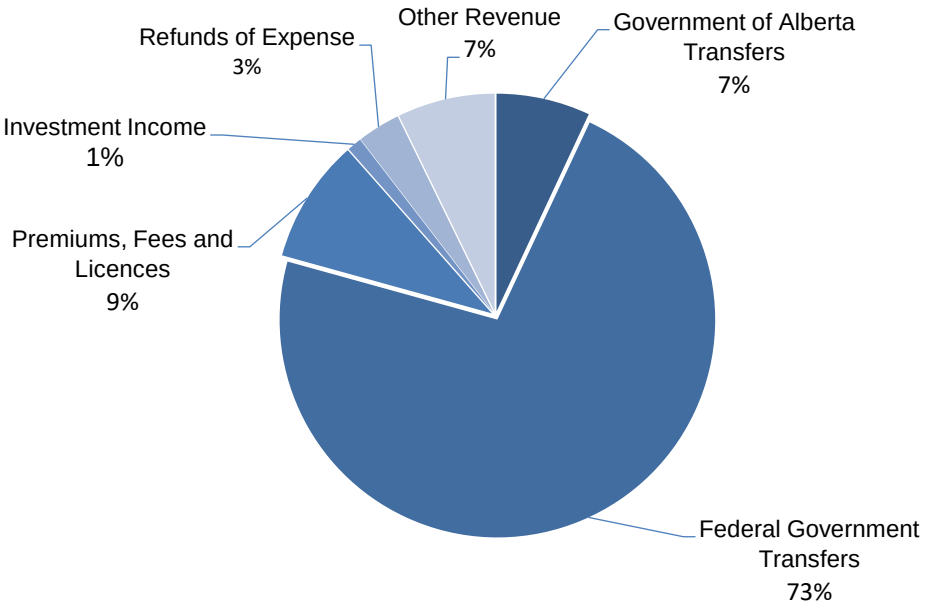
Ministry of Health

The consolidated Ministry Financial Statements includes: Department of Health; Alberta Health Services; and Health Quality Council of Alberta.

Revenue and Expense Highlights

Revenues

Consolidated Actual Revenues (prior to inter-ministry consolidation adjustments)



Actual revenues exceeded the budget by $64 million mainly due to:

- Premium, Fees & Licenses resulting from increased number of patients availing health services that were billed to other jurisdictions and non-residents of Canada;
- Refunds of Expense due to recoveries of unutilized grant funding from previous years and clearing unpaid prior year over accruals for demand-driven programs; and
- Other Revenue due to higher than anticipated recoveries from external entities such as Workers Compensation Board and contracted health service providers, and unbudgeted revenue related to spending for various initiatives funded by donations and non-government grants.

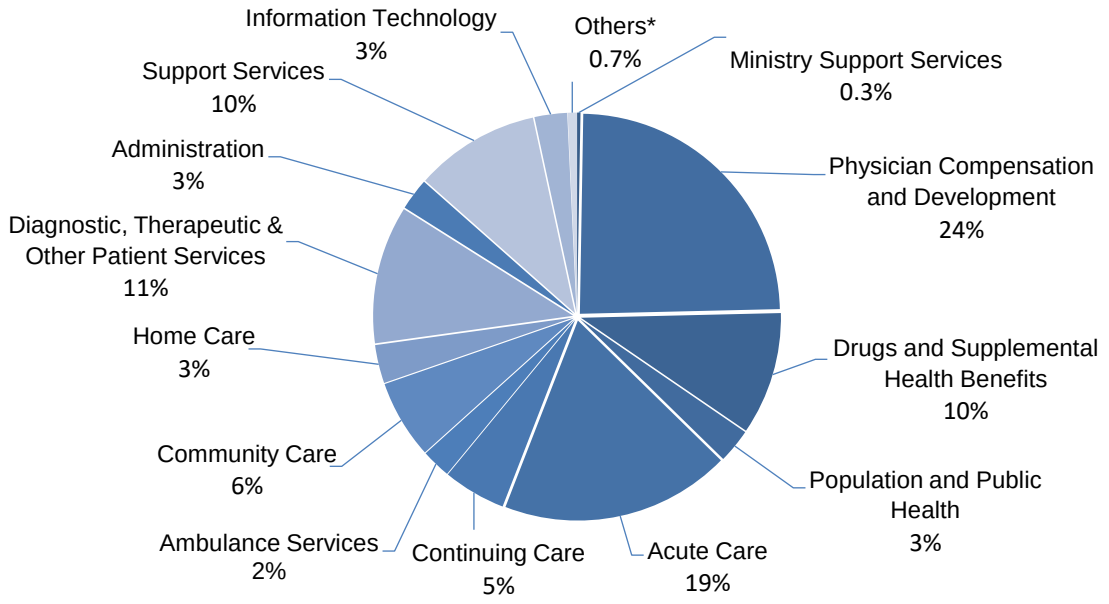
Partially offsetting the excess is reduced Canada Health Transfers due to negative prior year adjustment and a downward revision to the population share of Alberta.

Compared to prior year, revenues increased by $189 million mainly due to:

- Federal Government Transfers resulting from annualized increase in Canada Health Transfer, and the newly established funding for Home and Community Care Services and Mental Health and Addiction Services.

Expenses

Consolidated Actual Expenses (prior to inter-ministry consolidation adjustments)



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

Actual expenses were lower than the budget by $56 million mainly due to surplus in:

- Drugs and Supplemental Health Benefits resulting from the new pricing agreement on generic drugs, higher cost recoveries from product listing agreements, and savings related to the new pharmacy agreement;
- Population and Public Health due to reduced requirements for the Insulin Pump Therapy program, and lower than anticipated requirements for Pharmacist Injection Services as a result of the new pharmacy agreement;
- Community Care due to timing of implementation of various initiatives, including the Continuing Care Capacity Plan, and a shift in actual expenses to Continuing Care related to new bed openings during the year while the related budget remained in Community Care; and
- Research and Education due to expenses related to clinical education originally budgeted in Research and Education but actual expenses recorded in Physician Compensation and Development for a better alignment.

The surplus was partially offset by deficits in:

- Physician Compensation and Development due to earlier than anticipated funding for the Medical Liability Reimbursement program and expenses for clinical education (as mentioned above); and
- Support Services due to reclassification of bad debt expense from Acute Care to Support Services to align with Canadian Institute for Health Information's Management Information System standards, increased activity, and direct and indirect costs related to the carbon levy.

Compared to prior year expenses increased by $715 million mainly due to:

- Physician Compensation and Development primarily attributed to volume growth in Fee for Service and increased activities including a higher number of surgeries performed;
- Drugs and Supplemental Health benefits due to increased utilization of newly approved cancer drugs and higher uptake of pharmacy services;
- Continuing Care due to increased spending related to the opening of beds under the Continuing Care Capacity Plan;
- Community Care due to increased spending and activity related to various initiatives, including the opening of new beds as part of the Continuing Care Capacity Plan;
- Home Care mainly due to increased spending related to Enhancing Care in the Community;
- Diagnostic, Therapeutic and Other Patient Services due to increased activity related to certain laboratory and diagnostic imaging tests, including colorectal cancer screening, CT and MRI scans; and
- Administration resulting from emerging insurance liability claims that increased the actuarial estimates, and decrease in vacancies from the prior year resulting from overall increase of activity throughout the organization.

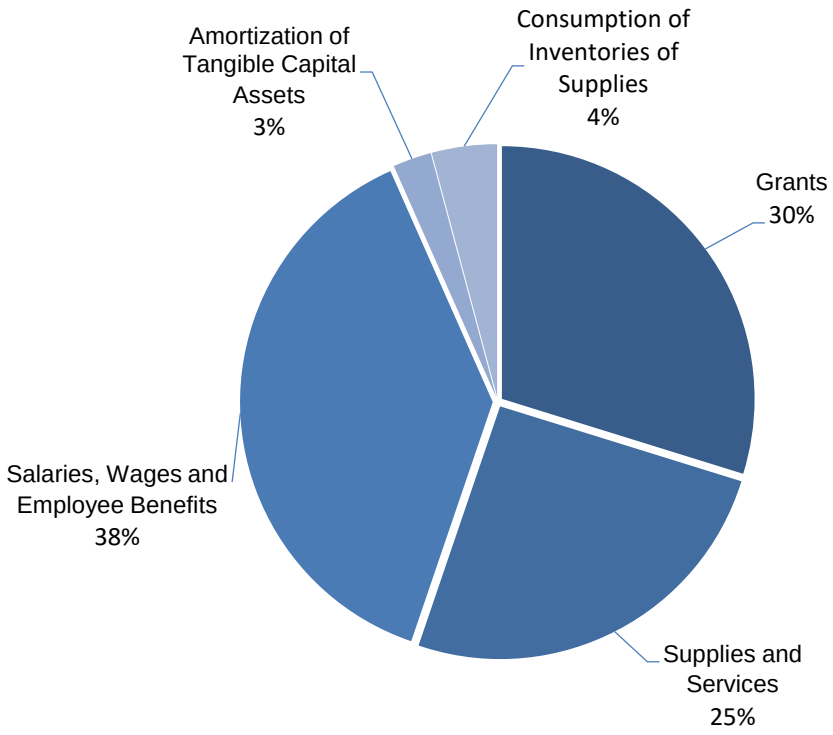
Ministry of Health

Expenses – Directly Incurred Detailed by Object (unaudited)

(in thousands)

	2019		2018
	Budget (Restated)	Actual	Actual (Restated)
Grants	$ 6,656,797	$ 6,579,024	$ 6,416,970
Supplies and Services	5,780,596	5,667,919	5,416,863
Salaries, Wages and Employee Benefits	8,355,888	8,420,613	8,183,057
Amortization of Tangible Capital Assets	551,468	544,239	553,829
Consumption of Inventories of Supplies	890,500	921,458	857,501
Financial Transactions and Other	18,140	64,608	54,373
	$ 22,253,389	$ 22,197,861	$ 21,482,593

2019 Actual (unaudited)



- The ministry's operating expenses incurred were primarily for Grants, Supplies and Services, and Salaries, Wages and Employee benefits, which accounted for 93% of the total operating expenses.
- Salaries, Wages, and Employee benefits totaled 38% ($8.4 billion) of the operating expenses and were primarily for delivery and provision of health services, and administering various grant programs.
- Grants comprised 30% ($6.6 billion) of the operating expenses and were primarily for Physician Compensation and Development, and Drugs and Supplemental Health benefits. Other grant expenses include restricted funding to support organizations and communities through grant programs, and funding for out-of-province health services.
- Supplies and Services resulted in 25% ($5.7 billion) of the operating expenses attributed mainly to contracts with health service providers, which include voluntary and private health service providers, and payments to non-employees under contract like physicians for referred-out services, purchased services, and home support contracts.
- The remainder of ministry expenses were amortization of tangible capital assets ($544 million), consumption of inventories of supplies ($921 million), and financial transactions and other expenses ($64 million).

Ministry of Health

Supplemental Financial Information

Tangible Capital Assets (unaudited)

(in thousands)

	2019							2018
	Land	Buildings [1]	Land Improvements	Equipment	Computer Hardware and Software	Leasehold Assets	Total	Total
Estimated Useful Life	Indefinite	10-40 years	5-40 years	3-20 years	3-10 years	Term of Lease		
Historical Cost [2]								
Beginning of year	$ 116,875	$ 10,958,874	$ 84,197	$ 2,502,386	$ 1,859,398	$ 243,426	$ 15,765,156	$ 14,852,596
Additions [3]	-	530,134	10,052	159,514	182,265	5,173	887,138	959,751
Disposals, including write-downs	(52)	(7,887)	(61)	(115,038)	(31,576)	(475)	(155,089)	(47,191)
	116,823	11,481,121	94,188	2,546,862	2,010,087	248,124	16,497,205	15,765,156
Accumulated Amortization								
Beginning of year	-	4,064,679	65,283	1,889,488	1,469,749	184,404	7,673,603	7,166,572
Amortization expense	-	291,885	3,627	147,836	92,458	8,433	544,239	553,829
Effect of disposals	-	(6,859)	(59)	(113,395)	(31,574)	(468)	(152,355)	(46,798)
	-	4,349,705	68,851	1,923,929	1,530,633	192,369	8,065,487	7,673,603
Net Book Value at March 31, 2019	$ 116,823	$ 7,131,416	$ 25,337	$ 622,933	$ 479,454	$ 55,755	$ 8,431,718	
Net Book Value at March 31, 2018	$ 116,875	$ 6,894,195	$ 18,914	$ 612,898	$ 389,649	$ 59,022		$ 8,091,553

[1] Buildings include parking lots.

[2] Historical cost includes work-in-progress at March 31, 2019 totaling $1,633,567 (2018 - $1,186,196).

[3] Additions include total contributed capital assets of $285,368 (2018 - $337,908) consisting of $285,322 from Ministry of Infrastructure (2018 - $337,837), of which $nil (2018 - $6,286) was related to land and $285,322 (2018 - $331,551) was related to other tangible capital assets, and $46 from other sources (2018 - $71).

Ministry of Health

Portfolio Investments (unaudited)

(in thousands)

	2019		2018	
	Cost	Fair Value	Cost	Fair Value
Cash held for investing purposes	$ 110,887	$ 110,887	$ 118,011	$ 118,011
Interest bearing securities				
Money market securities	177,199	177,199	124,320	124,320
Fixed income securities	1,467,858	1,485,637	1,549,534	1,540,139
	1,645,057	1,662,836	1,673,854	1,664,459
Equities:				
Canadian pooled equity funds	157,851	175,391	142,929	158,030
Global pooled equity funds	288,454	329,954	326,465	376,252
	446,305	505,345	469,394	534,282
Total Portfolio Investments	$ 2,202,249	$ 2,279,068	$ 2,261,259	$ 2,316,752

The following is a breakdown of portfolio investments:

	2019		2018	
	Cost	Fair Value	Cost	Fair Value
Operating	$ 2,127,092	$ 2,203,911	$ 2,186,565	$ 2,242,058
Endowments	75,157	75,157	74,694	74,694
Total Portfolio Investments	$ 2,202,249	$ 2,279,068	$ 2,261,259	$ 2,316,752

Financial Statements of Other Reporting Entities

Index of Audited Financial Statements

Alberta Health Services

Consolidated Financial Statements

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Management's Responsibility for Financial Reporting

The accompanying consolidated financial statements for the year ended March 31, 2018 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 the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgement.

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 regulation, and properly recorded so as to maintain accountability of public money;
- Safeguard the assets and properties of the "Province of Alberta" under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit & 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 Dr. Verna Yiu, MD, FRCPC]

Dr. Verna Yiu, MD, FRCPC
President and Chief Executive Officer
Alberta Health Services

[Original signed by Deborah Rhodes, CPA, CA]

Deborah Rhodes, CPA, CA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

May 30, 2019

Independent Auditor's Report

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

Auditor General OF ALBERTA

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, 2019, 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, 2019, 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.

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

May 30, 2019
Edmonton, Alberta

Alberta Health Services

Consolidated Statement of Operations

Year ended March 31, 2019

(thousands of dollars)

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31	2019		2018
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,486,000	$ 12,485,595	$ 12,147,985
One-time base operating	-	29,558	14,683
Other operating	1,283,000	1,192,862	1,134,483
Recognition of expended deferred capital revenue	62,000	65,104	66,085
Other government transfers (Note 4)	427,000	429,665	438,127
Fees and charges	488,000	538,721	518,930
Ancillary operations	136,000	133,513	132,661
Donations, fundraising, and non-government contributions (Note 5)	149,000	167,192	160,076
Investment and other income (Note 6)	209,000	232,494	242,813
TOTAL REVENUE	**15,240,000**	**15,274,704**	**14,855,843**
Expenses:			
Community-based care	1,514,000	1,439,434	1,369,846
Home care	692,000	688,295	609,579
Continuing care	1,118,000	1,136,343	1,072,800
Population and public health	352,000	347,726	344,283
Ambulance services	527,000	528,045	503,274
Acute care	5,054,000	5,044,824	4,928,854
Diagnostic and therapeutic services	2,450,000	2,505,411	2,413,056
Education and research	317,000	316,285	299,179
Support services (Note 7)	2,210,000	2,259,472	2,222,553
Information technology	497,000	507,605	510,835
Administration (Note 8)	509,000	539,895	490,188
TOTAL EXPENSES (Schedules 1 and 3)	**15,240,000**	**15,313,335**	**14,764,447**
ANNUAL OPERATING (DEFICIT) SURPLUS	**-**	**(38,631)**	**91,396**
Accumulated surplus, beginning of year	1,317,000	1,317,055	1,225,659
Accumulated surplus, end of year (Note 19)	**$ 1,317,000**	**$ 1,278,424**	**$ 1,317,055**

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

Alberta Health Services

Consolidated Statement of Financial Position

As at March 31, 2019
(thousands of dollars)

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31	2019 Actual	2018 Actual
Financial Assets:		
Cash	$ 60,610	$ 66,253
Investments (Note 10)	2,279,068	2,316,752
Accounts receivable (Note 11)	445,208	426,558
	2,784,886	2,809,563
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,505,873	1,412,913
Employee future benefits (Note 13)	688,496	673,136
Unexpended deferred operating revenue (Note 14)	453,219	420,245
Unexpended deferred capital revenue (Note 15)	206,880	153,751
Debt (Note 17)	347,642	369,775
	3,202,110	3,029,820
NET DEBT	**(417,224)**	**(220,257)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	8,381,004	8,031,307
Inventories for consumption	106,509	96,573
Prepaid expenses and other non-financial assets	167,722	165,721
	8,655,235	8,293,601
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	8,238,011	8,073,344
Expended deferred capital revenue (Note 16)	6,925,118	6,735,454
NET ASSETS	**1,312,893**	**1,337,890**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,278,424	1,317,055
Accumulated remeasurement gains	34,469	20,835
	$ 1,312,893	**$ 1,337,890**

Contractual Obligations and Contingent Liabilities (Note 20)

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

Approved by the Board of Directors:

[Original signed by Linda Hughes]

Linda Hughes
Board Chair

[Original signed by David Carpenter, FCPA, FCA]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

Alberta Health Services

Consolidated Statement of Change in Net Debt

Year ended March 31, 2019
(thousands of dollars)

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31	2019		2018
	Budget (Note 3)	Actual	Actual
Annual operating (deficit) surplus	$ -	$ (38,631)	$ 91,396
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(1,406,000)	(879,325)	(950,869)
Amortization and disposals of tangible capital assets (Note 18)	533,000	529,628	538,639
Effect of other changes:			
Net increase in expended deferred capital revenue	709,000	189,664	185,684
Net decrease (increase) in inventories for consumption	7,000	(9,936)	(4,691)
Net decrease (increase) in prepaid expenses and other non-financial assets	7,000	(2,001)	(37,663)
Net remeasurement (losses) gains for the year	(1,000)	13,634	(8,031)
Increase in net debt for the year	**(151,000)**	**(196,967)**	**(185,535)**
Net debt, beginning of year	(220,000)	(220,257)	(34,722)
Net debt, end of year	**$ (371,000)**	**$ (417,224)**	**$ (220,257)**

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

Alberta Health Services

Consolidated Statement of Remeasurement Gains and Losses

Year ended March 31, 2019
(thousands of dollars)

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2019 Budget (Note 3)	2019 Actual	2018 Actual
Unrestricted unrealized gains (losses) attributable to:			
Derivatives	$ -	$ 253	$ (40)
Portfolio Investments	(16,000)	17,751	8,730
Amounts reclassified to the Consolidated Statement of Operations:			
Portfolio Investments	15,000	(4,370)	(16,721)
Net remeasurement gains (losses) for the year	**(1,000)**	**13,634**	**(8,031)**
Accumulated remeasurement gains, beginning of year	21,000	20,835	28,866
Accumulated remeasurement gains, end of year (Note 10)	**$ 20,000**	**$ 34,469**	**$ 20,835**

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

Alberta Health Services

Consolidated Statement of Cash Flows

Year ended March 31, 2019
(thousands of dollars)

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2019 Actual	2018 Actual
Operating transactions:		
Annual operating (deficit) surplus	$ (38,631)	$ 91,396
Non-cash items:		
Amortization and disposals of tangible capital assets	529,628	538,639
Recognition of expended deferred capital revenue	(383,405)	(384,337)
Revenue recognized for acquisition of land	-	(6,286)
Decrease (increase) in:		
Accounts receivable related to operating transactions	48,303	2,116
Inventories for consumption	(9,936)	(4,691)
Prepaid expenses and other non-financial assets	(2,001)	(37,663)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	76,173	61,996
Employee future benefits	15,360	20,099
Unexpended deferred operating revenue	(31,957)	(37,555)
Cash provided by operating transactions	203,534	243,714
Capital transactions:		
Acquisition of tangible capital assets	(593,957)	(612,961)
Increase in accounts payable and accrued liabilities related to capital transactions	19,732	142,554
Cash applied to capital transactions	(574,225)	(470,407)
Investing transactions:		
Purchase of investments	(3,161,266)	(3,168,353)
Proceeds on disposals of investments	3,220,278	3,109,935
Cash provided by (applied to) investing transactions	59,012	(58,418)
Financing transactions:		
Restricted capital contributions received	331,364	264,565
Unexpended deferred capital revenue returned	(250)	(7,381)
Proceeds from debt	-	67,300
Principal payments on debt	(22,133)	(17,612)
Payments on obligations under capital leases	(2,349)	(2,207)
Payment on life lease deposits	(596)	596
Cash provided by financing transactions	306,036	305,261
(Decrease) increase in cash	**(5,643)**	**20,150**
Cash, beginning of year	66,253	46,103
Cash, end of year	**$ 60,610**	**$ 66,253**

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

Alberta Health Services

Notes to the Consolidated Financial Statements

For the year ended March 31, 2019
(thousands of dollars)

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 revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For a complete picture of the costs of provincial health care, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

Under the *Income Tax Act (Canada)*, AHS is a registered charity.

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 (PSAS) and 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 entities:

- Alberta Public Laboratories Ltd. (APL) (formerly Calgary Lab Services Ltd.) - provides medical diagnostic services throughout Alberta. AHS owns 100% of the Class A voting shares.
- Capital Care Group Inc. (CCGI) - manages continuing care programs and facilities in the Edmonton area. AHS owns 100% of the Class A voting shares.
- Carewest - manages continuing care programs and facilities in the Calgary area. AHS owns 99% of the Class A voting shares and 1% of the Class A voting shares are held in trust for the benefit of AHS by the Chair of the Board of Directors.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

- Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation
American Friends of the Calgary Health Trust Foundation
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust (*inactive)*
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn and District Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation
Lacombe Health Trust
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Rocky Mountain House & Area Health Services Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation
Vermillion and Region Health and Wellness Foundation (*inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP)
- Queen Elizabeth II Hospital Child Care Centre

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

(ii) Government Partnerships

AHS proportionately consolidates its 50% interests in Primary Care Network (PCN) partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 22).

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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen Primary Care Network
Big Country Primary Care Network
Bighorn Primary Care Network
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Lakeland Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Saddle Hills Primary Care Network (formerly Sexsmith / Spirit River Primary Care Network and West Peace Region Primary Care Network)
Sherwood Park/Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
WestView Primary Care Network
Wetaskiwin and Area Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

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 23). AHS provides services to certain entities not included in these consolidated financial statements.

(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 the province. The largest of these service providers is Covenant Health, a denominational health care organization, providing a full spectrum of care. Covenant Health is an independent, separate legal entity with a separate Board of Directors and accordingly, these 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 statement of operations.

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Transfers

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Government transfers and 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 its 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.

Deferred revenue consists of unexpended deferred operating revenue, unexpended deferred capital revenue, and expended deferred capital revenue. The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

Unallocated costs, which excludes land and buildings, comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

(ii) Donations, Fundraising, and Non-Government Contributions

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

Unrestricted donations, fundraising, 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, fundraising, 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 its communicated use.

In-kind donations 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.

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recognized as deferred revenue when received and as revenue when the land is purchased.

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

Fees and charges, ancillary operations, and other income are recognized in the period that goods are delivered or services are provided. 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 exclusive of restricted transfers or donations are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related 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 or donations are allocated to their respective balances according to the provisions within the individual agreements.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(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.

(d) Financial Instruments

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

Financial Assets and Liabilities	Subsequent Measurement and Recognition
Cash and 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.
Accounts receivable, accrued vacation pay, accounts payable and accrued liabilities and debt	Measured at amortized cost.

PSAS requires investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS 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 its money market securities, fixed income securities, and certain other equity investments at fair value. The three levels of information that may be 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.

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.

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 investments. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

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.

Transaction costs associated with the acquisition and disposal of investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade date accounting.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(e) Cash

Cash is comprised of cash on hand. Cash on hand is held for the purpose of meeting short-term commitments rather than for investment purposes

(f) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and replacement cost.

(g) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, 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. Costs incurred by Alberta Infrastructure (AI) to build 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	10-40 years
Equipment	3-20 years
Information systems	3-10 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 transferring substantially all benefits and risks of tangible capital asset ownership are classified as capital leases and reported as tangible capital assets. Capital leases and leasehold improvements are amortized over the term of the lease. Capital lease obligations associated with these capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.) and reported as obligations under capital leases. 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 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. Net write-downs are accounted for as expenses in the Consolidated Statement of Operations.

Works of art, historical treasures, and collections are not recognized in tangible capital assets.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants 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. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). Prior to March 1, 2019, the President of Alberta Treasury Board and Minister of Finance was the legal trustee and administrator for LAPP and MEPP. Although there has been no change in MEPP governance, effective March 1, 2019, LAPP Corporation became the legislated administrator and trustee of LAPP. As a participating government organization, 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, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (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.

(iii) Supplemental Retirement Plan for Designated Employees (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.

The obligations and related costs of SERP benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. AHS uses a discount rate based on plan asset earnings to calculate the accrued benefit obligation.

The net SERP retirement benefit cost reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post-employment period. The key components of retirement benefits expense include the cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. Retirement benefit costs are not cash payments in the period but are the period expense for rights to future compensation. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets.

AHS amortizes actuarial gains and losses over the average remaining service life of the related employee group.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

(iv) 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.

(v) Sick Leave Liability

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' final 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 accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for sick leave benefits that do not accumulate beyond the current reporting period as these are renewed annually.

The accumulating non-vesting sick leave liability is actuarially 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 rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

(vi) 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.

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. A liability for remediation of contaminated sites is recognized when all of the following criteria are met:

(i) an environmental standard exists;
(ii) contamination exceeds the environmental standard;
(iii) AHS is directly responsible or accepts responsibility;
(iv) it is expected that future economic benefits will be given up; and
(v) a reasonable estimate of the amount can be made.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) 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 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 period 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.

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for use by AHS for future operating and capital purposes, to meet legislative insurance equity requirements and to recognize certain donor commitments by AHS' controlled foundations. Transfers to, or from, internally restricted surplus for future purposes are recorded to the respective surplus account when approved.

(l) 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. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related tangible capital 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 employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, social, and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made. 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, which may be material, could require adjustment in subsequent reporting periods.

(m) Changes in Accounting Policy

AHS has prospectively adopted the following accounting standard as of April 1, 2018:

PS 3430 – Restructuring Transactions

PS 3430 provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related programs or operating responsibilities. The adoption of this standard did not have any impact on AHS' consolidated financial statements.

(n) Future Accounting Changes

The following accounting standards are applicable in future years:

- **PS 3280 – Asset Retirement Obligations (effective April 1, 2021)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset.

- **PS 3400 – Revenue (effective April 1, 2022)**
  PS 3400 provides guidance on how to account for and report revenue.

AHS is currently assessing what the impact of these new standards will have on future consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan, which included the 2018-19 annual budget, was approved by the AHS Board on May 31, 2018 and by the Minister of Health on October 3, 2018.

Note 4 Other Government Transfers

	Budget	2019	2018
Unrestricted operating	$ 31,000	$ 32,790	$ 38,571
Restricted operating (Note 14)	115,000	114,269	112,460
Recognition of expended deferred capital revenue (Note 16)	281,000	282,606	287,096
	$ 427,000	**$ 429,665**	**$ 438,127**

Other government transfers include $420,622 (2018 – $429,855) transferred from the GOA, $9,043 (2018 – $8,272) from government entities outside the GOA, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	Budget	2019	2018
Unrestricted operating	$ 3,000	$ 4,073	$ 2,281
Restricted operating (Note 14)	119,000	126,961	126,311
Recognition of expended deferred capital revenue (Note 16)	27,000	35,695	31,156
Endowment contributions and reinvested income	-	463	328
	$ 149,000	**$ 167,192**	**$ 160,076**

Note 6 Investment and Other Income

	Budget	2019	2018
Investment income	$ 68,000	$ 68,521	$ 69,215
Other income:			
GOA (Note 21)	31,000	30,847	32,004
AH	20,000	12,698	16,361
Other	90,000	120,428	125,233
	$ 209,000	**$ 232,494**	**$ 242,813**

Note 7 Support Services

	Budget	2019	2018
Facilities operations	$ 899,000	$ 893,598	$ 872,817
Patient: health records, food services, and transportation	426,000	424,288	408,825
Materials management	182,000	174,916	176,438
Housekeeping, laundry, and linen	218,000	217,296	211,762
Support services expense of full-spectrum contracted health service providers	152,000	154,714	151,616
Ancillary operations	113,000	103,122	110,046
Fundraising expenses and grants awarded	54,000	45,689	46,279
Other	166,000	245,849	244,770
	$ 2,210,000	**$ 2,259,472**	**$ 2,222,553**

Note 8 Administration

	Budget	2019	2018
General administration	$ 265,000	$ 286,312	$ 235,338
Human resources	97,000	116,116	112,776
Finance	80,000	73,075	76,627
Communications	28,000	24,415	24,737
Administration expense of full-spectrum contracted health service providers	39,000	39,977	40,710
	$ 509,000	**$ 539,895**	**$ 490,188**

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 order to earn financial returns at an acceptable level of market risk, the consolidated investment portfolio is governed by an investment bylaw and policies with clearly established target asset mixes. The target assets range between 0% and 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 2.26% (2018 – 2.85%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in accumulated remeasurement gains and losses and unrealized net gains and losses attributable to deferred revenue and endowments of $38,130 (2018 – $50,819).

(i) Price Risk

Price risk relates to the possibility that equity 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 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 $50,535 or 2.22% of total investments (March 31, 2018 – $53,428 or 2.31%).

(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 investments 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 bonds and mortgage funds 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.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $78,148 (March 31, 2018 – $71,683).

Fixed income securities include bonds and money market securities. The fixed income securities have the following average maturity structure ranging from 2019 and 2067:

	2019	2018
0 – 5 years	77%	80%
6 – 10 years	8%	8%
Over 10 years	15%	12%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	2.44%	2.05%	2.92%	2.47%

(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. The fair value of cash and investments denominated in foreign currencies is 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 investment 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 pooled 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, 2019, investments in non-Canadian equities represented 14.5% (March 31, 2018 – 16.2%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by forward contracts and holding minimal foreign currency cash balances. At March 31, 2019, AHS held US dollar forward contracts with ATB Financial to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2019, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2018 – $24,000). The fair value of these forward contracts as at March 31, 2019 was $714 (2018 – $461) and is included in 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, Workers' Compensation Board, 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.

Note 9 Financial Risk Management (continued)

Under the investment bylaw and policies governing the consolidated 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 fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. AHS holds unrated mortgage fund investments. Short selling is not permitted.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2019. The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2019	2018
Investment Grade (AAA to BBB)	87%	89%
Unrated	13%	11%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding provided in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities, and bonds traded in an active market that are easily sold and converted to cash.

Note 10 Investments

	2019		2018	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 110,887**	**$ 110,887**	**$ 118,012**	**$ 118,012**
Interest bearing securities:				
Money market securities	177,199	177,199	124,320	124,320
Fixed income securities	1,485,637	1,467,856	1,540,138	1,549,534
	1,662,836	**1,645,055**	**1,664,458**	**1,673,854**
Equities:				
Canadian equity investments	45,866	38,488	24,350	17,477
Canadian equity funds	129,525	119,364	133,680	125,451
Global equity funds	329,954	288,454	376,252	326,465
	505,345	**446,306**	**534,282**	**469,393**
	$ 2,279,068	**$ 2,202,248**	**$ 2,316,752**	**$ 2,261,259**

	2019	2018
Items at Fair Value		
Portfolio investments designated to the FV category	$ 2,232,488	$ 2,291,941
Portfolio investments in equity instruments that are quoted in an active market	45,866	24,350
Derivatives	714	461
	$ 2,279,068	**$ 2,316,752**

Included in investments is $212,323 (March 31, 2018 – $173,725) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* of Alberta. Endowments included in investments amount to $75,157 (March 31, 2018 – $74,694).

Note 10 Investments (continued)

The following are the total net remeasurement gains on investments:

	2019	2018
Accumulated remeasurement gains	$ 34,469	$ 20,835
Restricted unrealized net gains attributable to unexpended deferred operating revenue and endowments (Note 14(b))	42,351	34,658
	$ 76,820	**$ 55,493**

Fair Value Hierarchy

	2019			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 110,887	$ -	$ -	$ 110,887
Interest bearing securities:				
Money market securities	-	177,199	-	177,199
Fixed income securities	-	1,320,899	164,738	1,485,637
Equities:				
Canadian equity investments	45,866	129,525	-	175,391
Global equity funds	-	329,954	-	329,954
	$ 156,753	**$ 1,957,577**	**$ 164,738**	**$ 2,279,068**
Percent of total	7%	86%	7%	100%

	2018			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 118,012	$ -	$ -	$ 118,012
Interest bearing securities:				
Money market securities	-	124,320	-	124,320
Fixed income securities	-	1,393,124	147,014	1,540,138
Equities:				
Canadian equity investments	24,350	133,739	-	158,089
Global equity funds	-	376,193	-	376,193
	$ 142,361	**$ 2,027,377**	**$ 147,014**	**$ 2,316,752**
Percent of total	6%	88%	6%	100%

Note 11 Accounts Receivable

	2019			2018
	Gross	Allowance for Doubtful Accounts	Net	Net
Patient accounts receivable	$ 127,952	28,440	99,512	$ 105,364
AH operating transfers receivable	36,768	-	36,768	81,104
AH capital transfers receivable	34,356	-	34,356	38,766
Other operating transfers receivable	14,824	-	14,824	30,025
Other capital transfers receivable	157,776	-	157,776	86,413
Other accounts receivable	102,498	526	101,972	84,886
	$ 474,174	**28,966**	**445,208**	**$ 426,558**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2018, the total allowance for doubtful accounts was $25,986.

Note 12 Accounts Payable and Accrued Liabilities

	2019	2018
Payroll remittances payable and related accrued liabilities	$ 543,427	$ 522,604
Trade accounts payable and accrued liabilities	608,740	572,282
Provision for unpaid claims[(a)]	202,511	157,583
Obligations under capital leases[(b)]	97,053	112,675
Other liabilities	54,142	47,769
	$ 1,505,873	**$ 1,412,913**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $284,970 (2018 – $268,183).

(a) Provision for Unpaid Claims is an estimate of liability claims within AHS. It is influenced by factors such as historical trends involving claim payment patterns, pending levels of unpaid claims, claims severity and claim frequency patterns.

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.45% (2018 – 2.35%) plus a provision for adverse deviation, based on actuarial estimates.

(b) Obligations under capital leases include a site lease with the University of Calgary, a site lease for the Northern Communications Centre in Peace River, vehicle leases and obligations related to a clinical information system.

The obligations expire between 2020 and 2036 and have an implicit interest rate payable ranging from 2.37% to 7.04% (2018 – 2.42% to 6.97%).

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

Year ended March 31	Minimum Contract Payments
2020	$ 25,758
2021	24,444
2022	23,521
2023	11,504
2024	2,867
Thereafter	22,156
	110,250
Less: interest	(13,197)
	$ 97,053

(c) Liability for Contaminated Sites

At March 31, 2019, AHS has not identified or accepted any liability for contaminated sites (2018 – $nil).

Note 13 Employee Future Benefits

	2019	2018
Accrued vacation pay	$ 566,415	$ 553,875
Accumulating non-vesting sick leave liability[a]	122,081	119,261
Registered defined benefit pension plans[b] [c]	-	-
	$ 688,496	**$ 673,136**

(a) Accumulating Non-Vesting Sick Leave Liability

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

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015 and extrapolated to March 31, 2019.

The following table summarizes the accumulating non-vesting sick leave liability.

	2019	2018
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 99,998	$ 115,177
Current service cost	8,498	10,595
Interest cost	3,517	3,779
Benefits paid	(8,156)	(8,870)
Actuarial gain	-	(20,683)
Accrued benefit obligation and funded status, end of year	**$ 103,857**	**$ 99,998**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 103,857	$ 99,998
Unamortized net actuarial gain	18,224	19,263
Accrued benefit liability	**$ 122,081**	**$ 119,261**
Components of expense		
Current service cost	$ 8,498	$ 10,595
Interest cost	3,517	3,779
Amortization of net actuarial gain	(1,039)	1,267
Net expense	**$ 10,976**	**$ 15,641**
Assumptions		
Discount rate – beginning of year	3.38%	2.02%
Discount rate – end of year	3.51%	3.38%
Rate of compensation increase per year	2018-2019 0.75% 2019-2020 0.75% Thereafter 2.75%	2017-2018 0.75% 2018-2019 0.75% Thereafter 2.75%

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the 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.

Note 13 Employee Future Benefits (continued)

(ii) LAPP Surplus

LAPP carried out an actuarial valuation as at December 31, 2016 and these results were then extrapolated to December 31, 2018. The LAPP's December 31, 2018 net assets available for benefits divided by the LAPP's pension obligation shows that the LAPP is 108% (2017 – 113%) funded.

	December 31, 2018	December 31, 2017
LAPP net assets available for benefits	$ 44,468,547	$ 42,728,515
LAPP pension obligation	40,999,200	37,893,000
LAPP surplus	**$ 3,469,347**	**$ 4,835,515**

The 2018 and 2019 LAPP contribution rates are as follows:

Calendar 2019		Calendar 2018	
Employer	**Employees**	**Employer**	**Employees**
9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	8.39% of pensionable earnings up to the YMPE and 12.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	9.39% of pensionable earnings up to the YMPE and 13.84% of the excess

(c) Pension Expense

	2019	2018
Local Authorities Pension Plan	$ 556,609	$ 587,007
Defined contribution pension plans and group RRSPs	48,408	49,021
Supplemental Pension Plan	2,265	2,303
Supplemental Executive Retirement Plans	812	(1,826)
Management Employees Pension Plan	378	393
	$ 608,472	**$ 636,898**

Note 14 Unexpended Deferred Operating Revenue

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

	2019				2018
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 137,662	$ 26,371	$ 256,212	$ 420,245	$ 411,079
Received or receivable during the year, net of repayments	1,206,568	59,771	148,795	1,415,134	1,349,839
Restricted investment income	1,058	1,611	6,796	9,465	7,176
Transferred from unexpended deferred capital revenue	3,407	53,127	703	57,237	44,874
Recognized as revenue	(1,192,862)	(114,269)	(126,961)	(1,434,092)	(1,373,254)
Miscellaneous other revenue recognized	(1,271)	(17)	(21,175)	(22,463)	(21,316)
	154,562	**26,594**	**264,370**	**445,526**	**418,398**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	740	2,985	3,968	7,693	1,847
Balance, end of year	**$ 155,302**	**$ 29,579**	**$ 268,338**	**$ 453,219**	**$ 420,245**

[i] The balance at March 31, 2019 for other government includes $506 of unexpended deferred operating revenue received from government entities outside the GOA (March 31, 2018 – $506). The remaining balance in other government all relates to the GOA, see Note 21.

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

	2019				2018
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 23,478	$ 1,554	$ 157,731	$ 182,763	$ 171,295
Physician revenue and alternate relationship plans	36,724	346	-	37,070	39,658
Primary Care Networks	24,354	-	-	24,354	27,332
Long term care partnerships	-	18,329	-	18,329	16,735
Promotion, prevention and community	13,354	1,665	758	15,777	16,373
Addiction and mental health	31,129	-	539	31,668	16,252
Cancer prevention, screening and treatment	5,863	-	1,096	6,959	14,198
Administration and support services	2,497	1,268	54,500	58,265	55,090
Others less than $10,000	16,787	3,432	15,464	35,683	28,654
	154,186	**26,594**	**230,088**	**410,868**	**385,587**
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	1,116	2,985	38,250	42,351	34,658
	$ 155,302	**$ 29,579**	**$ 268,338**	**$ 453,219**	**$ 420,245**

Note 15 Unexpended Deferred Capital Revenue

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

	2019				2018
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 48,336	$ 8,858	$ 96,557	$ 153,751	$ 137,806
Received or receivable during the year	141,144	169,246	87,927	398,317	306,947
Other transfers	(18)	18	-	-	-
Unexpended deferred capital revenue returned	(242)	-	(8)	(250)	(7,381)
Transfer to expended deferred capital revenue	(131,951)	(118,822)	(36,928)	(287,701)	(238,399)
Transferred to unexpended deferred operating revenue[(ii)]	(3,407)	(53,127)	(703)	(57,237)	(44,874)
	53,862	**6,173**	**146,845**	**206,880**	**154,099**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	-	-	-	-	(348)
Balance, end of year	**$ 53,862**	**$ 6,173**	**$ 146,845**	**$ 206,880**	**$ 153,751**

[(i)] The balance at March 31, 2019 for other government all relates to the GOA, see Note 21.
[(ii)] The transfer mainly comprises restricted funding related to capital expenditures that do not meet AHS' capitalization criteria.

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

	2019	2018
AH		
Information systems	$ 16,712	$ 42,132
Medical Equipment Replacement Upgrade Program	2	147
Diagnostic Equipment	19,585	-
Other equipment	17,563	6,057
Total AH	**53,862**	**48,336**
Other government		
Facilities and improvements	6,173	8,858
Total other government	**6,173**	**8,858**
Donors and non-government		
Equipment	138,334	92,626
Facilities and improvements	8,511	3,931
Total donors and non-government	**146,845**	**96,557**
	$ 206,880	**$ 153,751**

Note 16 Expended Deferred Capital Revenue

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

	2019				2018
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 273,582	$ 6,270,765	$ 191,107	$ 6,735,454	$ 6,549,770
Transferred from unexpended deferred capital revenue	131,951	118,822	36,928	287,701	238,399
Contributed tangible capital assets	-	285,322	46	285,368	331,622
Less: amounts recognized as revenue	(65,104)	(282,606)	(35,695)	(383,405)	(384,337)
Balance, end of year	**$ 340,429**	**$ 6,392,303**	**$ 192,386**	**$ 6,925,118**	**$ 6,735,454**

[i] The balance at March 31, 2019 for other government includes $36 of expended deferred capital revenue received from government entities outside the GOA (March 31, 2018 – $52). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2019	2018
Debentures payable[a]:		
Parkade loan #1	$ 26,500	$ 29,424
Parkade loan #2	25,522	27,951
Parkade loan #3	34,048	36,630
Parkade loan #4	132,577	140,098
Parkade loan #5	32,200	33,938
Parkade loan #6	22,557	23,505
Parkade loan #7	49,516	51,500
Energy savings initiative loan	24,089	25,800
Other	633	929
	347,642	**369,775**

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), 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 built, renovated, owned, and operated by AHS as security for these debentures.

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

AHS is in compliance with all performance requirements of its debenture loans. The maturity dates and interest rates for the 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%
Energy savings initiative loan	December 2030	2.4160%
Other	March 2021	4.6000%

Note 17 Debt (continued)

(b) At March 31, 2019, AHS had entered into an agreement to borrow $157,000 from ACFA. The proceeds will be received by AHS in December 2019 for the construction of the Calgary Cancer Center parkade. The loan matures March 2059 and has a fixed interest rate of 3.6%. Semi-annual principal and interest payments of $3,719 will commence June 2020. Commitments related to this agreement have been included in the table below.

AHS is committed to making payments as follows:

	Debentures Payable and Other Loans Payable
Year ended March 31	Principal Payments
2020	$ 23,091
2021	25,893
2022	26,666
2023	27,810
2024	29,008
Thereafter	372,174
	$ 504,642

During the year, the total interest related to debt was $15,199 (2018 – $14,551).

As at March 31, 2019, AHS holds a $220,000 (March 31, 2018 - $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, 2019, AHS has $nil (March 31, 2018 - $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2018 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2019, AHS has $4,419 (March 31, 2018 – $4,790) in a letter of credit outstanding against this facility. AHS is in compliance with performance requirements relating to this letter of credit.

Note 18 Tangible Capital Assets

Cost	2018	Additions[a]	Transfers	Disposals/write-downs	2019
Facilities and improvements	$ 9,300,463	$ -	$ 108,258	$ (7,331)	$ 9,401,390
Work in progress	1,179,069	692,879	(246,007)	-	1,625,941
Equipment[b]	2,512,888	164,704	(923)	(115,513)	2,561,156
Information systems	1,438,547	21,742	46,064	(31,550)	1,474,803
Building service equipment	648,352	-	81,747	(555)	729,544
Land[c]	116,875	-	-	(52)	116,823
Leased facilities and improvements	229,065	-	809	-	229,874
Land improvements	84,197	-	10,052	(61)	94,188
	$15,509,456	**$ 879,325**	**$ -**	**$ (155,062)**	**$ 16,233,719**

Accumulated Amortization	2018	Amortization Expense	Effect of Transfers	Disposals/write-downs	2019
Facilities and improvements	$ 3,666,479	$ 255,001	$ -	$ (6,305)	$ 3,915,175
Work in progress	-	-	-	-	-
Equipment[b]	1,898,695	148,701	-	(113,863)	1,933,533
Information systems	1,277,120	75,320	-	(31,546)	1,320,894
Building service equipment	398,200	36,884	-	(553)	434,531
Land[c]	-	-	-	-	-
Leased facilities and improvements	172,370	7,361	-	-	179,731
Land improvements	65,285	3,627	-	(61)	68,851
	$ 7,478,149	**$ 526,894**	**$ -**	**$ (152,328)**	**$ 7,852,715**

	Net Book Value	
	2019	2018
Facilities and improvements	$ 5,486,215	$ 5,633,984
Work in progress	1,625,941	1,179,069
Equipment[b]	627,623	614,193
Information systems	153,909	161,427
Building service equipment	295,013	250,152
Land[c]	116,823	116,875
Leased facilities and improvements	50,143	56,695
Land improvements	25,337	18,912
	$ 8,381,004	**$ 8,031,307**

Note 18 Tangible Capital Assets (continued)

Cost	2017	Additions[a]	Transfers out of Work in Progress	Disposals	2018
Facilities and improvements	$ 8,996,755	$ 3,646	$ 304,041	$ (3,979)	$ 9,300,463
Work in progress	914,106	681,588	(416,625)	-	1,179,069
Equipment[b]	2,302,819	248,781	1,640	(40,352)	2,512,888
Information systems	1,362,656	10,568	68,023	(2,700)	1,438,547
Building service equipment	611,021	-	37,391	(60)	648,352
Land[c]	110,589	6,286	-	-	116,875
Leased facilities and improvements	224,968	-	4,097	-	229,065
Land improvements	82,764	-	1,433	-	84,197
	$ 14,605,678	**$ 950,869**	**$ -**	**$ (47,091)**	**$ 15,509,456**

Accumulated Amortization	2017	Amortization Expense	Effect of Transfers	Disposals	2018
Facilities and improvements	$ 3,412,872	$ 257,586	$ -	$ (3,979)	$ 3,666,479
Work in progress	-	-	-	-	-
Equipment[b]	1,802,535	136,123	-	(39,963)	1,898,695
Information systems	1,180,818	99,000	-	(2,698)	1,277,120
Building service equipment	365,016	33,244	-	(60)	398,200
Land[c]	-	-	-	-	-
Leased facilities and improvements	162,322	10,048	-	-	172,370
Land improvements	63,038	2,247	-	-	65,285
	$ 6,986,601	**$ 538,248**	**$ -**	**$ (46,700)**	**$ 7,478,149**

	Net Book Value	
	2018	2017
Facilities and improvements	$ 5,633,984	$ 5,583,883
Work in progress	1,179,069	914,106
Equipment[b]	614,193	500,284
Information systems	161,427	181,838
Building service equipment	250,152	246,005
Land[c]	116,875	110,589
Leased facilities and improvements	56,695	62,646
Land improvements	18,912	19,726
	$ 8,031,307	**$ 7,619,077**

(a) Contributed Tangible Capital Assets

Additions include total contributed tangible capital assets of $285,368 (2018 – $337,908) consisting of $285,322 from AI (2018 – $337,837), of which $nil (2018 - $6,286) was related to the transferred land and $285,322 (2018- $331,551) was related to other tangible capital assets. AHS also received $46 from other sources (2018 – $71).

(b) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $17,240 (2018 – $13,352) with accumulated amortization of $12,119 (March 31, 2018 – $11,637). For the year ended March 31, 2019, leased equipment included a net increase of $4,363 related to vehicles under capital leases (2018 – net increase of $494).

Note 18 Tangible Capital Assets (continued)

(c) Leased Land

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

Site	Leased from	Lease Expiry
Cross Cancer Institute Parkade	University of Alberta	July 2019
Evansburg Community Health Centre	Yellowhead County	April 2031
Myrnam Land	Eagle Hill Foundation	May 2038
Two Hills Helipad	Stella Stefiuk	August 2041
McConnell Place North	City of Edmonton	September 2044
Northeast Community Health Centre	City of Edmonton	February 2047
Foothills Medical Centre Parkade	University of Calgary	July 2054
Alberta Children's Hospital	University of Calgary	December 2103

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2019					2018
	Invested in Tangible Capital Assets[a]	Endowments[b]	Internally Restricted Surplus for Future Purposes[c]	Unrestricted Surplus[d]	Total	Total
Balance, beginning of year	$ 817,160	$ 74,694	$ 237,176	$ 188,025	$ 1,317,055	$ 1,225,659
Annual operating (deficit) surplus	-	-	-	(38,631)	(38,631)	91,396
Tangible capital assets acquired with internal funds	244,268	-	(44,482)	(199,786)	-	-
Amortization of internally funded tangible capital assets	(146,223)	-	-	146,223	-	-
Principal payments on debt	22,133	-	-	(22,133)	-	-
Payments on obligations under capital leases	2,349	-	-	(2,349)	-	-
Payment on life lease deposits	596	-	-	(596)	-	-
Transfer of internally restricted surplus	-	-	24,532	(24,532)	-	-
Transfer of endowment contributions	-	463	-	(463)	-	-
Balance, end of year	**$ 940,283**	**$ 75,157**	**$ 217,226**	**$ 45,758**	**$ 1,278,424**	**$ 1,317,055**

(a) Invested in Tangible Capital Assets

The accumulated surplus invested in tangible capital assets represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus. AHS has no plans to monetize these assets to cover future operations

Note 19 Accumulated Surplus (continued)

(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 $463 (2018 - $328) of contributions and reinvested income received in the year (Note 5) offset by other transfers of $nil (2018 - $344).

(c) Internally Restricted Surplus for Future Purposes

The Board has approved the restriction of accumulated surplus for future purposes as follows:

	2019	2018
Ancillary services [(i)]	$ 112,508	$ 124,525
Insurance equity requirements [(ii)]	21,568	34,835
Foundations [(iii)]	42,816	41,395
Other [(iv)]	40,334	36,421
Internally restricted surplus for future purposes	**$ 217,226**	**$ 237,176**

(i) Restriction of ancillary operation surpluses from parking, retail food services, and controlled entities.
(ii) Restriction of surplus related to equity of the LPIP.
(iii) Restriction of surplus related to AHS' Controlled Foundations.
(iv) Restriction of surplus to address funding of expenses for certain initiatives spanning multiple fiscal years.

(d) Unrestricted Surplus

Unrestricted surplus represents the portion of accumulated surplus that has not been internally restricted for future purposes, invested in tangible capital assets, or endowments.

Note 20 Contractual Obligations and Contingent Liabilities

(a) Leases

AHS is contractually committed to future operating lease payments as follows:

Year ended March 31	Total Lease Payments
2020	$ 61,390
2021	54,899
2022	51,788
2023	45,550
2024	36,295
Thereafter	103,790
	$ 353,712

(b) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability 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, 2019, 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 20 Contractual Obligations and Contingent Liabilities (continued)

AHS has been named in 225 legal claims (2018 – 223 claims) related to conditions in existence at March 31, 2019 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 205 claims have $415,883 in specified amounts and 20 have no specified amounts (2018 – 208 claims with $308,012 of specified claims and 15 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

AHS has been named as a co-defendant, along with the GOA, in a certified Class Action (the Claim) arising from increases to long-term accommodation charges implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The Claim was originally dismissed after trial, but is now currently under appeal. The likelihood of the Claim is considered by AHS to be indeterminable, and the amount of the Claim has not yet been specified.

Note 21 Related Parties

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

The Minister of Health 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 table below.

Related parties also include key management personnel of AHS. AHS has defined key management personnel to include those disclosed in Sub-Schedule 2A & 2B of these consolidated financial statements. Related party transactions with key management personnel primarily consist of compensation related payments and are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Transactions between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenues[a]		Expenses	
	2019	2018	2019	2018
Ministry of Advanced Education [b]	$ 57,266	$ 55,936	$ 184,812	$ 179,759
Ministry of Infrastructure [c]	340,892	350,196	1	276
Other ministries [d]	55,399	58,101	31,064	31,460
Total for the year	**$ 453,557**	**$ 464,233**	**$ 215,877**	**$ 211,495**

	Receivable from		Payable to	
	2019	2018	2019	2018
Ministry of Advanced Education [b]	$ 7,692	$ 4,578	$ 35,618	$ 22,749
Ministry of Infrastructure [c]	50,566	21,526	65,000	-
Other ministries [d]	8,483	16,891	349,886	378,440
Balance, end of year	**$ 66,741**	**$ 42,995**	**$ 450,504**	**$ 401,189**

(a) Revenues with GOA ministries include other government transfers of $420,622 (2018 – $429,855), (Note 4), other income of $30,847 (2018 – $32,004), (Note 6), and fees and charges of $2,088 (2018 – $2,374).

Note 21 Related Parties (continued)

(b) Most of AHS transactions with the Ministry of 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 revenue and expense transactions are a result of funding provided from one to the other and recoveries of shared costs.

(c) The transactions with the Ministry of Infrastructure (AI) relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $58,957 (2018 – $63,699) and recognition of expended deferred capital revenue of $281,935 (2018 – $286,497) 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 18(a) is the transfer of land and other tangible capital assets from AI of $285,322 (2018 – $337,837).

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

At March 31, 2019, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $29,073 (March 31, 2018 – $25,865) related to unexpended deferred operating revenue (Note 14), $6,173 (March 31, 2018 – $8,858) related to unexpended deferred capital revenue (Note 15) and $6,392,267 (March 31, 2018 – $6,270,713) related to expended deferred capital revenue (Note 16).

Contingent liabilities in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 20.

Note 22 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.

	2019	2018
Financial assets	$ 71,913	$ 74,306
Liabilities	71,913	74,306
Accumulated surplus	$ -	$ -
Total revenues	$ 247,615	$ 248,123
Total expenses	247,615	248,123
Annual surplus	**$ -**	**$ -**

Note 23 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 of representation on the HBTA governance board. The HBTA is a formal health and welfare 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.

HBTA's balances as at December 31 are as follows:

	2018	2017
Financial assets	$ 145,274	$ 131,234
Liabilities	15,887	15,340
Net financial assets	$ 129,387	$ 115,894
Non-financial assets	6	6
Net assets	**$ 129,393**	**$ 115,900**

Note 23 Trusts under Administration (continued)

AHS has included in prepaid expenses $93,784 (March 31, 2018 – $91,077) representing in substance a prepayment of future premiums to HBTA. For the fiscal year ended March 31, 2019, AHS paid premiums of $391,734 (2018 – $382,090) to HBTA.

(b) Other Trust Funds

AHS receives 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, 2019, the balance of funds held in trust by AHS for research and development is $100 (March 31, 2018 – $150).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2019, the balance of these funds is $1,452 (March 31, 2018 – $1,686). 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, 2019, there are $32,674 in plan assets (March 31, 2018 - $34,474). These amounts are not included in the consolidated financial statements.

Note 24 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 the organization.

AHS' revenues, as reported on the 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) Community-based care

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

(b) Home care

Home care is comprised of home nursing and support.

(c) Continuing care

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

(d) Population and public health

Population and public health is comprised primarily of health promotion, disease and injury prevention, and health protection.

Note 24 Segment Disclosure (continued)

(e) Ambulance services

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

(f) Acute care

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

(g) Diagnostic and therapeutic services

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

(h) Education and research

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

(i) 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, food services, and emergency preparedness.

(j) Information technology

Information technology is comprised of costs pertaining to the provision of services to design, develop, implement, and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development.

(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, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, and legal. Activities and costs directly supporting clinical activities are excluded.

Note 25 Corresponding Amounts

Certain amounts have been reclassified to conform to 2019 presentation.

Note 26 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on May 30, 2019.

Alberta Health Services

Schedule 1 – Consolidated Schedule of Expenses by Object

For the year ended March 31, 2019
(thousands of dollars)

	2019		2018
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 8,239,000	$ 8,321,637	$ 8,081,785
Contracts with health service providers	2,762,000	2,749,686	2,621,371
Contracts under the Health Care Protection Act	18,000	17,186	18,337
Drugs and gases	496,000	506,662	465,753
Medical and surgical supplies	427,000	431,125	400,795
Other contracted services	1,381,000	1,322,806	1,253,012
Other[(a)]	1,384,000	1,434,605	1,384,755
Amortization and loss on disposals of tangible capital assets (Note 18)	533,000	529,628	538,639
	$ 15,240,000	**$ 15,313,335**	**$ 14,764,447**
(a) Significant amounts included in Other are:			
Equipment expense	$ 198,000	$ 212,312	$ 217,147
Other clinical supplies	146,000	161,392	153,879
Utilities	109,000	118,372	118,091
Building and ground expenses	120,000	118,206	119,590
Building rent	115,000	112,921	112,318
Insurance and liability claims	54,000	90,867	58,398
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	85,000	90,608	86,825
Food and dietary supplies	74,000	80,827	79,346
Office supplies	43,000	63,279	63,583
Minor equipment purchases	53,000	59,246	49,204
Fundraising and grants awarded	56,000	51,336	51,621
Travel	50,000	45,423	38,646
Telecommunications	39,000	38,917	38,026
Licenses, fees and memberships	31,000	17,211	19,216
Education	18,000	12,428	12,695
Other	193,000	161,260	166,170
	$ 1,384,000	**$ 1,434,605**	**$ 1,384,755**

Alberta Health Services

Schedule 2 – Consolidated Schedule of Salaries and Benefits

For the year ended March 31, 2019
(thousands of dollars)

	2019								2018	
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e] Number of Individuals	Severance [e] Amount	Total	FTE [a]	Total
Total Board (Sub-Schedule 2A)	10.82	$ -	$ 334	$ -	$ 334	-	$ -	$ 334	9.25	$ 311
Total Executive (Sub-Schedule 2B)	14.00	5,165	57	806	6,028	-	-	6,028	14.12	6,085
Management Reporting to CEO Direct Reports	56.86	12,876	285	2,636	15,797	-	-	15,797	72.86	20,069
Other Management	3,031.59	363,150	4,333	81,856	449,339	30	3,377	452,716	2,964.39	438,982
Medical Doctors not included above[f]	141.84	44,184	1,235	3,519	48,938	3	996	49,934	148.12	49,908
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	19,566.39	1,862,083	272,500	410,140	2,544,723	4	86	2,544,809	19,137.97	2,479,561
LPNs	5,233.39	343,230	45,744	75,851	464,825	2	58	464,883	4,987.54	440,381
Other health technical and professional	16,948.48	1,523,761	92,622	346,116	1,962,499	14	502	1,963,001	16,461.03	1,901,555
Unregulated health service providers	9,310.80	467,839	60,249	110,357	638,445	2	7	638,452	8,908.36	613,100
Other staff	27,251.74	1,712,694	99,212	373,098	2,185,004	45	1,100	2,186,104	26,738.08	2,132,245
Sub-total	**81,565.91**	**6,334,982**	**576,571**	**1,404,379**	**8,315,932**	**100**	**6,126**	**8,322,058**	**79,441.72**	**8,082,197**
Less amounts included in Other contracted services		(345)	(2)	(74)	(421)	-	-	(421)		(412)
Total		**$ 6,334,637**	**$ 576,569**	**$ 1,404,305**	**$ 8,315,511**	**100**	**$ 6,126**	**$ 8,321,637**		**$ 8,081,785**

This schedule does not include $27,393 in capitalized salaries and benefits (2018 - $10,303).

The accompanying footnotes and sub-schedules are part of this schedule

Alberta Health Services

Sub-Schedule 2A – Board Remuneration

	Term	2019 Committees	2019 Remuneration	2018 Remuneration
Board Chair				
Linda Hughes[g]	Since Nov 27, 2015	ARC, CEC, FC, GC, HRC, QSC	$ 69	$ 67
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), HR, QSC	49	48
David Carpenter	Since Nov 27, 2015	ARC (Chair), CEC, FC (Chair), HR	35	35
Heather Crowshoe (nee Hirsch)	Since Nov 3, 2016	CEC, GC, QSC	30	31
Richard Dicerni	Since Nov 27, 2015	CEC, FC, HRC (Chair)	27	30
Robb Foote	Apr 12, 2018 to Feb 1, 2019	CEC, FC, GC	24	-
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	31	33
Marliss Taylor	Since Nov 27, 2015	CEC, GC, HRC (Chair), QSC	34	32
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	31	33
Board Committee Participants[h]				
Dr. Brian Postl	Since Jan 1, 2018	QSC	2	-
Gord Winkel	Since Nov 27, 2015	QSC	2	2
Total Board			**$ 334**	**$ 311**

Board members were remunerated with monthly honoraria. In addition, they 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. Board committee participants are eligible to receive remuneration for meetings attended, and in addition Board committee chairs also receive a monthly honorarium.

Committee legend: ARC = Audit and Risk Committee, CEC = Community Engagement Committee, FC = Finance Committee, GC = Governance Committee, HRC = Human Resources Committee, QSC = Quality and Safety Committee

Alberta Health Services

Sub-Schedule 2B - Executive Salaries and Benefits

For the year ended March 31, 2019
(thousands of dollars)

For the Current Fiscal Year	2019						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer[n]	1.00	$ 211	$ 3	$ 34	$ 248	$ -	$ 248
Ronda White – Chief Audit Executive[n]	1.00	276	2	43	321	-	321
Dr. Verna Yiu – President and Chief Executive Officer[i,o]	1.00	572	-	84	656	-	656
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[n]	1.00	462	-	62	524	-	524
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta[n]	1.00	395	-	71	466	-	466
Mauro Chies – VP, CancerControl Alberta and Clinical Support Services[j,n]	0.52	171	-	28	199	-	199
Sean Chilton – VP, Health Professions and Practice[n]	1.00	329	-	55	384	-	384
Todd Gilchrist – VP, People, Legal and Privacy[k,n]	1.00	448	1	62	511	-	511
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta[n]	1.00	369	-	83	452	-	452
Karen Horon – Interim VP, Clinical Support Services[l]	0.48	110	-	19	129	-	129
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta[n]	1.00	369	-	62	431	-	431
Dr. Mark Joffe – VP and Medical Director, Northern Alberta[m,p]	1.00	447	35	41	523	-	523
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer[n]	1.00	388	1	54	443	-	443
Dr. Kathryn Todd – VP, System Innovations and Programs[m,p]	1.00	289	15	43	347	-	347
Colleen Turner – VP, Community Engagement and Communications[n]	1.00	329	-	65	394	-	394
Total Executive	**14.00**	**$ 5,165**	**$ 57**	**$ 806**	**$ 6,028**	**$ -**	**$ 6 ,028**

Alberta Health Services

Sub-Schedule 2B - Executive Salaries and Benefits

For the year ended March 31, 2019 (continued)
(thousands of dollars)

	2018						
For the Prior Fiscal Year	**FTE [a]**	**Base Salary [b]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer	0.79	$ 166	$ -	$ 40	$ 206	$ -	$ 206
Ronda White – Chief Audit Executive	1.00	276	-	64	340	-	340
Dr. Verna Yiu – President and Chief Executive Officer	1.00	572	-	104	676	-	676
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	462	-	43	505	-	505
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta	1.00	395	-	47	442	-	442
Mauro Chies – VP, Clinical Support Services	1.00	304	-	52	356	-	356
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions	1.00	329	-	72	401	-	401
Todd Gilchrist – VP, People, Legal and Privacy	1.00	449	-	64	513	-	513
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	369	-	27	396	-	396
Karen Horon – Acting VP, Clinical Support Services	0.19	44	-	8	52	-	52
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	369	-	45	414	-	414
Noela Inions – Chief Ethics and Compliance Officer	0.06	13	-	3	16	-	16
Dr. Mark Joffe – VP and Medical Director, Northern Alberta	1.00	449	35	44	528	-	528
Dr. David Mador – VP and Medical Director, Northern Alberta	0.08	36	-	4	40	-	40
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	433	-	68	501	-	501
Dr. Kathryn Todd – VP, System Innovations and Programs	1.00	286	15	39	340	-	340
Colleen Turner – VP, Community Engagement and Communications	1.00	329	-	30	359	-	359
Total Executive	**14.12**	**$ 5,281**	**$ 50**	**$ 754**	**$ 6,085**	**$ -**	**$ 6,085**

Alberta Health Services

Sub-Schedule 2C - Executive Supplemental Pension Plan and Supplemental Executive Retirement Plan
(thousands of dollars)

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 SERP is disclosed in Note 2(h)(iii). 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 Sub-Schedule 2B are prorated for the period of time the individual was in their position directly reporting to the Board or directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to the Board or President and Chief Executive Officer during the current fiscal year are disclosed.

	2019			2018			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2018	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2019
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	$ 6	$ -	$ 6	$ 5	$ 12	$ 5	$ 17
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	36	-	36	36	219	20	239
Dr. Ted Braun - VP and Medical Director, Central and Southern Alberta							
SERP	-	5	5	(10)	215	5	220
SPP	28	-	28	28	117	23	140
Mauro Chies - VP, CancerControl Alberta and Clinical Support Services	18	-	18	17	87	15	102
Sean Chilton – VP, Health Professions and Practice	20	-	20	20	139	17	156
Todd Gilchrist - VP, People, Legal and Privacy	34	-	34	34	104	28	132
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	15	15	(31)	666	17	683
SPP	25	-	25	24	147	18	165
Karen Horon - Interim VP, Clinical Support Services	6	-	6	4	21	6	27
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	9	9	(18)	389	11	400
SPP	25	-	25	24	`155	19	174
Dr. Mark Joffe - VP and Medical Director, Northern Alberta[m]	-	-	-	-	-	-	-
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	27	-	27	32	211	18	229
Dr. Kathryn Todd - VP, System Innovations and Programs[m]	-	-	-	-	-	-	-
Colleen Turner - VP, Community Engagement and Communications	20	-	20	20	94	14	108
Ronda White - Chief Audit Executive	14	-	14	14	80	10	90
Dr. Verna Yiu - President and Chief Executive Officer	49	-	49	49	90	47	137

(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 plans' 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.

Alberta Health Services

Footnotes to the Consolidated Schedule of Salaries and Benefits

For the year ended March 31, 2019

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours. FTE for the Board and Board committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

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

   Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer whose vacation accruals are included in other non-cash benefits.

c. Other cash benefits include, as applicable, honoraria, overtime, acting pay, membership fees, travel and automobile allowances, lump sum payments and an allowance for professional development. 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 Sub-Schedule 2C
   - 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 for direct reports of the Board or President and Chief Executive Officer, 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.

f. Compensation provided by AHS for medical doctors included in salaries and benefits expense includes medical doctors paid through AHS payroll. The compensation provided by AHS for the remaining medical doctors is included in other contracted services.

Board and Board Committee Participants

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

h. These individuals were participants of Board committees, but are not Board members or AHS employees.

Executive

i. The incumbent is engaged in an employment agreement with AHS while on leave of absence from the University of Alberta. The contract term ends June 2, 2021.

j. The incumbent held the position of Vice President, Clinical Support Services until April 2, 2018 at which time the incumbent was seconded to Calgary Laboratory Services/Alberta Public Laboratories (CLS/APL) to serve as Interim Chief Executive Officer and was no longer a direct report to the President and Chief Executive Officer at AHS. During this tenure, CLS/APL reimbursed AHS for the incumbent's base salary and benefits. The incumbent held the position of Interim Chief Executive Officer at CLS/APL until September 24, 2018 at which time the incumbent resumed the role of Vice President, Clinical Support Services at AHS and returned to being a direct report to the President and Chief Executive Officer at AHS. As a result of additional responsibilities effective November 1, 2018, the incumbent's position was retitled Vice President, CancerControl Alberta and Clinical Support Services.

k. The incumbent received a vacation payout of $9 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.

l. The incumbent held the position of Senior Operating Officer, Pharmacy Services until April 2, 2018 at which time the incumbent was appointed to Interim Vice President, Clinical Support Services and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary for the Interim Vice President, Clinical Support Services position. The incumbent held the position of Interim Vice President, Clinical Support Services until September 24, 2018 at which time the incumbent resumed the role of Senior Operating Officer, Pharmacy Services and is no longer a direct report to the President and Chief Executive Officer.

Alberta Health Services

Footnotes to the Consolidated Schedule of Salaries And Benefits

For the year ended March 31, 2019 (continued)

m. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta, and AHS reimburses the University for the incumbent's base salary and benefits. In lieu of enrollment into the AHS SPP, the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits.

Termination Obligations

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

o. 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.

p. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

Alberta Health Services

Schedule 3 – Consolidated Schedule of Segment Disclosures

For the year ended March 31, 2019

(thousands of dollars)

	2019								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical and surgical supplies	Other contracted services	Other	Amortization and loss on disposals of tangible capital assets	Total
Community-based care	$ 676,683	$ 657,092	$ -	$ 3,562	$ 3,668	$ 31,951	$ 66,106	$ 372	$ 1,439,434
Home care	327,974	246,052	-	179	7,651	83,441	22,850	148	688,295
Continuing care	316,452	775,491	-	7,600	4,030	5,278	25,340	2,152	1,136,343
Population and public health	299,568	9,860	-	6,840	4,089	14,836	12,218	315	347,726
Ambulance services	299,635	174,932	-	1,953	2,538	1,572	30,246	17,169	528,045
Acute care	2,990,169	394,435	17,186	461,210	344,354	600,224	172,436	64,810	5,044,824
Diagnostic and therapeutic services	1,563,024	293,708	-	22,738	60,534	291,808	228,911	44,688	2,505,411
Education and research	186,064	2,911	-	15	78	98,743	28,309	165	316,285
Support services	1,069,471	154,714	-	2,560	3,931	112,198	593,575	323,023	2,259,472
Information technology	241,201	514	-	-	16	37,156	152,125	76,593	507,605
Administration	351,396	39,977	-	5	236	45,599	102,489	193	539,895
Total	**$ 8,321,637**	**$ 2,749,686**	**$ 17,186**	**$ 506,662**	**$ 431,125**	**$ 1,322,806**	**$ 1,434,605**	**$ 529,628**	**$ 15,313,335**

Alberta Health Services

Schedule 3 – Consolidated Schedule of Segment Disclosures (Continued)

For the year ended March 31, 2019
(thousands of dollars)

	2018								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical and surgical supplies	Other contracted services	Other	Amortization and loss on disposals of tangible capital assets	Total
Community-based care	$ 627,454	$ 621,358	$ -	$ 3,145	$ 3,487	$ 34,256	$ 79,651	$ 495	$ 1,369,846
Home care	286,788	220,857	-	200	6,271	72,220	22,930	313	609,579
Continuing care	311,317	717,001	-	7,417	3,967	4,271	27,115	1,712	1,072,800
Population and public health	296,632	9,584	-	7,342	2,620	13,702	13,967	436	344,283
Ambulance services	284,172	167,566	-	2,191	2,480	1,376	32,105	13,384	503,274
Acute care	2,958,575	392,382	18,337	429,181	321,496	600,951	152,921	55,011	4,928,854
Diagnostic and therapeutic services	1,514,809	300,341	-	13,360	57,078	264,219	222,739	40,510	2,413,056
Education and research	181,971	3,135	-	10	90	84,733	28,891	349	299,179
Support services	1,044,967	151,616	-	2,365	3,017	104,698	594,678	321,212	2,222,553
Information technology	226,839	584	-	-	-	37,570	141,772	104,070	510,835
Administration	348,261	36,947	-	542	289	35,016	67,986	1,147	490,188
TOTAL	**$ 8,081,785**	**$ 2,621,371**	**$ 18,337**	**$ 465,753**	**$ 400,795**	**$ 1,253,012**	**$ 1,384,755**	**$ 538,639**	**$ 14,764,447**

Health Quality Council of Alberta

Financial Statements

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Management's Responsibility for the Financial Statements March 31, 2019

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 Andrew Neuner]

Chief Executive Officer
Andrew Neuner
May 22, 2019

[Original signed by Jessica Wing]

Director, Financial Services
Jessica Wing
May 22, 2019

Independent Auditor's Report

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

Auditor General 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, 2019, 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, 2019, 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 22, 2019
Edmonton, Alberta

Health Quality Council of Alberta

Statement of Operations

Year ended March 31, 2019
(thousands of dollars)

	2019		2018
	Budget	Actual	Actual
	(Note 4)		
Revenues			
Government transfers			
Alberta Health - operating grant	$ 7,156	$ 7,222	$ 7,145
Investment income	6	22	10
Other revenue	35	70	50
	7,197	7,314	7,205
Expenses			
Administration	1,946	1,893	1,841
Health system analytics	2,669	2,319	2,065
Health system improvement	1,141	1,449	1,021
Collaborative learning and education	605	405	624
Communication	721	688	634
Ministerial assessment/study	588	719	452
	7,670	7,473	6,637
Annual operating (deficit) surplus	(473)	(159)	568
Accumulated operating surplus, beginning of year	1,384	1,926	1,358
Accumulated operating surplus, end of year	$ 911	$ 1,767	$ 1,926

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

Health Quality Council of Alberta

Statement of Financial Position

As at March 31, 2019
(thousands of dollars)

	2019	2018
Financial Assets		
Cash	$ 1,462	$ 1,568
Accounts receivable	60	49
	1,522	1,617
Liabilities		
Accounts payable and accrued liabilities	757	627
Employee future benefits (Note 6)	121	94
Deferred revenue (Note 7)	-	6
Deferred lease inducements (Note 8)	147	98
	1,025	825
Net Financial Assets	497	792
Non-Financial Assets		
Tangible capital assets (Note 9)	1,188	1,067
Prepaid expenses	82	67
	1,270	1,134
Net Assets	1,767	1,926
Net Assets		
Accumulated operating surplus (Note 11)	$ 1,767	$ 1,926

Contractual obligations (Note 10)

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

Health Quality Council of Alberta

Statement of Change in Net Financial Assets

Year ended March 31, 2019
(thousands of dollars)

	2019		2018
	Budget	**Actual**	**Actual**
Annual operating (deficit) surplus	$ (473)	$ (159)	$ 568
Acquisition of tangible capital assets (Note 9)	(56)	(374)	(193)
Amortization and write down of tangible capital assets (Note 9)	218	253	207
(Increase) Decrease in prepaid expenses	-	(15)	6
(Decrease) Increase in net financial assets in the year		(295)	588
Net financial assets, beginning of year		792	204
Net financial assets, end of year		$ 497	$ 792

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

Health Quality Council of Alberta

Statement of Cash Flows

Year ended March 31, 2019
(thousands of dollars)

	2019	2018
Operating Transactions		
Annual operating (deficit) surplus	$ (159)	$ 568
Non-cash items:		
Amortization and write down of tangible capital assets (Note 9)	253	207
Amortization of deferred lease inducements (Note 8)	(37)	(41)
Increase in employee future benefits (Note 6)	27	26
	84	760
(Increase) in accounts receivable	(11)	(5)
(Increase) Decrease in prepaid expenses	(15)	6
Increase (Decrease) in accounts payable and accrued liabilities	130	(100)
(Decrease) Increase in deferred revenue	(6)	6
Increase in deferred lease inducements (Note 8)	86	86
Cash provided by operating transactions	268	753
Capital Transactions		
Acquisition of tangible capital assets (Note 9)	(374)	(193)
Cash (applied to) capital transactions	(374)	(193)
(Decrease) Increase in cash	(106)	560
Cash at beginning of year	1,568	1,008
Cash at end of year	$ 1,462	$ 1,568

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

Health Quality Council of Alberta

Notes to the Financial Statements

Year ended March 31, 2019
(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 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. Cash received for which services have not been provided by year end is recognized as deferred revenue.

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 revenue 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.

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 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.

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

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

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 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 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 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.

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

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

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.

Change in Accounting Policy

The HQCA has prospectively adopted the following standard from April 1, 2018: PS 3430 Restructuring Transactions. The adoption of this standard did not affect the financial statements.

Note 3 FUTURE ACCOUNTING CHANGES

The Public Sector Accounting Board has approved the following accounting standards:

PS 3280 Asset Retirement Obligations (effective April 1, 2021)

Effective April 1, 2021, this standard provides guidance on how to account for and report liabilities for retirement of tangible capital assets.

PS 3400 Revenue (effective April 1, 2022)

This standard provides guidance on how to account for and report on revenue, and specifically, it addresses revenue arising from exchange transactions and unilateral transactions.

Management is currently assessing the impact of these standards on the financial statements.

Note 4 BUDGET

The HQCA's 2018-2019 operating budget with a budgeted deficit of ($473) was approved by the Board of Directors on October 26, 2017 and submitted to the Ministry of Health. Subsequently, changes to three expense descriptions on the statement of operations were made. They are as follow:

2019 Expense description	2018 Expense description
Health system analytics	Survey, measure and monitor initiatives
Health system improvement	Patient safety initiatives
Collaborative learning and education	Quality initiatives

Note 5 FINANCIAL RISK MANAGEMENT

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

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

(a) Interest rate risk

Interest rate risk is the risk that the rate of return and future cash flows on the HQCA's short-term investments will fluctuate because of changes in market interest rates. As the HQCA invests in short term deposits of 90 days or less and accounts payable are non-interest bearing, the HQCA is not exposed to significant interest rate risk relating to its financial instruments.

(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 cash resources and investing in short-term deposits of 90 days or less.

(c) Other price risk

Other price risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices (other than those arising from interest rate risk or foreign currency risk), whether those changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market. Price risk is managed by holding short-term deposits for 90 days or less.

(d) 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.

Note 6 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 $405 for the year ended March 31, 2019 (2018 - $421).

At December 31, 2018, the Local Authorities Pension Plan reported a surplus of $3,469,347 (2017 – surplus of $4,835,515).

The Supplementary Executive Retirement Plan (SERP) payable at year ended March 31, 2019 is $121 (2018 - $94). Interest contribution related to this plan is $27 (2018 - $26).

Note 7 DEFERRED REVENUE

Deferred revenue represents unspent externally restricted resources. Changes in the balance are as follows:

	2019	2018
Balance, beginning of the year	$ 6	$ -
Amount received during the year	-	6
Less: Amount recognized as revenue	(6)	-
Balance, end of the year	$ -	$ 6

Note 8 DEFERRED LEASE INDUCEMENTS

The HQCA received a leasehold inducement of $137 for renovations in 2015. The inducement is accounted for as a reduction of rent expense and amortized over the term of the lease.

The HQCA received an additional lease inducement in the form of free rent relating to a lease renewal of the premises effective 2018. 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.

	2019	2018
Lease inducements - renovations	$ 137	$ 137
Lease inducements - rent free periods	209	123
Less accumulated amortization	(199)	(162)
	$ 147	$ 98

Note 9 TANGIBLE CAPITAL ASSETS

	2019				2018
	Office Equipment	Computer Hardware & Software	Leasehold improvements	Total	Total
Estimated useful life	10 yrs	5 yrs	5-10 yrs		
Historical Cost					
Beginning of year	$ 401	$ 466	$ 1,013	$ 1,880	$ 1,771
Additions	-	374	-	374	193
Disposals, including write-downs	-	(27)	-	(27)	(84)
	401	813	1,013	2,227	1,880
Accumulated Amortization					
Beginning of year	185	229	399	813	690
Amortization expense	32	98	123	253	204
Effect of disposals, including write-downs	-	(27)	-	(27)	(81)
	217	300	522	1,039	813
Net book value at March 31, 2019	$ 184	$ 513	$ 491	$ 1,188	
Net book value at March 31, 2018	$ 216	$ 237	$ 614		$ 1,067

Note 10 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	Total lease payments
2019 - 20	$ 461
2020 - 21	475
2021 - 22	479
2022 - 23	479
Thereafter	-
	$ 1,894

Note 11 ACCUMULATED OPERATING SURPLUS

Accumulated operating surplus is comprised of the following:

	2019				2018
	Investment in Tangible Capital Assets[a]	Internally Restricted Surplus[b]	Unrestricted Surplus (Deficit)	Total	Total
Balance, April 1, 2018	$ 1,065	$ 861	$ -	$ 1,926	$ 1,358
Annual operating (deficit) surplus	-	-	(159)	(159)	568
Net investments in capital assets	121	-	(121)	-	-
Transfers, prior year restricted		(861)	861	-	
Transfers, current year restricted	-	581	(581)	-	-
Balance, March 31, 2019	$ 1,186	$ 581	$ -	$ 1,767	$ 1,926

(a) Net assets equal to net book value of internally funded tangible capital assets are restricted as these net assets are not available for any other purpose.

Note 11 ACCUMULATED OPERATING SURPLUS (CONT'D)

(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 business plan is summarized as follows:

	2019	2018
Build capacity	$ -	$ 16
Measure to improve	240	670
Monitor the health system	37	85
Engage with the public	304	90
	$ 581	$ 861

Note 12 COMPARATIVE FIGURES

Certain 2018 figures have been reclassified to conform to the 2019 presentation.

Note 13 APPROVAL OF THE FINANCIAL STATEMENTS

The financial statements were approved by the HQCA Board of Directors on May 22, 2019.

Health Quality Council of Alberta

Schedule 1 – Expenses – Detailed by Object

Year ended March 31, 2019
(thousands of dollars)

	2019		2018
	Budget	Actual	Actual
Salaries and benefits	$ 4,635	$ 4,207	$ 4,146
Supplies, services and other	2,817	3,013	2,287
Amortization of tangible capital assets (Note 9)	218	253	204
	$ 7,670	$ 7,473	$ 6,637

Health Quality Council of Alberta

Schedule 2 – Salary and Benefits Disclosure

Year ended March 31, 2019
(thousands of dollars)

	2019				2018
	Base Salary [1]	Other Cash Benefits [2]	Other Non-Cash Benefits [3]	Total	Total
Board of Directors-Chair	$ -	$ 13	$ -	$ 13	$ 12
Board of Directors-Members	-	50	-	50	28
Chief Executive Officer	346	49	58	453	407
Executive Director	184	-	35	219	220
	$ 530	$ 112	$ 93	$ 735	$ 667

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include honoraria for board members and vacation payouts. There were no bonuses paid in 2019.

(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, dental coverage, vision coverage, out of country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short-term disability plans, employee assistance program, employment insurance and fair market value parking.

Health Quality Council of Alberta

Schedule 3 – Related Party Transactions

Year ended March 31, 2019
(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.

	2019	2018
Revenues		
Grants	$ 7,222	$ 7,146
Other	33	7
	$ 7,255	$ 7,153
Expenses		
Other services	$ 301	$ 265
Receivable from related parties	$ -	$ 1
Payable to related parties	$ 19	$ 47

Other Financial Information

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Department of Health

Statement of Credit or Recovery (unaudited)

Year ended March 31, 2019
(in thousands)

	2019				
	Authorized	Actual Revenue Recognized	Unearned Revenue	Total Revenue Received / Receivable	(Shortfall) / Excess
Support Programs					
Other Support Programs [(a)]	$ 1,000	$ -	$ -	$ -	$ (1,000)
	$ 1,000	$ -	$ -	$ -	$ (1,000)

(a) The Department receives funding from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection.

Department of Health

Lapse/Encumbrance (unaudited)

Year ended March 31, 2019
(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
	(Restated)					
1 Ministry Support Services						
1.1 Minister's Office	$ 745	$ -	$ -	$ 745	$ 724	$ 21
1.2 Associate Minister's Office	395	-	-	395	91	304
1.3 Deputy Minister's Office	1,553	-	-	1,553	1,313	240
1.4 Strategic Corporate Support	50,471	-	-	50,471	41,007	9,464
1.5 Policy Development and Strategic Support	19,300	-	-	19,300	15,623	3,677
1.6 Health Advocates' Office	1,893	-	-	1,893	1,289	604
	74,357	-	-	74,357	60,047	14,310
2 Alberta Health Services						
2.1 Continuing Care	1,102,000	-	-	1,102,000	1,102,000	-
2.2 Community Care	1,200,000	-	-	1,200,000	1,200,000	-
2.3 Home Care	687,000	-	-	687,000	687,000	-
2.4 Acute Care	3,725,595	-	-	3,725,595	3,750,095	(24,500)
2.5 Ambulance Services	456,000	-	-	456,000	461,000	(5,000)
2.6 Diagnostic and Therapeutic Services	2,363,000	-	-	2,363,000	2,363,000	-
2.7 Population and Public Health	317,000	-	-	317,000	317,000	-
2.8 Health Workforce Education and Research	79,000	-	-	79,000	79,000	-
2.9 Information Technology	444,000	-	-	444,000	444,000	-
2.10 Support Services	1,624,000	-	-	1,624,000	1,624,000	-
2.11 Administration	488,000	-	-	488,000	488,000	-
	12,485,595	-	-	12,485,595	12,515,095	(29,500)
3 Physician Compensation and Development						
3.1 Program Support	9,687	-	-	9,687	6,994	2,693
3.2 Physician Remuneration	4,374,198	-	-	4,374,198	4,358,325	15,873
3.3 Physician Development	177,443	-	-	177,443	171,837	5,606
3.4 Physician Benefits	358,671	-	-	358,671	397,050	(38,379)
	4,919,999	-	-	4,919,999	4,934,206	(14,207)

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2019
(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
	(Restated)					
4 Drugs and Supplemental Health Benefits						
4.1 Program Support	$ 44,027	$ -	$ -	$ 44,027	$ 45,473	$ (1,446)
4.2 Outpatient Cancer Therapy Drugs	207,627	-	-	207,627	203,598	4,029
4.3 Outpatient Specialized High Cost Drugs	129,324	-	-	129,324	106,544	22,780
4.4 Seniors Drug Benefits	574,600	-	-	574,600	564,348	10,252
4.5 Seniors Dental, Optical and Supplemental Health Benefits	130,226	-	-	130,226	132,687	(2,461)
4.6 Non-Group Drug Benefits	271,193	-	-	271,193	230,076	41,117
4.7 Non-Group Supplemental Health Benefits	900	-	-	900	826	74
4.8 Assured Income for the Severely Handicapped Health Benefit	235,153	-	-	235,153	214,130	21,023
4.9 Child Health Benefit	30,930	-	-	30,930	30,172	758
4.10 Adult Health Benefit	225,033	-	-	225,033	216,991	8,042
4.11 Alberta Aids to Daily Living	156,630	-	-	156,630	157,932	(1,302)
4.12 Pharmaceutical Innovation and Management	102,995	-	-	102,995	102,309	686
	2,108,638	-	-	2,108,638	2,005,086	103,552
5 Addiction and Mental Health						
5.1 Program Support	3,228	-	-	3,228	2,567	661
5.2 Addiction and Mental Health	83,396	-	-	83,396	84,904	(1,508)
	86,624	-	-	86,624	87,471	(847)
6 Primary Health Care						
6.1 Program Support	3,745	-	-	3,745	2,821	924
6.2 Primary Health Care	244,500	-	-	244,500	222,344	22,156
	248,245	-	-	248,245	225,165	23,080
7 Population and Public Health						
7.1 Program Support	16,540	-	-	16,540	11,401	5,139
7.2 Immunization Support	3,721	-	-	3,721	2,181	1,540
7.3 Community-Based Health Services	62,275	-	-	62,275	50,319	11,956
	82,536	-	-	82,536	63,901	18,635
8 Allied Health Services	112,416	-	-	112,416	115,504	(3,088)
9 Human Tissue and Blood Services	192,232	-	-	192,232	190,254	1,978

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2019
(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
	(Restated)					
10 Support Programs						
10.1 Program Support	$ 9,448	$ -	$ -	$ 9,448	$ 7,425	$ 2,023
10.2 Health Quality Council of Alberta	7,130	-	-	7,130	7,222	(92)
10.3 Protection for Persons in Care	2,318	-	-	2,318	1,875	443
10.4 Monitoring, Investigations and Licensing	7,910	-	-	7,910	6,464	1,446
10.5 Research and Support Programs	22,244	-	-	22,244	27,863	(5,619)
10.6 Health System Projects	4,000	-	-	4,000	790	3,210
	53,050	-	-	53,050	51,639	1,411
11 Out-of-Province Health Care Services						
11.1 Program Support	7,999	-	-	7,999	7,446	553
11.2 Out-of-Province Health Care Services	163,878	-	-	163,878	144,152	19,726
	171,877	-	-	171,877	151,598	20,279
12 Information Technology						
12.1 Program Support	7,875	-	-	7,875	6,372	1,503
12.2 Development and Operations	75,970	-	-	75,970	73,291	2,679
	83,845	-	-	83,845	79,663	4,182
13 Cancer Research and Prevention Investment	25,000	-	-	25,000	19,378	5,622
Program - Capital Grants						
5 Addiction and Mental Health						
5.2 Addiction and Mental Health	-	-	-	-	1,987	(1,987)
14 Infrastructure Support						
14.1 Continuing Care Beds	48,990	-	-	48,990	31,360	17,630
14.6 Other Health Initiatives	-	-	-	-	13,000	(13,000)
	48,990	-	-	48,990	46,347	2,643
Credit or Recovery (Shortfall)	-	-	(1,000)	(1,000)	-	(1,000)
Total	$ 20,693,404	$ -	$ (1,000)	$ 20,692,404	$ 20,545,354	$ 147,050
Lapse						$ 147,050

Department of Health

Lapse/Encumbrance (unaudited) (continued)

Year ended March 31, 2019
(in thousands)

		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
		(Restated)					
Program - Capital Investment							
Department Capital Acquisitions							
7	**Population and Public Health**						
7.2	Immunization Support	$ -	$ -	$ -	$ -	$ 94	$ (94)
12	**Information Technology**						
12.2	Development and Operations	22,230	-	-	22,230	7,344	14,886
Capital Payments to Related Parties							
5	**Addiction and Mental Health**						
5.2	Addiction and Mental Health	-	-	-	-	110	(110)
14	**Infrastructure Support**						
14.2	External Information Systems Development	5,748	-	-	5,748	-	5,748
14.3	Equipment for Cancer Corridor Projects	3,469		-	3,469	-	3,469
14.4	Medical Equipment Replacement			-			-
	and Upgrade Program	30,000		-	30,000	30,000	-
14.5	Clinical Information System	80,000	-	-	80,000	73,249	6,751
14.6	Other Health Initiatives	50,000	-	-	50,000	37,785	12,215
Total		$ 191,447	$ -	$ -	$ 191,447	$ 148,582	$ 42,865
Lapse							$ 42,865
Program - Financial							
4	**Drugs and Supplemental Health Benefits**						
4.3	Outpatient Specialized High Cost Drugs	$ 10,700	$ -	$ -	$ 10,700	$ 6,311	$ 4,389
7	**Population and Public Health**						
7.2	Immunization Support	63,500	-	-	63,500	59,639	3,861
Total		$ 74,200	$ -	$ -	$ 74,200	$ 65,950	$ 8,250
Lapse							$ 8,250

[1] As per "Expense Vote by Program", "Capital Investment Vote by Program" and "Financial Transactions Vote by Program" page 156 to 158 of 2018-2019 Government Estimates. Effective April 1, 2018, the responsibility for the administration of human resources services was transferred to the Department of Treasury Board and Finance (Order in Council 297/2018). As a result voted estimates in Strategic Corporate Support under Ministry Support Services has been restated by ($2,697).

[2] Adjustments include encumbrances, capital carry over amounts, transfers between votes and credit or recovery increases approved by Treasury Board Committee and credit or recovery shortfalls (Schedule 2). 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.

[3] Actuals exclude non-voted amounts such as amortization, inventory consumption, and valuation adjustments.

Department of Health

Statement of Remissions, Compromises and Write-offs (unaudited)

Year ended March 31, 2019
(in thousands)

	2019	2018
Write-Offs		
Medical Claim Recoveries	$ 2,621	$ 1,790
Pharmaceuticals and Health Benefits	85	238
Other Receivables	458	432
Total Write-offs [(1)]	$ 3,164	$ 2,460

[(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.

Ministry of Health

Payments Based on Agreements (unaudited)

Year ended March 31, 2019
(in thousands)

The Ministry entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments to provide health services on their behalf. The Ministry pays service providers for services rendered under the agreements and recovers the amount paid from the program sponsors. Service providers include Alberta Health Services and physicians. Costs based on these agreements are incurred by the Ministry under authority in section 25 of the *Financial Administration Act.*

Amounts paid based on agreements with program sponsors are as follows:

	2019	2018
Other Provincial and Territorial Governments	$ 310,183	$ 287,557

Accounts receivable includes $46,723 (2018 - $40,911).

Trust Funds under Administration (unaudited)

(in thousands)

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.

At December 31, 2018, the Health Benefit Trust of Alberta reported fund balance of $129,393 (2017 - $115,900). At March 31, 2019, balance of trust funds held for others is $1,552 (2018 - $1,836).

The Ministry and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. At March 31, 2019, there are $32,674 in plan assets (2018 - $34,474).

Annual Report Extracts and Other Statutory Reports

Public Interest Disclosure (Whistleblower Protection) Act

Section 32 of the *Public Interest Disclosure (Whistleblower Protection) Act* states:

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 on request.

There were no disclosures of wrongdoing for the Department of Health between April 1, 2018 and March 31, 2019.

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.