Health

Annual Report
2017–18

Alberta
Government

Note to Readers:
Copies of the annual report are available on the Alberta Open Government Portal website:
https://open.alberta.ca/publication/2367-9824

Information about the entities that were part of the Ministry of Health in 2017–18 is available on their respective websites:

Ministry of Health
www.health.alberta.ca

Alberta Health Services
www.albertahealthservices.ca

Health Quality Council of Alberta
www.hqca.ca

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Health

Annual Report 2017–18

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 ministers' accountability statements, 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 minister's accountability statement, the audited consolidated financial statements 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 the 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*, either as separate reports or as a part of the financial statements, to the extent that the ministry has anything to report.**

Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2018, was prepared under my direction in accordance with the *Fiscal Planning and Transparency Act* and the government's accounting policies. All of the government's policy decisions as at June 5, 2018, with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original signed by]

Honourable Sarah Hoffman
Minister of Health

Message from the Minister

I am honoured and privileged to serve as Alberta's Minister of Health. Looking back to when I first became Health Minister, I was honoured to have the opportunity to be a champion for Alberta's public health care system, and a champion for all of the hard- working people who make that system a reality. I was eager to move quickly toward our shared vision and goals – to deliver the right health care, in the right place, at the right time.

Every day has been an opportunity to listen to Albertans and work with health care providers to find ways to enhance our services and quality of care for Albertans.

Our government believes in a strong public health care system that puts patients first, and delivers high-quality, compassionate care. We believe that health care services should be based on medical need, not the size of your wallet. Those are the values our health care system was built on, and those are the values we fight for every day when we champion our health care system.

Thanks to the commitment of ministry staff and our valued partners we made a lot of progress by implementing key evidence-based initiatives with solutions. These solutions are improving the way we deliver health care, the way Albertans experience health care, and the way we sustain our health care spending.

We're working to reduce the rate of growth in health spending, while protecting and improving the health services Albertans count on. Compared to previous governments, that increased spending by an average of six per cent yearly from 2008–2014, we've been able to reduce spending to 3.3 per cent yearly. With an aging population and increased demands for health services, finding efficiencies through collaboration is vital to ensuring we are providing the best possible health care, today and into the future. I want to thank our dedicated health care professionals for working with us to build a more sustainable health care system.

Collaboration with health professionals and Alberta Health Services has continued as we create more sustainable funding and service models to enhance community-based health care delivery. A major accomplishment was the support of family physicians for a new primary care network governance framework

to ensure Albertans have better access to consistent, comprehensive and seamless primary care.

This year, we also boosted funding for home and community care to a total of $2 billion, allowing hundreds more Albertans to remain in their homes and communities longer, with family and social supports around them.

We continue to make strategic investments in health infrastructure across the province to support access to high quality care as close to home as possible. We also celebrated the completion of new builds and renovations at health facilities in communities across the province, including a new hospital in High Prairie that brings a range of services under one roof, new obstetrical operating rooms at Red Deer Regional Hospital Centre and upgrades to the hospital in Canmore. We also launched new capital projects in 2017–18, including breaking ground on the new Calgary Cancer Centre, moving forward on a new emergency department at the Misericordia Community Hospital and announcing funding for a new hospital in south Edmonton to meet the needs of the city's growing population for years to come.

We are making important investments into Alberta's continuing care system and are on track to achieve our commitment to build 2,000 long-term care and dementia spaces by 2019. This additional capacity will assist seniors and persons with disabilities to remain in their communities.

Addressing health disparities and reducing the gap in health outcomes between Indigenous and non-Indigenous Albertans is important for our government. Through renewed relationships with Indigenous peoples, we continue to strengthen coordination and implementation of culturally appropriate and accessible health services.

Our work continues on substance use and mental health, improving access to primary health care, providing continuing care closer to home, working with health providers to keep our health system sustainable, and improving health information management. I look forward to building on our accomplishments over the coming year.

[Original signed by]

Honourable Sarah Hoffman
Minister of Health

Message from the Associate Minister

Working with the Honourable Sarah Hoffman and staff in the ministry to support and enhance access and delivery of high quality health care to Albertans has been a wonderful experience for the past three years.

I would like to acknowledge the work of the Minister's Opioid Emergency Response Commission since May 2017. Our opioid response for 2017–18 was backed by $56 million in funding to address this growing crisis. With this funding, over 49,000 life-saving naloxone kits were dispensed from over 1,400 distribution sites. This has already resulted in 3,300 self-reported life-saving reversals – each one bringing an opportunity for someone to seek supports to make a different choice for themselves. Harm reduction strategies have been strengthened and expanded across the province, including the opening of supervised consumption services and enhanced opioid dependency treatment programs and counselling services. A rural opioid-dependency program has also launched in central Alberta to treat patients in Wetaskiwin, Rocky Mountain House, Stettler and Ponoka through tele-mental health programming.

As we listen to Albertans, we know mental health supports are a priority for them and their families. Working with our partners in the community, we have undertaken over 100 initiatives under *Valuing Mental Health: Next Steps*.

Strategies to reduce harm and provide mental health and addiction supports will continue to be enhanced through 2018–19 as we expand treatment and services, such as the recently announced children's mental health clinic in Edmonton, and new mental health and substance treatment beds at Edmonton's Royal Alexandra Hospital.

Other major initiatives this past year have supported women's health and maternal and infant care. Alberta Health Services and the Alberta Association of Midwives reached a two-year agreement that will increase the number of midwives practising in Alberta. The plan includes more publicly-funded midwives caring for families in rural and remote areas. Our government is committed to supporting women's health care choices, which is why we have expanded funding for midwifery services by 400 courses of care every single year since 2015. Today, more births are supported by midwives in Alberta than ever before.

Taking care of vulnerable individuals is a priority for Albertans, and a priority for this ministry. With a grant of $1.2 million to the Zebra Child Protection Centre, young survivors of sexual and physical child abuse now have greater access to supports and counselling services. We will continue to support the development of child advocacy centres in every region of the province to better ensure that any child who needs the help of these services will have them. We have also provided funding to support joint work with Children's Services on a youth suicide prevention plan, beginning with Indigenous youth and communities.

Albertans care deeply about the health services available to them and to their families. Our government will continue our work to provide them with the supports they need and deserve to lead healthy lives as part of vital communities. As we work together, these are the connections that help make life better for all Albertans.

[Original signed by]

Honourable Brandy Payne
Associate Minister of Health

Management's Responsibility for Reporting

The Ministry of Health includes:

- Department of Health
- Alberta Health Services; and
- 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 consolidated financial statements are prepared in accordance with 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 2017.

As Deputy Minister and Associate Deputy Minister, in addition to program responsibilities, we are 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, 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 our responsibilities for the Ministry, we have relied, as necessary, on the executives of the individual entities within the Ministry.

[Original signed by]

Milton Sussman
Deputy Minister of Health
June 5, 2018

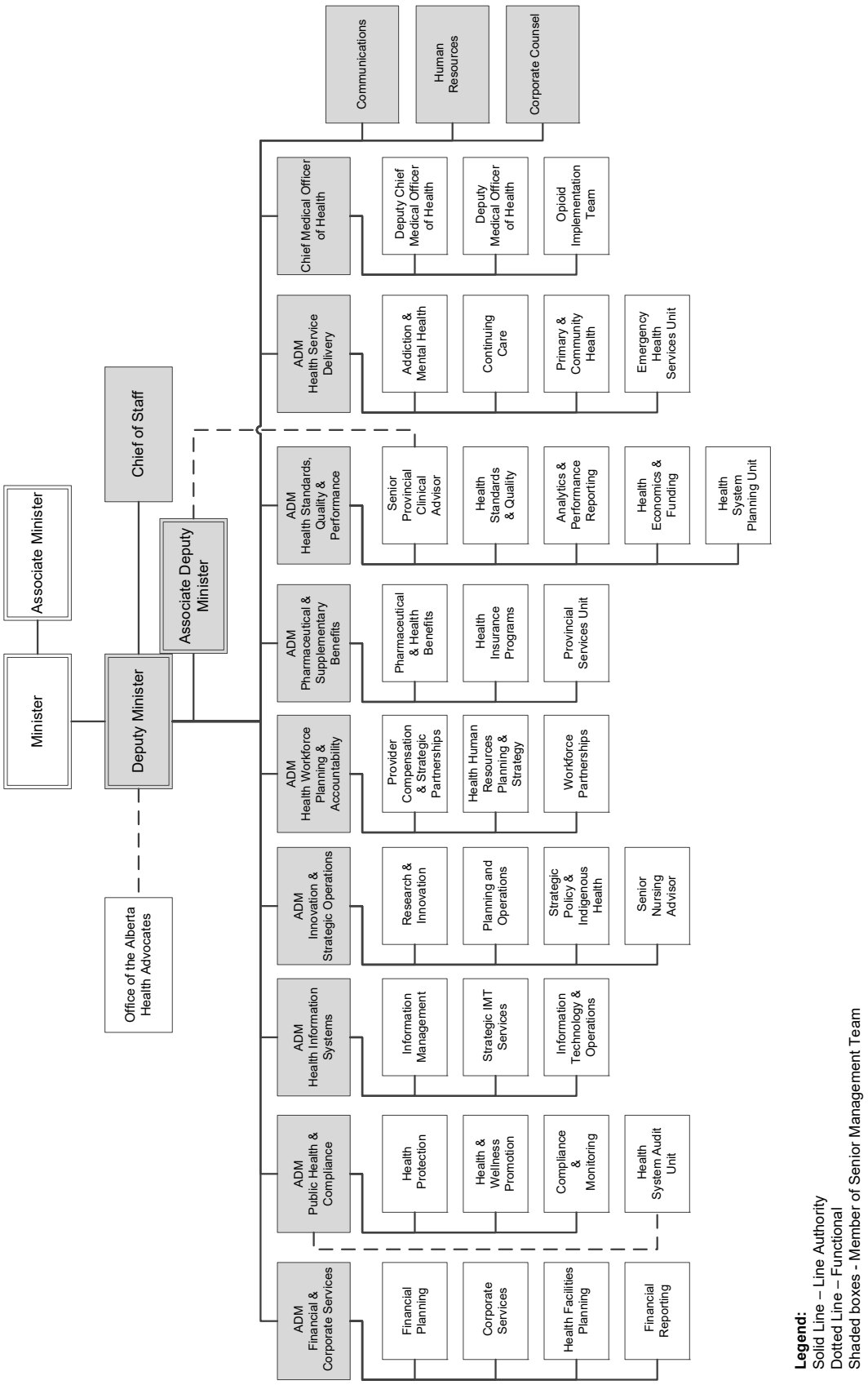
[Original signed by]

Andre Tremblay
Associate Deputy Minister of Health
June 5, 2018

Results Analysis

Ministry Overview

Ministry Overview – The Department of Health Organizational Chart



Legend:
Solid Line – Line Authority
Dotted Line – Functional
Shaded boxes - Member of Senior Management Team

Ministry Overview

The Ministry of Health is responsible for setting strategic policy direction, administering legislation and overseeing Alberta's public health care system to ensure that health resources are used as effectively as possible in alignment with government's goals. The ministry is comprised of the Department of Health, Alberta Health Services, and the Health Quality Council of Alberta.

The Department of Health implements the Government of Alberta's direction for health and is responsible for the overall design of Alberta's health system, developing strategic policy and administering legislation. The department also monitors health system performance to make sure the system is supporting positive health outcomes and patient experiences. In addition to providing general oversight, the department advises the minister and government on the development of health policy, supports policy implementation, and funds the health system.

As the regional health authority, Alberta Health Services delivers a large portion of the publicly funded health care services available across Alberta. The Health Quality Council of Alberta is a legislated council that monitors the health system to improve health service quality and patient safety.

With direction from the Minister and Associate Minister, the Deputy Minister and Associate Deputy Minister are 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, Alberta Health Services, and stakeholder organizations. The office provides policy co-ordination and issues management for the Minister and Associate 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 works with the Auditor General in preparing annual financial statements, ensuring compliance with Government of Alberta financial legislation. The division oversees health facilities planning and co-ordinates infrastructure projects with Alberta Infrastructure and Alberta Health Services. 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 compliance monitoring, communicable diseases, immunization, 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, and injury and disease prevention. The division's functions further protect Albertans through the investigation of reports of fraud and abuse, and through monitoring compliance with applicable legislation and continuing care and accommodation standards.

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 ehealth environment; and, manages Alberta Netcare, the province's electronic health record.

Innovation and Strategic Operations Division – manages and facilitates the corporate processes that develop and deliver the ministry's strategic priorities and enable increased innovation adoption in the health care system. The division's responsibilities include: leadership and co-ordination of the ministry's strategic policy, corporate planning and reporting; Indigenous health policy; strategic support on federal/provincial/territorial health issues; Alberta Health Services accountability; governance of health sector public bodies; support and coordination 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 – engages in policy development to support the governance, oversight and 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 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.

Health Standards, Quality and Performance Division – leads the evidence-informed development, negotiation, monitoring and renewal of health service guidelines and standards, and provides leadership in quality enhancement and long-range health system planning. The division includes responsibility for the ministry's analytics function, to foster an evidence-based culture and enhance performance management, as well as health economics and funding capacity, and provision of clinical expertise to support the cost effective application of standards and quality-setting functions across the health system.

Health Service Delivery Division – is responsible for policy development and implementation, legislation, regulation, and standard development and monitoring for continuing care, addiction and mental health, primary and community 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 expertise on issues of public health importance. This includes facilitating processes, policies and programs to improve population health, prevent chronic diseases, control the spread of communicable diseases, and respond to new and emerging pathogens and threats to public health. The Office is currently leading the provincial response to Alberta's opioid crisis. 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 Alberta Health Services and other reporting entities to co-ordinate 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 department and Minister.

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 bodies; providing information about the Alberta Health Charter; and addressing patients' issues and concerns in relation to the *Mental Health Act*.

Results Analysis

Discussion and Analysis of Results

Discussion and Analysis of Results

Introduction

During 2017-18, the Ministry of Health worked closely with health and community partners to deliver high-quality programs and services. Our goal is to improve Albertans' health and well-being by delivering the health services Albertans need — where and when they need them. As part of our ongoing effort to reach this goal, we continue to focus on making sure that health services in our province are integrated, coordinated and as easy as possible for Albertans to access.

The Government of Alberta continues its strong emphasis on the delivery of high quality acute care services while recognizing the need to also focus on delivering services close to home and in communities. The performance of the acute care system is central to the overall performance of the health care system. While improvements are underway in many areas, from quality to improved efficiencies, Alberta Health Services (AHS) has had success in identifying and implementing best practices, looking at and developing a plan to address wait times for medical treatments and supporting patient safety.

While health facilities and acute care services remain a vital part of our health system, the evidence shows that community-based health care is safe, effective and supports the long-term sustainability of our health system. By placing an emphasis on community-based health care, we can further slow increasing health care costs, respond to changing demographics and provide the quality care Albertans expect and deserve. The effectiveness of the acute care system will be key in supporting throughput of patients into community.

Community-based health care has many components, and its success requires shared responsibility from the Government of Alberta, AHS, health care providers, community partners and Albertans. During 2017-18, the Ministry of Health made progress in a number of areas to advance the vision for community-based health care:

Primary Health Care: The announcement of a new Primary Care Network (PCN) Governance Framework in June 2017 paved the way for closer collaboration between PCNs and AHS. This framework will improve efficiency and service delivery across more than 40 Alberta PCNs, giving more Albertans access to team-based care closer to home and strengthening Albertans' connections to primary care providers such as family physicians.

Continuing Care: With additional provincial and federal funding for home and community care, the department and AHS have worked collaboratively in determining how best to allocate the investment to address increasing demand for home and community care services and to support Albertans with complex care needs to remain at home rather than moving to facility-based continuing care. At the same time, when patients are in acute care, the health system is working to increase patient transition back to home or into continuing care spaces. New continuing care spaces opened in rural and urban communities across Alberta, providing more care options for Albertans close to home.

Addictions and Mental Health: The Department of Health continues to lead the implementation of the actions outlined in *Valuing Mental Health: Next Steps*, in response to the recommendations from *Valuing Mental Health: Report of the Alberta Mental Health Review Committee* and to engage stakeholders and community members through the Valuing Mental Health Advisory Committee. Thanks largely to increased funding for community-based addiction and mental health services, more than 100 initiatives are underway -- many focused on making it easier for Albertans to navigate the health system and access the addiction and mental health supports they need. In May 2017, government established the Minister's Opioid Emergency Response Commission to provide recommendations for urgent actions to address the opioid crisis.

Health Information: The Department continues to provide leadership and funding support for several major health information initiatives that are crucial to community-based care. During 2017-18, AHS continued to implement Connect Care, which will allow AHS to create a single health record for every Albertan. At the same time, the department made significant progress on a Community Information Integration project that will make patient data collected in the community more readily available to community-based providers, thereby improving continuity of care. The department also expanded the personal health record platform to include laboratory and immunization data and continues to work towards a full public launch of the personal health record in late 2018.

Ministry leadership on the development of a robust clinical information system for Alberta's health care sector has achieved results. Alberta is leading the country in the development of a single, province-wide electronic health record. Alberta Netcare currently provides over 50,000 registered health providers with direct access to key patient information to support decision-making at the point of care. AHS' Connect Care initiative is expected to create significant savings by reducing duplication of IT systems and operations across the hundreds of platforms currently within the various AHS facilities and programs. The Personal Health Record will consolidate information from Alberta Netcare, Connect Care, and health information generated in the community and will give patients access to their own health care records, prescription drug information and laboratory/diagnostic testing results to support more information for decision-making and empower self-management of health and wellness.

Indigenous Health: The ministry continues to collaborate with First Nations and Métis peoples to address health priorities, support culturally safe programs and services, and take action on priorities. Together with AHS, the department is developing mandatory cultural sensitivity training for front-line health providers. During 2017-18, the department worked with the Treaty 8 First Nations Alberta Chiefs to identify short-term priorities including improved access to primary healthcare services, data collection and analysis, capital initiatives to support community needs and address systemic racism.

Ongoing Challenges

The opioid crisis remains a major challenge for the Government of Alberta and governments across Canada. Alberta continues to take action at several levels to reduce the impacts of opioids in our province and has increased access to opioid treatment, harm-reduction services and life-saving options for Albertans who use opioids. Guided by the Minister's Opioid Emergency Response Commission, the government will continue to work closely with service providers, families and people with lived experience to reduce opioid-related harms.

The Government of Alberta is committed to long-term, stable funding to protect the health and well-being of all Albertans. From 2008-09 to 2014-15, annual health spending grew an average of approximately six per cent. From 2015-16 to 2017-18, spending was contained with an average growth of only 3.3 per cent a year. This reduction in annual spending growth was due largely to successful negotiations with health professions and the introduction of a hiring restraint for non-frontline positions within the department and AHS. While Alberta's economy is bouncing back, a constrained fiscal environment underscores the importance of a continued focus to control health spending and keep annual spending growth at sustainable levels.

Key Strategies and Initiatives

In addition to the above, the ministry moved forward on a number of key strategies and initiatives during 2017-18 to strengthen health services for Albertans:

- The *Resident and Family Councils Act* came into force this spring to ensure residents and families have a voice in quality of life in supportive living and long-term care facilities.
- Four supervised opioid consumption sites opened in the province, including North America's first in-patient hospital setting for supervised consumption services.

- Enhancements to the province's take home naloxone program saw more than 49,000 naloxone kits distributed to Albertans at more than 1,400 sites.
- The *Paramedics Profession Regulation* supports the expansion of the role and services of paramedics to care for patients in their homes and reduce the number of patients transported to hospital.
- The *Alberta Dementia Strategy and Action Plan* was released in December. It brings forward a number of actions to support individuals living with dementia and their families, caregivers and communities.
- The S*kin Cancer Prevention (Artificial Tanning) Act* and *Artificial Tanning Regulation* came into force in January to protect young Albertans from the risks of ultraviolet artificial tanning.
- The new Alberta Dental Fee Guide, launched in November 2017, includes an 8.5 per cent drop in fees for the 60 most common dental procedures and gives Albertans more information to work with when choosing dental care.
- Started development of a targeted approach to fund new continuing care spaces for priority communities, complex and vulnerable populations, and Indigenous communities.

Building on these achievements of the past year, the ministry will continue its focus on a range of key priorities in 2018-19, such as:

- New investments in home and community care to support initiatives such as enhancing care in the community, Designated Supportive Living and mental health care spaces, hospice bed expansion, and midwifery care.
- Support for enhanced team-based care from family physicians and other health care providers.
- Improve access to health care by addressing pressures and wait times in areas such as surgeries, MRI and CT scans, cancer treatments, and access to specialist consults.
- Continue to improve access to midwifery services for rural and underserved areas, vulnerable populations, and areas that lack existing obstetrical resources.
- Adding full-time mobile community paramedics to provide on-site care to seniors and other Albertans with chronic conditions, so as to reduce the use of ambulance transport, acute care beds and hospital resources for these patients.
- Continue to open new treatment spaces, establishing supervised consumption services, supporting opioid awareness programs and expanded access to opioid dependency treatment programs, and boosting the take-home naloxone program.

The following information provides details about the ministry's progress and achievements in responding to the outcomes and the key strategies set out in the 2017-20 Health Business Plan.

Outcome One: Improved health outcomes for all Albertans

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

Achievements

Key Strategy 1.1: Lead the shift from a focus on hospitals and facilities to more community-based care closer to home by:

► **Implementing the Valuing Mental Health Action Plan to move toward a more coordinated and integrated addiction and mental health system.**

During 2017-18, the Ministry of Health continued its focus on making it easier for Albertans to navigate the health care system and access the addiction and mental health supports they need.

Alberta Health committed more than $50 million in grants to increase community-based delivery of addiction and mental health services. Through the Valuing Mental Health Advisory Committee, the department engaged with more than 200 community and government stakeholders from 100 different organizations to synthesize recommendations of the Alberta Mental Health Review Committee into 18 actions reflected in *Valuing Mental Health: Next Steps*, released in June 2017. These actions focus on co-ordinating and integrating health and community services, with an emphasis on meeting the needs of vulnerable and underserved populations. More than 100 initiatives are already underway as a result of these efforts.

In March 2017, the federal and Alberta governments announced a 10-year, $1.3 billion funding agreement to help meet Albertans' home and community care and addiction and mental health needs. Over the past year, the two governments developed a bilateral agreement and action plan to allocate $584 million to these services over the next five years; $233 million is targeted for addiction and mental health services. The funding will be used to expand access to community-based services for children and youth (ages 10-25); integrate evidence-based models of community mental health care and culturally-appropriate interventions into primary health care services; and expand community-based mental health and addiction services for people with complex health needs.

Federal/provincial/territorial health ministers agreed to work together with the Canadian Institute for Health Information (CIHI) to identify and report progress on three to five indicators of access to home and community care and addiction and mental health services. Over the past year, the department and Alberta Health Services (AHS) have worked with CIHI on the development of these indicators. Annual reporting on these indicators is expected to begin in 2019.

Did you know?

One in five Albertans will experience a mental illness in his or her lifetime and one in ten Albertans over the age of 15 will experience a drug or alcohol dependency.

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

Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose and manage a health condition. Primary health care may include a visit to a family doctor, a consultation with a nurse practitioner, advice from a pharmacist or an appointment with a dietitian or therapist. Ideally, it draws on the expertise of many different providers working together to support people and their families.

In June 2017, Alberta Health, in partnership with AHS, the Alberta Medical Association (AMA) and Primary Care Networks (PCNs), implemented a new PCN governance framework. This new governance structure will help Albertans receive the health care they need close to home. Under the framework, PCN governance structures have been created at the provincial and AHS zone levels to provide greater oversight and stakeholder accountability. These changes will support increased continuity of care for Albertans through the provision of more consistent, comprehensive and seamless team-based primary health care, as well as increased collaboration amongst PCNs in sharing their best practices.

Did you know?

Approximately 80% of primary care physicians are registered in a Primary Care Network (PCN). Alberta has 41 PCNs providing services to close to 3.6 million Albertans.

In March 2018, the Government of Alberta announced $9.5 million for the Primary Health Care Opioid Response Initiative as part of the Minister's Opioid Emergency Response Commission. This initiative will support increased access to services and provide training for primary care providers and teams to offer treatment, medication and care to patients and families affected by the opioid crisis.

► **Encouraging community partners to collaborate on new and existing wellness initiatives to create equitable conditions for Albertans to be active partners in their own health.**

The Department of Health actively supports Albertans in making healthy choices in their lives through the development and monitoring of population-based public health policies. In collaboration with AHS, other ministries and community partners, the department works to foster integrated approaches to prevent disease and promote wellness.

With funding from the department, the Alberta Recreation and Parks Association's Communities ChooseWell program supported capacity building for 231 community wellness champions to develop health-promoting programs and policies that foster healthy and supportive social and physical environments in their communities. The program's Indigenous Community Network expanded to 30 members with representatives from Treaties 6, 7 and 8, Metis Settlements, and Indigenous organizations in Alberta's urban centres. Seed grants aimed at reducing barriers to community wellness contributed to multi-sector partnerships with schools and the health and recreation sectors. Learning events increased participants' knowledge, skills and confidence, and new relationships were formed with AHS departments, PCNs and Family and Community Support Services departments.

Alberta Health continued to collaborate with Alberta Education to support a comprehensive school health approach that addresses school health in a planned, integrated and holistic way. Comprehensive School Health enhances activities in the classroom and motivates the whole school. Grants to the Ever Active Schools Provincial initiative and the Alberta Healthy School Community Wellness Fund build capacity in school staff, students, and parents to improve mental health, healthy eating, and physical activity levels of school-age children and youth in all Alberta school districts.

► **Implementing a system-wide response to chronic conditions and disease prevention and management by aligning and integrating work being done on chronic disease across the province.**

A growing number of Albertans are living with chronic conditions and diseases, and finding support and services in the health system can be challenging for these Albertans and their families. Supports and services – including many outside the health care system – must be integrated and better co-ordinated to prevent and manage chronic conditions and diseases. The department and AHS continued working collaboratively with Albertans, patients, care providers and communities to improve the integration of care for Albertans living with chronic conditions.

Alberta worked with its health and community partners to develop a Chronic Condition and Disease Prevention and Management framework. This framework provides overall policy direction, and will be used to develop more detailed guidelines to support AHS and PCNs to implement appropriate services and models for Albertans based on their needs for prevention and management of chronic conditions and diseases.

As Alberta's population continues to grow and age, the number of new cancer cases is also on the rise. Nearly one in two Albertans is expected to develop cancer in their lifetime. Because of investments in cancer control, including prevention, early detection and treatment, the overall cancer survival rate has increased from about 25 per cent in the 1940's to 60 per cent today,

Using the Alberta Cancer Prevention Legacy Fund, the department signed a three-year $27.8 million agreement with AHS to lead 15 cancer prevention initiatives. As a result, primary care physicians now have screening data on individual patients available through Alberta Netcare to assist in recognizing cancer in its early stages. This funding will help engage and build capacity among community stakeholders for action on wellness initiatives to address key risk factors for cancer and chronic disease across the province. A portion of this funding also supported the development of an Alberta Skin Cancer Prevention Framework to improve awareness and policy related to skin cancer prevention.

AHS has introduced cancer patient navigators, who are Registered Nurses with oncology specific system and clinical knowledge, to support and guide cancer patients with complex symptoms, co-morbidities, or social determinants of health through their cancer experience. They work to improve care coordination at key transition points in the patient journey when their care pathway requires coordination across multiple settings, health systems, treatment modalities and provider teams.

The department worked with the Cardiovascular Health and Stroke Strategic Clinical Network and other key stakeholders to improve access to endovascular therapy (EVT) treatment for patients with acute ischemic stroke. Access to this treatment has substantially improved stroke survival for Albertans and reduced the burden on family caregivers as well as the health care system. Research in Alberta showed that for those people who sustained a large stroke and received EVT therapy, almost twice as many returned to functional independence and only half as many died, compared to those who did not receive the treatment.

► **Supporting appropriate and reasonable access to pharmaceuticals and supplemental health benefits for Albertans.**

Albertans have said they want the most effective medications at an affordable cost, as well as affordable access to supplemental health benefits, like dental care. A review of dental fees in Alberta found these fees are higher and growing faster than anywhere else in Canada. Following the review, a new Dental Fee Guide, developed with the Alberta Dental Association and College, came into effect January 1, 2018. This guide – the first in Alberta in more than two decades – will help bring Albertans' dental costs more in line with the national average, and give Albertans an easy-to-use tool when choosing a dental provider.

Alberta continues to work with other provinces and territories through the pan-Canadian Pharmaceutical Alliance to make prescription drugs more affordable and accessible. In January 2018, in co-operation with the Canadian Generic Pharmaceutical Association, the alliance announced the development of a new, five-year initiative that will provide significant savings for all Canadians who use prescription generic drugs, as well as participating public employee drug plans. In addition to savings of more than $1 billion to participating drug plans over the past five years, and ongoing annual savings of $250 million, this initiative will save an estimated $385 million in its first year and up to $3 billion over the next five years, through a combination of price reductions and the launch of new generic drugs.

During 2017-18, the department consulted with the Alberta Pharmacists' Association and Alberta Blue Cross to develop an updated pharmacy funding framework for 2018-19 and 2019-20. Under the new framework, announced in February 2018, growth in forecasted pharmacy compensation expenditures will decrease from 12.3 per cent to a more sustainable 4.3 per cent, saving $150 million in incremental costs.

In July 2017, Alberta became the second province in Canada to provide coverage for Mifegymiso at no cost through licensed pharmacies. This coverage, provided under the Women's Choice Program, allows Alberta women to exercise their choice in sexual health.

Alberta Aids to Daily Living moved several types of equipment, including pediatric feeder seats, bath and toileting equipment and mattress overlays, to a benchmark model. As a result, eligible clients now have wider choice and quicker access to improved assistive products on the market.

► **Expanding home care services that will increase access to health services, reduce reliance on acute care facilities, and enable Albertans to stay at home longer.**

Home care is foundational to continuing care with most Albertans wishing to remain in their homes as their care needs change due to age, injury or disability. Access to these services can also help Albertans avoid or delay admission to facility-based continuing care services and support early discharge from acute care facilities.

Did you know?

Alberta's continuing care system provides Albertans with the health, personal care and accommodation services they need to support their independence and quality of life. Continuing care includes home care, supportive living and long-term care.

The department and AHS have worked closely together to determine the best way to allocate the enhanced funding for home and community care announced in Budget 2017. The goal for this and future investments is to support more Albertans, including those with complex needs, to remain at home as they age or their care needs change. Enhancements have already been initiated across the province and include the addition of new adult day program spaces, enhanced supports for caregivers, community paramedic initiatives and improved access to home care services, including palliative and end-of-life care, particularly for Albertans residing in rural and remote parts of the province.

In addition to these enhancements, acute care facilities are continually evolving and optimizing practice. Quality care initiatives are supporting patients pre and post-surgery, while reducing patient length of stay and strengthening discharge planning so patients transition to home with better support.

In March 2017, the federal and Alberta governments announced a 10-year funding agreement that allocates $1.3 billion to help meet Albertans' home and community care needs, as well as their addiction and mental health needs. The funding will be divided into two five-year contribution agreements. Over the past year, the two governments have worked to develop a bilateral agreement and action plan for the $584 million allocated toward these services over the next five years, of which $350 million is targeted for home and community care. This targeted investment will:

- Help Albertans maintain their independence and avoid or delay the need for higher levels of care by implementing a standard basket of home care services accessible by all Albertans regardless of where they reside in the province;
- Improve access to specialized interdisciplinary services and care teams;
- Enhance access to community-based palliative and end-of-life services; and
- Increase supports for family and friend caregivers.

► Developing a targeted approach for funding new continuing care spaces and upgrading or replacing existing sites, focusing on complex populations, communities in the greatest need and Indigenous communities.

The department continues to work with AHS and other key ministries to develop a targeted, multi-phased approach to fund the development of new continuing care spaces in high priority and Indigenous communities and for complex populations. This approach emphasizes collaboration with Indigenous organizations to understand how to develop culturally-appropriate services and ensure that services and supports meet and reflect community needs. The addition of new continuing care spaces frees up emergency department and hospital beds, improves access to acute care services, and allows more Albertans to receive care closer to home.

► Enhancing care for patients with dementia so they receive timely diagnosis and support in their communities with accessible, integrated and high quality care and services.

As of April 2017, there were more than 44,000 Albertans diagnosed and living with dementia. This diagnosis has a significant impact on those living with dementia as well as on their families, friends, caregivers and communities.

In December 2017, the ministry released the *Alberta Dementia Strategy and Action Plan*, which addresses dementia not only as a health matter, but as a larger societal issue that government, communities, and Albertans must work together to address. The action plan identifies four outcomes to support the vision that Albertans are committed to optimizing brain health and valuing and supporting individuals impacted by dementia from onset through to end-of-life:

- Albertans understand the impact of dementia and actively work towards optimal brain health;
- Albertans and their caregivers are supported in communities;
- Albertans and their caregivers receive timely recognition, diagnosis and clinical management through primary health care, supported by specialized services; and
- Albertans and their caregivers experience timely, accessible, integrated and high quality care and services.

An Implementation and Monitoring Committee was established in January 2018 to support implementation of the strategy. This committee includes individuals living with dementia and caregivers as well as members of health and community organizations.

In 2017-18, the department provided more than $1.5 million in funding to support individuals living with dementia and their caregivers. A portion of this funding has enabled the continuation of the Alzheimer Society of Alberta and Northwest Territories' First Link® program and Dementia Advice through Health Link (811). Both services provide individuals living with dementia and their

caregivers with access to knowledgeable people, information and supports to assist them after diagnosis and with navigating the health and social systems. Additionally, part of this funding was allocated toward several community innovation pilot programs aimed at supporting individuals living with dementia to remain at home through the provision of integrated community-based health and social services that optimize their independence, quality of life and well-being.

Funded by the ministry and developed by AHS' Seniors Health Strategic Clinical Network, an Elder Friendly Toolkit was also released in October 2017 to support care teams working with older adults in acute care facilities. Older adults who are cognitively and physically frail, including those with dementia, often decline in health, mobility and independence in hospital. This toolkit better equips hospital care teams with the knowledge and training necessary to address factors within their scope to minimize these negative outcomes and to provide the highest quality care to older Albertans experiencing dementia or other changes to cognition and brain function.

► **Developing sustainable physician compensation models which enable the provision of high quality care and support collaborative practice within a team-based environment.**

The Amending Agreement signed by the Government of Alberta, the AMA and AHS in November 2016 included commitments to developing new compensation models for physicians to reward time and quality of care given to patients rather than just the number of services provided.

Funding for academic medicine was consolidated under the umbrella of the Alberta Academic Medicine and Health Services Program to enable shared oversight between the department, AHS, the University of Alberta and the University of Calgary. This enables more cohesive provincial standards for funding physician remuneration in academic medicine, and improved reporting and accountability between partners. Modernizing the funding for academic physicians allows them to teach, conduct research and offer clinical services. Alberta's Faculties of Medicine are key drivers of research and innovation and help to ensure Alberta's health care system meets the needs of Albertans and contributes to health and academic success.

► **Enhancing and expanding the authorized collection and sharing of health information in a patient-centred, integrated shared health record to support clinical decision-making.**

Having a shared health record supports team-based, integrated care with a focus on the patient and the efficient and effective provision of services, and will help to reduce disjointed care, gaps, overlaps, errors and delays.

During 2017-18, the department and AHS continued to implement Connect Care, which will allow AHS to create a single electronic health record for every Albertan, and codify best practice standards and guidance. Through this work all AHS health providers will have access to, and contribute to, the same information through a common provincial clinical information system. In October 2017, AHS signed an agreement with Epic to provide the platform solution for Connect Care. In addition, AHS, the AMA, and the Universities of Calgary and Alberta signed an agreement in October 2017 for a new information sharing construct to support sharing of health information through shared electronic systems, thereby paving the way for Connect Care.

Did you know?

More than 80% of Alberta's community physicians and specialists use an Electronic Medical Record system.

The department also continued to work on the Community Information Integration project, which will improve continuity of care across the health system through better access to primary healthcare and community health information.

The Community Information Integration (CII) will:

- Collect clinical patient data from community family physician offices, specialists and other community-based clinics;
- Display clinical reports from community providers in Alberta Netcare as part of a comprehensive patient Electronic Health Record; and,
- Analyze patient health data to support quality improvement, population health assessment and health system planning.

Phase 1 of the CII project is nearing completion and major electronic medical record vendors have signed up to participate; the first specialist consult reports are being uploaded to Alberta Netcare from community clinics; and, the first Community Encounter Digest reports are now available in Alberta Netcare. Community Encounter Digest reports provide a snapshot of all encounters a patient has had with community physicians over the past year.

The Central Patient Attachment Registry, a collaboration of the department, AHS, the AMA and Alberta Blue Cross, is being readied to begin accepting patients. The registry will help primary care providers identify who their attached patients are and also help other health care providers (e.g. emergency department staff) identify a patient's primary care provider.

► Providing Albertans with secure access to their own health information to assist them in taking an active role in managing their health.

The Personal Health Record (PHR) will consolidate information from Alberta Netcare, the AHS clinical information system, and health information generated in the community. The PHR will permit patients to access their own health care records, prescription drug information and laboratory/ diagnostic testing results to support more informed decision-making and empower self-management of health and wellness. This information can be shared with health service providers, helping to provide a continuum of care.

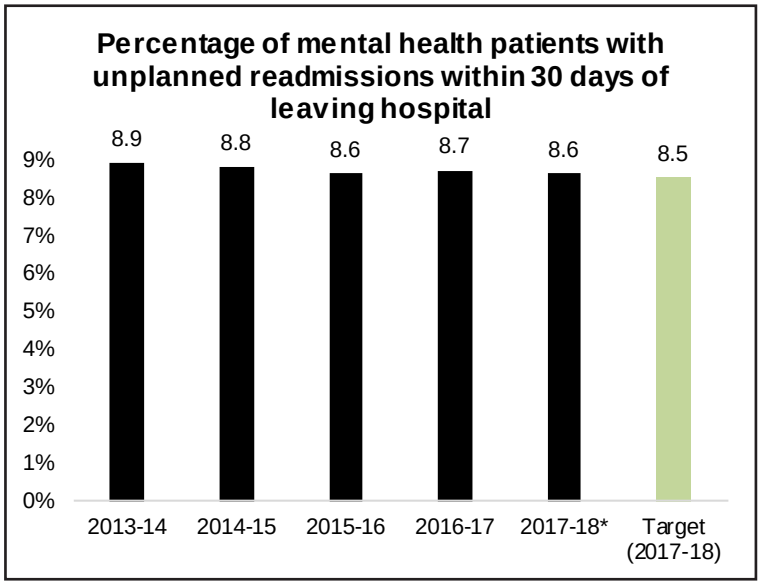
The PHR platform was expanded in 2017-18 to include access to laboratory and immunization data so pilot users can access this additional health information. In addition, the department completed the procurement process to find a vendor to provide a new platform for the PHR to replace the original platform which is now outdated. A preferred vendor was identified and a new contract negotiated and ultimately signed in March 2018. Work is being completed to ensure the application is fully compatible with mobile devices.

Performance Measures and Indicators

Performance Measure 1.a **Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital**

Description

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 index hospital stay for which the most responsible diagnosis was selected mental illness. This measure is reported a quarter later due to the requirement to follow up with patients after the end of the reporting quarter. 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.



Source: Canadian Institute for Health Information, Alberta Health Services, Provincial Inpatient Database.
**Note: The results for 2017-18 (8.6%) are Q3 year-to- date, as the measure is reported a quarter later due to the requirement to follow-up with patients after the end of the reporting quarter.*

Results Analysis

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., elderly patients and patients with complex health needs) or by accessibility of mental health care in the community.

The ministry views this measure as an indication of whether policies, programs and initiatives are having the desired impact on patients with mental illness. Continued investment and focus on implementing the actions arising from *Valuing Mental Health: Next Steps* will help achieve the target and reduce unplanned readmissions. Alberta's results have stayed rather consistent the past three years, with continued efforts underway to achieve the target.

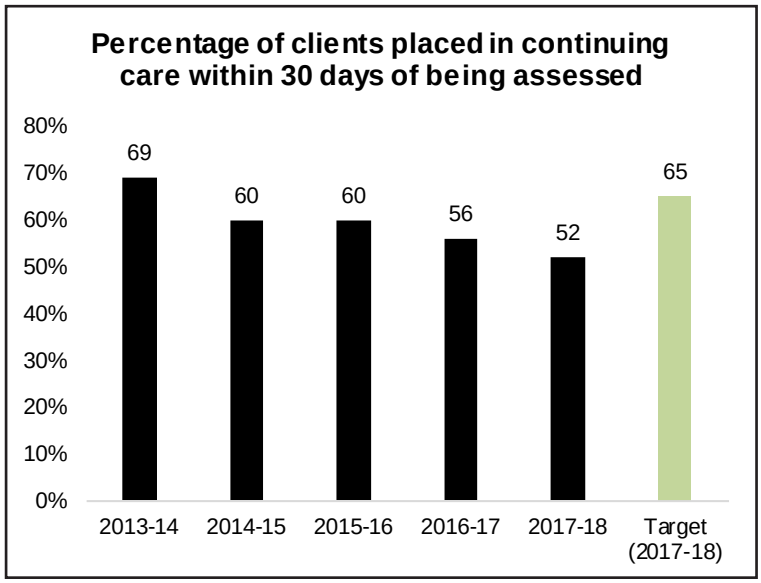
Alberta Health Services continues to monitor hospital readmissions and a range of initiatives are being undertaken to address the needs specific to each zone. There are also a number of province-wide initiatives underway that address readmissions including:

- Working with Primary Care Networks to ensure comprehensive services are in place for patients with complex health needs, such as Patients Collaborating with Teams (PACT) which focuses on planning for those with complex health needs and Bridging the Gap which determines solutions for discharge and transition of patients with complex health needs to community family practices.
- The work underway by the Addiction and Mental Health Strategic Clinical Network to develop clinical care pathways to support coordination within and transitions between all service providers, including service providers from the health, social services and education sectors.
- Community Treatment Orders (CTOs) will continue to be issued under the *Mental Health Act* (MHA) to support individuals who have mental disorders and satisfy the requirements of the MHA for a CTO to help them to stay in the community and reduce hospital readmission rates. CTOs are an important tool used to establish a treatment and care plan outlining service providers and supports required for the client to stay well in the community.
- TeleMental health uses technology to ensure clients receive help without leaving their community by linking them to mental health professionals. The number of contacts/calls to TeleMental health continues to increase, with over 10,000 contacts/calls made in 2016-17 (the most recent data available).

Performance Measure 1.b **Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed**

Description

This measure is used to monitor and report on access to continuing care living options in Alberta, as indicated by the wait times experienced by individuals who move into a continuing care facility within the reporting period. Continuing care living option refers to the level of care in a publicly funded resident accommodation that provides health and support services appropriate to meet the client's assessed unmet needs (i.e., Designated Supportive Living Level 3, 4, 4-Dementia, or Long-term Care). 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.



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

Results Analysis

The current result of 52 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, when combined with an increasingly aging Alberta population, have not yet achieved an improvement in the percentage of clients who are moved into facility-based continuing care within 30 days of being assessed. Alberta Health Services track results on a monthly basis and there are indications that the results began to show improvement in late 2017. However, there is need for the investments in home and community care to more quickly expand and for facility-based continuing care to be more readily available.

For the past three years, the results have been 60 per cent or lower. This recent trend reflects an interaction among a number of factors. Historically there was a 9 per cent drop between 2013-14 and 2014-15 which was mostly due to rescinding the "First Available Bed" policy in June 2013 and subsequent implementation in May 2015 of the *Designated Living Option: Access and Waitlist Management in Continuing Care* policy. The new policy established a consistent, principle-based, transparent approach for individuals to access a continuing care living option and provides greater choice and a more person-centred process where client needs and preferences are taken into consideration. This means that clients can now choose to wait for a preferred bed, as opposed to having to take the first available bed. Although

the timeliness has been impacted, the balance point has been that clients and their families have been given more choice of living options and have experienced an improved person-centred process.

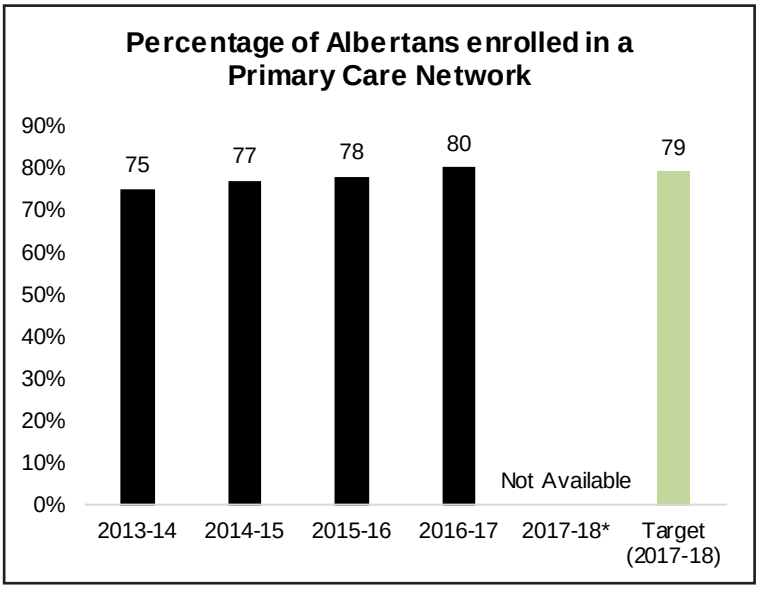
At the same time as the policy shift happened, other factors that influence the achievement of this measure have also occurred, and continue to be addressed. Investments have been made in home and community care and the number of available continuing care living spaces is increasing as the planned 2,000 long-term care and dementia spaces start to open and become available, with a significant number of those planned to open in 2018-19. Together, these investments will provide additional capacity to enable those Albertans who need facility-based continuing care options to access those in a more timely manner.

Performance Measure 1.c **Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network**

Description

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 and ensure that primary health care programs and services are available to all Albertans.



Source: Ministry of Health, Alberta Health Care Insurance Plan Statistical Supplement, Claims Assessment System.
**Note: The 2017-18 result was not available at the time of this publication.*

Results Analysis

The 2017-18 result for this performance measure is not available for reporting. In 2016-17, 80 per cent of Albertans were enrolled in a PCN, this is one per cent higher than 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 and which provide 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 enrolment 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.

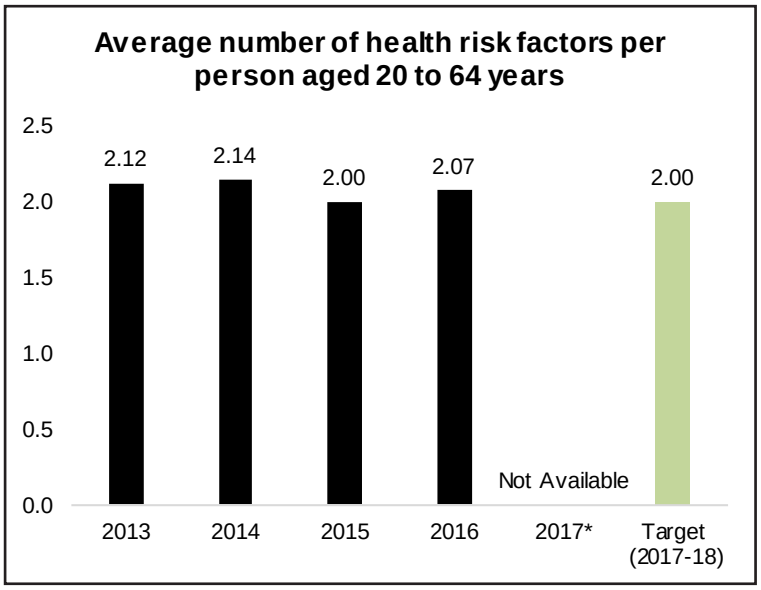
As part of the ministry's goal for more community-based health care, the department is working with the PCN Physician Leads, Alberta Health Services, and primary health care partners to support the evolution of primary healthcare delivery across the province. According to research conducted by the Canadian 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 Measure 1.d **Healthy Alberta Trend Index (HATi): Average number of health risk factors per person aged 20 to 64 years**

Description

The Healthy Alberta Trend Index (HATi) is a composite index that measures six self-reported, complex health behaviours: life stress; BMI (overweight/obesity); fruit and vegetable consumption; physical activity; smoking status; and binge drinking alcohol.

The reduction of risk factors is a precursor to chronic disease prevention. The HATi was developed as a single combined measure to monitor progress achieved towards improving healthy behaviours and reducing risks for development of disease and disabilities among Albertans aged 20 to 64 years.



Source: Statistics Canada, Canadian Community Health Survey.
**Note: The 2017 result was not available at the time of this publication.*

Results Analysis

HATi results could be anywhere between 0 and 6, where 0 would be most healthy and 6 most unhealthy. There is no statistically significant difference among the results for 2015, 2016, and the 2017-18 target. Results for 2015 and 2016 cannot be compared to prior years because in 2015 the Canadian Community Health Survey, the foundation of the data for the HATi, was changed in terms of content and sampling frame. Efforts to resolve data quality issues produced by the change to the survey have not been successful. As a result, the department has decided to stop using the HATi measure and will instead be reporting on the prevalence of cigarette smoking among Albertans, beginning in 2018-19, as a proxy for changes in healthy behaviours.

As the HATi measures population level shifts, the changes over time are notably small, incremental and often fluctuating. Shifts in the trends are driven by a range of factors including to a large extent, social economic conditions, and the number of interconnected determinants impacted by policy and program initiatives outside of the health system (e.g., housing, education, availability of childcare).

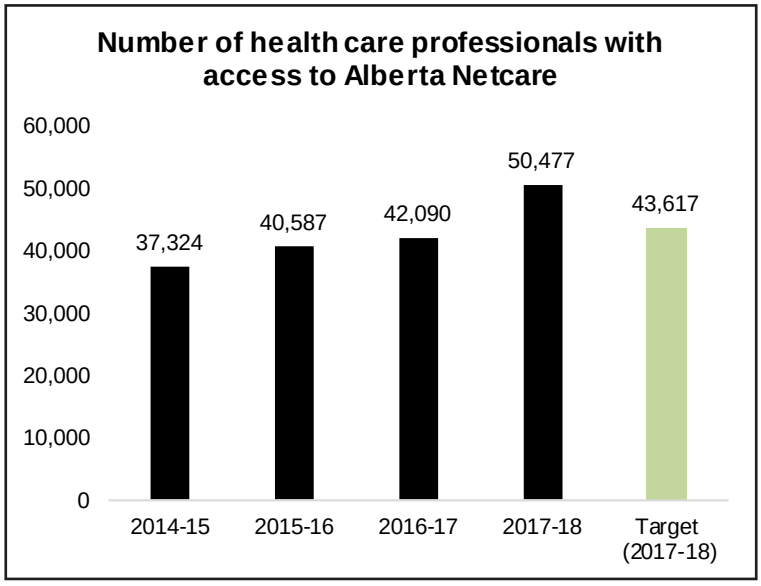
The government is committed to supporting Albertans in their efforts to lead longer, healthier lives by implementing targeted health care policy and program initiatives that contribute to wellness. In collaboration with community partners, the ministry is working to provide better access to supports and services that promote and protect

the physical and mental health and well-being of Alberta's children and youth (e.g., preventing and reducing tobacco use; offering resources and support to encourage healthy eating and active living for children; and, helping young adults learn about what it means to drink responsibly).

Performance Measure 1.e **Access to the provincial Electronic Health Record (EHR): Number of health care professionals with access to Alberta Netcare**

Description

Alberta Netcare is the common name for all the projects related to 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. The broader adoption and utilization of Alberta Netcare enables enhanced quality of care by providing better access to patient information at point of care.



Source: Alberta Netcare Monthly Utilization Report

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.

Over 50,000 health professionals now have access to patient records through Netcare, significantly exceeding our target. While previous years showed a steady growth rate of 5 per cent year-over-year, in 2017-18 there was a jump of 19.9 per cent in the number of new Netcare users. There was an increase in the number of users across all of the health professions that previously had access to Netcare—physicians (including medical residents), nurses, pharmacists and allied health professionals—and in the past year, access was also provided to those in optometry, chiropractic and dentistry professions. The 2017-18 result shows strong endorsement from health care professionals for the value of information in the provincial EHR.

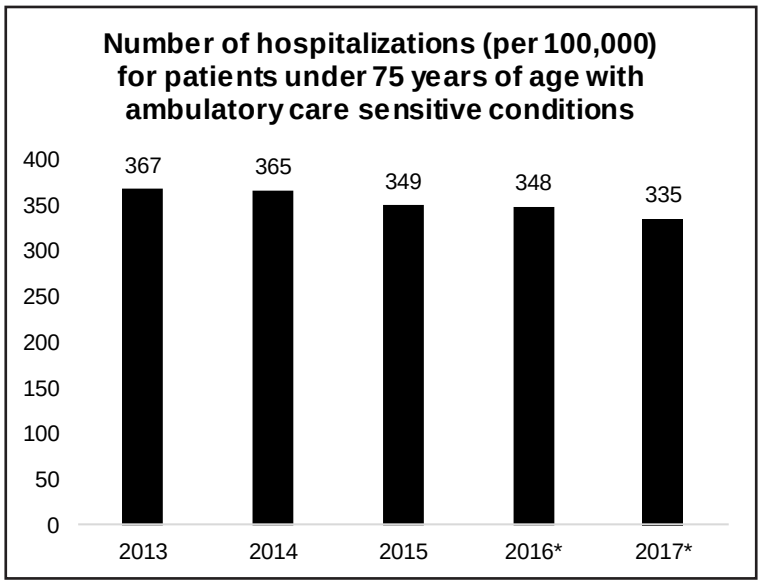
A number of initiatives may have positively influenced adoption of Netcare. In particular, the Real Time Integration (RTI) project focused on connecting community pharmacies so that pharmacy updates were reflected in real time, this may have contributed to the increase in the number of pharmacists. Additionally, 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.

Performance Indicator 1.a **Ambulatory sensitive care 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**

Description

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 Alberta Health Services, 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.



Source: Numerator: Discharge Abstract Database, Canadian Institute for Health Information. Denominator: Statistics Canada, post-censal population estimate.
** Note: The 2016 result of 348 updates the preliminary result (344) as published in the 2016-17 Health Annual Report. The 2017 result is preliminary.*

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 ranked Alberta sixth out of 13 provinces and territories for this health indicator in 2015-16. While additional work is needed to further reduce this rate, Alberta's trend is decreasing each year and community options are increasing.

The ministry continues to focus on making investments to increase 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 Alberta Health Services are working collaboratively to coordinate the planning and delivery of supports and services with Albertans, patients, care providers and communities as partners.

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

What this means: 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 will continue to work with its partners to address health inequities among and within vulnerable populations and to encourage Albertans to stay healthy supported by policies, programs and initiatives focused on prevention of injury and disease.

Achievements

Key Strategy 2.1: Support the protection of Albertans' health and well-being by:

► **Strengthening policies and practices to protect environmental public health, based on environmental public health science and international best practices.**

Environmental public health focuses on the relationships between people and their environment, promotes human health and well-being, fosters healthy and safe communities, and is a key part of any comprehensive public health system.

Implementation of the Horse River Wildfire (Fort McMurray) Environmental Public Health Recovery Plan continued in 2017-18, with the development of a Ministry Recovery team supported by federal, provincial and municipal government partners. Funding to implement this plan originates from Recovery Initiatives facilitated by the Alberta Emergency Management Agency and includes research grants, contracted expertise and temporary staffing positions. The Plan includes activities and deliverables from all areas of environmental public health (air, water, food and soil), and is being shared publicly on the government's website at www.alberta.ca/environmental-monitoring-fort-mcmurray.aspx.

The Department of Health is creating the Environmental Public Health Toolkit to support its role in response, re-entry and recovery for the next disaster event. Lessons learned and gaps identified during the Horse River Wildfire are being addressed through the recovery plan and further incorporation into the toolkit.

On January 1, 2018, the *Skin Cancer Prevention (Artificial Tanning) Act* was brought into force along with the *Artificial Tanning Regulation*. This legislation protects Albertans under the age of 18 and helps inform all Albertans about the health risks of ultraviolet (UV) artificial tanning.

The Alberta Environmental Public Health Information Network and "Should I Eat this Fish?" mobile app were launched on February 1, 2018. The network and app translate environmental public health monitoring onto user-friendly platforms where all types of stakeholders can engage and learn about how the environment impacts public health and their own health. For example, Albertans can search for information about the quality of their drinking water or the safety of recreational lake water. Engagement with the University of Alberta, provincial and federal cross-ministry partners and other researchers was essential to translate volumes of data for the network and app. This engagement was supported by a grant to the university and a further contract to support the two web-based platforms. In 2018-19, the department will continue to update the data being displayed and to look at including additional data on cyanobacteria (blue-green algae) and air quality.

► Collaborating with Agriculture and Forestry and engaging with stakeholders to develop and implement a provincial strategy on antimicrobial resistance that supports the federal pan-Canadian antimicrobial resistance framework and action plan.

Antimicrobial resistance occurs when microorganisms become resistant to drugs that were previously effective in killing or slowing their growth. A significant cause of antimicrobial resistance is improper use of antimicrobials in humans as well as in animals, and spread of resistant strains between the two.

Engagement with both health and agricultural sector stakeholders to inform the development of a provincial strategy on antimicrobial resistance began in January 2018, and will continue into summer 2018. The engagement focuses on questions related to antimicrobial resistance stewardship, surveillance, research, innovation, and infection prevention and control.

► Working with key partners to enhance food safety reporting mechanisms and ensure effective policies and a regulatory environment that promotes best practices in the food industry.

The Department of Health is responsible for the administration of the *Public Health Act* and *Food Regulation*. Enforcement of the regulation is the responsibility of Alberta Health Services (AHS) through its inspection programs. Alberta Agriculture and Forestry administers and enforces acts and regulations (such as the *Meat Inspection Act*) that support inspections of slaughter and associated meat processing facilities.

The department, AHS and Alberta Agriculture and Forestry work closely together to strengthen the province's food safety system, throughout the supply chain, to better protect the public from food borne illness. In October 2017, collaboration between the partners led to full implementation of outstanding recommendations made by the Office of the Auditor General in 2006, addressing potential weaknesses in Alberta's food safety system.

► Safeguarding Albertans from communicable disease through increased immunization rates and initiatives aimed at decreasing sexually transmitted infections.

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. As of March 31, 2018, 1,223,059 doses of influenza vaccine had been administered covering approximately 28.6 per cent of the population. This is a slight increase over the 2016-17 season which saw 1,157,061 doses administered covering approximately 27 per cent of the population.

The amendments to the *Public Health Act*, introduced in fall 2016 — related to the immunization of school-aged children — require Alberta Education to share parent contact information and student enrolment information under the custody and control of that ministry with Alberta Health. Over the past year, the two departments worked together to transfer this data from the Provincial Approach to Student Information (PASI) application, Alberta Education's central repository for student information, through a secure web-based service to the Provincial Immunization Repository (Imm/ARI) held by Alberta Health. The transfer of data was in production by December 2017 and will allow Alberta Health to cross-reference student information with immunization records and provide a list of students by grade and school to AHS so they can identify children in all grades with incomplete immunizations or missing immunization information.

In addition, five of Alberta's 44 First Nations communities are submitting immunization data to Imm/ARI through a web service, including two which began submitting data in 2017. Discussions with additional First Nations communities are in progress regarding opportunities for data sharing.

Alberta continues to experience outbreak levels of gonorrhea and infectious syphilis. In November 2017, gonorrhea and chlamydia testing was added

to the Alberta Prenatal Screening Program for Selected Communicable Diseases in order to both improve the health of mothers and prevent serious illness in infants in Alberta. Full achievement of this program is currently hindered by technical limitations at the laboratories. Discussions are underway to determine the best method of flagging these specimens for reporting purposes and standardizing lab processes.

After engagement with AHS and community organizations during 2017-18, the department completed the Sexually Transmitted and Blood Borne Infection Framework, which provides policy guidance for AHS and community organizations to address issues surrounding sexually transmitted and blood borne infections, including HIV and Hep C, and support vulnerable Albertans.

In February 2018, the province began offering Human Papillomavirus (HPV) immunization to men who have sex with men and transgender women aged 17 to 26. Providing provincially funded vaccines to this group aims to decrease sexually transmitted infections related to HPV and, in the long term, decrease incidences of anal cancer.

Also in February 2018, the department gained access to Rifapentine via Health Canada's Access to Drugs in Exceptional Circumstances process. Rifapentine is used to treat latent tuberculosis (TB) in populations with high risk of progression to TB. Rifapentine improves treatment options for individual Albertans and reduces the treatment regime from nine months to 12 weeks.

The Provincial Surveillance Information System is the core communicable disease application for laboratory surveillance purposes for both Alberta Health and AHS. Phase 1 went into production in January 2018, delivering the lab-processing module that captures, validates, and processes electronic lab records from the two largest laboratory information systems in the province, which represents approximately 80 per cent of all notifiable disease laboratories.

Did you know?

Under the Public Health Act, Alberta monitors and tracks over 100 notifiable communicable diseases, providing provincial leadership in outbreak identification and response preparedness.

Key Strategy 2.2: Reduce the gap in health outcomes between Indigenous and non-Indigenous peoples through collaboration in program design and delivery with the federal government, Indigenous communities, and other organizations.

Significant gaps continue in the overall health status of Indigenous Albertans compared to non-Indigenous Albertans. Through work that supports the *United Nations* (UN) *Declaration on the Rights of Indigenous Peoples* and the *Truth and Reconciliation Commission of Canada: Calls to Action*, the Government of Alberta is responding to health challenges experienced by Alberta's First Nations and Métis populations in a manner consistent with Alberta law and the *Constitution Act*. Health care systems and health care providers need to be culturally appropriate, accessible and inclusive.

In December 2017, the Ministry of Health and Treaty 8 First Nations of Alberta adopted the Health Protocol Table Work Plan, building a joint working relationship to take necessary steps to identify and address the gap in specific health outcomes between Treaty 8 First Nations of Alberta peoples, as compared to the people of Alberta generally. Key areas of interest include examination of available health services and programs, the compilation of health information relating to health outcomes and health system utilization, and measures to prevent racism in the health setting. In addition, the department provided direct funding to Treaty 8 First Nations of Alberta for a full-time Health Table Coordinator to support these efforts. This work is guided by the principles outlined in the Government of Alberta/Treaty 8 First Nations of Alberta Protocol Agreement (2016), the spirit and intent of the UN Declaration and the Calls to Action of the TRC in a manner consistent with Alberta law and the *Constitution Act*.

Alberta Health also strengthened its collaboration with the Alberta First Nations Information Governance Centre by providing a $1 million grant through the Alberta Cancer Prevention Legacy Fund. This funding will support information sharing between First Nations and key stakeholders and help to advance planning and action related to cancer prevention and screening.

The department also established the Indigenous Integration Committee under *Valuing Mental Health: Next Steps*, which has met 13 times since April 2017 and includes representation from the federal government, multiple provincial ministries, and First Nation and Métis organizations. One of the responsibilities of the committee is to partner with other Valuing Mental Health implementation committees to provide an Indigenous perspective on implementation activities, identify opportunities for Indigenous-specific projects, and identify ways Valuing Mental Health (governance, actions, initiatives) can be leveraged to address gaps for First Nations and Métis communities related to addiction and mental health needs.

Lastly, the department has embarked on engagement models at local community levels to best understand community needs and how to plan health services and programs. This engagement approach supported the distribution of $5 million to each of Alberta's Treaty areas, the Métis Nation of Alberta, and Metis Settlements General Council to support Indigenous communities in responding to the opioid crisis and to save lives.

Key Strategy 2.3: Improve maternal, infant and child health by supporting initiatives that foster maternal-infant health and early childhood development.

The Government of Alberta supports maternal-infant health initiatives to foster healthy birth outcomes including healthy birth weights, Fetal Alcohol Spectrum Disorder (FASD) prevention, and support for improved maternal mental health, as well as overall maternal and infant health.

The Early Hearing Detection and Intervention Program is a comprehensive program that includes newborn hearing screening, referral, assessment, follow-up and outcome tracking. Newborn hearing screening was fully implemented in all Neonatal Intensive Care Units in 2017-18, with screening and assessment anticipated to be fully implemented for all eligible infants by October 2018.

Alberta's Early Development Instrument (EDI) is a cross-ministry initiative of Alberta Health, Alberta Education, and Alberta Community and Social Services that gathers data on the ability of kindergarten-aged children to meet age appropriate developmental expectations. In 2017-18, the department developed the EDI Community Profile Reports using EDI data collected by Alberta Education on kindergarten children in 2016.

Data are aggregated and reported for communities, and the reports provide a snapshot of the development of a community's children in the first five years of life, including information about how young children are doing in five developmental domains (physical health and wellbeing, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge). The reports are intended to help parents, communities, service providers, and government support positive early childhood development.

Key Strategy 2.4: Lead an urgent government response to reduce the harms associated with opioid misuse and oversee the implementation of priority activities to address overdoses and deaths related to fentanyl and other opioids.

The Minister's Opioid Emergency Response Commission was established under the *Public Health Act* and under the *Opioid Emergency Response Regulation* in May 2017 with a mandate to develop recommendations for, and facilitate the implementation of, urgent co-ordinated actions to effectively address the opioid crisis. In 2017-18, the commission made 26 public recommendations. Commission members and recommendations can be found at: www.alberta.ca/opioid-emergency-response-commission.aspx.

The department executed multiple grants to support implementation of the recommendations of the Commission, including to:

- enhance the provincial naloxone program (in 2017, more than 49,000 naloxone kits were distributed to Albertans at more than 1,400 sites);
- increase access to opioid treatment programs;
- initiate programming for injectable opiate agonist therapy programs in Edmonton and Calgary (opiate agonist therapy involves replacing opioids with other, less harmful drugs, such as methadone, to prevent withdrawal symptoms);
- increase the participation of primary care settings in opioid response;
- support Calgary's Punjabi Community Health Services to deliver culturally appropriate, family-centred services;
- expand the Addiction Recovery and Community Health teams in Edmonton and Calgary, which work with a patient's care team in the emergency

department or inpatient setting to provide support and treatment recommendations;
- support Indigenous communities in responding to the opioid crisis; and,
- support public awareness about opioids through AHS and social media campaigns.

Other actions included accelerating the availability of supervised consumption services in Alberta, with Health Canada approving six supervised consumption service locations across the province. Four of these began operations in 2017, with Lethbridge becoming the first location in Canada to offer supervised inhalation service and the Royal Alexandra Hospital in Edmonton becoming the first in-patient hospital setting for supervised consumption service in North America. Additionally, needs assessments for supervised consumption services were completed in seven cities that had pre-established, publicly funded needle distribution programs, and Alberta's first emergency overdose prevention site was established on the Kainai First Nation reserve in southern Alberta.

Standardization of sample collection fees and additional funding of $285,000 was provided to the Alberta Centre for Toxicology to support necessary analytical testing for Albertans participating in AHS' Opioid Dependency Program. This was vital to maintaining services from collection sites across the province and to minimizing service disruption for Albertans seeking treatment. The Alberta Centre for Toxicology, a public health laboratory fully supported by the ministry, had experienced a 57.2 per cent increase in sample submission between 2015-16 and 2016-17.

The department worked closely with regulatory bodies during 2017-18 to enhance the response to the opioid crisis: the College of Physicians and Surgeons of Alberta (CPSA) released new standards for appropriate prescribing of opioids; the Alberta College of Pharmacists released new standards of practice for appropriate dispensing of opioids (aligned with the CPSA standards); and, opioid agonist initiation and maintenance are now included in the scope of practice for nurse practitioners through the College and Association of Registered Nurses of Alberta.

The department also continued to publish quarterly and interim Opioid and Substances of Misuse Reports during the year as a direct result of the Ministry's close relationship with the Office of the Chief Medical Examiner. This reporting was expanded to include publication of the Opioid and Substances of Misuse Report among First Nations People, in partnership with the Alberta First Nations Information and Governance Centre.

Performance Measures and Indicators

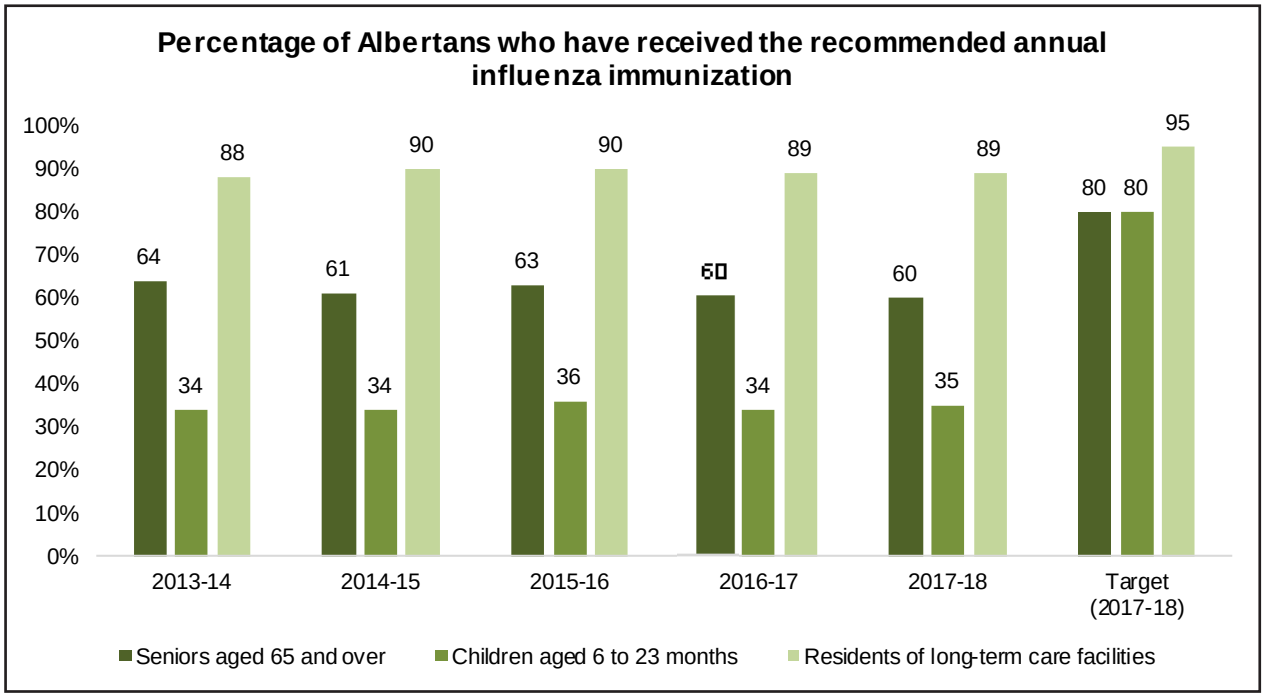
Performance Measure 2.a **Percentage of Albertans who have received the recommended annual influenza immunization**

- **Seniors aged 65 and over**
- **Children aged 6 to 23 months**
- **Residents of long-term care facilities**

Description

This performance measure tracks efforts towards immunization among high risk groups, including seniors (aged 65 and over), young children (aged six months to 23 months) 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.



Source: Numerator: Number of individuals immunized by age category: Alberta Health Services zones; Alberta Health's weekly pharmacists data; First Nations and Inuit Health, Indigenous Services Canada, Alberta Region.
Denominator: For seniors and children, the denominator is the ministry's population estimates, based on mid-year registration population estimates from Alberta's Interactive Health Data Application. For residents of long-term care facilities, the denominator is the number of residents as of December 15, 2017 provided by Alberta Health Services..

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 and 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, which are set at an aspirational national level required to prevent disease outbreaks and protect vulnerable populations (e.g., those who are not eligible for certain vaccines such as infants, pregnant women, or immune-compromised individuals).

Targets are not easily achievable for influenza vaccine as there is a short window of time in which to immunize the population before influenza begins to spread. Vaccine hesitancy has been increasing, despite increasing access to vaccines and providing education about the benefits of annual influenza immunization. Another contributing factor to low immunization rates is that influenza vaccine is not like other vaccines in terms of its effectiveness as it ranges from 10 to 50 per cent effective. Also, a large number of people think that influenza is not a serious illness and do not realize that they can carry it and infect high-risk people even if they do not feel sick.

From results reported by the Canadian Institute for Health Information, the average rate of influenza immunization for seniors in Canada in 2013 (last data available) was 65.4 per cent (the range was from a low of 54.4 per cent in Newfoundland and Labrador to 75.2 per cent in Nova Scotia). In comparison, Alberta was slightly lower than average at 64 per cent in that same year.

The department continues to work with Alberta Health Services, pharmacists, physicians and other stakeholders across Alberta to increase access to influenza immunization, to communicate the importance and benefits of the annual influenza immunization program, and to focus efforts on steady improvement of influenza immunization rates over time.

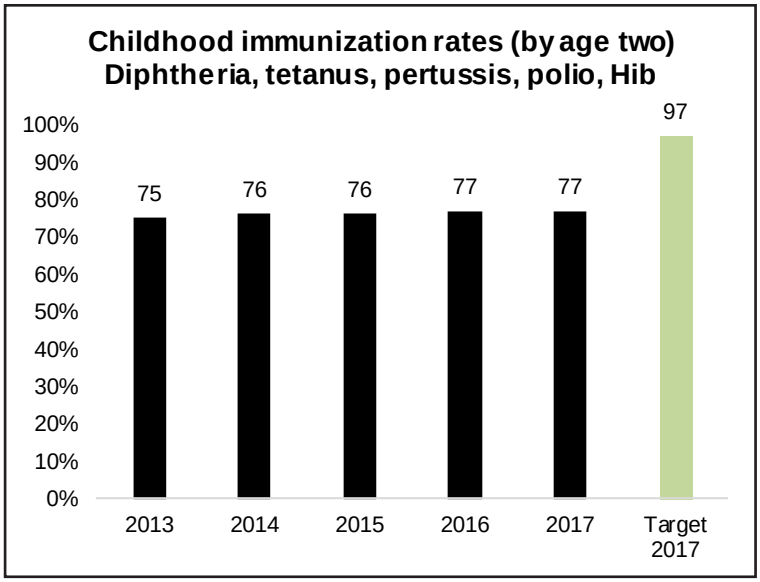
Pharmacist administration of publicly funded vaccines has proven to be an effective means of expanding distribution through more points of access across Alberta communities. In an effort to capitalize on this successful distribution model, for the upcoming 2018-19 Influenza Immunization Program, pharmacists will be able to expand offering vaccination to children from five years of age and older, whereas previously the Influenza Immunization Policy restricted pharmacists to administration for children nine years of age and older.

Performance Measure 2.b **Childhood immunization rates (by age two):**

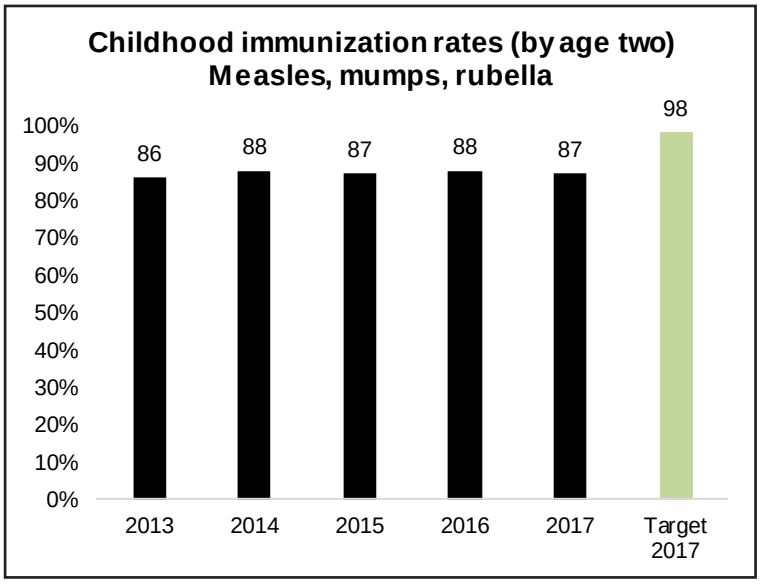
- **Diphtheria, tetanus, pertussis, polio, Hib**
- **Measles, mumps, rubella**

Description

This performance measure indicates 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 also serves to control outbreaks. 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.



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



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

Results Analysis

The provincial electronic immunization information registry captures all immunization information in Alberta including immunization of Albertans under the age of two years of age. 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 diphtheria, tetanus, pertussis, polio and haemophilus influenza type b (DTaP-IPV-Hib) and between 86 per cent and 88 per cent to prevent measles, mumps and rubella (MMR).

Targets are not easily achievable as vaccine hesitancy is increasing, despite increasing access to vaccines and providing education about the benefits of immunization. The department and Alberta Health Services (AHS) continue to work together to increase coverage rates. For example, AHS focuses on increasing access and decreasing wait times at public health clinics for routine childhood immunization. AHS also continues to raise awareness in geographical areas where immunization rates are low, including working with other stakeholders to harmonize childhood immunization between Indigenous communities and non-Indigenous communities.

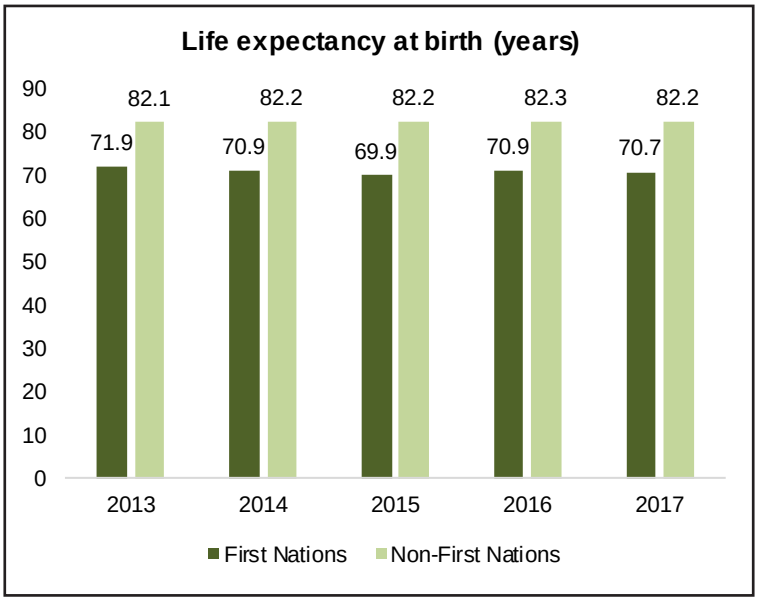
To increase protection against these vaccine-preventable diseases, beginning in the 2018-19 school year, public health professionals will ask parents of students in grades 1 to 9 who do not appear to be fully immunized or who have not provided complete immunization information to: provide their child's immunization records; complete any needed immunizations to bring their child up to date with recommended immunization schedules; indicate that their child cannot receive a vaccine for medical reasons; or indicate they have declined immunization for their child for other reasons.

Performance Indicator 2.a **Life expectancy at birth (years):**

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

Description

This measure 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, and it only takes into account the length of life and not quality of life.



Source: Alberta Health Care Insurance Plan Adjusted Population; Alberta Health Postal Code Translator File; Alberta Vital Statistics Death File; First Nations Status Registry.

Results Analysis

In 2017, the gap in life expectancy between First Nations and Non-First Nations populations in Alberta was 11.5 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. In developed countries such as Canada, however, it is thought that differences in life expectancy are primarily driven by the social determinants of health. These include factors such as income, housing, education, and employment conditions. Importantly, for First Nations people, life expectancy may be influenced by a complex colonial history that includes intergenerational trauma from residential schools, higher rates of poverty, and systemic racism.

The Ministry of Health is working to address health service improvements and health priorities to improve health outcomes for Indigenous Albertans by collaborating with the province's regional Indigenous organizations, Alberta Health Services, 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 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 in Alberta.

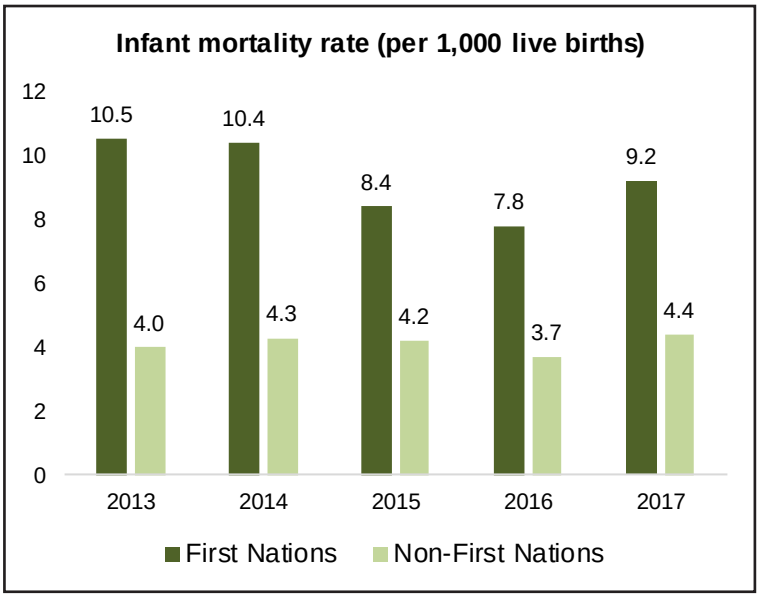
In addition, the department is involved with the Treaty 8 Protocol Agreement Health Table, Blackfoot Confederacy Protocol Agreement, Métis Nation of Alberta Framework Agreement, and the Metis Settlements General Council Long-Term Governance and Funding Arrangement. Progress is being made in several key areas including: strengthened immunization information sharing; coordination of actions under Alberta's *Valuing Mental Health: Next Steps* 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. 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.b **Infant mortality rate (per 1,000 live births)**

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

Description

Infant mortality is an important indicator of population health. First Nations' infants have a higher rate of mortality than Non-First Nations' infants. The infant mortality rate provides the number of deaths among 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.



Source: Alberta Vital Statistics Death File (infant deaths); Newborn Metabolic Screening (NMS) Database (live births); First Nations Status Registry.
Note: Infants less than one year of age.

Results Analysis

There is a notable and 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; however, there appears to be an increasing rate in 2017 for First Nations people in the province while the rates for Non-First Nations people have also increased. This is more apparent when looking at trends over a longer period of time.

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-economic factors such as income, housing, education, and employment conditions. Importantly, for First Nations people, infant mortality rates may be influenced by a complex colonial 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. The Government of Alberta's commitment to the *United Nations Declaration on the Rights of Indigenous Peoples* and the *Truth and Reconciliation Commission of Canada: Calls to Action* is reflected in the ministry's

priority for renewing relationships with Indigenous peoples in Alberta. A formalized engagement and coordination process 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 Tsuu T'ina Tribal Council, builds upon the foundation of reconciliation and relationships as well as community driven and culturally appropriate engagement processes.

Treaty 8 First Nations of Alberta and the department have developed and endorsed a long-term work plan focusing on areas such as: racism, mental health, youth and family treatment centre, long-term care, physician services, primary care, and a 24 Nations Lodge.

The ministry will continue to work in partnership with Indigenous peoples and federal and provincial partners to strengthen health services for Indigenous people in our province, including holistic primary care, obstetrical and pediatric care services. As part of the Maternal, Newborn, Child & Youth Strategic Clinical Network, the department and Alberta Health Services are supporting key initiatives aimed at reducing disparities between Indigenous and non-Indigenous Albertans. These include:

- MERCK for Mothers, a partnership between Merck Canada Inc., AHS and Alberta Innovates, and a collaborative initiative aimed at improving access and quality of care for Indigenous mothers in Maskwacis, Little Red River Cree Nation, and inner-city Edmonton. This project will also focus on building resilience, promoting positive images of the community, celebrating birth and sharing Indigenous knowledge on pregnancy.
- AHS' Pregnancy Pathways to support health care practitioners with evidence-based guidelines to support optimal care and outcomes for mothers and babies.
- In spring 2017, work began on the development of an antenatal (pre-birth) care pathway to support maternity services in geographical zones across the province so that expectant mothers can access consistent antenatal care.
- The Pregnancy Pathways initiative for homeless, pregnant and parenting women in need of housing, health and social supports in Edmonton's inner-city.

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.

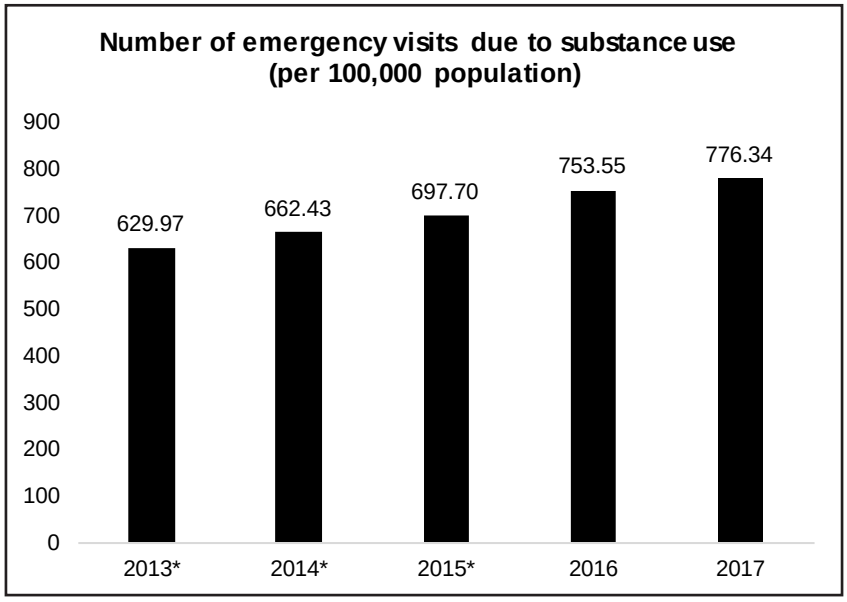
The Office of the Chief Medical Officer of Health and the Alberta First Nations Information Governance Centre are working together with an advisory committee to develop a report on the health status of First Nations in Alberta. The report aims to highlight health inequities and identify initial areas for action to reduce identified gaps and improve the health of First Nations in Alberta.

Performance Indicator 2.c Emergency visits due to substance use (per 100,000 population)

Description

This indicator provides the age-standardized rate of visits to emergency departments and urgent care centres related to substance use and misuse. This includes psychoactive substances (such as opioids and alcohol).

This indicator identifies only the primary diagnostic code; future reporting will include the primary diagnostic code as well as the diagnostic codes of other contributing factors when a patient presents to an emergency department or urgent care centre, resulting in a higher number of incidents.



*Source: Alberta Ambulatory Care database,Alberta Health Care Insurance Plan Population Registry Files. Alberta Postal Code Translator File, Statistics Canada, Census 2011 population data.*Note: The results for 2013 to 2015 have been updated as population estimates are retroactively changed every year.*

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.

Steps being taken by the ministry to reduce the harms associated with the problematic use of opioids may increase emergency visits, at least in the short term. For example, since more naloxone is available and accessible to save the lives of Albertans experiencing opioid overdoses, more individuals will be brought to emergency for follow-up care. Enhancing the provincial naloxone program was one of 26 public recommendations made by the Minister's Opioid Emergency Response Commission, established in May 2017 to guide the provincial response to the opioid crisis. Other results include increased access to a variety of opioid dependency treatment options and social media campaigns to increase the public's understanding of opioids and addiction. For the first time in Alberta's history, supervised consumption services are available to reduce the risks of disease, overdose and death of Albertans dealing with chronic addiction issues.

Alberta Health continues to be involved in supporting responsible alcohol consumption as co-chair of the National Alcohol Strategy; this work supports pan-Canadian sharing of best

practices. Alberta Health Services (AHS) is working with municipalities to support and promote the development and implementation of bylaws that support responsible alcohol use. Alberta Health, AHS, and the Alberta Gaming and Liquor Commission have all worked collaboratively to implement the Alcohol Strategy.

Alberta Health has also invested $1.6 million in public education and social marketing campaigns in response to urgent drug issues in Alberta. A campaign addressing opioid use launched in 2017-18 with further specific campaigns planned to address prescription drug and fentanyl use.

The Ministry is also implementing recommendations from the *2016 Valuing Mental Health: Report of the Alberta Mental Health Review Committee* report to improve access to addiction and mental health services, especially within rural areas, and to develop better coordination and transition between addiction and mental health services.

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

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

Achievements

Key Strategy 3.1: Improve access to health care providers across the province and develop sustainable strategies that ensure the appropriate education, scope of practice, supply and distribution of health care providers.

Highly skilled health care providers are paramount throughout the health system. This is especially important in acute care as it's central to the overall performance of Alberta's health care system. The quality of care received in hospital will have a direct impact on Albertans' safety and recovery. As we see advances in diagnosis, treatment, discharge and follow-up care, the ministry will continue to support the need for well-trained and skilled health providers to ensure quality, safety and appropriateness in the provision of acute care services and community care, while also listening to patient experience.

In summer 2017, the Government of Alberta approved regulatory amendments to the *Alberta Health Care Insurance Regulation* and the *Claims for Benefits Regulation* to help set the direction for the implementation of physician resource planning in Alberta. Further to these amendments, the Minister of Health established the Physician Resource Planning Advisory Committee with membership from Alberta Health, Alberta Health Services, the Alberta Medical Association, the College of Physicians and Surgeons of Alberta, the University of Alberta and University of Calgary (both the Faculties of Medicine and medical students' associations), the Alberta Rural Health Professions Action Plan, and the Professional Association of Resident Physicians of Alberta.

The Committee's role is to provide the Minister with advice on the appropriate supply, distribution, and mix of physicians in Alberta. Led by the department, the Committee provided a final recommendation to the Minister on the number of additional physicians required to provide insured services in Alberta for 2018-19. In making its recommendation, the Committee considered current available evidence, physician supply forecasts and health system demand, while recognizing that a population health needs model required a longer time to be completed. The department also led the Committee in developing an implementation plan with recommended actions for member organizations to implement in 2018-19. Particular emphasis will be placed on improving physician distribution to rural and remote communities, underserviced urban areas and Indigenous communities.

Key Strategy 3.2: Enhance accountability and promote practice excellence among regulated health care providers.

Throughout the year, the department reviewed and provided feedback on several proposals by councils for colleges to adopt new or amended standards of practice or codes of ethics for their members. New or revised codes of ethics were submitted by the Alberta College of Speech Language Pathologists and Audiologists; Physiotherapy Alberta – College and Association; and, the College of Alberta Psychologists. New or revised standards of practice were submitted by the College of Physicians and Surgeons of Alberta; the Alberta College of Pharmacists; Alberta College and Association of Chiropractors, Alberta College of Medical Diagnostic and Therapeutic Technologists, and the College and Association of Registered Nurses of Alberta.

In 2016, the Minister of Health requested the department conduct a comprehensive review of the College of Naturopathic Doctors of Alberta standards of practice and code of ethics to assist the college in strengthening patient safety. The review, spread over five phases, looked at 30 standards, including the code of ethics. The first three phases were completed in 2016, and the final two phases were completed by December 2017. Each phase required ministry staff to provide feedback and guidance to the College during the drafting phases. To support development of the department's formal feedback, the standards were circulated to health system stakeholders for review and comment. Wrap-up meetings to discuss the feedback from the last phase, as well as any outstanding issues will be scheduled with the College in 2018.

Did you know?

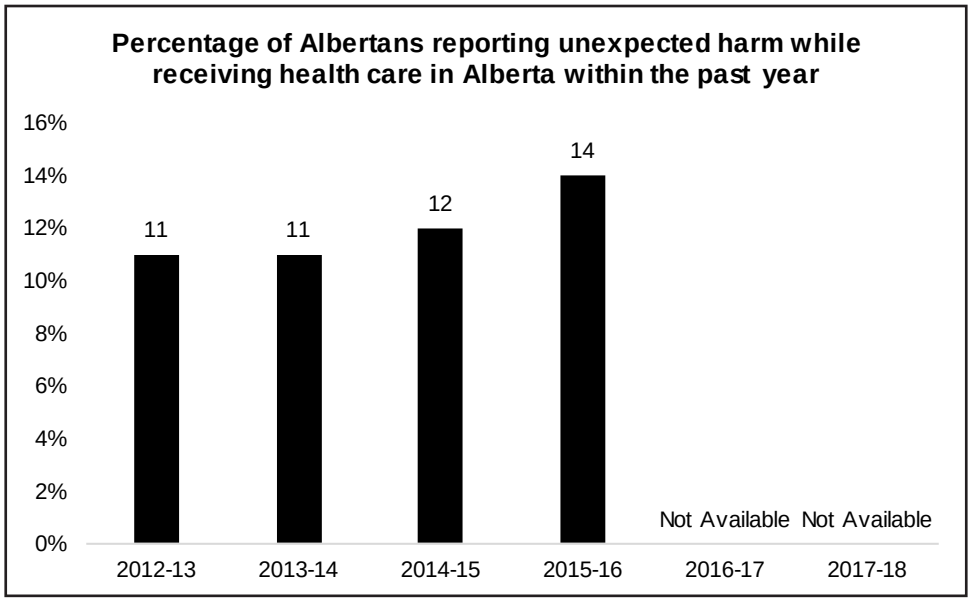
Alberta has more than 151,000 health providers comprised of 27 self-governing regulatory colleges regulated under the Health Professions Act covering over 30 health professions.

Performance Measures and Indicators

Performance Indicator 3.a **Patient Safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year**

Description

Patient experience with adverse events, such as unexpected harm as a result of health care provided to themselves or a family member, is a high level indicator of system safety. Unexpected harm can affect a patient's health and/or quality of life and can result in additional or prolonged treatment, pain or suffering, disability or death. Unexpected harm is different from complications which may occur due to an expected risk of some treatments. Monitoring patient experience supports the provision of safe care to improve patient outcomes and fosters continuous improvement in patient safety in Alberta's health care system.



Source: Health Quality Council of Alberta (HQCA): Provincial Survey about Health and the Health System in Alberta (2013, 2015, 2016). HQCA, Satisfaction and Experience with Health Care Services in Alberta (2012, 2014).
Note: The provincial surveys conducted by the HQCA have been discontinued. Alberta Health is working with the HQCA to identify a replacement for these surveys.

Results Analysis

The Health Quality Council of Alberta (HQCA) has conducted telephone surveys annually over the last ten years to collect information from Albertans on their perspectives of various aspects of patient satisfaction, including experience of quality and safety in the Alberta's health care system. Response rates to the telephone surveys have gradually declined over time, resulting in the HQCA evaluating new sampling strategies.

This survey conducted by the HQCA for this indicator has been discontinued due to declining response rates; 2016 is the last year for which results are available. Assuming this survey is a representative sample of provincial experience of health care, past results indicate that most Albertans do not experience unexpected harm while receiving health care. Based on the 2015-16 survey, 14 per cent of Albertans said they or an immediate family member experienced unexpected harm within Alberta's health care system which

is statistically significant from the 2012-13 and 2013-14 results (11 per cent).

The Patient Safety Framework for Albertans, released by the HQCA in 2010, helps guide, direct and support continuous and measurable improvement of patient safety in Alberta's health care system. Each health care provider has a responsibility to deliver safe care and every patient has the right to expect the safest care possible.

The new *Resident and Family Councils Act* means that as of April 1, 2018, through self-governing councils Albertans living in long-term licensed supportive care facilities have a voice in how their facilities are run. The councils benefit all residents through more effective complaints resolution and information sharing across the facility.

Alberta Health Services (AHS) continues to hold accredited status, based on the Accreditation Canada on-site survey, which demonstrates Alberta's commitment to meeting national standards for quality and safety in providing health care services.

Preventing harm during the delivery of care is foundational to all activities at AHS because it is one key way to ensure a safe and positive experience for patients and families interacting with the health system. Protection from infections acquired by patients in healthcare settings is a crucial component of patient safety. Hand hygiene is the easiest and more effective way to reduce health care-associated infections and prevent the spread of antimicrobial resistant organisms. AHS' Infection Prevention and Control Hand Hygiene program launched a call to action on Global Handwashing Day on October 15, 2017, to increase hand hygiene awareness. This was followed by release in February 2018 of a *Leadership Toolkit: Hand Hygiene, Helping Leaders Achieve Success* to help leaders foster a culture of improved hand hygiene engagement and compliance. AHS continues to implement the Antimicrobial Stewardship program and monitor hospital-acquired *Clostridium difficile* infection (CDI) and Methicillin-resistant *Staphylococcus aureus* blood stream infections.

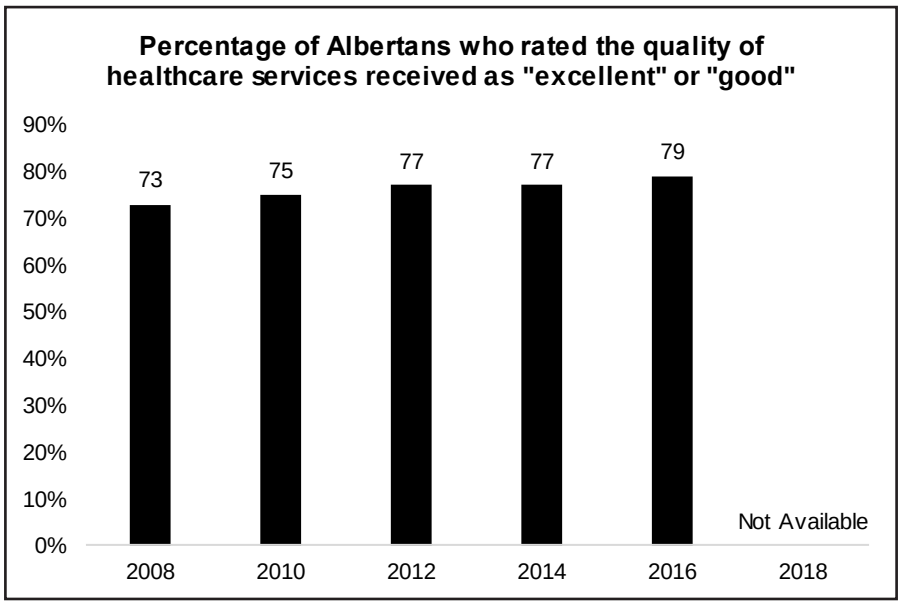
Work also continues on a Patient Safety Strategy including policies that focus on recognizing and responding to hazards, close calls, and clinical adverse events, as well as improving safety by developing consistent practices for creating and acting upon medication orders in AHS settings. Some medications are classified as high alert medications if significant harm may occur when it is used incorrectly or without regard to accepted leading practice standards. Parenteral nutrition (intravenous feeding) is provided to some of the most vulnerable patients and is a high-alert medication that is closely tracked.

"Health Information Exchange – Engaging Providers in Health Care Innovation," a white paper endorsed by Provincial Health Information Governance, states that our health system needs to transform care so that it is focused on the patient by having health stakeholders create an integrated health information ecosystem. Albertans will benefit from the Integrated Health Record through improved efficiency or care, reduction in duplicated efforts, and a reduction in hospitalizations and medical errors. To date, 23 Colleges and the Alberta Medical Association have declared support for Integrated Health Records.

Performance Indicator 3.b **Albertans rating of the quality of health care services received (biennial survey)**

Description

This indicator examines Albertans' perceptions of the overall quality of health care services received by themselves or a family member within the past year. Services include those that may be provided by family physicians, specialist physicians, pharmacists, mental health therapists, or other health care professionals. This rating is an indicator of whether Alberta's health care system is safe, effective, patient-centred, timely, efficient, and equitable in meeting the needs of Albertans.



Source: Health Quality Council of Alberta (HQCA), Provincial Survey about Health and the Health System in Alberta (2016). HQCA, Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014), Satisfaction with Health Care Services: A Survey of Albertans 2008.
Note: This biennial provincial survey conducted by the HQCA has been discontinued. Alberta Health is working with the HQCA to identify a replacement for this survey.

Results Analysis

The Health Quality Council of Alberta (HQCA) has conducted telephone surveys annually over the last ten years to collect information from Albertans on their perspectives of various aspects of patient satisfaction, including experience of quality and safety in the Alberta's health care system. Response rates to the telephone surveys have gradually declined over time, indicating the need for a new sampling strategy.

The survey conducted by the HQCA for this indicator has been discontinued due to declining response rates; 2016 is the last year for which results are available. In place of this high-level general measure, the HQCA is implementing sector-specific surveys (e.g., emergency department, long-term care, supportive living, home care, acute-hospital care). It is anticipated these surveys will provide results that are more meaningful for decision-making purposes and will be less costly to undertake.

The results for this indicator were reported every second year. In 2016, 79 per cent of survey respondents described the quality of health care services received as good or excellent. For each of the four telephone surveys since 2010, at least three quarters of respondents rated the quality of the health care services personally received in Alberta as "excellent" or "good" rather than "fair" or "poor".

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

What this means: 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.

Achievements

Key Strategy 4.1: Support the development and implementation of a stable budget for health care services.

The Government of Alberta is committed to protecting the health and well-being of all Albertans through long-term stable funding, while slowing health care spending to a rate that is more sustainable for the future. During 2017-18, the Ministry of Health maintained stable funding while reducing the spending rate in comparison to historical averages. For example, between 2008-09 and 2014-15, health spending grew at an average rate of approximately six per cent per year. From 2015-16 to 2017-18, spending was contained to an average growth rate of only 3.3 per cent per year.

Alberta Health Services (AHS) continued to focus health care spending on areas that are important for Albertans, such as community and home care initiatives. Efforts to shift to community and home care have the potential to reduce demand for acute care services in the future, without compromising the quality of care to Albertans. To achieve financial sustainability, AHS compares its health care service delivery with counterparts in other jurisdictions, to identify best practices and opportunities to deliver health services more efficiently.

The Alberta Pharmacists Association and the province established a new collaborative funding framework in 2017-18. This framework is a first of its kind in Canada, with the association and the government working closely to reach an agreement that makes pharmaceuticals more affordable for Albertans, respects pharmacists and protects the stability of the industry.

Alberta hosted a pan-Canadian health/medical equipment procurement workshop in November 2017 to discuss opportunities for provinces/territories to collaborate to procure high volume and specialized medical equipment. From this, working groups were developed based on procurement priorities to inform provinces/territories on how best to work together to buy medical equipment with a view to ensuring sustainable costs.

Key Strategy 4.2: Lead health system planning to coordinate and integrate service delivery, capital and health human resource planning by:

► Assessing and balancing the needs of rural, remote and urban populations.

The department is working together with other health system stakeholders such as Alberta Health Services (AHS) and Alberta Infrastructure to ensure that health services are planned and delivered based on the demonstrated community health needs of Albertans, with planning at the local, AHS zone and provincial levels. Zone health care planning focuses on longer-range vision and strategies (5-15 years), which drives planning and decisions in shorter-term operational planning cycles (1-3 years) in alignment with department directions regarding community-based care and providing care closer to home.

In 2017-18, building upon the expertise and community knowledge of health system stakeholders, and with input and support from the department, draft health care plans were developed for the AHS Central and Calgary Zones. When finalized, these plans will outline strategies and actions that are expected to improve patient outcomes and patient experiences, while protecting the sustainability of services that patients and families rely upon. The zone plans also capture the current state of health care, explain why change is needed and project what health care could look like in the Central and Calgary Zones over the next 15 years. All five AHS Zones have formally agreed to a coordinated provincial planning approach that shares the same focus on “care closer to home” priorities.

In spring 2017, the department and AHS established the provincial cardiac services planning oversight committee to begin work on an approach to assess the needs for interventional cardiac services in major urban communities outside of Calgary and Edmonton. Work is progressing to ensure alignment with national and international best practices and takes into account local health trends, current demand, future need and infrastructure capital requirements.

► Repairing aging health infrastructure and building new health care facilities, where appropriate, to ensure that such infrastructure meets current and future health care needs.

The Government of Alberta continues to make investments in the province’s health infrastructure to support access to health care services for Albertans. Alberta Health works closely with AHS and Alberta Infrastructure on the planning and delivery of health facility projects. Capital funding for building new health care facilities and repairing existing infrastructure is included in the annual budget for Alberta Infrastructure, the department responsible for project delivery.

In 2017-18, the government allocated $149.7 million in capital funding to the Infrastructure Maintenance Program. This funding was provided to AHS and supported 741 projects to ensure the preservation and maintenance of publicly funded health facilities throughout the province.

In 2017-18, seven Affordable Supportive Living Initiative projects were completed, representing 601 affordable supportive living and long-term care spaces. An additional 199 spaces were added through other projects and initiatives. These 800 new beds are part of the government’s commitment to create 2,000 new continuing care spaces.

The following table lists the health capital projects underway during 2017-18:

Projects approved in Budget 2017 and started in 2017-18	• Edmonton hospital • Child and Adolescent Mental Health facility in Edmonton • Complex Continuing Care Centre in Calgary • Misericordia Community Hospital Modernization in Edmonton • Foothills Medical Centre Urgent Power Plant Capacity in Calgary • Edmonton Clinical Laboratory Hub • Provincial Pharmacy Central Drug Production and Distribution Centre in Edmonton • Norwood long-term care facility in Edmonton • Clinical Information System
Previously approved projects which continued in 2017-18	• Calgary Cancer Centre • Critical Care Program renovations at the Stollery Children's Hospital in Edmonton • Fort McMurray Residential Facility Based Care Centre (Willow Square) • Grande Prairie Regional Hospital • Provincial Heliports Initiative • Medicine Hat Regional Hospital renovations • Protection of Children Abusing Drug Facility in Red Deer.
Projects and facilities completed and handed over to Alberta Health Services in 2017-18	• new wing of the Medicine Hat Regional Hospital; • renovations for obstetrics at the Red Deer Regional Hospital Centre; • renovations for Concurrent Disorder Capable Treatment Continuum at the Royal Alexandra Hospital in Edmonton; • Community Health and Wellness Clinic at the High Prairie Health Complex; • Emergency Department renovations and expansion at the Foothills Medical Centre in Calgary; • Chinook Regional Hospital redevelopment in Lethbridge; and, • renovations to Women's Services at the Peter Lougheed Centre in Calgary.

► **Supporting the development and implementation of initiatives that address long wait times, by measuring and monitoring wait times and supporting the management of wait lists.**

Reducing wait times to receive health care services in the province is a priority for the Government of Alberta. Although Alberta is a top performing province on wait times for hip fracture surgery, bypass surgery and radiation therapy, and ranked first out of four provinces (compared to British Columbia, Ontario, Saskatchewan) in 2016-17 for total time spent in emergency departments for admitted patients, there is more work to do in other areas. The effectiveness and results of improving access to services received in acute care facilities will have implications for the overall functioning of the health care system and ultimately support enhanced health outcomes for Albertans.

The government is working with and supporting Alberta Health Services (AHS) to improve access to health services, including:

- Providing funding to AHS for additional procedures, including cancer surgeries, cardiovascular surgeries, hip and knee surgeries, and cataract surgeries;
- Improving 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; and,
- Better managing wait times for surgery using specific wait time targets and re-allocating operating room time according to the greatest need and when wait times exceed targets.

In addition, the Surgery Strategic Clinical Network has visited all 16 major hospital sites to talk to staff and patients with the objective of informing development of the Alberta Surgical Plan. This plan has the potential to vastly improve surgical services for Albertans across the province. There may be opportunities to reduce wait times for some surgical services by utilizing capacity at rural facilities. For example, hip replacement surgeries are already provided in Westlock, Bonnyville and Camrose.

AHS is implementing recommendations to reduce inappropriate MRI and CT scans, which will help to reduce wait times. Demand for MRI and especially CT scans has been increasing because they are valuable tools for accurate diagnosis and treatment, and because Alberta's population is growing and aging. AHS is working with physicians to gain a better understanding of patient needs and ordering practices to ensure: appropriate referrals, timely access, and to improve communications between primary care providers, radiologists and other specialists for referrals in advice, consultation and treatment. Alberta publicly reports wait times for urgent, semi-urgent, non-urgent MRI scans through the Alberta Wait Times Reporting website. Emergency MRI scans are provided without delay and are not reported on this site.

The department supported AHS' development and deployment of the Access Improvement and Path to Care projects, including $1.51 million in grant support to AHS for 2017-18. Access Improvement is an AHS initiative that utilizes electronic advice requests and referrals as a means of improving patient access to scheduled services. Path to Care continues to work with AHS clinics and specialists who receive referrals to implement best practices in referral management, wait list management and standardizing wait time measurement.

A key component of the Access Improvement project is eReferral which leverages existing information from Alberta Netcare (such as demographics, labs and diagnostic imaging) into a referral form that can be saved as a draft, checked for completeness and tracked in real time as it is submitted, received, triaged and scheduled for an appointment. During 2017-18, eight additional specialties were added to e-referral advice request, allowing primary care providers to obtain advice from specialists on how best to treat their patients. In many cases, this eliminates the need to refer a patient to a specialist. There are now 12 specialties receiving e-referral advice requests, including breast cancer and lung cancer, hip and knee replacement, pulmonary medicine, gastroenterology, obstetrics/gynecology, spinal neurosurgery, endocrinology, addiction medicine (opiate agonist therapy), general internal medicine,

urology, nephrology, and medical and radiation oncology.

AHS recently completed updating the Alberta Referral Directory (ARD) which contains over 4,900 profiles of clinics and specialists to facilitate primary health care provider referral to specialists. The ARD enables primary care providers to navigate referral options and direct referrals to available specialists sooner.

► Supporting efforts to improve the performance of Alberta's metro and regional emergency departments.

In November 2017, the Canadian Institute for Health Information (CIHI) released data on emergency department visits and lengths of stay in Canada. The report shows that emergency department (ED) wait times are rising across Canada, including in Alberta.

Improving patient flow in emergency departments is complex and requires many coordinated actions, such as standardized processes and the ability to respond effectively to crisis situations. The broader health system also plays a role, through improving access to primary care and increasing support for patients who no longer require hospital-based care to move into more appropriate community-based care.

Albertans who need urgent or emergency care will receive it. Unfortunately, many people end up in the ED because they don't know where else to go. The department and AHS are taking action to help reduce demand on EDs, including increasing capacity in primary and community care, and continuing care. AHS is increasing continuing care capacity through additional spaces and home care to expedite discharge of Alternate Level of Care patients from hospitals, In addition, to encourage the appropriate use of EDs, AHS launched a Know Your Options public education campaign aimed at diverting patients not requiring EDs to other care options more suitable for them.

In February 2018, the government announced a $11 million program expansion to add full-time mobile community paramedics in both Calgary and Edmonton, and to establish new teams in Lethbridge, Medicine Hat, Red Deer, Camrose/ Westaskiwin, Grande Prairie and Peace River. Mobile community paramedics provide on-site care to seniors and other Albertans with chronic conditions, with the goal of reducing the use of acute care beds and hospital resources for these patients.

The Emergency Strategic Clinical Network (SCN), developed by AHS, focused on activities to improve care that Albertans received in emergency departments and urgent care centers across the province. These activities included standardizing processes and rural triage tools, and a grant-supported process to develop a response to the opioid crisis. The SCN continues to engage in the emergency research community work to improve the quality of care for First Nations peoples in Alberta's emergency departments.

During 2017-18, the Department of Health facilitated and supported data sharing processes between itself, Alberta Infrastructure, AHS, and contracted consultants to strengthen the evidence base for planning and to enhance access for patients seeking emergency medical services within the Edmonton Zone. This data is also being used to understand both current and future patient utilization patterns for emergency department usage specific to the planned catchment areas for the new Edmonton hospital.

► **Improving the effectiveness, efficiency and accountability of Alberta's emergency medical services.**

Community Paramedicine programs, including Mobile Integrated Health Teams, were developed and began working in the Alberta Health Services' (AHS) Central and North Zones in February 2017. These teams work with physicians and community health care providers to deliver on-site non-emergency care to residents of pre-selected supportive living facilities. The care includes treatments and diagnostics such as medication administration, sutures, blood transfusions and electrocardiograms. These teams assist patients in avoiding unnecessary emergency department use and improve patient outcomes through physician consults to ensure appropriate care for patients is in place. The department is working to implement the program in more communities across the province by summer 2018.

Key Strategy 4.3: Enhance the governance and accountability of the health care sector by:

► **Improving governance structures and establishing clear mandates and roles for all health agencies, boards and commissions.**

The *Alberta Public Agencies Governance Act* (APAGA) requires agencies to which APAGA applies to have a mandate and roles document, and a competency-based recruitment process. These documents and processes must be made publicly available. The department continues working to ensure public agencies for which the Minister of Health is the responsible Minister and, which are governed by APAGA, meet these requirements.

Seven of the 10 public agencies within the Ministry of Health have approved and signed mandate and role documents in place. The mandate and roles documents for the remaining public agencies are at various stages in the process (one is pending approval and two are being drafted). The APAGA also requires mandate and roles documents to be reviewed every three years. In 2017-18, two of the above public agencies' documents required review. One is currently in the review/approval process, and the other is being reviewed/revised.

Additionally, more than 250 members were appointed to the Ministry's public agencies during 2017-18, including 13 members to the Minister's Opioid Emergency Response Commission and 15 members to the Physician Resource Planning Advisory Committee.

► **Providing compliance, monitoring and performance oversight to improve quality and accountability through the completion of audits, promotion of best practices, and monitoring adherence to regulations and directives.**

The *Resident and Family Council Act* came into force April 1, 2018. The Act supports the establishment of resident and family councils, which provide a forum for residents and their families to discuss ways of maintaining and enhancing the quality of life in supportive living and long-term care facilities. The department developed a tool kit to support residents and families to set up and maintain a council, along with an information guide to assist operators of supportive living and long-term care accommodations, in understanding the requirements set out in the Act. The department also delivered a series of operator information sessions in March 2018 that provided an opportunity for clarifying questions and additional support. Continuing care accommodation licensing inspectors will be assessing compliance to the Act annually, and results will be publicly reported.

Under the *Public Sector Transparency Compensation Act*, public sector bodies (including public agencies under APAGA) must disclose remuneration paid to their employees where it is above the threshold, including AHS and the Health Quality Council of Alberta (HQCA). Remuneration paid in 2016 was posted publicly on

the department, AHS and HQCA websites during 2017-18. The department also participated in the Public Agency Secretariat's remuneration review to ensure consistent practices are conducted government-wide.

Key Strategy 4.4: Set health system standards to enhance quality with an initial focus on addressing barriers to access, safety, minimizing unwarranted clinical variation in practices, and appropriateness.

In 2017-18, the department 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, including initiatives focused on evidence-based appropriateness, enhancing patient safety, reducing clinical variation, and enhancing quality across the health care spectrum. For example, the department worked with AHS to select a set of initiatives for 2017-18 for specific focus on enhancing quality and minimizing variation. The department also worked collaboratively with AHS and the Alberta Medical Association on a framework to identify and prioritize initiatives for clinical appropriateness and quality. In addition, the department met with stakeholders, including the Canadian Patient Safety Institute and AHS, to understand current patient safety strategies and identify areas for future collaboration and opportunities for spreading and scaling of best practices.

Key Strategy 4.5: Increase the capacity for evidence-informed policy, planning and practice by:

► **Enhancing data sharing, research, innovation, health technology assessment, and knowledge translation.**

The department has a number of ongoing initiatives that increase provincial capacity for making evidence-informed decisions, including Health Technology Assessments (HTA) which provide comprehensive and contextualized evidence to support optimal and innovative health care delivery. In 2017-18, the department completed 10 HTAs and reviews on a range of topics, including:

- endovascular therapy (EVT) for ischemic stroke;
- community paramedicine;
- palliative and end-of-life care;
- mental health courts/diversion programs;
- early hearing detection and intervention programs;
- proton beam therapy;
- robot-assisted surgery for prostatectomy, partial nephrectomy and transoral surgery;
- image-guided injections;
- platelet-rich plasma injections; and,
- long-term care nursing coverage.

In consultation with key stakeholders, the department also developed a new HTA Framework to maximize the value, and enhance dissemination, of health evidence for decision makers in the health system. The new approach was tested with the EVT for ischemic stroke review, which informed a new provincial EVT delivery model to optimize care and economic efficiency based on the geographic location of stroke onset. AHS made investments to implement the new service delivery model and promote equitable access to EVT throughout Alberta based on the results of the review.

The department has engaged key stakeholders in the development of a new strategic framework that better aligns investment from the Alberta Cancer Prevention Legacy Fund (ACPLF) with Alberta's Cancer Plan to 2030 and Ministry priorities in the province. The ACPLF invested in two key projects in 2017-18: Alberta's Tomorrow Project to support a research study that examines why some people get cancer while others do not; and, through Alberta

Innovates to support cancer research commitments that aim to provide insight into ways of preventing cancer in Albertans.

The department launched the Secondary Use Data Access (SUDA) initiative in collaboration with partners across Alberta's health innovation ecosystems. The goal of the initiative is to mobilize anonymized health and non-health data, while maintaining the privacy and confidentiality of these data, to create knowledge that drives change, research and innovation to improve health system performance, health outcomes and quality of life for Albertans.

► Enabling a robust health system analytics environment in which to better inform quality improvements, health system planning, management, delivery, performance reporting, and research.

Health analytics and data management are an important part of system reporting and performance management. In 2017-18, capacity was increased through a series of activities focused on infrastructure, policy, and partnerships.

The Department of Health implemented a methodology and state-of-the-art software for risk-based assessment and de-identification of data. The software implementation was undertaken collaboratively with Alberta Health Services (AHS) to ensure better alignment of approaches and policies related to non-identifying health information. The department also developed a Privacy Impact Assessment and process to increase data-sharing between Alberta Health and AHS, including diagnostic imaging and laboratory results data. Work also continued on the development of a roadmap for health data mobilization to enhance analytic capability within the health sector in Alberta.

Working in partnership with stakeholders is an important way of ensuring all parties are working with the best available data. For example, the Department co-chairs the SUDA Initiative with Alberta Innovates to bring provincial partners closer together on the use of data for research, clinical service delivery and policy development. The SUDA successfully completed four of its five concept projects, with the fifth one to wrap up during 2018-19.

The department also partnered with Indigenous organizations on a number of initiatives during 2017-18, including:

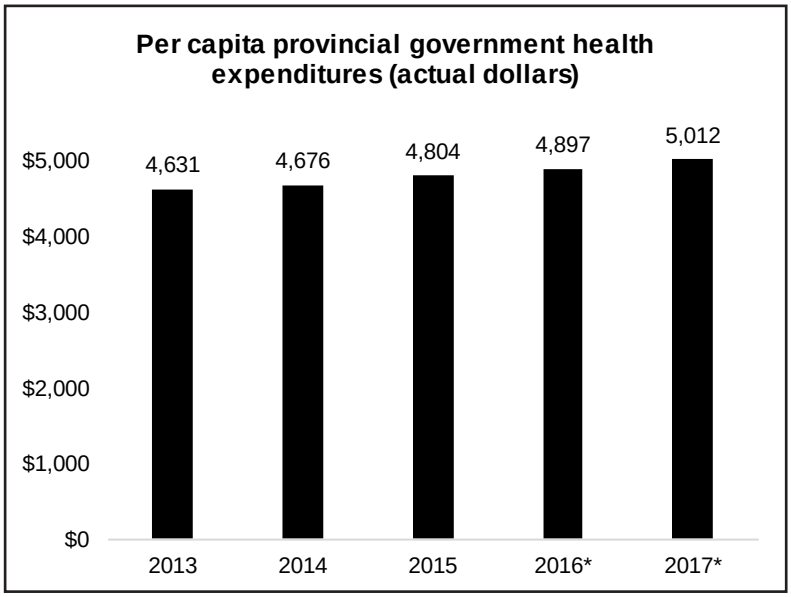
- Development of agreements with Maskwacis and Bigstone Cree Nation to share immunization data with the department;
- Generation of 13 First Nations-specific reports together with the Alberta First Nations Information Governance Centre (AFNIGC) to engage First Nations communities in discussions aimed at improving health status;
- Together with the AFNIGC, the development of the first report on the impact of the opioid crisis on Alberta's First Nations; and,
- Work with the Métis Nation of Alberta on the production of reports on cancer and respiratory illness among Métis people.

Performance Measures and Indicators

Performance Indicator 4.a **Per capita provincial government health expenditures (actual dollars)**

Description

This measure 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, including Alberta Health Services (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.



Source: Canadian Institute for Health Information (CIHI) National Health Expenditure Trends (NHEX), 1975-2017.

** Note: The results for 2016 and 2017 are forecast rather than actual as there is a two-year lag in available results.*

Results Analysis

Based on the 5-year (2013-2017) period, per capita provincial government health expenditures increased at an average of 2 per cent. This percentage is significantly lower compared to the previous 5-year period (2008-2012) where per capita provincial government health expenditures increased at an average of 4.6 per cent. Alberta's per capita health expenditure growth rate between 2016 and 2017 is forecast to be 2.3 per cent which is lower than four provinces (Quebec, New Brunswick, Prince Edward Island, Newfoundland and Labrador) and the same as the national average per capita health expenditure growth rate.

The Ministry of Health continues to strive towards keeping year-over-year expenses restrained while delivering effective and efficient care that meets the needs of Albertans. 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.

The government has worked with the Alberta Medical Association (AMA) to reduce costs for physician services, including substantive savings that will occur through implementation of the 2016 AMA Amending Agreement. In addition, the ministry

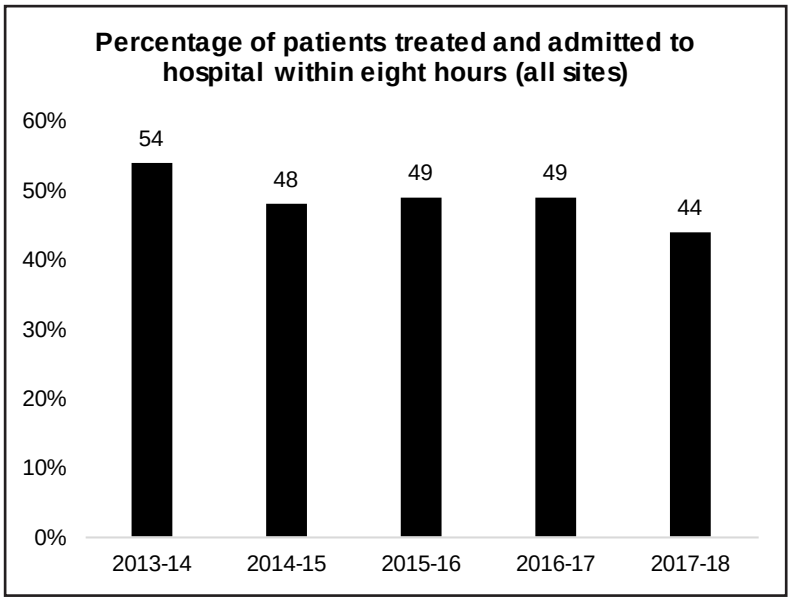
has saved more than $100 million in prescription drug costs over the last three years through its efforts to reduce generic drug prices. The ministry has also saved more than $20 million since 2015-16 by offering a wider range of medication options for Albertans with retinal conditions. As a result of changes to coverage for acid reflux medications, approximately $10 million has been saved since February 2017, with anticipated total savings of $40 million by February 2020. Alberta Health Services (AHS) has reduced costs through operational best practices (a total of $163 million over two years in 2016-17 and 2017-18) and savings of $49 million in 2017-18 have been achieved by AHS and the department through administrative constraint.

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 Indicator 4.b **Emergency department length of stay: Percentage of patients treated and admitted to hospital within eight hours (all sites)**

Description

This indicator tracks length of stay in emergency departments that are located in facilities with inpatient spaces. Patients treated in an emergency department or urgent care centre should be assessed and treated in a timely fashion to ensure quality of care. The emergency department length of stay for admitted patients is measured from the earliest reported time after arrival in the emergency department (either the triage or registration time) to the time the patient enters the hospital as an inpatient following discharge from the emergency department.



Source: National Ambulatory Care Reporting System format (NACRS).
NACRS sites: All Alberta hospital sites.

Results Analysis

The percentage of patients treated in an emergency department (ED) and admitted to inpatient care within eight hours has dropped from around 54 per cent in 2013, to just under 50 per cent for the subsequent three years and to 44 per cent in the past year. This means that patients are waiting longer in an ED for an inpatient bed to become available. This trend is consistent with the rise in ED wait times across Canada. Alberta Health Services (AHS) continues to monitor and report on this 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. Several initiatives are underway across the province such as expansion of home and palliative care, specialized intensive home care programs, and implementation of Emergency Medical Services programs, including the expanded role of community paramedics, to improve access to

care in the community and at home. 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 Living Options. That's why government is committed to building 2,000 long-term care and dementia spaces

The effectiveness of acute care is strongly aligned with the access to and throughput of EDs. A number of initiatives are underway to improve the flow in hospitals and EDs, improve transitions of care, and address hospital readmissions including the following:

- CoACT implementation is underway across the province which will demonstrate a positive impact on efficiency and ED flow. CoACT is a provincial AHS initiative that is strengthening our commitment to team-based care and giving patients a voice in the care they receive. Clinicians are brought together with collaborative tools and processes that enable each provider to contribute to one complete and integrated patient care plan. Whiteboards at the bedside track the patient's care team, the plan for the day, and record questions.
- The Patients Collaborating with Teams (PaCT) is a partnership between AHS and the Alberta Medical Association to ensure services are in place for complex patients. PaCT, together with the Bridging the Gap initiative, determines solutions for discharge and transition of patients with complex health needs to community family practices.

To address readmissions, AHS implemented clinical care pathways through Strategic Clinical Networks to maximize quality of care and improve transitions of care for specific diagnosis groups and patient populations such as chronic obstructive pulmonary disease and heart failure, enhanced recovery after surgery, and hip and knee replacement clinical care pathway.

Results Analysis

Analysis of Strategic Risks

Analysis of Strategic Risks

As part of the planning process, the Ministry of Health considers strategic risks that can have an overarching effect on its ability to meet its mandate, mission and long-term outcomes. Health's 2017-20 Business Plan identified five high level and high impact risks in this context. An update on their status is provided below:

Financial

2017-20 Identified Risk:
The Government of Alberta continues to be faced with lower provincial revenues. At the same time, the health system is challenged by increased demand for services as well as upward pressure on key health sector input costs such as those for acute care facilities, health care professionals and prescription drugs.

2017-18 Update:
Financial risk. Declining provincial revenues without corresponding actions to address the cost of health care could impact access to services as well as decrease the range of health care services available to Albertans. The ministry recognizes these risks and is mitigating them through a range of initiatives and actions.

A key solution is a focus on integration of programs and services across the province's series of systems (primary care, acute care, continuing care, public health, information technology, and health workforce). The ministry has made substantive progress toward integration, including the new AHS provincial clinical information system to reduce the number of information systems used across health; the new Primary Care Network Governance Framework to better integrate primary care with other program areas; Physician Resource Planning to better allocate physicians based on community, health and cultural needs; and, amalgamating public and private laboratory services organizations to better integrate diagnostic services.

The ministry continued to maintain stable and predictable funding in 2017-18 while achieving a slower, more sustainable spending rate (i.e., 3-per cent) compared to historical averages. This is attributable to the ministry working closely with health professional colleges and associations, maintaining labour costs, ongoing initiatives within Alberta Health Services, restraint in recruitment of civil servants, wage freezes for all managerial staff, and reductions in generic drug prices.

Integration/collaboration

2017-20 Identified Risk:
The success of shifting the health system to one that is more person-centred and sustainable is highly dependent on the integration of efforts within the ministry – including between Alberta Health, Alberta Health Services (AHS), and the Health Quality Council of Alberta – and with key partners and stakeholders outside the ministry. Continued work between health system organizations to clearly define roles and responsibilities and accountabilities will increase clarity regarding identified opportunities and will result in better alignment and reduce duplication.

2017-18 Update:
Strategic and operational risks. If health system partners and stakeholders are unable to develop a cohesive and aligned approach to system-wide planning and health service delivery, improved integration, quality, and value for investment could be impeded. The ministry recognizes these risks and has been working to address them through a range of initiatives.

Integrated planning is reflected in the ministry planning processes which ensure alignment between AHS' Health Plan, Business Plan and operational plans with the department's strategic direction. Accountability requirements are established by the department to AHS where expectations are clearly set out and then monitored through the fiscal year via reporting and performance measurement.

New investments in home, continuing care and community care will support integration across community-based settings. Home care services are also increasingly linked to family physician offices and Primary Care Networks, which builds an integrated pathway for patients between their family physician and home care services.

The ministry is also moving ahead with the development of a common clinical information system (CIS), which will provide a platform for AHS to create a single electronic health record for every Albertan, ensuring all AHS health providers have access to, and contribute, the same information. This will support team-based, integrated care and reduce duplication, overlaps, and delays. When complete, it is estimated the CIS will save the health care system money by reducing hospital stays, increasing the use of community clinics, reducing drug costs, improving efficiency for testing and laboratories, and reducing filing and transcription costs.

Public expectations and lifestyle

2017-20 Identified Risk:
The demand for health care services in Alberta continues to increase. An increased understanding of the health system will help the ministry to reallocate funding to support transformation of the health sector to one that is more person-centred and financially sustainable.

2017-18 Update:
Operational and reputational risks. If the ministry is unable to transform the health care system to person and family-centred care, the result could be an inability to meet the health care needs of an aging population, those with complex chronic diseases and those with unequal access to our health system. The ministry recognizes this risk and has taken action to improve the supports for Albertans and to empower self-management.

The ministry and its partners are focused on expanding home care to improve access for clients in rural and remote areas, support seniors to remain independent in their own homes longer, and help Albertans avoid premature admission to facilities. In addition, revised regulations for health professions have contributed to expanded scope of practice, including paramedicine, nurse practitioners, and other allied health providers. Paramedics now support programs such as home care and primary care.

The new Primary Care Networks (PCN) Governance Framework will help improve integration between PCN services, Alberta Health Services programs, and services provided by community-based organizations. It will also increase alignment of services across communities leading to better access and easier navigation for Albertans.

Through implementation of *Valuing Mental Health: Next Steps* the ministry continues to work with community partners to create a more integrated addiction and mental health system, strengthen the role of primary care, prevention and early admissions, enhance the system through legislation, standards, funding and infrastructure, and on other initiatives aimed at reducing unplanned readmissions to acute care facilities.

The ministry is also implementing recommendations from Choosing Wisely Canada and other appropriateness initiatives which will reduce unnecessary medical tests and procedures. This will improve care and slow the rate of growth of health care expenditures.

In addition, Strategic Clinical Networks (SCNs) engage clinical leaders and the public to find innovative ways of delivering care that will provide better quality, better health outcomes and better value for every Albertan. Many SCN projects have a cost-saving element by removing obsolete treatments, improving efficiency, and improving appropriate use of technologies and services.

Long wait times for treatment and surgeries are costly to the health system. To address this, the ministry is expanding the Alberta Referral Directory to give primary health care providers access to specialists' availability and wait times, by developing Alberta Referral Pathways to improve the quality of referral requests so specialists only see patients who require their services, and by improving the functionality of eReferral which enables primary care providers to obtain advice from specialists.

The ministry is also developing the Personal Health Record (PHR) which will consolidate information from Alberta Netcare, the CIS, and health information generated in the community. The PHR will provide Albertans with secure access to their own health care records, prescription drug information, and laboratory and other diagnostic testing and will support them in taking an active role in managing their health. This information can also be shared with health service providers, helping to provide a continuum of care.

Data and analytics

2017-20 Identified Risk:
Policy development and implementation is more robust if it is founded on strong data and analysis of the current state of issues and opportunities. Better access to integrated and comprehensive data and information will optimize care. In addition, data to support effective performance measurement, accountability and governance activities can be improved.

2017-18 Update:
Compliance and operational risks. The development and implementation of policies and programs that are not evidence-informed, risks creating a situation where policies do not have the intended or desired impacts on the health care system or on Albertans' health outcomes. To mitigate this risk, the ministry has undertaken a series of actions aimed at ensuring robust policy development, optimized services, and improved health outcomes for Albertans.

The ministry continues to develop its information systems and analytical capacity to support government policy. Supporting initiatives include the development of data-sharing agreements with Indigenous organizations, the Secondary Use Data Access project to mobilize anonymized health and non-health data, and the development of online community profiles of 132 Alberta communities. The department also produces health trends and surveillance reports which provide a snapshot of a wide range of health topics, identify issues of concern within the health care system and to stimulate thought and discussion as part of the policy development process. In addition, the Alberta Wait Times Reporting website enables Albertans interested in treatment options to view wait time information on medical procedures and diagnostic tests.

The ministry is also moving ahead with the development of a common clinical information system (CIS) which will directly impact everyone who provides patient care within Alberta Health Services (AHS). The CIS will provide AHS with a single organizational health record for every Albertan, along with standardized clinical pathways that embed best practices in health care, ensuring all AHS health providers have access to and contribute to the same information. The outcome will be an increased focus on the patient and improved continuity of care across the health system.

The objectives of a unified patient record are supported by Alberta Netcare, the province's electronic health record, a portal that enables health care providers to access available health information from a variety of sources including hospitals, laboratories, testing facilities, pharmacies and physician clinics. In 2017-18, Alberta Netcare had over 50,000 registered users (health practitioners) accessing and contributing to this information (an increase of 19.9 per cent over the previous year), thereby also providing for improved care continuity and integrated data exchange.

Health system capacity

2017-20 Identified Risk:
There is a need for trained health care workers to provide continuing care and other health services if the transition of the system from "hospital to community" is to be successful. In professions where staff levels are sufficient, unequal distribution across Alberta remains a factor, with particular difficulty in recruiting to rural and remote areas where the planned expansion of home and community care services is most needed. The challenge to meet the health system's need for the right mix of trained health care workers could compromise the ministry's ability to meet the health care needs of Albertans in a way that is stable, financially sustainable and improves health outcomes.

2017-18 Update
Strategic, operational and reputational risks.
A health workforce that has the skills and competencies required to deliver high-quality, team-based, integrated health care to Albertans close to where they live is a key component of community-based health care. An absence of such a workforce risks compromising this objective.

While the number of doctors in Alberta has grown, many rural and remote communities in Alberta still don't have the doctors they need. The department is working with the Physician Resource Planning Advisory Committee to develop a long-term needs-based physician resource plan and a short-term implementation plan that identifies recommendations and immediate actions to achieve our supply and distribution goals for 2018-19.

There is also a review of regulations under the *Health Professions Act* to identify opportunities to expand scope of practice for health care providers, including registered nurses and midwives. The Ministry has committed to supporting midwifery as one option for women giving birth. With funding of more than $18 million for 2018-19, the department will continue working with Alberta Health Services (AHS) and the Alberta Association of Midwives to improve access to this health service for rural and underserved areas, vulnerable populations, and areas that lack existing obstetrical resources.

Together with other health system partners such as AHS and PCNs, there is work to ensure that health services are planned and delivered based on demonstrated community health needs, with planning at the local, AHS zone and provincial levels.

Results Analysis

Performance Measure and Indicator Methodology

Performance Measure and Indicator Methodology

Performance Measures indicate the degree of success a ministry has in achieving its desired outcomes. Performance measures contain targets which identify a desired level of performance to be achieved in each year of the business plan.

Performance Indicators assist in assessing performance where causal links are not necessarily obvious. The ministry may or may not have direct influence on a performance indicator; therefore, they do not contain targets.

Performance Measure 1.a **Percentage of mental health patients with unplanned readmissions within 30 days of leaving hospital**

RESULTS					TARGET
2013-14	2014-15	2015-16	2016-17	2017-18	2017-18
8.9%	8.8%	8.6%	8.7%	**8.6%**[1]	**8.5%**

[1]The 2017-18 result is preliminary.

Data Sources
Canadian Institute for Health Information (CIHI)
Alberta Health Services, Provincial Inpatient Database

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.

Notes:
1. Information is available once data from the Discharge Abstract Database 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.
2. 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. Readmission rate reporting always lags by a quarter for this reason. 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.

Calculation
Crude Readmission Rate (CRR):

$$CRR = \frac{\#\ discharged\ patients\ readmitted\ to\ any\ acute\ hospital\ in\ Alberta\ within\ 30\ days\ of\ index\ discharge}{\#\ \ index\ hospital\ discharges\ with\ MRDx\ as\ selected\ mental\ illness}\ x\ 100$$

Risk Adjusted Rate (RAR):

$$RAR = \frac{\#\ of\ observed\ cases}{\#\ of\ expected\ cases}\ x\ the\ Canadian\ CRR$$

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 CIHI 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.

Performance Measure 1.b **Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed**

RESULTS					TARGET
2013-14	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2017-18**
69%	60%	60%	56%	**52%**	**65%**

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

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

CCLO refers to the level of care in a publicly funded resident accommodation that provides health and support services appropriate to meet the client's assessed unmet needs (i.e., Designated Supportive Living Level 3 or 4, 4-Dementia or Long-term Care).

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

Calculation

Continuing Care Living Option – Designated Supportive Living or Long-term Care.

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

Note: 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.

Performance Measure 1.c **Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network**

RESULTS					TARGET
2013-14	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2017-18**
75%	77%	78%	80%	**n/a[1]**	**79%**

[1]The 2017-18 result was not available at time of this publication.

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

Methodology
The numerator is the total number of patients enrolled in a Primary Care Networks (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 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.

$$\% = \frac{total\ \#\ of\ Albertans\ informally\ enrolled\ in\ a\ PCN\ in\ a\ given\ year}{total\ population\ covered\ by\ the\ Alberta\ Health\ Care\ Insurance\ Plan\ as\ of\ March\ 31\ in\ same\ year}\ x\ 100$$

Performance Measure 1.d **Healthy Alberta Trend Index (HATi): Average number of health risk factors per person aged 20 to 64 years**

RESULTS					TARGET
2013	**2014**	**2015**	**2016**	**2017**	**2017-18**
2.12	2.14	2.00	2.07	**n/a[1]**	**2.00**

[1]The 2017 result was not available at time of this publication.

Data Sources
Statistics Canada, Canadian Community Health Survey (CCHS)

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 Indigenous 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 disclosure 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.

The calculation of the HATi involves each of the six indicators listed below being dichotomized as 0 or 1 (0 for not having the behaviour or 1 for having the behaviour) and totalling the results. A HATi of 0 would be most healthy and 6 would be most unhealthy.

1. Life Stress – Respondents self-reporting life stress as extremely or quite a bit stressful.
2. BMI Category – Respondents self-reporting as "overweight" or "obese" (BMI of 25 or higher).
3. Fruit and Vegetable Consumption – Respondents self-reporting having eaten five or more servings of fruit and vegetables per day.
4. Physical Activity – Respondents who are moderately active or active. Category derived from reported physical activities.
5. Smoking Status – Respondents who are current daily smokers.
6. Binge Drinking frequency – Respondents reporting having five or more drinks (for male) or four or more drinks (for female) two or more times per month.

Calculation

HATi = Overweight value + (1 – Fruit & Vegetable Consumption value) + Daily Smoker value + Binge Drinker value + Life Stress value + (1 - Physical Activity value).

The calculation takes into account that Fruit and Vegetable Consumption and Physical Activity are measuring healthy activities.

Performance Measure 1.e **Access to the provincial Electronic Health Record (EHR): Number of health care professionals with access to Alberta Netcare**

RESULTS				TARGET
2014-15	**2015-16**	**2016-17**	**2017-18**	**2017-18**
37,324	40,587	42,090	**50,477**	**43,617**

Data Sources
Alberta Netcare, Monthly Utilization Report.

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).

Calculation
Sum of the following health professionals:

14,004	Physicians (including medical residents)
21,974	Nurses
7,109	Pharmacists
61	Optometrists
24	Dentists
10	Chiropractors
7,295	Allied Professionals
50,477	

Performance Indicator 1.a **Ambulatory sensitive care 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**

RESULTS				
2013	**2014**	**2015**	**2016**	**2017**
367	365	349	348[1]	**335[2]**

[1]The 2016 result of 348 updates the preliminary result 346 published in Health's 2016-17 Annual Report.
[2]The 2017 result is preliminary.

Data Sources
Numerator: Alberta Health Services, Discharge Abstract Database; Canadian Institute for Health Information
Denominator: Statistics Canada, post-censal population estimate

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 and older, death before discharge, admission category recorded as newborn or stillbirth.

Denominator: The denominator is the total mid-year population younger than age 75.

Calculation

$$Rate = \frac{Total\ \#\ of\ acute\ care\ hospitalizations\ for\ ACSCs\ under\ age\ 75\ years}{Total\ mid-year\ population\ under\ age\ 75\ years}\ x\ 100{,}000$$

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.

Performance Measure 2.a **Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization**

- **Seniors aged 65 and over**
- **Children aged 6 to 23 months**
- **Residents of long-term care facilities**

Population	RESULTS					TARGET
	2013-14	2014-15	2015-16	2016-17	2017-18	2017-18
Seniors aged 65 and over	64%	61%	63%	60%[1]	**60%**	**80%**
Children aged 6 to 23 months	34%	34%	36%	34%	**35%**	**80%**
Residents LTC facilities	88%	90%	90%	89%	**89%**	**95%**

[1] *Revised from 62 per cent due to a retroactive update in population estimates.*

Data Sources

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

Denominator: For seniors and children, the denominator is the ministry's population estimates, based on mid-year (June 30) registration population estimates. For residents of long-term care facilities the denominator is the number of residents as of December 15 of the current year.

Methodology

Seniors aged 65 and over:

$$Rate = \frac{\#\ of\ seniors\ aged\ 65\ years\ and\ over\ who\ received\ one\ dose\ of\ the\ influenza\ vaccine}{mid-year\ population\ estimate\ of\ age\ category}\ x\ 100$$

Children aged 6 to 23 months:

$$Rate = \frac{\#\ of\ children\ aged\ 6\ to\ 23\ months\ who\ received\ dose\ 2\ of\ 2\ doses, or\ an\ annual\ dose\ of\ the\ influenza\ vaccine}{mid-year\ population\ estimate\ of\ age\ category} x\ 100$$

Children aged six months to 23 months who require two doses of the influenza vaccine will only be included if they have received two doses during the current season up to and including April 30 of the current year. Children six to 23 months of age who have received two doses in the past season will be included if they receive an annual (single) dose during the 2017-18 season.

Residents of long-term care (LTC) facilities:

$$Rate = \frac{\#\ of\ LTC\ residents\ on\ Dec\ 15, 2017\ who\ received\ one\ dose\ of\ influenza\ vaccine\ (Oct\ 1\ to\ Dec\ 15, 2017)}{\#\ of\ LTC\ residents\ on\ Dec\ 15, 2017} x\ 100$$

Note: 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.

Performance Measure 2.b **Childhood immunization rates (by age two)**

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

Immunization	RESULTS					TARGET
	2013	2014	2015	2016	2017	2017
Diphtheria, tetanus, pertussis, polio, Hib	75%	76%	76%	77%	**77%**	**97%**
Measles, mumps, rubella	86%	88%	87%	88%	**87%**	**98%**

Data Sources

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

Methodology

Using data from the 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 2017 rates relate to the 2015 birth cohort which turned age two in 2017 – the earliest possible time to report coverage by 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.

Performance Indicator 2.a **Life expectancy at birth (years):**

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

Population	RESULTS				
	2013	2014	2015	2016	2017
First Nations	71.9	70.9	69.9	70.9	**70.7**
Non-First Nations	82.1	82.2	82.2	82.3	**82.2**

Data Sources

Alberta Health Care Insurance Plan
Alberta Health Postal Code Translator File
Alberta Vital Statistics Death File
First Nations Status Registry

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 mortality rates into life expectancy at birth can be found in Appendix 3 of Alberta Health’s Chronic Disease Projections Methodology, 2008 https://open.alberta.ca/publications/9780778566175.

Performance Indicator 2.b **Infant mortality rate (per 1,000 live births)**

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

Population	RESULTS				
	2013	2014	2015	2016	2017
First Nations	10.5	10.4	8.4	7.8	**9.2**
Non-First Nations	4.0	4.3	4.2	3.7	**4.4**

Data Sources

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

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).

Calculation

$$Infant\ Mortality\ Rate\ = \frac{\#\ of\ infant\ deaths\ during\ a\ calendar\ year}{\#\ of\ live\ births\ during\ a\ calendar\ year} x\ 1{,}000$$

Performance Indicator 2.c Emergency visits due to substance use (per 100,000 population)

RESULTS				
2013	**2014**	**2015**	**2016**	**2017**
629.97	662.43	697.70	753.55	776.34

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

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.

Calculation

Crude Visit Rate (CVR):

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

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.

Performance Indicator 3.a **Patient safety: Percentage of Albertans reporting harm to self or an immediate family member while receiving health care in Alberta within the past year**

RESULTS					
2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
11%	11%	12%	14%	n/a	n/a

Data Sources
HQCA, Provincial Survey about Health and the Health System in Alberta (2013, 2015, 2016).
HQCA, Satisfaction and Experience with Health Care Services in Alberta (2012, 2014).

Methodology
These surveys were conducted by the Health Quality Council of Alberta (HQCA) for the purpose of obtaining views and perceptions of Albertans on the quality, safety and performance of the publicly funded health care system. Results for 2016-17 and 2017-18 are not available as the surveys have been cancelled by the HQCA due to decreasing responses over the years. The calculation below refers to the results for 2015-16. Alberta Health is working with the HQCA to identify replacements for these surveys.

Patient safety is defined as the reduction and mitigation of unsafe acts within the health care system rather than from the patient's underlying illness, as well as through the use of best practices shown to improve patient safety outcomes.

Calculation
Based on the percentage of respondents to the HQCA provincial survey about Health and the Health System in Alberta who responded "yes" to the question:

> *"To the best of your knowledge, have you, or has a member of your immediate family experienced unexpected harm while receiving health care in Alberta within the past year?"*

From February 2, 2016, to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,346 respondents answered the question on experiencing unexpected harm while receiving health care in Alberta within the past year. Results were reliable within ± 1.9 per cent, 19 times out of 20 for this question.

Performance Indicator 3.b Albertans' rating of the quality of health care services received

RESULTS					
2008	**2010**	**2012**	**2014**	**2016**	**2018**
73%	75%	77%	77%	79%	n/a

Data Sources
HQCA, Provincial Survey about Health and the Health System in Alberta (2016).
HQCA, Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).
HQCA, Satisfaction with Health Care Services: A Survey of Albertans (2008).

Methodology
These surveys were conducted by the Health Quality Council of Alberta (HQCA) for the purpose of obtaining views and perceptions Albertans on the quality, safety and performance of the publicly funded health care system. Results for 2018 are not available as the surveys have been cancelled by the HQCA due to decreasing responses over the years. The calculation below refers to the results for 2016. Alberta Health is working with the HQCA to identify replacements for these surveys.

This indicator examines Albertans' perceptions of the overall quality of health care services received within the past year and is reported every second year.

Calculation
Based on the percentage of respondents to the HQCA Provincial Survey about Health and the Health System in Alberta 2016 who responded "good" or "excellent" to the question:

> *"Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, how would you describe the overall quality of those services? Excellent, good, fair or poor?"*

From February 2, 2016, to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,360 (weighted total) respondents answered the question on the overall quality of health care services personally received in Alberta within the past year. Results are reliable within ±2.2 per cent, 19 times out of 20, for this question.

Performance Indicator 4.a **Per capita provincial government health expenditures (actual dollars)**

RESULTS				
2013	**2014**	**2015**	**2016**	**2017**
$4,631	$4,676	$4,804	$4,897[1]	$5,012[1]

[1]Forecast results are provided for 2016 and 2017 as there is a two-year lag in available results.

Data Sources
Canadian Institute for Health Information (CIHI), National Health Expenditure Trends (NHEX), 1975 to 2017.
Statistics Canada, Demography Division (population estimates)

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 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, CIHI's estimates of provincial/territorial government health expenditures were submitted to provincial/territorial departments of health for review.

Calculation

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

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.

Performance Indicator 4.b **Emergency department length of stay: Percentage of patients treated and admitted to hospital within eight hours (all sites)**

RESULTS				
2013-14	**2014-15**	**2015-16**	**2016-17**	**2017-18**
54%	48%	49%	49%	44%

Data Sources

National Ambulatory Care Reporting System format (NACRS). NACRS sites: all Alberta hospital sites.

Methodology

The Emergency Department (ED) length of stay for admitted patients is measured from the earliest reported time after arrival in the ED (either the triage or registration time) to the time the patient enters the hospital as an inpatient (discharged from the ED). This metric does not apply to Urgent Care facilities as these facilities do not have inpatient spaces. For data sources submitted via abstracting (not operational source systems) the time the patient leaves the ED is determined through investigation of the inpatient visit record.

Calculation

Length of stay is captured in minutes between a Start Time and End Time where the Start Time is the earliest of either the ED Triage Time or the ED Visit (Registration) Time and the End Time is the valid discharge date and time.

Percentage of patients treated and admitted to hospital within 8 hours (all sites):

$$\% = \frac{\#\ of\ valid\ records\ with\ a\ length\ of\ stay\ of\ less\ than\ 8\ hours\ (480\ minutes)}{total\ \#\ of\ valid\ records}\ x\ 100$$

Financial Information

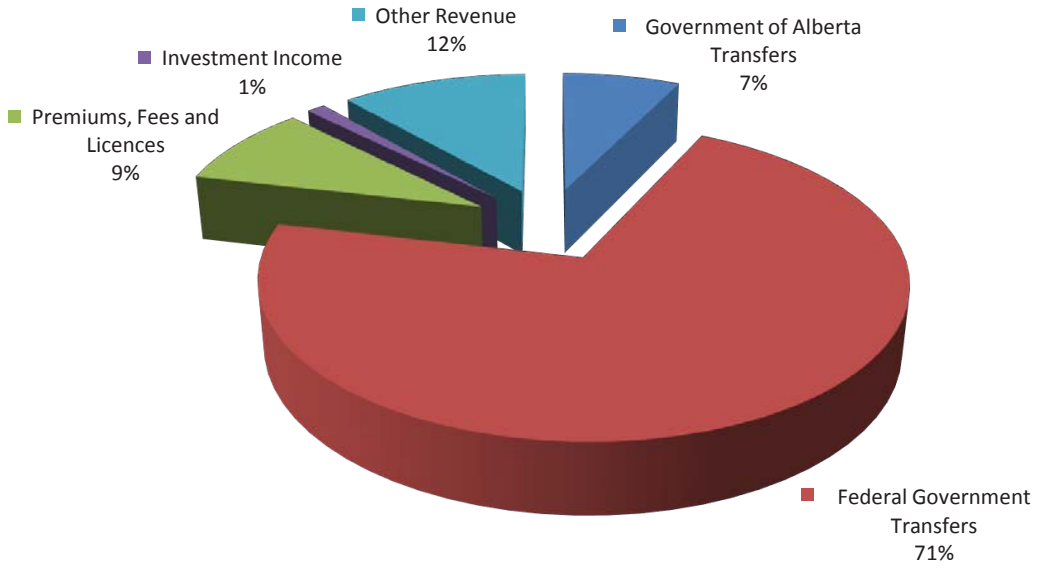
Financial Highlights

Financial Highlights

The consolidated Ministry Financial Statements include:

- Department of Health
- Alberta Health Services
- Health Quality Council of Alberta

Consolidated Actual Revenues *(in thousands)*



	2018		2017
	Budget	Actual	Actual
Government of Alberta Transfers	$ 443,000	$ 441,981	$ 446,403
Federal Government Transfers	4,404,447	4,375,151	4,209,342
Premiums, Fees and Licences	523,002	545,842	524,716
Investment Income	68,006	67,999	65,558
Other Revenue	683,461	697,897	652,826
	$ 6,121,916	**$ 6,128,870**	**$ 5,898,845**

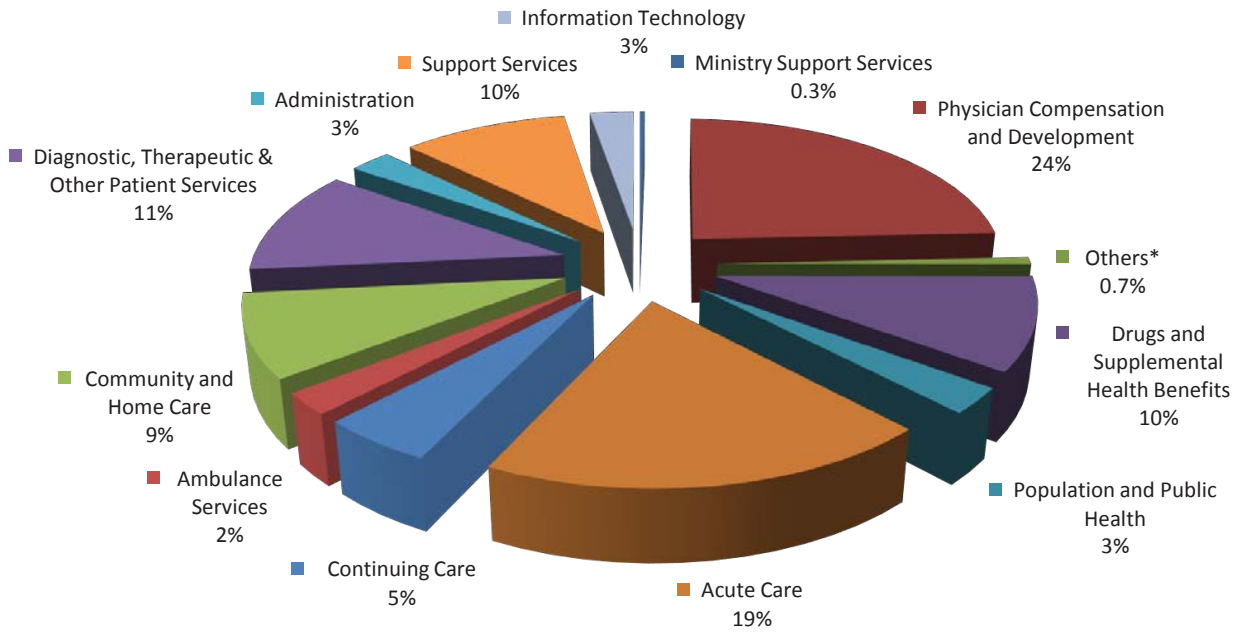
Actual revenues exceeded the budget by $7 million due to higher than anticipated receipts in Premiums, Fees and Licences resulting from increased services for non-residents of Canada and/or services related to the Workers Compensation Board; and an increase in donations and non-government grants in Other Revenue. These revenues were partially offset by a reduction in the Canada Health Transfer entitlement due to a downward revision to the population projection for Alberta in 2017/18.

Compared to prior year, revenues increased by $230 million due to: annualized increase for Canada Health Transfer entitlement and new funding for home care and mental health services from the Federal Government; Premiums, Fees and Licences due to additional fees for non-residents of Canada and/or services related to the Workers Compensation Board; and Other Revenue due to reimbursement from Canada Health Infoway and increase in aggregate assessment from automobile insurers.

Financial Highlights

Consolidated Actual Expenses

(in thousands)



	2018		2017
	Budget	Actual	Actual
Ministry Support Services	$ 85,626	$ 63,133	$ 62,318
Physician Compensation and Development	5,197,587	5,162,989	5,081,857
Drugs and Supplemental Health Benefits	2,249,354	2,142,839	1,998,863
Population and Public Health	694,998	598,078	574,032
Acute Care	4,076,858	4,160,762	4,109,255
Continuing Care	1,071,620	1,061,874	1,041,436
Ambulance Services	471,000	509,937	494,648
Community and Home Care	2,027,000	1,927,210	1,808,180
Diagnostic, Therapeutic & Other Patient Services	2,380,459	2,420,211	2,388,461
Administration	537,291	543,168	507,366
Support Services	2,115,000	2,167,830	2,108,153
Information Technology	594,045	574,863	577,948
Others*	312,425	159,746	182,389
	$ 21,813,263	**$ 21,492,640**	**$ 20,934,906**

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

Expenses were lower than budgeted by $321 million due to recognition of product listing agreement receipts as net program cost in Drugs and Supplemental Health Benefits. Others areas of reduced costs when compared to budget include: Population and Public Health due to spending being lower than anticipated, prior year surplus resulting in reduced funding requirements, and lower than anticipated growth of enrollees in primary care networks; Community and Home Care as a result of slower than expected implementation of the enhancing care in the community plan; and Infrastructure Support due to unallocated funding for a potential new continuing care capital program and some delays in Affordable Supportive Living Initiative projects. These decreases were partially offset by increase in Acute Care due to higher elapsed patient days, higher costs related to influenza season, and increased number of surgeries to address surgery wait times.

Expenses increased by $558 million compared to the prior year due to: Physician Compensation and Development as a result of higher service volumes and retention benefit obligations; Drugs and Supplemental Health Benefits due to increase in net cost of claims and growth in population served through these programs; Acute Care as a result of increased activity, higher elapsed patient days, and increased number of surgeries; Community and Home Care due to increased home care service hours and increased spending on new priority initiatives for community services; and Support Services for amortization of new facilities and additional supplies to meet increased demand for health services. Efforts were made to contain costs throughout the year to minimize the overall year-over-year expenditure growth.

Financial Information

Ministry of Health

Consolidated Financial Statements
March 31, 2018

Ministry of Health

Consolidated Financial Statements

Year Ended March 31, 2018

Consolidated Financial Statements
March 31, 2018

Auditor General
OF ALBERTA

Independent Auditor's Report

To the Members of the Legislative Assembly

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of the Ministry of Health, which comprise the consolidated statement of financial position as at March 31, 2018, and the consolidated statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Ministry of Health as at March 31, 2018, and the results of its operations, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

W. Doug Wylie FCPA, FCMA, ICD.D
Auditor General

CONSOLIDATED STATEMENT OF OPERATIONS

Year Ended March 31, 2018

(in thousands)

	2018		2017
	Budget	Actual	Actual
			(Restated - Note 3)
Revenues (Schedule 1)			
Government Transfers			
Government of Alberta Transfers	$ 443,000	$ 441,981	$ 446,403
Federal Government Transfers	4,404,447	4,375,151	4,209,342
Premiums, Fees and Licences	523,002	545,842	524,716
Investment Income	68,006	67,999	65,558
Other Revenue	683,461	697,897	652,826
	6,121,916	6,128,870	5,898,845
Expenses - Directly Incurred (Note 2b(ii) and Schedules 2 & 4)			
Ministry Support Services	85,626	63,133	62,318
Physician Compensation and Development	5,197,587	5,162,989	5,081,857
Drugs and Supplemental Health Benefits	2,249,354	2,142,839	1,998,863
Population and Public Health	694,998	598,078	574,032
Acute Care	4,076,858	4,160,762	4,109,255
Continuing Care	1,071,620	1,061,874	1,041,436
Ambulance Services	471,000	509,937	494,648
Community and Home Care	2,027,000	1,927,210	1,808,180
Diagnostic, Therapeutic & Other Patient Services	2,380,459	2,420,211	2,388,461
Administration	537,291	543,168	507,366
Support Services	2,115,000	2,167,830	2,108,153
Information Technology	594,045	574,863	577,948
Research and Education	163,000	99,400	98,630
Debt Servicing	15,000	15,825	16,221
Infrastructure Support	122,325	44,521	59,268
Cancer Research and Prevention Investment	12,100	-	8,270
	21,813,263	21,492,640	20,934,906
Annual Deficit	$ (15,691,347)	$ (15,363,770)	$ (15,036,061)

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at March 31, 2018
(in thousands)

	2018	2017 (Restated - Note 3)
Financial Assets		
Cash	$ 67,862	$ 73,747
Accounts Receivable (Note 4)	502,859	455,465
Portfolio Investments		
- Operating (Schedule 5)	2,186,565	2,128,132
- Endowments (Note 11 and Schedule 5)	74,694	74,710
	2,831,980	2,732,054
Liabilities		
Accounts Payable and Accrued Liabilities (Note 5)	2,667,882	2,343,603
Deferred Operating Contributions (Note 6)	248,306	252,653
Unspent Deferred Capital Contributions (Note 6)	105,414	98,248
Debt (Note 7)	369,775	320,087
	3,391,377	3,014,591
Net Debt	(559,397)	(282,537)
Non-Financial Assets		
Tangible Capital Assets (Note 8)	8,091,553	7,686,024
Inventories of Supplies	114,037	107,366
Prepaid Expenses	153,014	116,044
	8,358,604	7,909,434
Net Assets Before Spent Deferred Capital Contributions	7,799,207	7,626,897
Spent Deferred Capital Contributions (Note 6)	6,461,872	6,302,448
Net Assets	$ 1,337,335	$ 1,324,449
Net Assets, Beginning of Year	$ 1,324,449	$ 1,325,835
Annual Deficit	(15,363,770)	(15,036,061)
Net Financing Provided from General Revenues	15,376,656	15,034,675
Net Assets, End of Year	$ 1,337,335	$ 1,324,449

Contractual Obligations and Contingent Liabilities (Notes 9 and 10)

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

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT

Year Ended March 31, 2018

(in thousands)

	2018		2017
	Budget	Actual	Actual (Restated - Note 3)
Annual Deficit	$ (15,691,347)	$ (15,363,770)	$ (15,036,061)
Acquisition of Tangible Capital Assets (Note 8)	(1,025,482)	(959,751)	(609,785)
Amortization of Tangible Capital Assets (Note 8)	566,447	553,829	569,377
Write-down of Tangible Capital Assets		393	572
Acquisition of Inventories of Supplies	(851,200)	(869,354)	(839,659)
Consumption of Inventories of Supplies	851,000	861,507	841,894
Write-down of Inventories of Supplies		1,176	6,648
Change in Prepaid Expenses		(36,970)	126
Change in Spent Deferred Capital Contributions (Note 6)		159,424	53,592
Net Financing Provided from General Revenues		15,376,656	15,034,675
(Increase) Decrease in Net Debt		(276,860)	21,379
Net Debt, Beginning of Year		(282,537)	(303,916)
Net Debt, End of Year		$ (559,397)	$ (282,537)

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

CONSOLIDATED STATEMENT OF CASH FLOWS

Year Ended March 31, 2018

(in thousands)	2018	2017 (Restated - Note 3)
Operating Transactions		
Annual Deficit	$ (15,363,770)	$ (15,036,061)
Non-cash items:		
Amortization of Tangible Capital Assets (Note 8)	553,829	569,377
Spent Deferred Capital Contributions recognized as Revenue (Note 6)	(329,032)	(323,348)
Revenue recognized for transfer of land	(6,286)	(687)
Write-down of Tangible Capital Assets / Inventories of Supplies	1,569	7,220
Valuation and Other Adjustments	49,983	72,638
Realized Gain on Sale of Portfolio Investments	(16,720)	(9,531)
	(15,110,427)	(14,720,392)
(Increase) in Accounts Receivable	(84,231)	(7,150)
Increase (Decrease) in Accounts Payable and Accrued Liabilities	304,931	(51,897)
(Decrease) in Deferred Operating Contributions	(41,071)	(38,845)
(Increase) Decrease in Inventories of Supplies	(7,847)	2,235
(Increase) Decrease in Prepaid Expenses	(36,970)	126
Cash (applied to) Operating Transactions	(14,975,615)	(14,815,923)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 8)	(621,843)	(393,165)
Cash (applied to) Capital Transactions	(621,843)	(393,165)
Investing Transactions		
Purchase of Portfolio Investments	(3,168,353)	(3,339,338)
Proceeds on Disposal of Portfolio Investments	3,126,656	3,299,926
Cash (applied to) Investing Transactions	(41,697)	(39,412)
Financing Transactions		
Net Financing provided from General Revenues	15,376,656	15,034,675
Restricted Capital Contribution received	207,236	213,839
Restricted Capital Contribution returned	(310)	(1,220)
Debt Retirement	(17,612)	(16,822)
Debt Issues	67,300	10,000
Cash provided by Financing Transactions	15,633,270	15,240,472
(Decrease) in Cash	(5,885)	(8,028)
Cash, Beginning of Year	73,747	81,775
Cash, End of Year	$ 67,862	$ 73,747

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2017

Note 1 Authority and Purpose

The Minister of Health (Minister) has been designated as responsible for various Acts by the *Government Organization Act*, Chapter G-10, revised Statutes of Alberta 2000 and its regulations. Following are the organizations that comprise the Ministry of Health (Ministry) and the authority under which each organization operates.

Department of Health	*Government Organization Act*
Alberta Health Services (AHS)	*Regional Health Authorities Act*
Health Quality Council of Alberta (HQCA)	*Health Quality Council of Alberta Act*

In support of the Government of Alberta's commitment for a stable, accountable, high quality and sustainable health system, the Ministry's goal is for Albertans to receive the right health services, in the right place, at the right time, by the right health providers and teams, with the right information.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS).

(a) Reporting Entity and method of consolidation

The reporting entity is the Ministry of Health, for which the Minister of Health is accountable. The accounts of the Department are fully consolidated with the entities listed in Schedule 6 on a line-by-line basis.

The accounts of government sector entities, except those designated as government business enterprises, are consolidated using the line-by-line method. Under this 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.

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year-end is recognized as unearned revenue and included in accounts payable.

Investment income earned from restricted sources is deferred and recognized when the stipulations imposed have been met. Gains and losses on portfolio investments are not recognized in the Consolidated Statement of Operations until realized.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Government Transfers

Transfers from all levels of governments are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recognized as deferred capital contributions or deferred operating contributions if the eligibility criteria for use of the transfer, or the stipulations together with the Ministry'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 Ministry 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 Ministry meets the eligibility criteria (if any).

Donations and Non-Government Grants

Donations and non-government grants are received from individuals, corporations, and private sector not-for-profit organizations. Donations and non-government grants may be unrestricted or externally restricted for operating or capital purposes. Unrestricted donations and non-government grants are recognized as revenue in the year received or in the year the funds are committed and the amounts can be reasonably estimated. Externally restricted donations, non-government grants, and realized gains and losses for the associated externally restricted investment income are recognized as deferred operating contributions if the terms for their use, or the terms along with the Ministry's actions and communications as to the use, create a liability. These resources are recognized as revenue as the terms are met and, when applicable, the Ministry complies with its communicated use.

Grants and Donations for Land

The Ministry recognizes transfers and donations for the purchase of land as a liability when received, and as revenue when the Ministry purchases the land. The Ministry recognizes in-kind contributions of land as revenue at the fair value of the land. When the Ministry cannot determine the fair value, it records such in-kind contributions at a nominal value.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(ii) Expenses

Directly Incurred

Directly incurred expenses are those costs the Ministry has primary responsibility and accountability for, as reflected in the Government's budget documents.

Grant Expense

Grants are recognized as expenses when authorized, all eligibility criteria have been met by the recipients, and a reasonable estimate of the amounts can be made.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets;
- inventory consumed;
- pension costs which comprise the cost of employer contributions for current service of employees during the year; and
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation and sick pay.

Incurred by Others

Services contributed by other related entities in support of the Ministry's operations are not recognized but disclosed in Schedule 4.

(iii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, and accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

(iv) 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 Ministry's financial claims on external organizations and individuals at the year-end.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Cash

Cash comprises of cash on hand.

Accounts Receivable

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

Portfolio Investments

Portfolio investments are recorded at cost, or amortized cost, less any write-downs associated with a loss in value that is other than a temporary decline. A write-down of a portfolio investment to reflect a loss in value is not reversed for a subsequent increase in value. Gains and losses on investments are recognized when an investment is sold or when there is a permanent impairment in the value of an investment.

Endowments are included in Financial Assets in the Consolidated Statement of Financial Position. Donors have placed restrictions on their contributions to endowments, for example capital preservation. The principal restriction is that the original contribution should be maintained in perpetuity. Other restrictions may include spending investment income earned by endowments for specific operational or capital purposes, or capitalizing a certain amount of investment income to maintain and grow the real value of endowments.

(v) Liabilities

Liabilities are present obligations of the Ministry to external organizations and individuals arising from 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.

Liabilities also include:
- all financial claims payable by Ministry at the year-end;
- accrued employee vacation entitlements; and
- contingent liabilities where future liabilities are likely.

Debt

Debentures and other debt are recognized at their face amount less unamortized discount, which includes issue expenses.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(vi) 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 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, inventories of supplies and prepaid expenses.

Tangible Capital Assets

Tangible capital assets of the Ministry are recorded at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. Costs incurred and reported by the Ministry of Infrastructure to build tangible capital assets on behalf of AHS are recorded as work-in-progress and spent deferred capital contributions. The threshold for capitalizing new systems development is $250,000 and the threshold for major enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land, with exception of Crown lands, is capitalized.

Amortization is only charged if the tangible capital asset is put into service.

Inventories of Supplies

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

Prepaid Expenses

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

Other Assets

Intangible assets, inherited natural resources, Crown lands, art and historic treasures and assets acquired by right are not recognized in these consolidated financial statements.

(vii) Foundations

Various foundations have been established under the *Regional Health Authorities Act* for the purpose of raising funds to enhance health care in various communities throughout Alberta. Depending on how the foundations are established, the Ministry either controls the foundations or has an economic interest in them. Foundations that are controlled by the Ministry are consolidated in these consolidated financial statements. Schedule 6 provides a listing of controlled foundations.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(viii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of the Canada Health Transfer.

Canada Health Transfer entitlements are determined on an equal per capita cash basis. Measurement uncertainty for the Canada Health Transfer relates to the population estimate upon which entitlements are based. As the population estimate is finalized, it is used to adjust the entitlements of open prior years. Accordingly, these amounts are estimated and could change by a material amount.

(c) Change in Accounting Policy

The Ministry has prospectively adopted the following standards effective April 1, 2017:

- PS 2200 Related Party Disclosures: This section requires providing sufficient information to assess the effect of recognized transactions, or, if not recognized, may have had, on the entity's financial position and financial performance. Disclosure also requires providing information on the nature of relationship with the related parties and types of transactions. Adoption of this standard did not result in new disclosures.

- PS 3420 Inter-Entity Transactions: This section addresses the accounting and reporting of transactions between public sector entities that comprise a government's reporting entity. Adoption of this standard did not result in new disclosures.

- PS 3210 Assets: This section provides guidance for applying the definition of assets as defined in PS 1000 - Financial Statement Concepts and general disclosure standards. Adoption of this standard did not result in new disclosures.

- PS 3320 Contingent Assets: This section establishes disclosure standards for possible assets arising from existing conditions or situations involving uncertainty. The existence of contingent assets should be disclosed when the occurrence of the confirming future event is likely. Adoption of this standard did not result in new disclosures.

- PS 3380 Contractual Rights: This section establishes disclosure standards for rights to economic resources arising from contracts or agreements that will result in both assets and revenues in the future when the terms of those contracts or agreements are met. Adoption of this standard did not result in new disclosures.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(d) Future Accounting Changes

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

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

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

- **PS 3450 Financial Instruments (effective April 1, 2021)**
  Adoption of this standard requires corresponding adoption of PS 2601 Foreign Currency Translation, PS 1201 Financial Statement Presentation, and PS 3041 Portfolio Investments in the same fiscal period. These standards provide guidance on: recognition, measurement and disclosure of financial instruments; standards on how to account for and report transactions that are denominated in a foreign currency; general reporting principles and standards for the disclosure of information in financial statements; and how to account for and report portfolio investments.

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

Note 3 Program Transfers

Effective September 1, 2017, Communications and Public Engagement branches were transferred from each Ministry to the Ministry of Treasury Board and Finance (Order in Council 275/2017). Comparatives for 2017 have been restated as if the current organization structure had always been the same.

Note 4 Accounts Receivable

(in thousands)

	2018			2017
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 528,845	$ (25,986)	$ 502,859	$ 455,465

Accounts receivable are unsecured and non-interest bearing.

Note 5 Accounts Payable and Accrued Liabilities

(in thousands)

	2018	2017
Accounts Payable and Accrued Liabilities	$ 1,870,962	$ 1,647,065
Employee Future Benefits	684,245	664,897
Capital Lease Obligations [(a)]	112,675	31,641
	$ 2,667,882	$ 2,343,603

[(a)] Capital Lease Obligations includes 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.

Principal repayment requirements for Capital Lease Obligations in each of the next five years and thereafter are as follows:

2018-19	$ 24,199
2019-20	23,349
2020-21	23,011
2021-22	23,011
2022-23	11,212
Thereafter	24,996
Less: amount representing interest under leases	(17,103)
	$ 112,675

Note 6 Deferred Contributions
(in thousands)

	2018	2017
Deferred Operating Contributions [(i)]	$ 248,306	$ 252,653
Unspent Deferred Capital Contributions [(ii)]	105,414	98,248
Spent Deferred Capital Contributions [(iii)]	6,461,872	6,302,448
	$ 6,815,592	$ 6,653,349

(i) Deferred Operating Contributions represents unexpended external resources with stipulations relating to operating expenditure. Changes in balances in deferred operating contributions are as follows:

	2018				2017
	Federal government	Government of Alberta	Other	Total	Total
Balance, beginning of year	$ 6,583	$ 45,083	$ 200,987	$ 252,653	$ 247,733
Received/receivable during the year	7,707	32,357	185,437	225,501	217,098
Restricted realized investment income	-	1,450	4,869	6,319	7,466
Transferred (to) from unspent deferred capital contributions	-	51,671	(14,947)	36,724	43,765
Recognized as revenue during the year	(13,783)	(104,697)	(154,411)	(272,891)	(263,409)
Balance, end of year	$ 507	$ 25,864	$ 221,935	$ 248,306	$ 252,653

(ii) Unspent deferred capital contributions represent unspent external resources with stipulations related to the purchase of tangible capital assets. Changes in balances in unspent deferred capital contributions are as follows:

	2018			2017
	Government of Alberta	Other	Total	Total
Balance, beginning of year	$ 15,957	$ 82,291	$ 98,248	$ 90,401
Received/receivable during the year	165,695	41,541	207,236	213,839
Transferred tangible capital assets	331,551	71	331,622	215,933
Other adjustments	(6,202)	-	(6,202)	-
Contributions returned	-	(310)	(310)	(1,220)
Transferred from (to) deferred operating contributions	(51,671)	14,947	(36,724)	(43,765)
Transferred to spent deferred capital contributions	(446,473)	(41,983)	(488,456)	(376,940)
Balance, end of year	$ 8,857	$ 96,557	$ 105,414	$ 98,248

Note 6 Deferred Contributions (continued)
(in thousands)

(iii) Spent deferred capital contributions represent resources which have been spent for acquisition of tangible capital assets stipulated to be used over their useful life. Revenue is recognized over the useful life of the assets. Changes in balances in spent deferred capital contributions are as follows:

	2018			2017
	Government of Alberta	Other	Total	Total
Balance, beginning of year	$ 6,111,310	$ 191,138	$ 6,302,448	$ 6,248,856
Transferred from unspent deferred capital contributions	446,473	41,983	488,456	376,940
Recognized as revenue during the year	(287,070)	(41,962)	(329,032)	(323,348)
Balance, end of year	$ 6,270,713	$ 191,159	$ 6,461,872	$ 6,302,448

Note 7 Debt
(in thousands)

	2018			2017
	Maturity	Interest Rate	Book Value	Book Value
Debentures [(a)]	2021 to 2038	2.42-4.93%	$ 368,846	$ 318,875
Other			929	1,212
Total			$ 369,775	$ 320,087

[(a)] The debentures have been issued by AHS to the Alberta Capital Finance Authority.

Principal repayment requirements in each of the next five years and thereafter are as follows:

2018-19	$ 22,133
2019-20	23,091
2020-21	24,092
2021-22	24,800
2022-23	25,878
Thereafter	249,781
	$ 369,775

Note 8 Tangible Capital Assets
(in thousands)

	2018							2017
	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	$ 110,589	$10,453,837	$ 82,764	$ 2,292,250	$ 1,673,760	$ 239,396	$ 14,852,596	$ 14,288,654
Additions [3]	6,286	509,076	1,433	249,929	188,438	4,589	959,751	609,785
Disposals, including write-downs	-	(4,039)	-	(39,793)	(2,800)	(559)	(47,191)	(45,843)
	116,875	10,958,874	84,197	2,502,386	1,859,398	243,426	15,765,156	14,852,596
Accumulated Amortization								
Beginning of year	-	3,777,889	63,037	1,793,590	1,358,194	173,862	7,166,572	6,642,466
Amortization expense	-	290,830	2,246	135,316	114,351	11,086	553,829	569,377
Effect of disposals	-	(4,040)	-	(39,418)	(2,796)	(544)	(46,798)	(45,271)
	-	4,064,679	65,283	1,889,488	1,469,749	184,404	7,673,603	7,166,572
Net Book Value at March 31, 2018	$ 116,875	$ 6,894,195	$ 18,914	$ 612,898	$ 389,649	$ 59,022	$ 8,091,553	
Net Book Value at March 31, 2017	$ 110,589	$ 6,675,948	$ 19,727	$ 498,660	$ 315,566	$ 65,534		$ 7,686,024

[1] Buildings include parking lots.

[2] Historical cost includes work-in-progress at March 31, 2018 totaling $1,186,196 (2017 - $924,754).

[3] Additions include total transferred capital assets of $331,622 (2017 - $215,933) consisting of $331,551 from Ministry of Infrastructure (2017 - $215,933) and $71 from other sources (2017 - $nil).

Note 9 Contractual Obligations
(in thousands)

Contractual obligations are obligations of the Ministry to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2018, the Ministry has the following contractual obligations:

	2018	2017
Capital Contracts	$ 2,889	$ 2,166
Service Contracts and Operating Leases	441,911	411,543
	$ 444,800	$ 413,709

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

	Capital Contracts	Service Contracts and Operating Leases	Total
2018-19	$ 2,747	$ 124,553	$ 127,300
2019-20	142	103,032	103,174
2020-21	-	61,134	61,134
2021-22	-	42,308	42,308
2022-23	-	34,935	34,935
Thereafter	-	75,949	75,949
	$ 2,889	$ 441,911	$ 444,800

Canadian Blood Services

The Government of Alberta is committed to provide funding to the Canadian Blood Services (CBS) for the provision of blood services in Canada. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $204,000 (2017 - $196,000).

Note 10 Contingent Liabilities and Equity Agreements
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Ministry has a contingent liability for buy-out of equity under Equity Agreements entered into between the Ministry and Voluntary Hospital Owners. The Ministry's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2018, the contingent payout liability upon termination is estimated at $12.8 million (2017 - $12.8 million).

Other Contingent Liabilities

The Ministry has been named in 225 (2017: 190) claims, the outcome of which the outcome are not determinable. Of these claims, 209 (2017: 180) have specified amounts totalling $392.6 million (2017: $396.1 million). Included in the total claims is one claim of $2.8 million (2017 – one claim of $2.8 million) in which the Ministry has been jointly named with the Ministry of Children's Services. The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

The Ministry has been named as a co-defendant 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 action was dismissed after trial and the plaintiffs have filed a notice of appeal in February, 2018. The amount of the claim has not been specified and the likelihood of the claim is considered indeterminable.

Indemnity

As described in Note 9, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250 million with respect to risks associated with the operation of the blood system.

CBSE was capitalized in whole through funding from the provinces and territories (except Quebec), through a Captive Support Agreement dated September 28, 2006 ("CSA"), between the provinces, territories, and CBSE. Under the CSA, each of the provinces and territories provided their Pro Rata Share (as defined in the CSA) through an indemnity. Alberta's Pro Rata Share is 13.1% of CBSE's total capital amount, which amounts to $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2018, no amount has been recognized for this indemnity.

Note 11 Endowment Funds
(in thousands)

The endowment funds are as follows:

	2018	2017
Balance, beginning of year	$ 74,710	$ 75,966
Endowment contributions	-	1,308
Reclassification of endowments	(16)	(2,564)
Balance, end of year	$ 74,694	$ 74,710

Note 12 Payments under Reciprocal and Other Agreements
(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 under these agreements are incurred by the Ministry under authority in section 25 of the *Financial Administration Act*.

Accounts receivable includes $40,911 (2017 - $46,508) and accounts payable includes $0 (2017 - $216).

Amounts paid under agreements with program sponsors are as follows:

	2018	2017
Other Provincial and Territorial Governments	$ 287,557	$ 298,807
Health Support Committee	-	216
	$ 287,557	$ 299,023

Note 13 Trust Funds under Administration
(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, 2017, the Health Benefit Trust of Alberta reported fund balance of $115,900 (2016 - $78,183). At March 31, 2018, fund balance held for research and development is $1,836 (2017 - $2,231).

Note 14 Benefit Plans

(in thousands)

Except as noted below, the Ministry participates in the multi-employer pension plans: Management Employees Pension Plan (MEPP), Public Service Pension Plan (PSPP), Local Authorities Pension Plan (LAPP), and Supplementary Retirement Plan for Public Service Managers (SRP). The expense for these pension plans is equivalent to the employer's annual contributions.

AHS also participates in Supplemental Pension Plan and Group Registered Retirement Savings Plans (GRRSPs) which are defined contribution plans for certain employee groups.

AHS and HQCA participate in Supplemental Executive Retirement Plan (SERP) which provides future pension benefits to participants based on years of service and earnings. AHS has closed SERP for new entrants since April 1, 2009. At March 31, 2018, the plan has net accrued benefit liability of $891 (2017-$2,734) which is reported in accounts payable and accrued liabilities.

At December 31, 2017, the MEPP reported a surplus of $866,006 (2016 – surplus $402,033), the PSPP reported a surplus of $1,275,843 (2016 – surplus $302,975), the LAPP reported a surplus of $4,835,515 (2016 - deficiency $637,357) and the SRP reported a deficiency of $54,984 (2016 – deficiency $50,020).

The Ministry's pension expense for the year is as follows:

	2018	2017 (Restated - Note 3)
Registered Benefit Plans	$ 599,367	$ 609,334
Supplemental Executive Retirement Plans	(1,800)	2,265
Supplemental Pension Plan and GRRSPs	51,324	50,627
	$ 648,891	$ 662,226

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2018, the Bargaining Unit Plan reported an actuarial surplus of $111,983 (2017 - $101,515) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $29,805 (2017 - $31,439). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 15 Comparative Figures

Certain 2017 figures have been reclassified to conform to the 2018 presentation.

Note 16 Approval of Financial Statements

The deputy minister and the senior financial officer approved these financial statements.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2018

Schedule 1

Consolidated Revenues

(in thousands)

	2018	2017 (Restated)
Government of Alberta Transfers		
Alberta Cancer Prevention Legacy Fund	$ 12,128	$ 22,174
Other Government Departments	429,853	424,229
	441,981	446,403
Federal Government Transfers		
Canada Health Transfer	4,324,618	4,200,830
Other	50,533	8,512
	4,375,151	4,209,342
Premiums, Fees and Licences		
Fees and Charges	502,233	479,182
Supplementary Health Benefit Premiums	43,609	45,534
	545,842	524,716
Investment Income	67,999	65,558
Other Revenue		
Ancillary operations	132,661	135,660
Donations	159,748	163,155
Previous years' refunds of expenditure	37,427	10,128
Third Party Recoveries	163,763	150,515
Miscellaneous	204,298	193,368
	697,897	652,826
	$ 6,128,870	$ 5,898,845

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2018

Schedule 2

Consolidated Expenses - Directly Incurred Detailed by Object

(in thousands)

	2018	2017 (Restated - Note 3)
Grants	$ 6,424,680	$ 6,254,883
Supplies and Services	5,424,684	5,119,079
Salaries, Wages and Employee Benefits	8,173,567	8,086,883
Amortization of Tangible Capital Assets	553,829	569,377
Consumption of Inventories of Supplies	861,507	841,894
Financial Transactions and Other	54,373	62,790
	$ 21,492,640	$ 20,934,906

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2018

Schedule 3
Consolidated Related Party Transactions
(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's consolidated financial statements. Related parties also include key management personnel in the Ministry.

The Ministry and its employees paid or collected certain taxes and fees set by regulation for permits, 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 Ministry had the following transactions with related parties recorded in the Consolidated Statement of Operations and the Consolidated Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2018	2017
Revenues		
Government of Alberta Transfers		
- Transfer from funds	$ 12,128	$ 22,174
- Alberta Infrastructure	346,243	348,885
- Other Ministries	85,302	23,086
Other	39,816	91,506
	$ 483,489	$ 485,651
Expenses - Directly Incurred		
Grants	$ 46,436	$ 115,919
Other	208,190	150,046
Interest	14,311	14,900
	$ 268,937	$ 280,865
Receivables	$ 43,000	$ 65,903
Payables/Deferred Contributions		
- Alberta Infrastructure	$ 6,285,637	$ 6,132,914
- Other Ministries	51,969	72,695
	$ 6,337,606	$ 6,205,609
Debt	$ 369,775	$ 320,087
Contractual Obligations	$ 3,375	$ 4,083

The Ministry receives services under contracts managed by Service Alberta. Any commitments under these contracts are reported by Service Alberta.

The Ministry also had transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not reported in the consolidated financial statements and are disclosed in Schedule 4.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2018

Schedule 4

Consolidated Allocated Costs

(in thousands)

Program	2018 Expenses [1]	2018 Expenses - Incurred by Others: Accommodation Costs [2]	2018 Expenses - Incurred by Others: Legal Services	2018 Expenses - Incurred by Others: Business Services [3]	2018 Total	2017 (Restated - Note 3) Total
Ministry Support Services	$ 63,133	$ 36,196	$ 4,706	$ 8,798	$ 112,833	$ 112,896
Physician Compensation and Development	5,162,989	-	-	-	5,162,989	5,081,857
Drugs and Supplemental Health Benefits	2,142,839	-	-	-	2,142,839	1,998,863
Population and Public Health	598,078	-	-	-	598,078	574,032
Acute Care	4,160,762	-	-	-	4,160,762	4,109,255
Continuing Care	1,061,874	-	-	-	1,061,874	1,041,436
Ambulance Services	509,937	-	-	-	509,937	494,648
Community and Home Care	1,927,210	-	-	-	1,927,210	1,808,180
Diagnostic, Therapeutic & Other Patient Services	2,420,211	-	-	-	2,420,211	2,388,461
Administration	543,168	-	-	-	543,168	507,366
Support Services	2,167,830	-	-	-	2,167,830	2,108,153
Information Technology	574,863	-	-	-	574,863	577,948
Research and Education	99,400	-	-	-	99,400	98,630
Debt Servicing	15,825	-	-	-	15,825	16,221
Infrastructure Support	44,521	-	-	-	44,521	59,268
Cancer Research and Prevention Investment	-	-	-	-	-	8,270
	$ 21,492,640	$ 36,196	$ 4,706	$ 8,798	$ 21,542,340	$ 20,985,484

[1] Expenses - Directly Incurred as per Consolidated Statement of Operations.

[2] Accommodation Costs, including grants in lieu of taxes.

[3] Business Services Costs, including charges for IT support, vehicles, internal audit services and other services.

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2018

Schedule 5
Consolidated Portfolio Investments
(in thousands)

	2018		2017	
	Cost	Fair Value	Cost	Fair Value
Cash held for investing purposes	$ 118,011	$ 118,011	$ 106,666	$ 106,666
Interest bearing securities				
Money market securities	124,320	124,320	101,113	101,113
Fixed income securities	1,549,534	1,540,139	1,546,500	1,543,462
	1,673,854	1,664,459	1,647,613	1,644,575
Equities:				
Canadian pooled equity funds	142,929	158,030	144,026	165,068
Global pooled equity funds	326,465	376,252	304,537	348,557
	469,394	534,282	448,563	513,625
Total Portfolio Investments	$ 2,261,259	$ 2,316,752	$ 2,202,842	$ 2,264,866

	2018		2017	
	Cost	Fair Value	Cost	Fair Value
Operating	$ 2,186,565	$ 2,242,058	$ 2,128,132	$ 2,190,156
Endowments	74,694	74,694	74,710	74,710
Total Portfolio Investments	$ 2,261,259	$ 2,316,752	$ 2,202,842	$ 2,264,866

PSAS requires using the following fair value hierarchy for fair value measurements:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets;
- Level 2 – Observable inputs, other than level 1, either directly (i.e. as prices) or indirectly (i.e. derived from prices) for similar assets; and
- Level 3 –Inputs for the assets that are not based on observable market data (unobservable inputs).

Fair Value Hierarchy

	2018				2017			
	Level 1	Level 2	Level 3	Total	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 118,011	$ -	$ -	$ 118,011	$ 106,666	$ -	$ -	$ 106,666
Interest bearing securities	-	1,517,445	147,014	1,664,459	-	1,507,654	136,921	1,644,575
Equities	398,450	135,832	-	534,282	377,429	136,196	-	513,625
	$ 516,461	$ 1,653,277	$ 147,014	$2,316,752	$ 484,095	$ 1,643,850	$ 136,921	$2,264,866

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2018

Schedule 6
List of Entities Included in the Consolidated Financial Statements

Department of Health

Health Quality Council of Alberta

Alberta Health Services

Owns majority of the Class A voting shares in:

Calgary Laboratory Services Ltd. - AHS owns 100% of the Class A voting shares.
Capital Care Group Inc. - AHS owns 100% of the Class A voting shares.
Carewest - AHS owns 99% of the Class A voting shares.

Controlled 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)
AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP.

Queen Elizabeth II Hospital Child Care Centre

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2018

Schedule 6 (continued)
List of Entities Included in the Consolidated Financial Statements

Alberta Health Services

Partnerships

AHS uses the proportionate consolidation method to account for its:

- 50% interest in the Primary Care Network (PCN) government partnerships with physician groups
- 50% interest in the Northern Alberta Clinical Trials Centre partnership with the University of Alberta
- 33% interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health

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

Alberta Heartland Primary Care Network
Aspen (Athabasca/Westlock) 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 (St. Paul/Aspen) 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
Sexsmith/Spirit River 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
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

Financial Information

Department of Health

Financial Statements
March 31, 2018

Department of Health

Financial Statements

Year Ended March 31, 2018

Financial Statements
March 31, 2018

Auditor General
OF ALBERTA

Independent Auditor's Report

To the Minister of Health

Report on the Financial Statements

I have audited the accompanying financial statements of the Department of Health, which comprise the statement of financial position as at March 31, 2018, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Department of Health as at March 31, 2018, and the results of its operations, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

W. Doug Wylie FCPA, FCMA, ICD.D
Auditor General

June 5, 2018
Edmonton, Alberta

STATEMENT OF OPERATIONS

Year Ended March 31, 2018
(in thousands)

	2018		2017
	Budget	Actual	Actual (Restated - Note 3)
Revenues (Schedule 1)			
Government Transfers			
Government of Alberta Transfers	$ 25,000	$ 12,128	$ 22,174
Federal Government Transfers	4,396,447	4,360,879	4,208,257
Premiums, Fees and Licences	48,002	43,612	45,536
Other Revenue	273,384	225,277	165,372
	4,742,833	4,641,896	4,441,339
Expenses - Directly Incurred (Note 2a(ii) and Schedule 8)			
Programs (Schedules 3 and 4)			
Ministry Support Services	85,626	63,299	62,528
Alberta Health Services	12,160,232	12,162,585	11,909,923
Physician Compensation and Development	4,797,460	4,776,064	4,611,423
Drugs and Supplemental Health Benefits	2,125,141	1,966,167	1,842,489
Addiction and Mental Health	80,556	86,704	44,122
Primary Health Care	248,647	231,511	172,639
Population and Public Health	149,088	114,302	126,011
Allied Health Services	111,402	108,104	101,369
Human Tissue and Blood Services	215,287	204,982	197,636
Support Programs	52,093	41,508	40,660
Out-of-Province Health Care Services	167,248	153,724	161,603
Information Technology	102,045	83,659	80,689
Cancer Research and Prevention Investment	25,000	12,128	22,175
Infrastructure Support	274,886	140,001	89,568
	20,594,711	20,144,738	19,462,835
Annual Deficit	$ (15,851,878)	$ (15,502,842)	$ (15,021,496)

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

STATEMENT OF FINANCIAL POSITION

As at March 31, 2018
(in thousands)

	2018	2017 (Restated-Note 3)
Financial Assets		
Cash	$ 42	$ 1,635
Accounts Receivable	190,362	146,280
	190,404	147,915
Liabilities		
Accounts Payable and Accrued Liabilities (Note 4)	707,950	543,981
	707,950	543,981
Net Debt	(517,546)	(396,066)
Non-Financial Assets		
Tangible Capital Assets (Note 5)	59,180	65,866
Inventories of Supplies	17,464	15,484
	76,644	81,350
Net Liabilities	$ (440,902)	$ (314,716)
Net Liabilities, Beginning of Year	$ (314,716)	$ (327,895)
Annual Deficit	(15,502,842)	(15,021,496)
Net Financing Provided from General Revenues	15,376,656	15,034,675
Net Liabilities, End of Year	$ (440,902)	$ (314,716)

Contractual Obligations and Contingent Liabilities (Notes 6 and 7)

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

STATEMENT OF CHANGE IN NET DEBT

Year Ended March 31, 2018
(in thousands)

	2018		2017
	Budget	Actual	Actual (Restated - Note 3)
Annual Deficit	$ (15,851,878)	$ (15,502,842)	$ (15,021,496)
Acquisition of Tangible Capital Assets (Note 5)	(22,230)	(8,692)	(12,684)
Amortization of Tangible Capital Assets (Note 5)	18,250	15,378	18,722
Acquisition of Inventories of Supplies	(66,200)	(63,833)	(61,341)
Consumption of Inventories of Supplies	65,000	60,678	61,020
Write-offs of Inventories of Supplies		1,175	6,647
Net Financing Provided from General Revenues		15,376,656	15,034,675
(Increase) Decrease in Net Debt		(121,480)	25,543
Net Debt, Beginning of Year		(396,066)	(421,609)
Net Debt, End of Year		$ (517,546)	$ (396,066)

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

STATEMENT OF CASH FLOWS

Year Ended March 31, 2018
(in thousands)

	2018	2017 (Restated - Note 3)
Operating Transactions		
Annual Deficit	$ (15,502,842)	$ (15,021,496)
Non-cash items included in Annual Deficit:		
Amortization of Tangible Capital Assets (Note 5)	15,378	18,722
Valuation Adjustments and write-offs	3,662	10,221
	(15,483,802)	(14,992,553)
(Increase) Decrease in Accounts Receivable	(46,542)	5,101
Increase (Decrease) in Accounts Payable and Accrued Liabilities	163,942	(32,912)
(Increase) in Inventories of Supplies	(3,155)	(321)
Cash (applied to) Operating Transactions	(15,369,557)	(15,020,685)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 5)	(8,692)	(12,684)
Cash (applied to) Capital Transactions	(8,692)	(12,684)
Financing Transactions		
Net Financing Provided from General Revenues	15,376,656	15,034,675
Cash provided by Financing Transactions	15,376,656	15,034,675
(Decrease) Increase in Cash	(1,593)	1,306
Cash, Beginning of Year	1,635	329
Cash, End of Year	$ 42	$ 1,635

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

NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2018

Note 1 Authority and Purpose

The Department of Health (the Department) operates under the authority of the *Government Organization Act*, Chapter G-10, Revised Statutes of Alberta 2000.

In support of the Government of Alberta's commitment for a stable, accountable, high quality and sustainable health system, the Department's goal is for Albertans to receive the right health services, in the right place, at the right time, by the right health providers and teams, with the right information.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards.

(a) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year-end is recognized as unearned revenue and included in accounts payable.

Government Transfers

Transfers from all levels of governments are referred to as government transfers.

Government transfers are recognized as deferred capital contributions or deferred revenue if the eligibility criteria of the transfer, or the stipulations, together with the Department's actions and communications as to the use of transfers create a liability. These transfers are recognized as revenues as the stipulations are met and, when applicable, the Department 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 Department meets the eligibility criteria (if any).

Credit or Recovery

Credit or recovery initiatives provide a basis for authorizing spending. Credits or recoveries are shown in the details of the government estimates for a supply vote. If budgeted revenues are not fully realized, spending is reduced by an equivalent amount. If actual credit or recovery amounts exceed budget, the department may, with the approval of the Treasury Board Committee, use the excess to fund additional expenses of the program. Schedule 2 discloses information on the department's credit or recovery initiatives.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(ii) Expenses

Directly Incurred

Directly incurred expenses are those costs the Department has primary responsibility and accountability for, as reflected in the Government's budget documents.

Grant Expense

Grants are recognized as expenses when authorized, all eligibility criteria have been met by the recipients, and a reasonable estimate of the amounts can be made.

In addition to program operating expenses such as salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets;
- inventory of supplies consumed;
- pension costs, which comprise the cost of employer contributions for current service of employees during the year; and
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Incurred by Others

Services contributed by other related entities in support of the Department's operations are not recognized but disclosed in Schedule 8.

(iii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, and accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(iv) 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 of the Department are limited to financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Accounts Receivable

Accounts receivable are recognized at the lower of cost or net recoverable value. Accounts receivable are unsecured and non-interest bearing. A valuation allowance is recognized when recovery is uncertain.

(v) Liabilities

Liabilities are present obligations of the Department to external organizations and individuals arising from past transactions or events, 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.

(vi) 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 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 of the Department are limited to tangible capital assets and inventories of supplies.

Tangible Capital Assets

Tangible capital assets of the Department are recognized at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000.

Amortization is only charged if the tangible capital asset is put into service.

Inventories of Supplies

Inventory of supplies consist of vaccines and drugs for distribution at no cost which are valued at the lower of cost and replacement cost. Cost is determined on a first-in first-out basis.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(vii) Other Assets

Intangible assets, inherited natural resources, Crown lands, art and historic treasures and assets acquired by right are not recognized in these financial statements.

(viii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of the Canada Health Transfer.

Canada Health Transfer entitlements are determined on an equal per capita cash basis. Measurement uncertainty for the Canada Health Transfer relates to the population estimate upon which entitlements are based. As the population estimate is finalized, it is used to adjust the entitlements of open prior years. Accordingly, these amounts are estimated and could change by a material amount

(b) Change in Accounting Policy

The Department has prospectively adopted the following standards effective April 1, 2017:

- PS 2200 Related Party Disclosures: This section requires providing sufficient information to assess the effect of recognized transactions, or, if not recognized, may have had, on the entity's financial position and financial performance. Disclosure also requires providing information on the nature of relationship with the related parties and types of transactions. Adoption of this standard did not result in new disclosures.

- PS 3420 Inter-Entity Transactions: This section addresses the accounting and reporting of transactions between public sector entities that comprise a government's reporting entity. Adoption of this standard did not result in new disclosures.

- PS 3210 Assets: This section provides guidance for applying the definition of assets as defined in PS 1000 - Financial Statement Concepts and general disclosure standards. Adoption of this standard did not result in new disclosures.

- PS 3320 Contingent Assets: This section establishes disclosure standards for possible assets arising from existing conditions or situations involving uncertainty. The existence of contingent assets should be disclosed when the occurrence of the confirming future event is likely. Adoption of this standard did not result in new disclosures.

- PS 3380 Contractual Rights: This section establishes disclosure standards for rights to economic resources arising from contracts or agreements that will result in both assets and revenues in the future when the terms of those contracts or agreements are met. Adoption of this standard did not result in new disclosures.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(c) Future Accounting Changes

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

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

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

- **PS 3450 Financial Instruments (effective April 1, 2021)**
  Adoption of this standard requires corresponding adoption of PS 2601 Foreign Currency Translation, PS 1201 Financial Statement Presentation, and PS 3041 Portfolio Investments in the same fiscal period. These standards provide guidance on: recognition, measurement and disclosure of financial instruments; standards on how to account for and report transactions that are denominated in a foreign currency; general reporting principles and standards for the disclosure of information in financial statements; and how to account for and report portfolio investments.

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

Note 3 Program Transfers

Effective September 1, 2017, Communications and Public Engagement branches were transferred from each Department to the Department of Treasury Board and Finance (Order in Council 275/2017). Comparatives for 2017 have been restated as if the current organization structure had always been the same.

Note 4 Accounts Payable and Accrued Liabilities
(in thousands)

	2018	2017
Accounts payable and accrued liabilities	$ 690,032	$ 524,893
Unearned revenue	7,794	8,991
Accrued vacation pay	10,124	10,097
	$ 707,950	$ 543,981

Note 5 Tangible Capital Assets
(in thousands)

	2018			2017
	Equipment [1]	Computer Hardware and Software	Total	Total
Estimated Useful Life	10 years	3 - 10 years		
Historical Cost [2]				
Beginning of year	$ 2,449	$ 242,699	$ 245,148	$ 232,464
Additions	-	8,692	8,692	12,684
Disposals, including write-downs	-	(17)	(17)	-
	2,449	251,374	253,823	245,148
Accumulated Amortization				
Beginning of year	2,169	177,113	179,282	160,560
Amortization expense	76	15,302	15,378	18,722
Effect of disposals	-	(17)	(17)	-
	2,245	192,398	194,643	179,282
Net Book Value at March 31, 2018	$ 204	$ 58,976	$ 59,180	
Net Book Value at March 31, 2017	$ 280	$ 65,586		$ 65,866

(1) Equipment includes office equipment and furniture.

(2) Historical cost includes work-in-progress at March 31, 2018 for computer hardware and software totaling $7,127 (2017 - $10,648).

Note 6 Contractual Obligations
(in thousands)

Contractual obligations are obligations of the Department to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2018, the Department has the following contractual obligations:

	2018	2017
Capital Contracts	$ 2,889	$ 2,166
Service Contracts	141,927	141,249
	$ 144,816	$ 143,415

Note 6 Contractual Obligations (continued)
(in thousands)

Estimated payment requirements for each of the next five years and thereafter are as follows:

	Capital Contracts	Service Contracts	Total
2018-19	$ 2,747	$ 67,213	$ 69,960
2019-20	142	53,843	53,985
2020-21	-	18,471	18,471
2021-22	-	2,127	2,127
2022-23	-	273	273
Thereafter	-	-	-
	$ 2,889	$ 141,927	$ 144,816

Canadian Blood Services

The Government of Alberta is committed to provide funding to Canadian Blood Services (CBS) for the provision of blood services in Alberta. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $204,000 (2017 - $196,000).

Note 7 Contingent Liabilities and Equity Agreements
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Department has a contingent liability for buy-out of equity under Equity Agreements entered into between the Department and Voluntary Hospital Owners. The Department's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2018, the contingent payout liability upon termination is estimated at $12.8 million (2017 - $12.8 million).

Other Contingent Liabilities

The Department has been named in six claims (2017 – nine claims), the outcome of which are not determinable. Of these claims, four have specified amounts totaling $88.9 million (2017 – five claims with a specified amount of $89.6 million). Included in the total claims is one claim of $2.8 million (2017 – one claim of $2.8 million) in which the Department has been jointly named with the Department of Children's Services. Included in the total claims are two claims totaling $63.9 million (2017 – three claims totaling $88.9 million) covered in whole (or in part) by the Alberta Risk Management Fund. The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

Note 7 Contingent Liabilities and Equity Agreements (continued)
(in dollars)

The Department has been named as a co-defendant, along with Alberta Health Services, 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 action was dismissed after trial and the plaintiffs have filed a notice of appeal in February, 2018. The amount of the claim has not been specified and the likelihood of the claim is considered indeterminable.

Indemnity

As described in Note 6, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250 million with respect to risks associated with the operation of the blood system.

CBSE was capitalized in whole through funding from the provinces and territories (except Quebec), through a Captive Support Agreement dated September 28, 2006 ("CSA"), between the provinces, territories, and CBSE. Under the CSA, each of the provinces and territories provided their Pro Rata Share (as defined in the CSA) through an indemnity. Alberta's Pro Rata Share is 13.1% of CBSE's total capital amount, which amounts to $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2018, no amount has been recognized for this indemnity.

Note 8 Benefit Plans
(in thousands)

The Department participates in the multi-employer pension plans: Management Employees Pension Plan (MEPP), Public Service Pension Plan (PSPP) and Supplementary Retirement Plan for Public Service Managers (SRP). The expense for these pension plans is equivalent to the annual contributions of $11,546 for the year ended March 31, 2018 (2017 – Restated $12,506). The Department is not responsible for future funding of the plan deficit other than through contribution increases.

At December 31, 2017, the MEPP reported a surplus of $866,006 (2016 - $402,033), the PSPP reported a surplus of $1,275,843 (2016 - $302,975) and the SRP reported a deficiency of $54,984 (2016 - $50,020).

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2018, the Bargaining Unit Plan reported an actuarial surplus of $111,983 (2017 - $101,515) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $29,805 (2017 - $31,439). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 9 Payments under Reciprocal and Other Agreements
(in thousands)

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

Accounts receivable includes $40,911 (2017 - $46,508) and accounts payable includes $0 (2017 - $216).

Amounts paid under agreements with program sponsors are as follows:

	2018	2017
Other Provincial and Territorial Governments	$ 287,557	$ 298,807
Health Support Committee	-	216
	$ 287,557	$ 299,023

Note 10 Comparative Figures

Certain 2017 figures have been reclassified to conform to the 2018 presentation.

Note 11 Approval of Financial Statements

The deputy minister and the senior financial officer approved these financial statements.

Schedule to Financial Statements
Year Ended March 31, 2018

SCHEDULE 1

Revenues
(in thousands)

	2018		2017
	Budget	Actual	Actual (Restated)
Government of Alberta Transfers			
Alberta Cancer Prevention Legacy Fund	$ 25,000	$ 12,128	$ 22,174
Federal Government Transfers			
Canada Health Transfer	4,360,247	4,324,618	4,200,830
Other	36,200	36,261	7,427
	4,396,447	4,360,879	4,208,257
Premiums, Fees and Licences			
Supplementary Health Benefit Premiums	48,000	43,609	45,534
Miscellaneous	2	3	2
	48,002	43,612	45,536
Other Revenue			
Third Party Recoveries	160,000	163,763	150,515
Previous years' refunds of expenditure	4,040	46,438	14,010
Miscellaneous	109,344	15,076	847
	273,384	225,277	165,372
	$ 4,742,833	$ 4,641,896	$ 4,441,339

Schedule to Financial Statements
Year Ended March 31, 2018

SCHEDULE 2
Credit or Recovery
(in thousands)

	2018				
	Authorized	Actual Revenue Recognized	Deferred Revenue	Actual 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.

Schedule to Financial Statements
Year Ended March 31, 2018

SCHEDULE 3

Expenses - Directly Incurred Detailed by Object

(in thousands)

	2018		2017
	Budget	Actual	Actual (Restated - Note 3)
Grants	$ 20,261,881	$ 19,846,271	$ 19,168,108
Supplies and Services	124,318	119,209	105,663
Salaries, Wages and Employee Benefits	123,152	99,423	99,143
Amortization of Tangible Capital Assets	18,250	15,378	18,722
Consumption of Inventories of Supplies	65,000	60,678	61,020
Other	2,110	3,779	10,179
	$ 20,594,711	$ 20,144,738	$ 19,462,835

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 4

Lapse/Encumbrance

(in thousands)

Program - Operating Expense		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
1	**Ministry Support Services**						
1.1	Minister's Office	$ 745	$ -	$ -	$ 745	$ 735	$ 10
1.2	Associate Minister's Office	365	-	-	365	331	34
1.3	Deputy Minister's Office	1,524	-	-	1,524	1,335	189
1.4	Communications	5,013	-	(5,013)	-	-	-
1.5	Strategic Corporate Support	56,197	-	-	56,197	43,517	12,680
1.6	Policy Development and Strategic Support	19,639	-	-	19,639	15,524	4,115
1.7	Health Advocates' Office	1,893	-	-	1,893	1,323	570
		85,376	-	(5,013)	80,363	62,765	17,598
2	**Alberta Health Services**						
2.1	Continuing Care	1,070,352	-	-	1,070,352	1,071,652	(1,300)
2.2	Community and Home Care	1,769,029	-	-	1,769,029	1,767,270	1,759
2.3	Acute Care	3,701,760	-	-	3,701,760	3,703,471	(1,711)
2.4	Ambulance Services	402,816	-	-	402,816	402,816	-
2.5	Diagnostic and Therapeutic Services	2,263,877	-	-	2,263,877	2,264,218	(341)
2.6	Population and Public Health	328,949	-	-	328,949	328,949	-
2.7	Research and Education	78,182	-	-	78,182	78,282	(100)
2.8	Information Technology	439,743	-	-	439,743	439,743	-
2.9	Support Services	1,645,573	-	-	1,645,573	1,646,513	(940)
2.10	Administration	459,951	-	-	459,951	459,671	280
		12,160,232	-	-	12,160,232	12,162,585	(2,353)

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
3	**Physician Compensation and Development**						
3.1	Program Support	$ 9,859	$ -	$ -	$ 9,859	$ 7,280	$ 2,579
3.2	Primary Care Physician Remuneration	1,498,848	-	-	1,498,848	1,513,216	(14,368)
3.3	Specialist Physician Remuneration	2,673,896	-	-	2,673,896	2,682,622	(8,726)
3.4	Physician Development	179,186	-	-	179,186	175,297	3,889
3.5	Physician Benefits	435,671	-	-	435,671	395,858	39,813
		4,797,460	-	-	4,797,460	4,774,273	23,187
4	**Drugs and Supplemental Health Benefits**						
4.1	Program Support	41,634	-	-	41,634	44,217	(2,583)
4.2	Outpatient Cancer Therapy Drugs	208,781	-	-	208,781	162,008	46,773
4.3	Outpatient Specialized High Cost Drugs	124,593	-	-	124,593	112,994	11,599
4.4	Seniors Drug Benefits	605,798	-	(44,720)	561,078	559,098	1,980
4.5	Seniors Dental, Optical and Supplemental Health Benefits	127,992	-	-	127,992	123,716	4,276
4.6	Non-Group Drug Benefits	271,725	-	(29,120)	242,605	226,900	15,705
4.7	Non-Group Supplemental Health Benefits	900	-	-	900	914	(14)
4.8	Assured Income for the Severely Handicapped Health Benefit	248,254	-	(15,600)	232,654	237,656	(5,002)
4.9	Child Health Benefit	31,970	-	(1,040)	30,930	29,137	1,793
4.10	Adult Health Benefit	224,749	-	(13,520)	211,229	227,096	(15,867)
4.11	Alberta Aids to Daily Living	152,985	-	-	152,985	150,038	2,947
4.12	Pharmaceutical Innovation and Management	76,560	-	-	76,560	85,038	(8,478)
		2,115,941	-	(104,000)	2,011,941	1,958,812	53,129

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
5	**Addiction and Mental Health**						
5.1	Program Support	$ 3,741	$ -	$ -	$ 3,741	$ 2,589	$ 1,152
5.2	Addiction and Mental Health	76,815	-	(3,100)	73,715	75,307	(1,592)
		80,556	-	(3,100)	77,456	77,896	(440)
6	**Primary Health Care**						
6.1	Program Support	3,861	-	-	3,861	2,983	878
6.2	Primary Health Care	244,786	-	-	244,786	228,528	16,258
		248,647	-	-	248,647	231,511	17,136
7	**Population and Public Health**						
7.1	Program Support	13,454	-	-	13,454	11,874	1,580
7.2	Immunization Support	7,735	-	-	7,735	4,233	3,502
7.3	Community-Based Health Services	72,099	-	-	72,099	43,459	28,640
		93,288	-	-	93,288	59,566	33,722
8	**Allied Health Services**	111,402	-	-	111,402	108,104	3,298
9	**Human Tissue and Blood Services**	215,287	-	-	215,287	204,982	10,305

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
10 Support Programs						
10.1 Program Support	$ 6,951	$ -	$ -	$ 6,951	$ 8,127	$ (1,176)
10.2 Health Quality Council of Alberta	7,186	-	-	7,186	7,145	41
10.3 Protection for Persons in Care	2,318	-	-	2,318	1,766	552
10.4 Monitoring, Investigations and Licensing	7,792	-	-	7,792	6,878	914
10.5 Other Support Programs	21,846	-	-	21,846	16,442	5,404
10.6 Health System Projects	4,000	-	-	4,000	1,150	2,850
	50,093	-	-	50,093	41,508	8,585
11 Out-of-Province Health Care Services						
11.1 Program Support	9,459	-	-	9,459	7,805	1,654
11.2 Out-of-Province Health Care Services	157,789	-	-	157,789	145,919	11,870
	167,248	-	-	167,248	153,724	13,524
12 Information Technology						
12.1 Program Support	8,375	-	-	8,375	6,452	1,923
12.2 Development and Operations	75,670	-	-	75,670	61,906	13,764
	84,045	-	-	84,045	68,358	15,687
13 Cancer Research and Prevention Investment	25,000	-	-	25,000	12,128	12,872
Program - Capital Grants						
5 Addiction and Mental Health						
5.2 Addiction and Mental Health	-	-	5,800	5,800	2,787	3,013
14 Infrastructure Support						
14.1 Continuing Care Beds	122,000	-	(31,100)	90,900	44,521	46,379
14.6 Climate Leadership Plan - Green Infrastructure	325	-	-	325	325	-
	122,325	-	(25,300)	97,025	47,633	49,392

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
Credit or Recovery (Shortfall) (Schedule 2)	$ -	$ -	$ (1,000)	$ (1,000)	$ -	$ (1,000)
Total	$ 20,356,900	$ -	$ (138,413)	$ 20,218,487	$ 19,963,845	$ 254,642
Lapse						$ 254,642
Program - Capital Investment						
5 Addiction and Mental Health						
5.2 Addiction and Mental Health	$ -	$ -	$ 2,300	$ 2,300	$ 6,021	$ (3,721)
12 Information Technology						
12.2 Development and Operations	22,230	-	-	22,230	8,691	13,539
14 Infrastructure Support						
14.2 External Information Systems Development	5,748	-	-	5,748	2,220	3,528
14.3 Equipment for Cancer Corridor Projects	11,000		-	11,000	11,000	-
14.4 Medical Equipment Replacement and Upgrade Program	30,000		13,500	43,500	43,500	-
14.5 Clinical Information System	100,000	-	(67,000)	33,000	32,622	378
14.6 Climate Leadership Plan - Green Infrastructure	5,813	-	-	5,813	5,813	-
Total	$ 174,791	$ -	$ (51,200)	$ 123,591	$ 109,867	$ 13,724
Lapse						$ 13,724

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
Program - Financial							
4	**Drugs and Supplemental Health Benefits**						
4.3	Outpatient Specialized High Cost Drugs	$ 9,200	$ -	$ -	$ 9,200	$ 7,117	$ 2,083
7	**Population and Public Health**						
7.2	Immunization Support	57,000	-	-	57,000	56,716	284
Total		$ 66,200	$ -	$ -	$ 66,200	$ 63,833	$ 2,367
Lapse							$ 2,367

[1] As per "Expense Vote by Program", "Capital Investment Vote by Program" and "Financial Transactions Vote by Program" page 152 to 154 of 2017-2018 Government Estimates.

[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.

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 5

Lottery Fund Estimates

(in thousands)

	Lottery Fund Estimates	Actual	Unexpended (Over Expended)
Alberta Health Services			
- Community and Home Care	$ 647,923	$ 647,923	$ -
	$ 647,923	$ 647,923	$ -

This table shows details of the initiatives within the department that are funded by the Lottery Fund and compares it to the actual results.

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 6

Salary and Benefits Disclosure

(in dollars)

	2018				2017
	Base Salary [1]	Other Cash Benefits [2]	Other Non-cash Benefits [3]	Total	Total
Deputy Minister [4]	$ 315,578	$ 55,521	$ 14,179	$ 385,278	$ 407,714
Associate Deputy Minister [5][6]	285,877	-	65,867	351,744	20,676
Executives - Assistant Deputy Ministers					
Financial and Corporate Services [7]	233,859	-	62,722	296,581	291,967
Health Information Systems	184,596	-	46,775	231,371	236,945
Health Standards, Quality and Performance [8]	183,081	14,773	48,304	246,158	273,823
Health Services Delivery	183,748	-	45,482	229,230	235,767
Health Workforce Planning and Accountability [9]	162,139	10,230	41,082	213,451	235,041
Innovation and Strategic Operations [10]	200,405	7,708	49,909	258,022	134,607
Pharmaceutical and Supplementary Benefits [11]	180,917	-	46,822	227,739	55,243
Public Health and Compliance [12]	169,159	23,970	43,443	236,572	214,892

[1] Base salary includes regular salary and earnings such as acting pay.

[2] Other cash benefits include vacation payouts, lump sum payments, and automobile allowance. There were no bonuses paid during the year.

[3] Other non-cash benefits include government's share of all employee benefits and contributions or payments made on behalf of employees including pension, supplementary retirement plan, health care, dental coverage, group life insurance, short and long-term disability plans, professional memberships, tuition fees, and parking benefits.

[4] The position was occupied by three individuals during the year. The occupancy of the position changed October 2017.

[5] The position was created on March 13, 2017.

[6] Automobile provided, no dollar amount included in other non-cash benefits.

[7] The position was occupied by two individuals during the year. The occupancy of the position changed May 2017.

[8] The position was occupied by two individuals during the year. The occupancy of the position changed February 2018. Included in other cash benefits is severance of $3,854.

[9] The position was occupied by two individuals during the year. The occupancy of the position changed October 2017.

[10] The position was created on September 19, 2016.

[11] The position was created on January 3, 2017. This position was occupied by two individuals during the year. The occupancy of the position changed October 2017.

[12] The position was occupied by two individuals during the year. The occupancy of the position changed November 2017.

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 7

Related Party Transactions

(in thousands)

Related parties are those entities consolidated or accounted for on the modified equity basis in the Government of Alberta Consolidated Financial Statements. Related parties also include key management personnel in the department and their close family members. Entities in the Ministry include Alberta Health Services (AHS) and Health Quality Council of Alberta (HQCA).

The Department and its employees paid or collected certain taxes and fees set by regulation for permits, licences 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 Department had the following transactions with related parties reported in the Statement of Operations and the Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2018	2017	2018	2017
Revenues				
Grants	$ -	$ -	$ 12,128	$ 22,174
Other	9,022	4,021	981	106
	$ 9,022	$ 4,021	$ 13,109	$ 22,280
Expenses - Directly Incurred				
Grants [1]	$ 13,421,591	$ 12,913,225	$ 46,436	$ 115,919
Other Services	1,530	1,292	11,051	11,708
	$ 13,423,121	$ 12,914,517	$ 57,487	$ 127,627
Receivable from	$ 7,004	$ 171	$ 8	$ 6,337
Payable to	$ 119,883	$ 64,065	$ 793	$ 5,117
Contractual Obligations	$ 567	$ 932	$ 391	$ -

[1] The grants paid to AHS include amounts that are separately reported on the Statement of Operations.

The Department also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not reported in the financial statements. Expenses are included in Schedule 8.

Schedule to Financial Statements

Year Ended March 31, 2018

SCHEDULE 8

Allocated Costs

(in thousands)

	2018					2017
		Expenses - Incurred by Others				(Restated - Note 3)
	Expenses [1]	Accommodation Costs [2]	Legal Services	Business Services [3]	Total	Total
Ministry Support Services	$ 63,299	$ 13,753	$ 4,706	$ 8,798	$ 90,556	$ 88,738
Alberta Health Services	12,162,585	-	-	-	12,162,585	11,909,923
Physician Compensation and Development	4,776,064	-	-	-	4,776,064	4,611,423
Drugs and Supplemental Health Benefits	1,966,167	-	-	-	1,966,167	1,842,489
Addictions and Mental Health	86,704	-	-	-	86,704	44,122
Primary Health Care	231,511	-	-	-	231,511	172,639
Population and Public Health	114,302	-	-	-	114,302	126,011
Allied Health Services	108,104	-	-	-	108,104	101,369
Human Tissue and Blood Services	204,982	-	-	-	204,982	197,636
Support Programs	41,508	-	-	-	41,508	40,660
Out-of-Province Health Care Services	153,724	-	-	-	153,724	161,603
Information Technology	83,659	-	-	-	83,659	80,689
Cancer Research and Prevention Investment	12,128	-	-	-	12,128	22,175
Infrastructure Support	140,001	-	-	-	140,001	89,568
	$ 20,144,738	$ 13,753	$ 4,706	$ 8,798	$ 20,171,995	$ 19,489,045

[1] Expenses - Directly Incurred as per Statement of Operations.

[2] Accommodation Costs, including grants in lieu of taxes.

[3] Business Services Costs, including charges for IT support, vehicles, internal audit services and other services.

Financial Information

Alberta Health Services

Consolidated Financial Statements
March 31, 2018

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 judgment.

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

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public 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 31, 2018

Auditor General
OF ALBERTA

Independent Auditor's Report

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

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2018, the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained in my audit is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2018, 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.

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

W. Doug Wylie FCPA, FCMA, ICD.D
Auditor General

May 31, 2018
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31	2018		2017
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,160,000	$ 12,147,985	$ 11,859,923
One-time base operating	-	14,683	50,000
Grant funding transferred to one-time base operating	-	-	14,515
Other operating	1,009,000	1,134,483	953,328
Recognition of expended deferred capital revenue	76,000	66,085	86,784
Other government transfers (Note 4)	451,000	438,127	456,152
Fees and charges	475,000	502,230	479,180
Ancillary operations	147,000	132,661	135,660
Donations, fundraising, and non-government contributions (Note 5)	144,000	160,076	164,016
Investment and other income (Note 6)	207,000	259,513	270,410
TOTAL REVENUE	**14,669,000**	**14,855,843**	**14,469,968**
Expenses:			
Community-based care	1,362,000	1,337,646	1,249,031
Home care	689,000	610,515	585,313
Continuing care	1,096,000	1,071,676	1,053,118
Population and public health	365,000	338,451	354,700
Ambulance services	480,000	512,410	497,686
Acute care	4,773,000	4,981,290	4,841,007
Diagnostic and therapeutic services	2,385,000	2,410,972	2,400,242
Education and research	305,000	298,160	285,300
Support services (Note 7)	2,211,000	2,181,641	2,145,541
Information technology	512,000	509,989	513,420
Administration (Note 8)	491,000	511,697	478,074
TOTAL EXPENSES (Schedules 1 and 3)	**14,669,000**	**14,764,447**	**14,403,432**
ANNUAL OPERATING SURPLUS	**-**	**91,396**	**66,536**
Accumulated surplus, beginning of year	1,226,000	1,225,659	1,159,123
Accumulated surplus, end of year (Note 19)	**$ 1,226,000**	**$ 1,317,055**	**$ 1,225,659**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31	2018 Actual	2017 Actual
Financial Assets:		
Cash	$ 66,253	$ 46,103
Investments (Note 10)	2,316,752	2,264,866
Accounts receivable (Note 11)	426,558	386,292
	2,809,563	2,697,261
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,412,913	1,209,974
Employee future benefits (Note 13)	673,136	653,037
Unexpended deferred operating revenue (Note 14)	420,245	411,079
Unexpended deferred capital revenue (Note 15)	153,751	137,806
Debt (Note 17)	369,775	320,087
	3,029,820	2,731,983
NET DEBT	**(220,257)**	**(34,722)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	8,031,307	7,619,077
Inventories for consumption	96,573	91,882
Prepaid expenses and other non-financial assets	165,721	128,058
	8,293,601	7,839,017
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	8,073,344	7,804,295
Expended deferred capital revenue (Note 16)	6,735,454	6,549,770
NET ASSETS	**1,337,890**	**1,254,525**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,317,055	1,225,659
Accumulated remeasurement gains	20,835	28,866
	$ 1,337,890	**$ 1,254,525**

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

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31	2018		2017
	Budget (Note 3)	Actual	Actual
Annual operating surplus	$ -	$ 91,396	$ 66,536
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(1,004,000)	(950,869)	(597,021)
Amortization and disposals of tangible capital assets (Note 18)	548,000	538,639	551,015
Effect of other changes:			
Net increase (decrease) in expended deferred capital revenue	330,000	185,684	19,338
Net (increase) decrease in inventories for consumption	-	(4,691)	2,557
Net (increase) decrease in prepaid expenses and other non-financial assets	2,000	(37,663)	(115)
Net remeasurement gains (losses) for the year	1,000	(8,031)	23,844
(Increase) decrease in net debt for the year	**(123,000)**	**(185,535)**	**66,154**
Net debt, beginning of year	(35,000)	(34,722)	(100,876)
Net debt, end of year	**$ (158,000)**	**$ (220,257)**	**$ (34,722)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2018 Actual	2017 Actual
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ (40)	$ 643
Portfolio investments		
Equity instruments quoted in an active market	27,873	32,926
Financial instruments designated to the fair value category	(19,143)	(194)
Amounts reclassified to the Consolidated Statement of Operations:		
Portfolio investments		
Equity instruments quoted in an active market	(20,493)	(555)
Financial instruments designated to the fair value category	3,772	(8,976)
Net remeasurement gains (losses) for the year	**(8,031)**	**23,844**
Accumulated remeasurement gains, beginning of year	28,866	5,022
Accumulated remeasurement gains, end of year (Note 10)	**$ 20,835**	**$ 28,866**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2018 Actual	2017 Actual
Operating transactions:		
Annual operating surplus	$ 91,396	$ 66,536
Non-cash items:		
Amortization and disposals of tangible capital assets	538,639	551,015
Recognition of expended deferred capital revenue	(384,337)	(402,887)
Revenue recognized for acquisition of land	(6,286)	(687)
Decrease (increase) in:		
Accounts receivable related to operating transactions	2,116	(26,890)
Inventories for consumption	(4,691)	2,557
Prepaid expenses and other non-financial assets	(37,663)	(115)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	62,592	(51,771)
Employee future benefits	20,099	32,350
Unexpended deferred operating revenue	(37,555)	(70,148)
Cash provided by operating transactions	244,310	99,960
Capital transactions:		
Acquisition of tangible capital assets	(612,961)	(380,401)
Increase in accounts payable and accrued liabilities related to capital transactions	140,347	25,433
Cash applied to capital transactions	(472,614)	(354,968)
Investing transactions:		
Purchase of investments	(3,168,353)	(3,339,338)
Proceeds on disposals of investments	3,109,935	3,290,394
Cash applied to investing transactions	(58,418)	(48,944)
Financing transactions:		
Restricted capital contributions received	264,565	278,230
Unexpended deferred capital revenue returned	(7,381)	(1,220)
Proceeds from debt	67,300	10,000
Principal payments on debt	(17,612)	(16,822)
Cash provided by financing transactions	306,872	270,188
Increase (decrease) in cash	**20,150**	**(33,764)**
Cash, beginning of year	46,103	79,867
Cash, end of year	**$ 66,253**	**$ 46,103**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2018

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).

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres, and urgent care centres.

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 owns majority of the Class A voting shares in the following three entities:

- Calgary Laboratory Services Ltd. (CLS) - provides medical diagnostic services in Calgary and southern 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 by Chair of the Board of Directors.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS has majority representation on the governance boards indicating control of the following entities:

- Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
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 (CHT)
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

(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 (Athabasca/Westlock) 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 (St. Paul/Aspen) 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
Sexsmith/Spirit River 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
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin 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.

Adjustments are made for consolidated entities whose fiscal year-ends are different from AHS' fiscal year end. This only consists of LPIP with a fiscal year-end of December 31, 2017. All significant transactions in the interim period to March 31 have been recorded in the consolidated financial statements.

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 23).

(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.

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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Unallocated costs, 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 realized and unrealized gains and losses for 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 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 a liability when received and as revenue when the land is purchased. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

(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.

(c) Expenses

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

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 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, 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. Embedded derivatives are recorded 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.

(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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(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.

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 put into service.

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.

(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). The President of Alberta Treasury Board and Minister of Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the GOA consolidated reporting entity on a defined benefit basis. 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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Supplemental Retirement Plan for Designated Employees (SERP)

The SERP covers certain employees and supplement 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.

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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(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. The liability is recognized net of any expected recoveries. A liability for remediation of contaminated sites normally results from operations that are no longer in productive use and 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.

(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 restrict amounts for legislatively required restricted equity and donations amounts restricted by third parties. Transfers to, or from, internally restricted surplus for future purposes are recorded to the respective reserved surplus when approved.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(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 standards as of April 1, 2017:

PS 2200 Related Party Disclosures

PS 2200, Related Party Disclosures requires sufficient information be disclosed about the terms and conditions on which transactions between related parties are conducted and the relationship underlying them. The disclosure provides information necessary to assess the effect that the related party relationships have had, or, if not recognized, may have had on the entity's financial position and financial performance. The effect of adopting this standard has resulted in no changes in the accounting treatment and disclosure of AHS' related party disclosures.

PS 3420 Inter-Entity Transactions

PS 3420, Inter-Entity Transactions specifically addresses the reporting of transactions between entities controlled by a government and that comprises the government's reporting entity from both a provider and recipient perspective. The effect of adopting this standard has resulted in changes in the accounting treatment of unallocated costs with related entities. Space provided rent free by a related party has not been recognized in these consolidated financial statements effective April 1, 2017 – see Note 2(b)(i) and Note 21.

PS 3210 Assets

PS 3210, Assets provides additional guidance on the definition of assets set out in PS 1000 – Financial Statement Concepts and new disclosure requirements for those assets not recognized in the government's financial statements. The effect of adopting this standard has resulted in no changes in the accounting treatment and disclosure of AHS' assets.

PS 3320 Contingent Assets

PS 3320, Contingent Assets establishes standards on the reporting and disclosure of possible assets that may arise from existing conditions or situations involving uncertainty. The effect of adopting this standard has resulted in no changes in the disclosure of AHS' contingent assets.

PS 3380 Contractual Rights

PS 3380, Contractual Rights establishes standards on the reporting and disclosure of a government's rights to economic resources that may arise from contracts or agreements that will result in both an asset and revenue in the future. The effect of adopting this standard has resulted in no changes in the disclosure of AHS' contractual rights.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(n) Future Accounting Changes

The following accounting standards are applicable in future years:

- **PS 3430 – Restructuring Transactions (effective April 1, 2018)**
  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.
- **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.

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

Note 3 Budget

The 2017-18 AHS Health Plan and Business Plan, which included the 2017-18 annual budget, was approved by the AHS Board on June 2, 2017 and by the Minister of Health on July 4, 2017.

Note 4 Other Government Transfers

	2018	2017
Unrestricted operating	$ 38,571	$ 59,737
Restricted operating (Note 14)	112,460	118,303
Recognition of expended deferred capital revenue (Note 16)	287,096	278,112
	$ 438,127	**$ 456,152**

Other government transfers include $429,855 (2017 – $449,067) transferred from the GOA and $8,272 (2017 – $7,085) from the federal government, 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

	2018	2017
Unrestricted operating	$ 2,281	$ 4,597
Restricted operating (Note 14)	126,311	120,120
Recognition of expended deferred capital revenue (Note 16)	31,156	37,991
Endowment contributions and reinvested income	328	1,308
	$ 160,076	**$ 164,016**

Note 6 Investment and Other Income

	2018	2017
Investment income	$ 67,988	$ 65,552
Other income:		
GOA (Note 21)	33,605	37,422
AH	16,361	19,166
Other	141,559	148,270
	$ 259,513	**$ 270,410**

Note 7 Support Services

	2018	2017
Facilities operations	$ 873,483	$ 869,181
Patient: health records, food services, and transportation	408,737	385,444
Materials management	177,090	207,661
Housekeeping, laundry, and linen	211,702	208,380
Support services expense of full-spectrum contracted health service providers	151,473	149,941
Ancillary operations	110,046	105,078
Fundraising expenses and grants awarded	46,279	42,866
Other	202,831	176,990
	$ 2,181,641	**$ 2,145,541**

Note 8 Administration

	2018	2017
General administration	$ 266,597	$ 251,703
Human resources	102,981	92,695
Finance	76,612	73,394
Communications	24,797	21,354
Administration expense of full-spectrum contracted health service Providers	40,710	38,928
	$ 511,697	**$ 478,074**

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 investment 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 2.85% (2017 – 2.76%) 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 $50,819 (2017 – $48,779).

Note 9 Financial Risk Management (continued)

(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 $53,428 or 2.31% of total investments (March 31, 2017 – $51,363 or 2.27%).

(ii) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. AHS manages the interest rate risk exposure of its fixed income 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.

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 $71,683 (March 31, 2017 – $68,009).

Fixed income securities include bonds and money market securities. The fixed income securities have the following average maturity structure ranging from 2018 and 2067:

	2018	2017
0 – 5 years	80%	78%
6 – 10 years	8%	13%
Over 10 years	12%	9%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	1.31%	2.18%	2.88%	2.13%

(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, 2018, investments in non-Canadian equities represented 16.2% (March 31, 2017 – 15.3%) of total portfolio investments.

Note 9 Financial Risk Management (continued)

Foreign exchange fluctuations on cash balances are mitigated by forward contracts and holding minimal foreign currency cash balances. At March 31, 2018, 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, 2018, AHS held derivatives in the form of forward contracts for future settlement of $24,000 (2017 – $18,000). The fair value of these forward contracts as at March 31, 2018 was $461 (2017 – $501) 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.

Under the investment 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, 2018.

Credit Rating	2018	2017
Investment Grade (AAA to BBB)	89%	90%
Unrated	11%	10%
	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

	2018		2017	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 118,012**	**$ 118,012**	**$ 106,666**	**$ 106,666**
Interest bearing securities:				
Money market securities	124,320	124,320	101,113	101,113
Fixed income securities	1,540,138	1,549,534	1,543,462	1,546,500
	1,664,458	**1,673,854**	**1,644,575**	**1,647,613**
Equities:				
Canadian pooled equity funds	158,030	142,929	165,068	144,026
Global pooled equity funds	376,252	326,464	348,557	304,536
	534,282	**469,393**	**513,625**	**448,562**
	$ 2,316,752	**$ 2,261,259**	**$ 2,264,866**	**$ 2,202,841**

	2018	2017
Items at Fair Value		
Financial instruments designated to the fair value category	$ 1,917,841	$ 1,886,936
Portfolio investments in equity instruments that are quoted in an active market	398,450	377,429
Derivatives	461	501
	$ 2,316,752	**$ 2,264,866**

Included in investments is $173,725 (March 31, 2017 – $161,134) 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 $74,694 (March 31, 2017 – $74,710).

The following are the total net remeasurement gains on investments:

	2018	2017
Accumulated remeasurement gains	$ 20,835	$ 28,866
Restricted unrealized net gains attributable to unexpended deferred operating revenue and endowments (Note 14(b))	34,658	32,811
Restricted unrealized net gains attributable to unexpended deferred capital revenue (Note 15(b))	-	348
	$ 55,493	**$ 62,025**

Note 10 Investments (continued)

Fair Value Hierarchy

	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 pooled equity funds	155,358	2,672	-	158,030
Global pooled equity funds	243,092	133,160	-	376,252
	$ 516,462	**$ 1,653,276**	**$ 147,014**	**$ 2,316,752**
Percent of total	23%	71%	6%	100%

	2017			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 106,666	$ -	$ -	$ 106,666
Interest bearing securities:				
Money market securities	-	101,113	-	101,113
Fixed income securities	-	1,406,541	136,921	1,543,462
Equities:				
Canadian pooled equity funds	148,172	16,896	-	165,068
Global pooled equity funds	229,257	119,300	-	348,557
	$ 484,095	**$ 1,643,850**	**$ 136,921**	**$ 2,264,866**
Percent of total	21%	73%	6%	100%

Note 11 Accounts Receivable

	2018			2017
	Gross	Allowance for Doubtful Accounts	Net	Net
Patient accounts receivable	$ 131,336	$ 25,972	$ 105,364	$ 85,357
AH operating transfers receivable	81,104	-	81,104	89,247
AH capital transfers receivable	38,766	-	38,766	-
Other operating transfers receivable	30,025	-	30,025	45,810
Other capital transfers receivable	86,413	-	86,413	82,797
Other accounts receivable	84,900	14	84,886	83,081
	$ 452,544	**$ 25,986**	**$ 426,558**	**$ 386,292**

At March 31, 2017, the total allowance for doubtful accounts was $24,323.

Note 12 Accounts Payable and Accrued Liabilities

	2018	2017
Payroll remittances payable and related accrued liabilities	$ 522,604	$ 523,543
Trade accounts payable and accrued liabilities	572,282	470,126
Provision for unpaid claims[(a)]	157,583	141,233
Obligations under capital leases[(b)]	112,675	31,641
Other liabilities	47,769	43,431
	$ 1,412,913	**$ 1,209,974**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $254,866 (2017 – $114,519).

(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 2.35% (2017 – 2.20%) 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 2018 and 2036 and have an implicit interest rate payable ranging from 2.42% to 6.97% (2017– 1.42% to 6.91%).

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

Year ended March 31	Minimum Contract Payments
2019	$ 24,199
2020	23,349
2021	23,011
2022	23,011
2023	11,212
Thereafter	24,996
	129,778
Less: interest	(17,103)
	$ 112,675

(c) Liability for Contaminated Sites

At March 31, 2018, AHS has not identified or accepted any liability for contaminated sites (2017 – $nil).

Note 13 Employee Future Benefits

	2018	2017
Accrued vacation pay	$ 553,875	$ 540,547
Accumulating non-vesting sick leave liability[a]	119,261	112,490
Registered defined benefit pension plans[b] [c]	-	-
	$ 673,136	**$ 653,037**

(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, 2018.

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

	2018	2017
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 115,177	$ 118,969
Current service cost	10,595	10,262
Interest cost	3,779	3,621
Benefits paid	(8,870)	(8,675)
Actuarial gain	(20,683)	(9,000)
Accrued benefit obligation and funded status, end of year	**$ 99,998**	**$ 115,177**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 99,998	$ 115,177
Unamortized net actuarial gain (loss)	19,263	(2,687)
Accrued benefit liability	**$ 119,261**	**$ 112,490**
Components of expense		
Current service cost	$ 10,595	$ 10,262
Interest cost	3,779	3,621
Amortization of net actuarial loss	1,267	1,267
Net expense	**$ 15,641**	**$ 15,150**
Assumptions		
Discount rate – beginning of year	2.02%	2.90%
Discount rate – end of year	3.38%	2.02%
Rate of compensation increase per year	2017-2018	2016-2017
	0.75%	2.43%
	2018-2019	2017-2018
	0.75%	0.75%
	Thereafter	Thereafter
	2.75%	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 (Deficiency)

An actuarial valuation of the LAPP was carried out as at December 31, 2016 and these results were then extrapolated to December 31, 2017. The LAPP's December 31, 2017 net assets available for benefits divided by the LAPP's pension obligation shows that the LAPP is 113% (2016 – 98%) funded.

	December 31, 2017	December 31, 2016
LAPP net assets available for benefits	$ 42,728,515	$ 37,722,943
LAPP pension obligation	37,893,000	38,360,300
LAPP surplus (deficiency)	**$ 4,835,515**	**$ (637,357)**

The 2017 and 2018 LAPP contribution rates are as follows:

Calendar 2018		Calendar 2017	
Employer	**Employees**	**Employer**	**Employees**
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	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

(c) Pension Expense

	2018	2017
Local Authorities Pension Plan	$ 587,007	$ 595,795
Defined contribution pension plans and group RRSPs	49,021	48,397
Supplemental Pension Plan	2,303	2,230
Supplemental Executive Retirement Plans	(1,826)	2,240
Management Employees Pension Plan	393	585
	$ 636,898	**$ 649,247**

Note 14 Unexpended Deferred Operating Revenue

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

	2018				2017
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 129,855	$ 45,686	$ 235,538	$ 411,079	$ 429,515
Received or receivable during the year, net of repayments	1,131,919	40,064	185,432	1,357,415	1,139,067
Restricted investment income	282	1,450	4,869	6,601	7,716
Transferred from (to) unexpended deferred capital revenue	8,150	51,671	(14,947)	44,874	47,461
Recognized as revenue	(1,134,483)	(112,460)	(126,311)	(1,373,254)	(1,191,751)
Miscellaneous other revenue recognized	(197)	(20)	(28,100)	(28,317)	(25,182)
	135,526	**26,391**	**256,481**	**418,398**	**406,826**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	2,136	(20)	(269)	1,847	4,253
Balance, end of year	**$ 137,662**	**$ 26,371**	**$ 256,212**	**$ 420,245**	**$ 411,079**

[(i)] The balance at March 31, 2018 for other government includes $506 of unexpended deferred operating revenue received from the federal government (March 31, 2017 – $582). 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:

	2018				2017
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 19,465	$ 1,521	$ 150,309	$ 171,295	$ 157,178
Physician revenue and alternate relationship plans	38,046	1,612	-	39,658	27,241
Primary Care Networks	27,319	-	13	27,332	19,372
Long term care partnerships	-	16,735	-	16,735	17,227
Promotion, prevention and community	11,819	4,395	159	16,373	26,839
Addiction and mental health	15,888	29	335	16,252	20,912
Cancer prevention, screening and treatment	13,306	-	892	14,198	28,165
Administration and support services	1,062	761	53,267	55,090	59,374
Others less than $10,000	10,381	1,318	16,955	28,654	21,960
	137,286	**26,371**	**221,930**	**385,587**	**378,268**
Unrealized net gain (loss) attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	376	-	34,282	34,658	32,811
	$ 137,662	**$ 26,371**	**$ 256,212**	**$ 420,245**	**$ 411,079**

Note 15 Unexpended Deferred Capital Revenue

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

	2018				2017
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 39,556	$ 15,958	$ 82,292	$ 137,806	$ 148,319
Received or receivable during the year	101,501	165,695	39,751	306,947	244,139
Transferred tangible capital assets (Note 18(a))	-	331,551	71	331,622	215,933
Other transfers	6,202	(6,202)	-	-	-
Unexpended deferred capital revenue returned	(7,071)	-	(310)	(7,381)	(1,220)
Transfer to expended deferred capital revenue	(83,354)	(446,473)	(40,194)	(570,021)	(422,225)
Transferred (to) from unexpended deferred operating revenue	(8,150)	(51,671)	14,947	(44,874)	(47,461)
	48,684	**8,858**	**96,557**	**154,099**	**137,485**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	(348)	-	-	(348)	321
Balance, end of year	**$ 48,336**	**$ 8,858**	**$ 96,557**	**$ 153,751**	**$ 137,806**

[i] The balance at March 31, 2018 for other government all relates to the GOA, see Note 21.

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

	2018	2017
AH		
Information systems less than $10,000	$ 42,132	$ 32,504
Medical Equipment Replacement Upgrade Program	147	18
Equipment less than $10,000	6,057	6,686
Total AH	**48,336**	**39,208**
Other government		
Facilities and improvements less than $10,000	8,858	15,958
Total other government	**8,858**	**15,958**
Donors and non-government		
Equipment less than $10,000	92,626	80,482
Facilities and improvements less than $10,000	3,931	1,810
Total donors and non-government	**96,557**	**82,292**
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 10)	-	348
	$ 153,751	**$ 137,806**

Note 16 Expended Deferred Capital Revenue

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

	2018				2017
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 256,313	$ 6,111,388	$ 182,069	$ 6,549,770	$ 6,530,432
Transferred from unexpended deferred capital revenue	83,354	446,473	40,194	570,021	422,225
Less: amounts recognized as revenue	(66,085)	(287,096)	(31,156)	(384,337)	(402,887)
Balance, end of year	**$ 273,582**	**$ 6,270,765**	**$ 191,107**	**$ 6,735,454**	**$ 6,549,770**

[i] The balance at March 31, 2018 for other government includes $52 of expended deferred capital revenue received from the federal government (March 31, 2017 – $78). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2018	2017
Debentures payable[a]:		
Parkade loan #1	$ 29,424	$ 32,223
Parkade loan #2	27,951	30,278
Parkade loan #3	36,630	39,089
Parkade loan #4	140,098	147,262
Parkade loan #5	33,938	35,605
Parkade loan #6	23,505	24,418
Parkade loan #7	51,500	51,500
Energy savings initiative loan	25,800	25,800
Other	929	1,212
	369,775	**387,387**
Loan proceeds to be received[b]	-	(67,300)
	$ 369,775	**$ 320,087**

(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 terms 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%

(b) During the year, loan proceeds of $46,500 were received relating to the Foothills Medical Centre Lot 1 parkade debenture (Parkade loan #7). Semi-annual principal and interest payments of $1,665 will commence September 2018. In addition, loan proceeds of $20,800 were received relating to the energy savings initiative. Semi-annual principal and interest payments of $1,162 will commence June 2018.

Note 17 Debt (continued)

AHS is committed to making payments as follows:

	Debentures Payable and Other Loans Payable
Year ended March 31	Principal Payments
2019	$ 22,133
2020	23,091
2021	24,092
2022	24,800
2023	25,878
Thereafter	249,781
	$ 369,775

During the year, the amount of total interest expensed, including interest related to obligations under capital leases, was $15,915 (2017 – $16,221).

As at March 31, 2018, AHS has access to a $220,000 (March 31, 2017 – $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, 2018, AHS has $nil (March 31, 2017 – $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2017 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2018, AHS has $4,790 (March 31, 2017 – $3,469) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit, therefore no liability has been recorded.

Note 18 Tangible Capital Assets

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**

Note 18 Tangible Capital Assets (continued)

Cost	2016	Additions[a]	Transfers out of Work in Progress	Disposals	2017
Facilities and improvements	$ 8,488,610	$ -	$ 510,770	$ (2,625)	$ 8,996,755
Work in progress	1,086,124	418,267	(590,285)	-	914,106
Equipment[b]	2,179,617	153,429	1,256	(31,483)	2,302,819
Information systems	1,331,861	24,391	17,754	(11,350)	1,362,656
Building service equipment	567,261	-	43,815	(55)	611,021
Land[c]	110,069	687	-	(167)	110,589
Leased facilities and improvements	219,937	247	4,784	-	224,968
Land improvements	70,919	-	11,906	(61)	82,764
	$ 14,054,398	**$ 597,021**	**$ -**	**$ (45,741)**	**$ 14,605,678**

Accumulated Amortization	2016	Amortization Expense	Effect of Transfers	Disposals	2017
Facilities and improvements	$ 3,179,295	$ 236,203	$ -	$ (2,626)	$ 3,412,872
Work in progress	-	-	-	-	-
Equipment[b]	1,678,226	155,393	-	(31,084)	1,802,535
Information systems	1,081,472	110,696	-	(11,350)	1,180,818
Building service equipment	332,616	32,449	-	(49)	365,016
Land[c]	-	-	-	-	-
Leased facilities and improvements	149,431	12,891	-	-	162,322
Land improvements	60,287	2,812	-	(61)	63,038
	$ 6,481,327	**$ 550,444**	**$ -**	**$ (45,170)**	**$ 6,986,601**

	Net Book Value	
	2017	2016
Facilities and improvements	$ 5,583,883	$ 5,309,315
Work in progress	914,106	1,086,124
Equipment[b]	500,284	501,391
Information systems	181,838	250,389
Building service equipment	246,005	234,645
Land[c]	110,589	110,069
Leased facilities and improvements	62,646	70,506
Land improvements	19,726	10,632
	$ 7,619,077	**$ 7,573,071**

(a) Transferred Tangible Capital Assets

Additions include total transferred tangible capital assets of $331,622 (2017 – $215,933) consisting of $331,551 from AI (2017 – $215,933) and $71 from other sources (2017 – $nil).

(b) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $13,352 (2017 – $13,417) with accumulated amortization of $11,637 (March 31, 2017 – $11,266). For the year ended March 31, 2018, leased equipment included a net increase of $494 related to vehicles under capital leases (2017 – net decrease of $1,137).

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	2019
Evansburg Community Health Centre	Yellowhead County	2031
Myrnam Land	Eagle Hill Foundation	2038
Two Hills Helipad	Stella Stefiuk	2041
McConnell Place North	City of Edmonton	2044
Northeast Community Health Centre	City of Edmonton	2047
Foothills Medical Centre Parkade	University of Calgary	2054
Alberta Children's Hospital	University of Calgary	2103

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2018					2017
	Unrestricted Surplus[a]	Internally Restricted Surplus for Future Purposes[b]	Invested in Tangible Capital Assets[c]	Endowments[d]	Total	Total
Balance, beginning of year	$ 211,715	$ 224,929	$ 714,305	$ 74,710	$ 1,225,659	$ 1,159,123
Annual operating surplus	91,396	-	-	-	91,396	66,536
Tangible capital assets acquired with internal funds	(237,934)	-	237,934	-	-	-
Amortization of internally funded tangible capital assets	154,302	-	(154,302)	-	-	-
Repayment of debt used to fund tangible capital assets	(17,612)	-	17,612	-	-	-
Payments on obligations under capital leases	(2,207)	-	2,207	-	-	-
Net receipt of life lease deposits	596	-	(596)	-	-	-
Transfer of internally restricted	(12,247)	12,247	-	-	-	-
Transfer of endowment contributions	16	-	-	(16)	-	-
Balance, end of year	**$ 188,025**	**$ 237,176**	**$ 817,160**	**$ 74,694**	**$ 1,317,055**	**$ 1,225,659**

(a) 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 19 Accumulated Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

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

	2018	2017
Ancillary services [(i)]	$ 124,525	$ 112,718
Insurance equity requirements [(ii)]	34,835	42,224
Foundations [(iii)]	41,395	39,987
Other [(iv)]	36,421	30,000
Internally restricted surplus for future purposes	**$ 237,176**	**$ 224,929**

(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.

(c) Invested in Tangible Capital Assets

The restriction of accumulated surplus is equal to the net book value of internally funded tangible capital assets as these amounts are only available to AHS for its health care mandate.

(d) 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 $328 (2017 - $1,308) of contributions and reinvested income received in the year (Note 5) offset by other transfers of $344 (2017 - $nil).

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
2019	$ 57,541
2020	48,727
2021	42,188
2022	39,702
2023	34,182
Thereafter	75,950
	$ 298,290

(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, 2018, 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.

AHS has been named in 223 legal claims (2017 – 186 claims) related to conditions in existence at March 31, 2018 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 208 claims have $308,012 in specified amounts and 15 have no specified amounts (2017 – 179 claims with $310,941 of specified claims and 7 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

Note 20 Contractual Obligations and Contingent Liabilities (continued)

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 the plaintiffs have filed a notice of appeal which will be heard at a later date. 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.

AH 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	
	2018	2017	2018	2017
Ministry of Advanced Education[b]	$ 55,936	$ 52,621	$ 179,759	$ 122,527
Ministry of Infrastructure[c]	350,196	373,253	276	24,538
Other ministries[d]	58,101	60,865	31,460	29,341
Total for the year	**$ 464,233**	**$ 486,739**	**$ 211,495**	**$ 176,406**

	Receivable from		Payable to	
	2018	2017	2018	2017
Ministry of Advanced Education [b]	$ 4,578	$ 5,536	$ 22,749	$ 26,449
Ministry of Infrastructure [c]	21,526	23,623	-	-
Other ministries [d]	16,891	30,412	378,440	322,157
Balance, end of year	**$ 42,995**	**$ 59,571**	**$ 401,189**	**$ 348,606**

(a) Revenues with GOA ministries include other government transfers of $429,855 (2017 – $449,067), (Note 4), other income of $33,605 (2017 – $37,422), (Note 6), and fees and charges of $773 (2017 – $250).

(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 grants 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 $63,699 (2017 – $71,225) and recognition of expended deferred capital revenue of $286,497 (2017 – $277,660) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Per Note 2(b), effective April 1, 2017 unallocated costs with AI, which comprise space provided rent free, are no longer recognized (2017 - $24,368) in these consolidated financial statements. Not included in the table above but included in total amounts disclosed in Note 18(a) is the transfer of tangible capital assets from AI of $331,551 (2017 – $215,933).

Note 21 Related Parties (continued)

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

At March 31, 2018, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $25,865 (March 31, 2017 – $45,104) related to unexpended deferred operating revenue (Note 14), $8,858 (March 31, 2017 – $15,958) related to unexpended deferred capital revenue (Note 15) and $6,270,713 (March 31, 2017 – $6,111,310) 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.

	2018	2017
Financial assets	$ 74,306	$ 57,950
Liabilities	74,306	57,950
Accumulated surplus	$ -	$ -
Total revenues	$ 248,123	$ 231,097
Total expenses	248,123	231,097
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;

	2017	2016
Financial assets	$ 131,234	$ 93,274
Liabilities	15,340	15,091
Net financial assets	$ 115,894	$ 78,183
Non- financial assets	6	-
Net assets	**$ 115,900**	**$ 78,183**

AHS has included in prepaid expenses $91,077 (March 31, 2017 – $64,317) as a share of the HBTA's net assets representing in substance a prepayment of future premiums. For the fiscal year ended March 31, 2018, AHS paid premiums of $382,090 (2017 – $340,947) 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, 2018, the balance of funds held in trust by AHS for research and development is $150 (March 31, 2017 – $514).

Note 23 Trusts under Administration (continued)

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2018, the balance of these funds is $1,686 (March 31, 2017 – $1,717). 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.

(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.

Note 24 Segment Disclosure (continued)

(h) 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.

(i) 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.

(j) 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 2018 presentation.

Note 26 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on May 31, 2018.

SCHEDULE 1 – CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
YEAR ENDED MARCH 31

	2018		2017
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 8,092,000	$ 8,070,000	$ 7,983,182
Contracts with health service providers	2,642,000	2,621,371	2,539,854
Contracts under the Health Care Protection Act	18,000	18,337	20,198
Drugs and gases	462,000	456,714	449,620
Medical and surgical supplies	403,000	413,840	385,213
Other contracted services	1,136,000	1,253,012	1,106,722
Other[a]	1,368,000	1,392,534	1,367,628
Amortization and disposals of tangible capital assets (Note 18)	548,000	538,639	551,015
	$ 14,669,000	**$ 14,764,447**	**$ 14,403,432**
(a) Significant amounts included in Other are:			
Equipment expense		$ 217,356	$ 223,364
Other clinical supplies		154,101	152,312
Building and ground expenses		119,572	121,044
Utilities		117,997	105,159
Building rent		112,318	132,080
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		92,498	90,259
Food and dietary supplies		82,107	81,985
Office supplies		61,378	54,040
Insurance and liability claims		58,398	49,639
Fundraising and grants awarded		51,621	50,859
Minor equipment purchases		47,230	45,831
Travel		38,646	41,734
Telecommunications		38,026	39,397
Licenses, fees and memberships		30,964	28,477
Education		12,691	12,107
Other		157,631	139,341
		$ 1,392,534	**$ 1,367,628**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2018

	2018								2017	
						Severance [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board (Sub-Schedule 2A)	9.25	$ -	$ 311	$ -	$ 311	-	$ -	$ 311	9.21	$ 310
Total Executive (Sub-Schedule 2B)	14.12	5,281	50	754	6,085	-	-	6,085	13.86	6,141
Management Reporting to CEO Direct Reports	72.86	16,161	432	3,115	19,708	2	361	20,069	66.06	18,691
Other Management	2,964.39	353,522	3,332	78,636	435,490	26	2,811	438,301	2,985.79	447,135
Medical Doctors not included above[f]	148.12	46,127	498	3,165	49,790	1	46	49,836	150.06	50,989
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	19,137.97	1,822,395	250,763	402,717	2,475,875	6	105	2,475,980	18,966.63	2,462,404
LPNs	4,987.54	327,262	41,251	71,217	439,730	-	-	439,730	4,836.11	422,959
Other health technical and professional	16,461.03	1,475,722	84,064	338,698	1,898,484	7	303	1,898,787	16,307.58	1,880,814
Unregulated health service providers	8,908.36	451,595	55,185	105,314	612,094	3	65	612,159	8,716.34	592,955
Other staff	26,738.08	1,670,483	91,267	365,723	2,127,473	55	1,681	2,129,154	26,382.57	2,101,209
Sub-total	**79,441.72**	**6,168,548**	**527,153**	**1,369,339**	**8,065,040**	**100**	**5,372**	**8,070,412**	**78,434.21**	**7,983,607**
Less amounts included in Other contracted services		(344)	(2)	(66)	(412)	-	-	(412)		(425)
Total		**$ 6,168,204**	**$ 527,151**	**$ 1,369,273**	**$ 8,064,628**	**100**	**$ 5,372**	**$ 8,070,000**		**$ 7,983,182**

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

SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2018

	Term	2018 Committees	2018 Remuneration	2017 Remuneration
Board Chair				
Linda Hughes[g]	Since Nov 27, 2015	ARC, CEC, FC, GC, HRC, QSC	$ 67	$ 71
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), QSC	48	51
David Carpenter	Since Nov 27, 2015	ARC (Chair), CEC, FC (Chair)	35	38
Richard Dicerni	Since Nov 27, 2015	FC, HRC (Chair)	30	30
Heather Hirsch	Since Nov 3, 2016	CEC, QSC	31	9
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	33	37
Marliss Taylor	Since Nov 27, 2015	CEC, GC, HRC	32	36
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	33	33
Board Committee Participants[h]				
Dr. Thomas Feasby	Nov 27, 2015 to Jan 18, 2017	QSC	-	2
Dr. Brian Postl	Since Jan 1, 2018	QSC	-	-
Gord Winkel	Since Nov 27, 2015	QSC	2	3
Total Board			**$ 311**	**$ 310**

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

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018

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

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018 (CONTINUED)

	2017						
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							
Dr. Verna Yiu – President and Chief Executive Officer	1.00	$ 565	$ 16	$ 163	$ 744	$ -	$ 744
Ronda White – Chief Audit Executive	1.00	240	-	39	279	-	279
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	370	-	44	414	-	414
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta	1.00	383	5	69	457	-	457
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	370	-	104	474	-	474
Dr. David Mador – VP and Medical Director, Northern Alberta	1.00	450	-	104	554	-	554
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions	0.27	89		14	103	-	103
Dave Bilan – Interim VP, Collaborative Practice, Nursing and Health Professions	0.77	130	-	2	132	-	132
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	456	-	93	549	-	549
Karen Horon – Acting VP, Clinical Support Services	0.02	5	-	1	6	-	6
Mauro Chies – VP, Clinical Support Services	0.80	245		40	285	-	285
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	264	13	32	309	-	309
Todd Gilchrist – VP, People, Legal and Privacy	1.00	450	-	78	528	-	528
Colleen Turner – VP, Community Engagement and Communications	1.00	314	-	81	395	-	395
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	370	-	65	435	-	435
Noela Inions – Chief Ethics and Compliance Officer	1.00	226	-	32	258	219	477
Total Executive	**13.86**	**$ 4,927**	**$ 34**	**$ 961**	**$ 5,922**	**$ 219**	**$ 6,141**

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

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.

	2018			2017			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2017	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2018
Dr. Verna Yiu - President and Chief Executive Officer	$ 49	$ -	$ 49	$ 41	$ 41	$ 49	$ 90
Ronda White - Chief Audit Executive	14	-	14	9	63	17	80
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	5	-	5	3	6	6	12
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	(18)	(18)	23	380	9	389
SPP	24	-	24	25	125	30	155
Dr. Ted Braun - VP and Medical Director, Central and Southern Alberta							
SERP	-	(10)	(10)	12	209	6	215
SPP	28	-	28	27	85	32	117
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	(31)	(31)	35	649	17	666
SPP	24	-	24	25	116	31	147
Dr. Mark Joffe - VP and Medical Director, Northern Alberta[n]	-	-	-	-	-	-	-
Dr. David Mador - VP and Medical Director, Northern Alberta	19	-	19	35	144	24	168
Sean Chilton - VP, Collaborative Practice, Nursing and Health Professions	20	-	20	18	115	24	139
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	36	-	36	35	172	47	219
Mauro Chies - VP, Clinical Support Services	17	-	17	16	67	20	87
Karen Horon - Acting VP, Clinical Support Services	4	-	4	4	16	5	21
Dr. Kathryn Todd - VP, System Innovation and Programs[n]	-	-	-	-	-	-	-
Todd Gilchrist - VP, People, Legal and Privacy	34	-	34	35	67	37	104
Colleen Turner - VP, Community Engagement and Communications	20	-	20	18	70	24	94
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	32	-	32	25	170	41	211
Noela Inions - Chief Ethics and Compliance Officer	-	-	-	8	76	(76)	-

(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.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2018

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, 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 and 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. As a result of a reclassification of their position, the incumbent received an increase in base salary effective April 1, 2017.

k. The incumbent held the position of Acting Chief Ethics and Compliance Officer until June 18, 2017 at which time the incumbent was appointed Chief Ethics and Compliance Officer and became a direct report to the AHS Board. The incumbent received an increase in compensation for the new position.

l. The incumbent received a vacation payout of $15 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. The incumbent was appointed to the position effective April 1, 2017.

n. 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.

o. The incumbent held the position of Vice President and Medical Director, Northern Alberta until May 1, 2017 at which time the incumbent moved to a part-time consultancy position and is no longer a direct report to the President and Chief Executive Officer.

p. The incumbent received a vacation payout of $39 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.

q. The incumbent returned from a temporary leave of absence on June 5, 2017, during which he received salary continuance, and resumed the role of Vice President, Clinical Support Services. The incumbent received a vacation payout of $2 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.

r. The incumbent held the position of Acting Vice President, Clinical Support Services until June 12, 2017 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.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2018 (CONTINUED)

s. 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.

t. The incumbent received a vacation payout of $22 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.

u. A compensation review for the incumbent was finalized May 23, 2017 and as a result, the incumbent's annual compensation was adjusted retroactive to September 29, 2014. The retroactive adjustment of $19 per annum is reflected in the current year base salary amount. In addition, the incumbent received a vacation payout of $1 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**.**

v. The incumbent held the position until April 21, 2017, at which time the accountability and scope of the position was expanded. The employer and employee negotiated a separation agreement which resulted in the incumbent resigning her position in exchange for a severance payment. The employer allowed this resignation to be communicated as a retirement. The incumbent received salary and other accrued entitlements to the date of resignation. The reported severance included 44 weeks of base salary at the rate in effect at the date of retirement and an additional 15% of the severance in lieu of benefits. This severance was expensed in the prior year. In addition, the incumbent received a vacation payout of $39 for unused accrued vacation at the time of resignation; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

Termination Obligations

w. 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.

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

y. 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.

z. SPP

Based on the provision of the applicable SPP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2017-18 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2017 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. The AHS obligations are paid through either a lump sum payment or regular instalments:

Position	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Chief Ethics and Compliance Officer (SPP)	April 1, 2009	$79,315	Once	May 2017

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES FOR THE YEAR ENDED MARCH 31

	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 disposals of tangible capital assets	Total
Community-based care	$ 610,867	$ 620,882	$ -	$ 3,076	$ 3,643	$ 20,961	$ 77,774	$ 443	$ 1,337,646
Home care	287,294	220,857	-	144	6,421	72,220	23,266	313	610,515
Continuing care	309,691	717,001	-	7,413	5,376	4,071	26,413	1,711	1,071,676
Population and public health	292,051	9,584	-	7,342	2,609	12,373	14,056	436	338,451
Ambulance services	283,286	167,566	-	2,185	3,021	1,376	41,592	13,384	512,410
Acute care	2,973,443	389,239	18,337	420,969	329,427	609,582	185,228	55,065	4,981,290
Diagnostic and therapeutic services	1,512,912	300,340	-	12,696	57,552	263,333	223,634	40,505	2,410,972
Education and research	180,880	3,135	-	9	88	84,733	28,965	350	298,160
Support services	1,037,413	151,473	-	2,341	5,535	104,613	559,054	321,212	2,181,641
Information technology	225,874	584	-	-	-	37,570	141,891	104,070	509,989
Administration	356,289	40,710	-	539	168	42,180	70,661	1,150	511,697
Total	**$ 8,070,000**	**$ 2,621,371**	**$ 18,337**	**$ 456,714**	**$ 413,840**	**$ 1,253,012**	**$ 1,392,534**	**$ 538,639**	**$ 14,764,447**

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES (CONTINUED)
FOR THE YEAR ENDED MARCH 31

	2017								
	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 disposals of tangible capital assets	Total
Community-based care	$ 563,059	$ 580,520	$ -	$ 2,897	$ 3,207	$ 27,385	$ 71,092	$ 871	$ 1,249,031
Home care	274,160	209,600		575	6,978	68,156	25,287	557	585,313
Continuing care	315,100	690,517	-	7,409	5,320	5,958	27,073	1,741	1,053,118
Population and public health	307,058	10,177	-	9,343	1,619	16,202	10,077	224	354,700
Ambulance services	270,847	171,845	-	2,004	2,563	2,329	36,514	11,584	497,686
Acute care	3,015,073	386,558	20,198	409,359	300,030	459,640	186,483	63,666	4,841,007
Diagnostic and therapeutic services	1,502,015	290,270	-	16,015	58,985	266,963	210,900	55,094	2,400,242
Education and research	184,434	3,355	-	83	202	72,865	23,903	458	285,300
Support services	1,006,376	149,941	-	1,789	6,136	100,340	577,282	303,677	2,145,541
Information technology	214,987	8,143	-	-	-	41,500	137,396	111,394	513,420
Administration	330,073	38,928	-	146	173	45,384	61,621	1,749	478,074
TOTAL	**$ 7,983,182**	**$ 2,539,854**	**$ 20,198**	**$ 449,620**	**$ 385,213**	**$ 1,106,722**	**$ 1,367,628**	**$ 551,015**	**$ 14,403,432**

Financial Information

Health Quality Council of Alberta

Financial Statements
March 31, 2018

HEALTH QUALITY COUNCIL OF ALBERTA

FINANCIAL STATEMENTS

YEAR ENDED MARCH 31, 2018

HEALTH QUALITY COUNCIL OF ALBERTA
MANAGEMENT'S RESPONSIBILITY FOR THE FINANCIAL STATEMENTS
MARCH 31, 2018

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 29, 2018

[Original signed by Jessica Wing]

Director, Financial Services
Jessica Wing
May 29, 2018

Auditor General
OF ALBERTA

Independent Auditor's Report

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

Report on the Financial Statements

I have audited the accompanying financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2018, and the statements of operations, change in net financial assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2018, and the results of its operations, its remeasurement gains and losses, its changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

W. Doug Wylie FCPA, FCMA, ICD.D
Auditor General

May 29, 2018
Edmonton, Alberta

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF OPERATIONS
Year ended March 31

	2018		2017
	Budget	Actual	Actual
	(in thousands)		
Revenues			
Government transfers			
Alberta Health - operating grant	$ 7,151	$ 7,145	$ 6,946
Investment income	6	10	6
Other revenue	39	50	43
	7,196	7,205	6,995
Expenses			
Administration	1,946	1,841	2,122
Survey, measure and monitor initiatives	2,612	2,127	2,572
Patient safety initiatives	1,221	959	1,297
Quality initiatives	862	624	816
Communication	494	634	481
Ministerial assessment/study	560	452	239
	7,695	6,637	7,527
Annual operating surplus (deficit)	(499)	568	(532)
Accumulated operating surplus, beginning of year	1,296	1,358	1,890
Accumulated operating surplus, end of year	$ 797	$ 1,926	$ 1,358

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF FINANCIAL POSITION
As at March 31

	2018	2017
	(in thousands)	
Financial Assets		
Cash	$ 1,568	$ 1,008
Accounts receivable	49	44
	1,617	1,052
Liabilities		
Accounts payable and accrued liabilities	627	727
Employee future benefits (Note 6)	94	68
Deferred revenue (Note 7)	6	-
Deferred lease inducements (Note 8)	98	53
	825	848
Net Financial Assets	792	204
Non-Financial Assets		
Tangible capital assets (Note 9)	1,067	1,081
Prepaid expenses	67	73
	1,134	1,154
Net Assets	1,926	1,358
Net Assets		
Accumulated operating surplus (Note 11)	$ 1,926	$ 1,358

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

	2018		2017
	Budget	Actual	Actual
	(in thousands)		
Annual operating surplus (deficit)	$ (499)	$ 568	$ (532)
Acquisition of tangible capital assets (Note 9)	(176)	(193)	(77)
Amortization and write down of tangible capital assets (Note 9)	198	207	182
Decrease (Increase) in prepaid expenses		6	(20)
Increase (Decrease) in net financial assets in the year		588	(447)
Net financial assets, beginning of year		204	651
Net financial assets, end of year		$ 792	$ 204

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CASH FLOWS
Year ended March 31

	2018	2017
	(in thousands)	
Operating Transactions		
Annual operating surplus (deficit)	$ 568	$ (532)
Non-cash items:		
Amortization and write down of tangible capital assets (Note 9)	207	182
Amortization of deferred lease inducements (Note 8)	(41)	(47)
Increase in employee future benefits (Note 6)	26	25
	760	(372)
(Increase) Decrease in accounts receivable	(5)	3
Decrease (Increase) in prepaid expenses	6	(20)
(Decrease) in accounts payable and accrued liabilities	(100)	(117)
Increase (Decrease) in deferred revenue	6	(7)
Increase in deferred lease inducements (Note 8)	86	19
Cash provided by (applied to) operating transactions	753	(494)
Capital Transactions		
Acquisition of tangible capital assets (Note 9)	(193)	(77)
Cash (applied to) capital transactions	(193)	(77)
Increase (Decrease) in cash	560	(571)
Cash at beginning of year	1,008	1,579
Cash at end of year	$ 1,568	$ 1,008

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

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2018
(in thousands)

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 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, 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 standards from April 1, 2017: PS 2200 Related Party Disclosures, PS 3420 Inter-Entity Transactions, PS 3210 Assets, PS 3320 Contingent Assets and PS 3380 Contractual Rights.

Disclosure of related party transactions provided in Schedule 3. The adoption of PS 3420 Inter-Entity Transactions, PS 3210 Assets, PS 3320 Contingent Assets and PS 3380 Contractual Right have no material impact on the financial statements.

Note 3 FUTURE ACCOUNTING CHANGES

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

PS 3430 Restructuring Transactions (effective April 1, 2018)

This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

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

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

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

Note 4 BUDGET

The HQCA's 2017-2018 business plan with a budgeted deficit of ($499) was approved by the Board of Directors on February 23, 2017. The approved financial plan was submitted to the Ministry of Health.

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.

(in thousands)

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 $421 for the year ended March 31, 2018 (2017 - $448).

At December 31, 2017, the Local Authorities Pension Plan reported a surplus of $4,835,515 (2016 - deficit of $637,357).

The Supplementary Executive Retirement Plan (SERP) expense for the year ended March 31, 2018 is $26 (2017 - $25).

Note 7 DEFERRED REVENUE

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

	2018	2017
Balance, beginning of the year	$ -	$ 7
Amount received	6	-
Amount repaid	-	(7)
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.

	2018	2017
Lease inducements - renovations	$ 137	$ 137
Lease inducements - rent free periods	123	37
Less accumulated amortization	(162)	(121)
	$ 98	$ 53

(in thousands)

Note 9 TANGIBLE CAPITAL ASSETS

	2018				2017
	Equipment	Computer Hardware & Software	Leasehold Improvements	Total	Total
Estimated useful life	10 yrs	5 yrs	5-10 yrs		
Historical Cost					
Beginning of year	$ 401	$ 357	$ 1,013	$ 1,771	$ 1,795
Additions	-	193	-	193	77
Disposals, including write-downs	-	(84)	-	(84)	(101)
	401	466	1,013	1,880	1,771
Accumulated Amortization					
Beginning of year	153	261	276	690	609
Amortization expense	32	49	123	204	182
Effect of disposals, including write-downs	-	(81)	-	(81)	(101)
	185	229	399	813	690
Net book value at March 31, 2018	$ 216	$ 237	$ 614	$ 1,067	
Net book value at March 31, 2017	$ 248	$ 96	$ 737		$ 1,081

(in thousands)

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
2018 – 19	$ 367
2019 - 20	461
2020 - 21	475
2021 - 22	479
2022 - 23	479
Thereafter	-
	$ 2,261

Note 11 ACCUMULATED OPERATING SURPLUS

Accumulated operating surplus is comprised of the following:

	2018				2017
	Investment in Tangible Capital Assets[(a)]	Internally Restricted Surplus[(b)]	Unrestricted Surplus (Deficit)	Total	Total
Balance, April 1, 2017	$ 1,065	$ 293	$ -	$ 1,358	$ 1,890
Annual operating surplus (deficit)	-	-	568	568	(532)
Net investments in capital assets	-	-	-	-	-
Transfers	-	568	(568)	-	-
Balance, March 31, 2018	$ 1,065	$ 861	$ -	$ 1,926	$ 1,358

(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.

(in thousands)

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 is summarized as follows:

	2018	2017
Build capacity	$ 16	$ 35
Measure to improve	670	258
Monitor the health system	85	-
Engage with the public	90	-
	$ 861	$ 293

Note 12 COMPARATIVE FIGURES

Certain 2017 figures have been reclassified to conform to the 2018 presentation.

Note 13 APPROVAL OF THE FINANCIAL STATEMENTS

The financial statements were approved by the HQCA Board of Directors on May 29, 2018.

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE 1 – EXPENSES – DETAILED BY OBJECT
Year ended March 31

	2018		2017
	Budget	Actual	Actual
	(in thousands)		
Salaries and benefits	$ 4,576	$ 4,146	$ 4,539
Supplies, services and other	2,921	2,287	2,806
Amortization of tangible capital assets (Note 9)	198	204	182
	$ 7,695	$ 6,637	$ 7,527

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE 2 – SALARY AND BENEFITS DISCLOSURE
Year ended March 31

	2018				2017
	Base Salary [1]	Other Cash Benefits [2]	Other Non-Cash Benefits [3]	Total	Total
	(in thousands)				
Board of Directors-Chair	$ -	$ 12	$ -	$ 12	$ 16
Board of Directors-Members	-	28	-	28	37
Chief Executive Officer	350	-	57	407	406
Executive Director	184	-	36	220	221
	$ 534	$ 40	$ 93	$ 667	$ 680

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include honoraria for board members.

(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

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 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 Statements of Operations and the Statements of Financial Position at the amount of consideration agreed upon between the related parties.

	2018	2017
	(in thousands)	
Revenues		
Grants	$ 7,146	$ 6,946
Other	7	10
	$ 7,153	$ 6,956
Expenses		
Other services	$ 265	$ 264
	$ 265	$ 264
Receivable from related parties	$ 1	$ -
Payable to related parties	$ 47	$ 35

Other Financial Information

Unaudited Information

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2018

(UNAUDITED)

(in thousands)

	2018	2017
Write-Offs		
Medical Claim Recoveries	1,790	2,953
Pharmaceuticals and Health Benefits	238	-
Other Receivables	432	539
Total Write-offs [1]	2,460	3,492

[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.

Other Statutory Reports

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, 2017 and March 31, 2018.

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.