GOVERNMENT OF ALBERTA

Annual Report

Health

2020-2021

Alberta

Health, Government of Alberta | Health 2020–2021 Annual Report

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Preface

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and *the Fiscal Planning and Transparency Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 20 ministries.

The annual report of the Government of Alberta contains ministers' accountability statements, the consolidated financial statements of the province and a comparison of actual performance results to desired results set out in the government's strategic plan, previously published in one volume entitled Measuring Up report.

This annual report of the Ministry of Health contains the minister's accountability statement, the financial information of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan. This ministry annual report also includes:

- **the financial statements of entities making up the ministry including Alberta Health Services and the Health Quality Council of Alberta, for which the minister is responsible;**

- **other financial information as required by the *Financial Administration Act* and *Fiscal Planning and Transparency Act*, as separate reports, to the extent that the ministry has anything to report.**

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

Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2021, 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 4, 2021** with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original signed by]

Honourable Tyler Shandro

Minister of Health

Message from the Minister

Looking back at this historic and challenging year – a year dominated by the COVID-19 pandemic – it has been a true honour to serve Albertans and this province as Minister of Health. Through each wave of the pandemic, we relied on the advice of our public health officials based on the evolving evidence and science across Canada and the world. Alberta's government made thoughtful and often difficult choices to protect the lives and livelihoods of Albertans as we worked towards recovery and a healthy, prosperous future.

Alberta has led the way in taking a balanced approach to the pandemic. We balanced the need for public health measures to protect the capacity of our health system with the longer-term psychosocial impacts and economic damage of the repeated lockdowns we have seen in other jurisdictions. Alberta had a number of firsts in its response to the pandemic: we were the first province to have a robust supply of personal protective equipment when global supply chains were strained. We were the first and only province to roll out a public mask distribution program, where we provided 40 million free masks to Albertans in June and July through local drive-thru restaurants. Our leading testing program was initiated and ramped up quickly and efficiently, while others struggled. We were also the first province to implement a contact-tracing application.

In December, we provided the first doses of the COVID-19 vaccine to health-care workers and long-term care residents. Since then, vaccinations have continued in a phased rollout based on the availability of vaccine and focusing on those most vulnerable. Albertans have been able to receive vaccine through multiple channels, including Alberta Health Services clinics, community pharmacies and family physicians.

While responding to the COVID-19 pandemic has been our No. 1 priority, Alberta's government and the Ministry of Health have made strides to strengthen the health system and keep it sustainable for future generations.

We remain committed to our promise to provide all Albertans the scheduled surgeries they need within wait times recommended by medical experts. AHS had to postpone non-urgent surgeries to make sure hospitals had room to care for COVID-19 patients. To respond to the challenges caused by the pandemic and deliver on the Alberta Surgical Initiative commitment, Alberta developed a plan to clear the backlog and increase surgical activity volume. The plan included extending contracts with current chartered surgical facilities in the community to conduct less complex surgeries, while Alberta Health Services increased surgical capacity in five targeted hospitals in Banff, Edson, Peace River, Innisfail, and the Royal Alexandra Hospital in Edmonton.

In October, the Alberta Health Services' (AHS) Review Implementation Plan was released but with only a portion of the plan's actions proceeding for now to ensure the health system can continue to keep resources focused on the pandemic response. Some initiatives from the AHS performance review have moved forward, such as virtual care options, integrating EMS dispatch operations and requests for proposals to support contracting out of laundry and community lab services. These initiatives support a more efficient health system focused on delivering safe, integrated and quality health services across the province.

Negotiations for a new agreement with physicians continued throughout the fall. While we are disappointed that the new agreement was not ratified, we respect the decision of Alberta's

physicians. Physicians will continue to be paid and supported through several physician support programs, and Albertans can be confident they will continue to be cared for by dedicated physicians committed to quality health care in Alberta. Alberta's government is committed to strengthening its relationship with physicians based on collaboration, trust and the shared goal of providing the very best patient care. We want to move forward together in the spirit of cooperation, for the sake of patients and all Albertans.

Supporting health professionals to work to their full scopes of practice continued being a high priority for the government during the past year. To ensure Albertans have greater access to timely care, we updated ambulance regulations to allow nurse practitioners to work as medical directors and provide real-time medical advice to paramedics. Nurse practitioners can now also act as independent primary care providers in nursing homes. As part of the $6.3-million commitment to the Primary Care Network Nurse Practitioner Support Program, work continued towards adding 50 additional nurse practitioner full-time equivalents to work in primary care settings in communities where many patients don't have a family doctor or have difficulty accessing a family physician. In addition, physician assistants are now regulated health professionals in Alberta. A physician assistant can complete an initial patient assessment and provide routine services, which frees the physician to spend more time with patients and focus on critical issues.

The ministry also proceeded with the facility-based continuing care review to inform government on how to transform and remodel continuing care in Alberta with the ultimate goal of improving the quality of life of residents. The review highlighted specific issues related to COVID-19, as well as long-standing issues of concern related to the continuing care system. Stakeholder engagement activities finished in February 2021, with residents and family members, staff, key stakeholders and members of the public providing their input through 7,000 online surveys and more than 90 interviews and focus groups. Findings from the review, paired with the development of new continuing care legislation, will create a solid foundation for a modernized continuing care system in Alberta.

The pandemic has changed the way Albertans interact with the health system and is a key driver for new and better technologies. Work to advance Connect Care implementation continues with the goal of giving health-care providers at Alberta Health Services and its partners a central access point for more complete, up-to-date patient information and best practices. In addition, the ministry is moving forward with virtual technology solutions to expand virtual health service delivery to Albertans across the province.

We also continued our work to modernize various pieces of health legislation to strengthen the health-care system and improve people's access to the health services they need.

Jason Luan, Associate Minister of Mental Health and Addictions, continued his focus this year on expanding access to a full continuum of recovery-oriented addiction and mental health supports.

Our health system has weathered a very difficult year, with doctors, nurses, pharmacists, lab technologists, public health inspectors and all sorts of other health-care professionals and support workers dedicated to saving lives, preventing the spread of the coronavirus and making sure every Albertan receives the very best care possible. You are the backbone of the health system. Thank-you for persevering, for being beside us, grieving with us, boosting us up and inspiring us to work together. I look forward to an even stronger health system, supported by a historic investment in *Budget 2021* and an Alberta determination to forge a path forward.

[Original signed by]

Honourable Tyler Shandro
Minister of Health

Message from the Associate Minister

It continues to be my honour to serve as Alberta's Associate Minister of Mental Health and Addictions. Working alongside my government colleagues, Alberta Health Services and many dedicated community partners, more Albertans continue to be supported on their path to life-long addiction and mental health recovery.

The COVID-19 pandemic resulted in a difficult year for many people, especially those vulnerable to addiction and mental health issues. Early in the pandemic, the Alberta government committed more than $53 million to ensure people have access to the addiction and mental health recovery supports they need during and after the COVID-19 pandemic. This includes improving access to helplines and online resources, such as the Addiction Helpline, Mental Health Helpline, Kids Help Phone, Alberta 211, and Togetherall.

Of this new, one-time funding, $25 million was allocated to support the Mental Health and Addiction COVID-19 Community Funding Grant program, which is helping more than 230 organizations meet the unique needs of their communities. Grant projects support recovery services, community connections, and individual, family or community wellness.

Despite the challenges presented by the pandemic, Alberta's government remains steadfast in our commitment to build a recovery-oriented addiction and mental health system, spanning from prevention and intervention, to treatment and recovery.

In the past, Alberta's approach focused on acute interventions, designed to manage the negative health effects of these chronic issues. The approach saved lives, but it has not been enough. There is so much more to the life of a person dealing with substance use or mental wellness issues than those acute situations.

We are working to transition to a recovery-oriented system of care model that offers a range of options designed for each individual's specific needs, giving them choices for getting help and responsibility for recovery – as close to home as possible and with support from their community.

We are already taking some important steps in creating this system.

Alberta's government remains committed to allocating $140 million over four years to increase access to a full continuum of recovery-oriented addiction and mental health supports. Funding is increasing access to services, expanding programs, establishing more than 4,000 new publicly funded mental health and addiction treatment spaces and introducing innovative supports.

We are investing in therapeutic recovery communities to provide long-term individualized residential addiction treatment services. These communities focus not just on abstinence from drug use, but on the whole person and the everyday changes necessary to lead a productive, meaningful life. The goal is that upon leaving the program each participant will be working, studying or training, with the path to a new life clearly visible before them.

This is part of the promise this government made two years ago to create thousands of new publicly funded addiction and mental health treatment, outpatient and detox spaces over four years – a promise we continue to deliver on.

A person's finances should never be a barrier to receiving help and supports. This year we also increased access to treatment and recovery by eliminating daily user fees for publicly funded residential addiction treatment facilities. We also introduced the Opioid Agonist Therapy Gap Coverage Program, so people needing opioid agonist treatment can start receiving treatment immediately as they wait for supplemental benefits to start. Over 5,000 Albertans accessed the program in its first eleven months.

We also focused on expanding virtual resources so more Albertans can get help, regardless of where they live in the province. This included expanding the Virtual Opioid Dependency Program and developing the Digital Overdose Response System (DORS). DORS, a mobile app to help protect people using opioids and other substances while alone will begin testing in 2021-22.

It has been my privilege to serve Albertans during this busy, challenging year. As we forge ahead, we will continue to work to ensure that every Albertan who needs it is able to access help and support on their path to long-term recovery.

Recovery is real, recovery is attainable, and recovery works.

[Original signed by]

Honourable Jason Luan
Associate Minister of Mental Health and Addictions

Management's Responsibility for Reporting

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

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

Responsibility for the integrity and objectivity of the accompanying ministry financial information and performance results for the ministry rests with the Minister of Health. Under the direction of the Minister, I oversee the preparation of the ministry's annual report, including the financial information and performance results on all objectives and initiatives identified in the ministry Business Plan, and performance results for all ministry-supported commitments that were included in the 2020-23 Government of Alberta Strategic Plan. The financial information and the performance results, of necessity, include amounts that are based on estimates and judgments. The financial information is prepared using the government's stated accounting policies, which are based on Canadian public sector accounting standards. The performance measures are prepared in accordance with the following criteria:

- Reliability – information used in applying performance measure methodologies agrees with the underlying source data for the current and prior years' results.
- Understandability – the performance measure methodologies and results are presented clearly.
- Comparability – the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- Completeness – outcomes, performance measures and related targets match those included in the ministry's Budget 2020.

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

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

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

[Original signed by]

Paul Wynnyk
Deputy Minister of Health
June 4, 2021

Results Analysis

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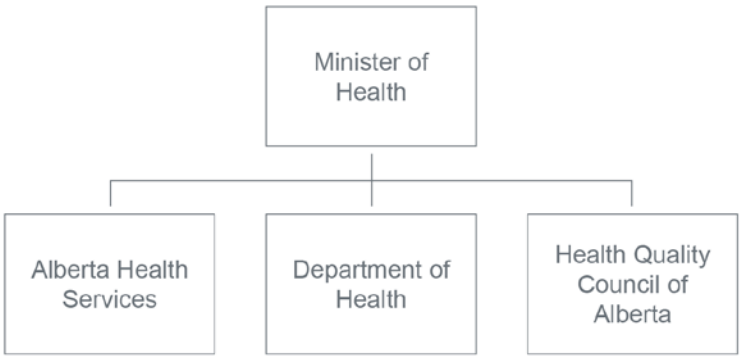
Ministry Overview

Organizational Structure

The Ministry of Health supports Albertans by protecting public health and promoting wellness; coordinating and delivering safe, person-centred, quality health services; leading a coordinated response to communicable disease outbreaks, and public health emergencies and concerns; planning capital infrastructure; supporting innovative information management and technologies; enabling health care professionals to work to their full scope of practice; and funding the health system.

The ministry includes the Department of Health, Alberta Health Services and the Health Quality Council of Alberta. These three entities report to the Minister of Health. The Minister is supported by the Associate Minister of Mental Health and Addictions.



The Department of Health establishes the Government of Alberta's strategic direction for health. Key functions include advising government on health policy, legislation and standards, and public health concerns; monitoring and reporting health system performance; and providing oversight across the health system.

Alberta Health Services (AHS) is the provincial health authority responsible for the delivery of a substantial portion of health care services across the province. AHS ensures high standards of quality and safety, and operational efficiency and effectiveness.

The Health Quality Council of Alberta (HQCA) works collaboratively with health system partners to promote and improve patient safety, person-centred care and health service quality on a province-wide basis.

The Ministry of Health's mandate encompasses the work of the three entities that report directly to the Minister and relies on collaboration with Albertans and a range of health professionals; business partners and organizations in the health and social sectors; academic and research institutions; Indigenous communities; and other government jurisdictions.

Operational Overview

Department of Health

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 across government ministries, AHS, HQCA, and partner organizations. The office provides policy coordination and issues management for the Minister and Associate Minister, as well as leadership in priority setting, decision-making, and operations of the ministry. The office is also responsible for ministry correspondence services.

Financial and Corporate Services Division – forecasts and manages the ministry's budget, and funds and monitors the financial activities of the department. It also provides financial advice and prepares annual financial statements, ensuring compliance with Government of Alberta financial legislation. The division oversees corporate planning and reporting; AHS accountability; governance of health sector public bodies; and, access to information requests under Alberta's *Freedom of Information and Protection of Privacy Act* and *Health Information Act*.

The division oversees capital planning, including health facilities planning, and coordinates infrastructure projects with the Ministry of Infrastructure and AHS. The division manages registration, designation and bed survey processes and reporting. The division coordinates the department's health system legislation reviews; input to the government's decision-making and legislative processes; and red tape reduction reporting. The division coordinates the grant approval process, and provides general administrative and contracting-based corporate services to enable the department to fulfill its mandate. The division is also responsible for the recovery of the cost of health services from liable third parties where appropriate.

Health Information Systems Division – provides leadership and strategic direction for the development and implementation of policy, legislation and standards for the provincial eHealth environment, the *Health Information Act* and the department's information and technology requirements. The division is responsible for Alberta Netcare (electronic health record) and MyHealth Records (personal health record), including health information policy and advice, stakeholder engagement, strategic planning, and delivery and operations of the department's information management and technology systems.

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

Health Standards, Quality and Performance Division – provides leadership for monitoring, assessing, and improving health system performance; and health care research and innovation. The division is the primary source for Alberta's overall health system data standards and analytics, evaluating the health system's performance to support evidence-based policy decisions for all health sectors: primary health care, acute and emergency care, continuing care, addiction and mental health, public health, and pharmaceuticals. It is the ministry's core strategic economic team

developing and producing economic evaluations, predictive models, financial forecasts and value for money analyses.

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

Health Workforce Planning and Accountability Division – develops and implements health workforce and system policies related to insured health care provider compensation, health professions self-regulation, primary and community health, chronic disease management, and the administration and governance of primary care networks to enable a health workforce that meets Albertans' needs. The division collaborates with stakeholders, such as physicians, optometrists, podiatrists, podiatric surgeons, oral maxillofacial surgeons, health professions regulatory colleges, and health system leaders from academia and the community to support provision of quality health care services to Albertans. The mandate of the division is achieved through evidence-based and value-oriented initiatives such as coverage for insured services, promotion of the patient medical home initiative through primary care networks and their governance structure, performance monitoring and evaluation, and collaboration with health professions' regulatory colleges to ensure patient safety. Together, these initiatives support the government's commitment to build a health care system that is sustainable and serves the needs of all Albertans.

Pharmaceutical and Supplementary Benefits Division – oversees and provides governance to the Alberta Health Care Insurance Plan (AHCIP) and all government-sponsored supplementary benefit programs that provide Albertans with pharmaceutical, optical, dental and other medical supports (wheelchairs, prosthetics, oxygen, medical/surgical supplies, etc.). This includes the registration of Albertans in the AHCIP and benefit programs; claims processing and remuneration for physicians, allied health professionals, and Albertans who receive insured medical and hospital services outside of the province; and the development and operation of programs that support Albertans requiring approved medically necessary treatment for services not available in Alberta and Canada.

The division is also responsible for Alberta's participation in the National Blood Program and advising the Minister in his role as a member of Canadian Blood Services; providing leadership to national and provincial organizations to ensure accountable and appropriate delivery of blood, organ and tissue donation, dialysis and other provincial clinical services; representing Alberta in matters of strategic importance at the federal level, such as national pharmacare, drug shortages and drugs for rare diseases; and providing leadership through the Interprovincial Health Insurance Coordinating Committee for the reciprocal billing of insured health services in Canada to increase access and reduce barriers.

Public Health and Compliance Division – provides strategic direction and leadership through the assessment, development and implementation of provincial policies, regulations, strategies, and standards. This work is focused on emerging public health crises; communicable diseases; immunization; Indigenous health policy; compliance monitoring; environmental public health; health promotion; and emergency preparedness, response and recovery. The division carries out these functions to support innovation and engagement with Albertans in wellness, health promotion, and injury and disease prevention. To support health system quality, the division collaborates with partners to perform compliance and monitoring activities and enforcement of the acts, regulations and standards administered by the division in the areas of physician billing;

continuing care accommodations; residential addiction treatment facilities; health care services; infection prevention and control oversight; and protection for persons in care.

Office of the Chief Medical Officer of Health – 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 includes legislated responsibilities related to disease surveillance, communicable disease outbreaks, infection prevention and control measures, health risk assessments and states of public health emergencies. The Office provides strategic leadership, oversight, support and clinical expertise on issues of public health importance to Albertans. The Office works closely with diverse partners within and beyond the health system, including the department's Public Health and Compliance division and AHS Medical Officers of Health, to facilitate processes, policies, and programs to prevent chronic diseases, control the spread of communicable diseases, support health surveillance and strengthen the public health system in Alberta.

Office of the Alberta Health Advocates – includes the Health Advocate and the Mental Health Patient Advocate. The office supports Albertans in resolving their health-related concerns by helping them navigate the health care system; referring individuals to the appropriate complaints resolution services; providing information about the Alberta Health Charter; requesting the inspection of provincial health care facilities; and addressing patients' issues and concerns in relation to the *Mental Health Act*. The office also provides information and referrals to address the concerns specific to Alberta seniors, their families and service providers.

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

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

Human Resources – through the Public Service Commission (PSC), 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.

Key Highlights in the Past Year

The ministry's 2020-23 business plan, released as part of *Budget 2020* on February 27, 2020, outlined government's commitments and priorities to make life better for Albertans. This report provides an overview of important actions taken by the ministry in response to the COVID-19 pandemic and describes the ministry's progress towards achieving the following desired outcomes:

- A modernized, seamless health care system built around Albertan and patient needs, that provides effective and timely health care services and leads to improved health outcomes.
- A safe, high quality health system that is sustainable into the future and provides the best care for each tax dollar spent.
- Albertans have increased access to health care professionals and the mix of professionals that best meets their needs.
- Albertans are supported by accessible and coordinated mental health and addiction services and supports.
- The health and well-being of Albertans is supported through population health initiatives.

In early 2020, prior to the World Health Organization declaring the COVID-19 global pandemic on March 11, 2020, the ministry began taking action to enable Alberta's health system to manage the unfolding public health emergency. Key highlights of the ministry's work on the pandemic response, and strengthening the health system to achieve better health outcomes and improved efficiency include:

COVID-19 response	Based on the advice of Alberta's Chief Medical Officer of Health and as approved by Cabinet, the government implemented measures aimed at reducing the spread of the virus and minimizing COVID-related hospitalizations and deaths, while ensuring appropriate health system capacity. (page 17) Alberta rolled out COVID-19 vaccines, approved by Health Canada, in phases as vaccines became available, with eligibility based on risk. (page 60)
Progress on Alberta's Surgical Initiative	Despite the surgical postponements that occurred in the spring and fall of 2020 due to the pandemic, several key strategies have been pursued to decrease surgical wait times and eliminate the surgical backlog. During this past year, progress was made on increasing Alberta's surgical capacity – contracts with chartered surgical facility providers were extended, contracts with new providers were established, and surgical volumes were increased in select hospitals. (page 23)
Facility-based continuing care system review	The results of public engagement through online surveys, focus groups and interviews conducted in 2020-21 will be used to improve facility-based continuing care for Albertans. (page 24)
Implementation of AHS review recommendations	Due to pandemic priorities, the government directed AHS to take a gradual and long-term approach to implementation of recommendations from the AHS Performance Review report. The financial benefits from these actions will save up to $600 million after full implementation. (page 32)
Addressing addiction and mental health needs	Significant action was taken to improve access to recovery-oriented addiction and mental health services and supports. (page 51)
Red tape reduction	Through consolidating, streamlining and repealing duplicative legislation and regulations, Health has reduced regulatory red tape for small businesses and regulated health professionals while still ensuring the health and safety of Albertans. (page 21)

Discussion and Analysis of Results

COVID-19 Pandemic Response

Spring and Summer 2020

The Government of Alberta declared a public health emergency on March 17, 2020, following the detection of the COVID-19 virus in Alberta, and based on the advice of Alberta's Chief Medical Officer of Health. The response focused on: limiting the spread of the virus, particularly to those most vulnerable to poor health outcomes; testing and contact tracing; and ensuring the health system maintained capacity to respond to the unfolding pandemic. Early steps taken by the province were reported in the Ministry of Health's 2019-20 Annual Report, available at open.alberta.ca/publications.

Public Health Order 01-2020 was issued on March 16, 2020, prohibiting attendance at early childhood service programs, day cares, out of school care, preschool programs, schools, post-secondary institutions and other educational settings in Alberta, to lessen the impact of the public health emergency caused by the prevalence of COVID-19 in Alberta. This order was amended on March 20, 2020, allowing essential workers to have access to child care services operating under specific terms and conditions. With public health measures including quarantine protocols in place, child care and pre-school facilities reopened in May 2020 and schools were able to open for in-person learning in fall 2020.

In April 2020, Alberta introduced temporary changes to the coverage provided under the Alberta Health Care Insurance Plan (AHCIP). This enabled testing and treatment for COVID-19 for those not eligible for AHCIP coverage, regardless of their ability to pay. In addition, coverage was extended for those individuals who had applied for an extension to their work or study permit but had not received a response from Immigration, Refugees and Citizenship Canada. The provincial government also temporarily waived the cost recovery fee related to providing AHCIP registration services for the period of January 1, 2020 to June 30, 2020, to assist Registry Agents with business continuity through the pandemic.

On April 15, 2020, Alberta's government announced an additional $53.4 million specifically to support the addiction and mental health needs of Albertans during and after the COVID-19 pandemic. This includes $25 million to support development of the new Mental Health and Addiction COVID-19 Community Grant Program aimed at enhancing community mental health and addiction recovery supports. This funding also supported the expansion of online and phone supports including the Addiction and Mental Health helplines, Alberta 211 phone line and Kids Help Phone to support all Albertans in accessing support for their addiction and mental health related needs, regardless of where they reside.

It is important to maintain service delivery for people experiencing addiction and mental health challenges during a pandemic. In addition to moving many services to a virtual platform, treatment and mutual support groups for addiction and mental health were able to continue with public health measures in place.

Continuing care facilities have been disproportionately affected by the COVID-19 pandemic, since older adults are at greater risk of requiring hospitalization or dying if they are diagnosed with COVID-19. Early in the pandemic, additional COVID-19 safety requirements, including limits and restrictions placed on visitors to these facilities, were implemented to reduce the spread of disease

and prevent hospitalization and death of residents. These restrictions were necessary to help protect lives, but also placed emotional and financial burdens on residents, families, staff, and operators. In spring 2020, Alberta announced $260 million to protect staff and residents in long-term care, designated supportive living facilities and seniors' lodges from COVID-19, and to help with the extra costs associated with preventing and managing outbreaks.

In May 2020, with public health guidelines in place, the government began reopening parts of the economy, striking a careful balance to support the province's social and economic well-being while keeping the risk of transmission of the virus as low as possible. With the help of drive-thru restaurants, the government distributed more than 40 million non-medical masks to Albertans in June and July 2020.

Infection rates declined in the spring and remained at relatively low levels in summer 2020. With public health guidance specific to sectors and activities in place, the government was able to implement progressive easing of restrictions. In July 2020, Alberta's Chief Medical Officer of Health released a revised visitor policy for licensed supportive living, long-term care and hospice settings. This revised policy responded to the growing evidence about the negative impacts of longstanding visitor restrictions, including input heard through virtual town hall meetings with continuing care and hospice residents, families, staff and operators. The revised visitor policy included a safer approach for visits with residents, recognizing the importance of designated family and support people, and incorporated a site-based risk assessment process for social visitors.

Edmonton was chosen as one of two cities to host the National Hockey League (NHL) Hub City Series in July and August 2020, and Stanley Cup Playoffs in August and September using a "bubble model". Twelve NHL teams were lodged in hotels in a restricted area of Edmonton's downtown core to insulate them from interactions with the general public. Alberta demonstrated the success of strong public health protocols and the bubble model as a viable approach to permitting elite sporting events during the pandemic. Subsequently, a bubble model was used to host the 2021 World Junior Ice Hockey Championships in Edmonton and the Curling Canada Hub City tournament series in Calgary.

Fall and Winter 2020-2021

In response to a rapid rise in hospitalizations and deaths due to COVID-19 in fall 2020, and based on the advice of Alberta's Chief Medical Officer of Health, the government re-declared a state of public health emergency in November 2020. This enabled the government to take additional actions to limit the spread of the virus and protect the health of the public, including reintroducing restrictions on indoor and outdoor social gatherings, in-person attendance at places of worship, and access to certain businesses. It was necessary to postpone scheduled surgeries in some areas of the province to manage the impact of COVID-19 hospital and Intensive Care Unit admissions. As the number of COVID-19 cases continued to rise, stricter public health measures were introduced in December, with all indoor social gatherings prohibited. On December 13, 2020, employees were required to work from home unless their employer required a physical presence for operational effectiveness. New cases peaked in December 2020 and declined until growing rapidly again in the middle of March 2021, in part due to the introduction into Alberta of mutated variants of the COVID-19 virus.

Knowing who may have an active COVID-19 infection is key to slowing the spread. The rising rate of infection required expansion of testing. In December 2020, the government rolled out a rapid testing pilot project at long-term care and designated supportive living facilities in the Edmonton

Zone and Calgary Zone using dedicated mobile testing centres. The program was expanded in February 2021 to provide thousands of rapid tests to operators of all long-term care and supportive living facilities in Alberta to routinely screen their asymptomatic staff.

By the end of March 2021, Alberta's government had distributed more than 1.8 million rapid tests to targeted facilities and industries across the province. This included hospitals, assessment centres, long-term care and supportive living facilities, oil sands companies, and private businesses including meat packing plants, airports and veterinary clinics. Rapid tests support screening programs to reduce the spread of COVID-19 and prevent outbreaks. As part of the distribution, a three-week pilot project at two schools in Calgary helped the government track outbreaks in near-real time by screening asymptomatic students.

In February 2021, the government announced $68.5 million to support operators of non-contracted licensed supportive living, contracted and non-contracted home care, hospices, and residential addiction and mental health treatment centres, with costs associated with the pandemic. This funding helps operators pay for increased staffing, additional cleaning supplies and personal protective equipment. Alberta's government also announced the Critical Worker Benefit to recognize Alberta's critical workers, including health care workers in continuing care and addiction and mental health settings. Through this program, a one-time payment of $1,200 will go to approximately 380,000 workers in health care, social services, education and private sectors. This includes approximately 161,000 eligible health care workers in a range of settings – acute care, home care, hospice, mental health and addiction, and continuing care.

Alberta began preparing for the receipt of vaccine and ancillary supplies, based on the per capita approach used by the federal government in November and December. Updates on progress were shared with Albertans as more details became available. As COVID-19 vaccines were in very limited supply, a three-phase plan to roll out the vaccine was developed and immunization of Albertans eligible in the first phase began in December 2020. As more vaccine doses became available, government opened up eligibility to additional people in subsequent phases. The program was also expanded to include multiple pathways for Albertans to be immunized through AHS and partnerships with community pharmacies, Indigenous Services Canada and physicians.

Throughout the pandemic, Albertans were kept informed through a provincial COVID-19 information website (alberta.ca/coronavirus-info-for-albertans.aspx) including live-streamed provincial updates. Government also engaged with municipalities, businesses and non-profit organizations to support them with accurate information in a timely manner. Further, these engagements have provided an opportunity for consultation to ensure public health orders and guidance were informed by stakeholder feedback.

Information Technology Support 2020-21

Alberta's pandemic response is heavily reliant on information technology systems and processes to collect health system data to inform decisions to address changing pandemic circumstances and keep the general public informed. The following IT initiatives are examples of work undertaken to support the pandemic response.

The development of the Alberta-specific contact tracing application, ABTraceTogether, was launched to the public on May 1, 2020. Alberta was the first jurisdiction in North America to use this technology. When a person tests positive for COVID-19, ABTraceTogether provides AHS contact

tracers with information so that close contacts can be notified and can isolate to protect those around them.

Expanded services were offered through MyHealth Records, which is the provincial personal health record portal. This included access to COVID-19 lab test results by adults and by the parents/guardians of minors who had been tested for COVID-19, and the addition of virtual care services through secure messaging between patients and providers. This technology enables virtual interactions, thereby helping reduce opportunity for virus spread.

To reduce the spread of COVID-19 and protect the most vulnerable Albertans, staff working at designated supportive living and long-term care facilities were limited to working within one single facility. The Single Site Staffing initiative was established to coordinate staffing at these facilities.

Two programs were implemented to reduce the duration of the required self-isolation/quarantine period for travellers entering Alberta. The Returning Traveller Outreach Program was established at both the Edmonton and Calgary international airports. This was in response to the public health order that included self-isolation requirements for those returning from international travel and those exhibiting symptoms consistent with COVID-19. An online form was developed for incoming travellers to check for symptoms and capture isolation plans to ensure a safe entry into Alberta. The Border Testing Pilot project (at the Coutts land border crossing and Calgary International Airport) is an enhanced surveillance initiative that allows travellers to voluntarily be tested for COVID-19 upon arrival in Alberta and again six to seven days later. The pilot was a first of its kind partnership with the Government of Canada and industry to safely explore ways to reduce the length of quarantine for travellers, while still protecting Albertans from virus transmission.

The development of a Health System Capacity Dashboard was established to consolidate information from multiple sources and organizations, and create a consistent view of health system capacity during the pandemic. This dashboard provides policy decision-makers with accurate up-to-date information.

Review of Programs and Services – Red Tape Reduction

The Ministry of Health is committed to the ongoing review of programs and services to ensure that the best possible outcomes are being achieved for Albertans. As part of this ongoing review, the ministry is committed to making life easier for hard-working Albertans and job creators by reducing regulatory requirements by one-third by 2023, and eliminating unnecessary administrative burden through more efficient processes. This work will improve service delivery for Albertans; foster economic growth, innovation and competitiveness; create a strong and attractive investment climate; and, make Alberta one of the freest and fastest moving economies in North America.

Streamlining processes and reducing regulatory requirements and unnecessary processes, where appropriate within the health system, helps save time, money and resources. Removing red tape barriers, enables health care professionals to work to their full or expanded scopes of practice to better support the health needs of Albertans.

Health Professions Act amendments consolidated common requirements and allows for amalgamation of colleges. These amendments resulted in significantly more concise professional regulations, and more flexibility for professional and regulatory colleges to manage their own policy changes more efficiently through their by-laws and standards, rather than require each change be made via regulatory amendment through the government approval process. This will allow colleges to more quickly implement best practices and respond to changes in the health system.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Supporting job creation

Objective:
Reducing red tape

- As planned in the Ministry of Health's 2020-23 Business Plan, progress was made on reducing red tape within the health system.
- Red tape reduction was achieved through a number of changes to legislation administered by the Ministry of Health. The changes ensure regulation is based on evidence-based policy that mitigates risk, maintains high standards of accountability, outlines requirements in plain language, and supports businesses by removing excessive or unnecessary regulation requirements.

Amendments to the Nursing Homes General Regulation and Nursing Homes Operation Regulation enables Nurse Practitioners to work to their full scope of practice and reduces barriers to Nurse Practitioners and other appropriate health care providers providing primary care in nursing homes. These amendments increase access to quality care for nursing home residents while reducing red tape and duplication for health professionals, service providers and operators.

The Ground Ambulance Regulation consolidates three outdated regulations into one. The new regulation supports more timely and appropriate access to emergency medical services by ensuring more ambulances are available for urgent situations. The regulation also maximize roles of paramedics and practitioners to make real-time decisions and provide medical advice. The result of the new regulation is more efficient and effective care for Albertans who require in-home medical treatment and assistance from community paramedics.

Changes to the Food Regulation reduced unnecessary regulatory burden on businesses and directly responds to public submissions on home-based food businesses. As of June 1, 2020, the Food

Regulation allows Albertans to make low-risk foods in their home kitchen for sale to the public, subject to certain restrictions and safe food handling. Small entrepreneurs now have more opportunities to sell without requiring permits, inspection, or investment in a commercial kitchen.

Amendments to the Out-of-Country Health Services Regulation clarified eligibility criteria, definitions and timelines, to enable Alberta physicians and dentists to submit funding applications to the Out-of-Country Health Services Committee on their patients' behalf, more fully and accurately. This facilitates quicker processing of applications and creates operational and administrative efficiencies to reduce ambiguity in the process.

Personal Services Regulation amendments combined five standards for safe operation of a personal service business into one outcome-based standard. The updated standard makes these popular services safer by removing outdated practices and adding new requirements, such as requiring business owners to ensure staff are skilled and knowledgeable. The amendments also removed obsolete and costly requirements for these businesses, provided increased clarity for business owners on how to meet safety objectives, and expanded the scope of regulated activities to address continual industry growth. The changes to the regulation and standard were designed to place minimal administrative and financial burden on businesses and align with similar protections implemented in other provinces.

AHS recognizes the importance of reducing red tape to improve processes for patients and their families, as well as health sector businesses. Significant reductions in AHS requirements have been achieved through centralizing and standardizing policies and forms. Going forward, the continued implementation of AHS' clinical information system, Connect Care, will play a key role in reducing duplication of information gathered from AHS health practitioners and patients, by reducing the need to use manual and paper-based information management systems and processes.

Outcome One: A modernized, seamless health care system built around Albertan and patient needs, that provides effective and timely health care services and leads to improved health outcomes

Key Objectives

1.1 Collaborate with health system stakeholders to reduce surgical wait times within clinical guidelines through increased surgery capacity in hospitals and surgical facilities operated by independent providers.

In Alberta's surgical system, surgeries are performed in hospitals and in chartered surgical facilities (CSFs) operated by independent providers. Alberta first began offering publicly funded surgical procedures in CSFs in the early 1990s. CSFs allow Alberta, like other provinces, to increase the number of surgeries and reduce wait times.

In Alberta, CSF's providing publicly funded surgeries are contracted by Alberta Health Services in the fields of: ophthalmology; dermatology; ear, nose and throat (ENT); oral and maxillofacial surgery; gynecology; and, non-cosmetic plastic surgery. CSFs offering publicly funded surgeries must be accredited by the College of Physicians and Surgeons of Alberta, have a signed service contract with AHS, be approved by the Minister, and designated as a CSF by the Minister.

CSFs will play a key role in the Alberta Surgical Initiative goal to decrease wait times by 2023, especially in the areas of ophthalmology and orthopedics. Part of the initiative focuses on increased use of CSFs in the province to deliver more publicly funded surgeries. As more surgeries become available in the community, hospitals will be able to focus on more complex surgeries.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
Delivering sustainable, high quality, patient-centred health care for all Albertans

- As planned in the Ministry of Health's 2020-23 Business Plan, progress was made on increasing surgery capacity in hospitals and chartered surgical facilities to ensure Albertans receive the surgeries they need within clinically acceptable wait times.
- The ministry is working to address the backlog of postponed surgeries, due to COVID-19, and increase surgical capacity going forward.
- Results are being achieved through prioritizing surgeries and allocating operating room time according to the greatest need; streamlining referrals from primary care to specialists; upgrading and building new surgical suites in hospitals; and, providing increased volumes of less-complex surgeries in CSFs where possible.

To ensure sufficient health system capacity during the COVID-19 pandemic, scheduled surgical procedures in hospitals and CSFs were paused from March 18 to May 4, 2020. Postponing surgeries during this period occurred throughout Canada. In Alberta this created a backlog of about 25,000 surgeries. Our province was one of the first in the country to resume surgeries in early May, and provided more scheduled surgeries compared to the previous year in the months of June through September of 2020. Whereas all provinces reduced surgeries by 40 per cent or more during the first wave of the pandemic, Alberta was able to leverage CSFs to prevent similar sized reductions seen in other provinces in the second wave. Overall, between April 2020 and March 2021, Alberta provided close to 268,000 surgeries, or 93 per cent of the number of surgeries it performed in the same period the previous year, prior to the pandemic.

Throughout 2020-21, COVID-19 has impacted the volume of surgeries that can be conducted in Alberta at any given time. Due to rising hospitalizations and the potential impact of COVID-19, Alberta has been forced to postpone non-emergency or non-urgent surgeries at multiple points, with the most recent pause in some scheduled surgeries at some facilities implemented in spring 2021. The backlog of surgeries due to the impact of COVID-19 was about 30,000 procedures by the end of March 2021.

Alberta developed a plan to clear the backlog and increase surgical activity volume. The plan included extending contracts with current CSF providers to December 31, 2021 (ophthalmology) and March 31, 2022 (ENT, publicly funded plastic surgery, dermatology) with increased volume ceilings; and signing new contracts with three CSFs to offer select publicly funded orthopedic surgeries. CSFs are expected to provide up to 90,000 surgeries annually by 2023, up from 40,000 per year previously. CSFs began increasing their surgical activity in January 2021.

In a further effort to reduce the surgical backlog, AHS also increased the number of surgeries provided in five hospitals (in Banff, Edson, Peace River, Innisfail, and the Royal Alexandra Hospital in Edmonton) by keeping their operating rooms open into evenings and weekends while still providing quality, safe care for other patients, including those with COVID-19.

Budget 2020 allocated $100 million of capital funding over three years for AHS to renovate, equip and open new operating rooms. Construction of new operating rooms in Grande Prairie has started and will be completed later in 2021. Construction at other sites is expected to start later in 2021, following design completion.

As part of the Alberta Surgical Initiative's focus on CSFs, AHS and the department are collaborating with the Health Contracting Secretariat to release Requests for Proposals (RFPs) for publicly funded ophthalmology and select orthopedic surgeries performed in CSFs that will help manage the increased surgical demand, and expand capacity in Edmonton and Calgary. Additional RFPs are planned for release in 2021.

Enoch Cree Nation, Maskwacis Bands, Tsuut'ina Nation, Bigstone Cree Nation, Blood Tribe and Siksika Nation each received $50,000 in grant funding from the Alberta government to support the development of proposals to participate in RFPs for CSFs that could offer publicly funded surgeries to Albertans.

Public reporting on the Alberta Surgical Initiative launched in March 2021, via an interactive dashboard. The dashboard is available at healthanalytics.alberta.ca/health-analytics.html and is updated on a monthly basis. New reporting elements will be added to the dashboard as the Alberta Surgical Initiative progresses.

In July 2020, the *Health Care Protection Act* and Health Care Protection Regulation were renamed the *Health Facilities Act* and Health Facilities Regulation. Amendments were made within the *Health Facilities Act* regarding the provision of surgical services in CSFs. These legislative changes better reflect the purpose of these facilities and streamline processes to approve and designate the facilities, while maintaining quality and safety standards to ensure ongoing protection of health care service delivery. The legislation received royal assent on December 9, 2020.

1.2 Support continuing care in the community so that patients can remain in their communities, and ensure timely transition of inpatients out of hospital to an appropriate community setting.

Alberta's continuing care system offers a spectrum of health, personal care and accommodation services to support safety, independence, and quality of life for Albertans of any age who are

assessed as needing supports. Approximately 73 per cent of home care clients and 91 per cent of residents living in facility-based continuing care (designated supportive living and long-term care) are seniors.

In 2020, a review of Alberta's facility-based continuing care system was initiated to identify opportunities to improve designated supportive living and long-term care in Alberta. Turning these opportunities into actions will positively impact the lives of continuing care residents and their families, as well as support staff and operators. Key areas being considered in this review include quality of care; quality of life; resident choice; navigation and information; and workforce. The review will also take into account learnings from the pandemic.

In January 2021, the public was invited to provide feedback on Alberta's facility-based continuing care system through online surveys. More than 7,000 surveys were completed and responses are informing the development of recommendations regarding how to improve facility-based continuing care. By fall 2021, an action plan will be developed outlining steps needed to implement the facility-based continuing care review recommendations. Information on the status of the facility-based continuing care review is available at alberta.ca/facility-based-continuing-care-review.aspx.

1.3 Support Albertans in accessing appropriate and timely palliative and end-of-life care by increasing awareness of how and when to access palliative care options, shift from hospital to community-based home and hospice care, expand effective caregiver supports in their homes and communities, and establish education, training and standards for health care professionals.

Across Alberta, palliative and end-of-life care is offered in a range of settings including, but not limited to, acute care hospitals, outpatient clinics, primary care provider settings, community hospice spaces, continuing care facilities (designated supportive living and long-term care), emergency medical services, and home care. A variety of programs and services aim to improve quality of life for those nearing the end of life, including those living with a life-limiting illness. A provincial palliative and end-of-life care website is available at myhealth.alberta.ca/palliative-care, providing information for patients, families, caregivers and health care providers.

On September 9, 2020, the province reconfirmed a $20 million commitment to improve access to palliative and end-of-life care for Albertans and their families. This included $5 million provided to the Covenant Health Palliative Institute to increase access to palliative and end-of-life services and promote advance care planning so Albertans can ensure their wishes are honoured. The government also provided $2.3 million to the Palliative Institute to establish palliative care standards, education and training to ensure health care providers have foundational competencies to support early identification of patients who would benefit from palliative care approaches and transitions. In addition, $1 million was provided to the Alberta Hospice Palliative Care Association to establish in-person and online support groups, develop Alberta's first telephone grief support line and expand workshops on palliative care for Albertans.

The Palliative Coverage Program provides subsidized benefits to Albertans who are diagnosed as palliative and remain in their home or in a hospice, where access to publicly funded drugs, diabetic supplies and ambulance services are not included. Every year, about 2,700 Albertans choose to die at home or in a hospice. Effective March 1, 2020, the government eliminated copayments for end-of-life drugs, so all Albertans, no matter where they choose to spend their final moments, will not have to factor the cost of drugs into their decisions. More information about the program is available at alberta.ca/palliative-care-health-benefits.aspx.

The government engaged with interest groups and Albertans in early 2021 to review the approach to palliative and end-of-life care in Alberta, with a focus on increasing awareness and access to services. Recommendations from this engagement are expected in spring 2021 and will help inform plans to allocate the remainder of the $20 million (approximately $14 million) in government funding for palliative care over the next three years.

1.4 Strengthen home care and supports for caregivers that keep Albertans in their homes, including access to client-directed funding models in order to support Albertans with disabilities and chronic conditions (including people living with dementia).

The home care program is a fundamental component of the overall continuing care system. Home care includes services such as nursing and personal care, respite, palliative care and wound care. Recent events, including the pandemic, highlighted a need for strategic planning and action to support the critical role of home care in supporting independence and quality of life for Albertans. In collaboration with AHS and key system partners, the government has launched work to develop and implement strategies to improve home care experiences for clients, families and caregivers.

Taking action to improve home care ensures Albertans with care needs are supported to remain living in their own homes and communities as they age or their care needs evolve. This includes reviewing Alberta's home care program to clarify roles and responsibilities, expand client-directed care models for eligible clients, and improve integration with other areas of the health care system. Consideration will also be given to support for caregivers who wish to care for their loved ones at home, as well as health workforce initiatives – to further support competency and quality assurance for health care aides in their critical and diverse role supporting clients in the community.

In 2020-21, the province invested approximately $2 million in health- and community-based partners for initiatives to support Albertans living with dementia. While some project timelines were extended, grant recipients were able to adapt and continue delivering their programs and services during the pandemic. For example, the government funded a project working to address worsening pain and depressive moods of residents in facility-based continuing care. The project continued and showed positive results for residents during the pandemic.

Government funding also supports 14 community-based projects for innovations in dementia care in the community and supports the Alzheimer Society of Alberta and Northwest Territories in leading the development of workplace supports and expansion of dementia supports to rural and remote communities in Alberta.

The Chief Medical Officer of Health Orders for continuing care sites during the pandemic have included evidence-informed considerations for providing care specific to persons living with dementia, including care planning, safe visiting practices and personal protective equipment considerations for people with cognitive impairments.

1.5 Drive efficiency and improvements in health system processes, including reducing regulatory burdens through the Red Tape Reduction initiative, digital transformation of the health system, and modernization of Alberta's personal health care cards.

Clinical access to digital records supports the right information at the right time and supports the digital transformation of the health system by reducing the need for clinicians to request paper records or call other providers to understand the patient's health status and history.

Alberta Netcare (available to clinicians in AHS and in the community) and MyHealth Records are essential components of the provincial eHealth strategy which supports transition from paper-based processes to digital processes where appropriate, and expanded virtual care options.

Alberta Netcare allows care providers access to lab test results; diagnostic images and reports; hospital discharge reports; immunization records; clinical reports such as surgery reports and specialist consults; cancer screening status reports for breast, colorectal and cervical cancer; senior's health profiles; community medication dispense information; pharmacy care plans; family doctor visit summaries; and electronic referral tracking. This information enables a view of a patient's health over time and facilitates better decisions at the point of care delivery.

To make Alberta's health system more person-centred, providing Albertans with digital access to their health information via the MyHealth Records (MHR) portal reduces the need for them to manually request that information separately from each health provider. The MHR portal also provides tools to help a person track their own health. This empowers Albertans to be active participants in their own health management. Access to MHR portal is free at myhealth.alberta.ca/myhealthrecords. Currently, Albertans can view parts of their Netcare record, including their medications dispensed through community pharmacies, lab results of commonly requested tests, and immunization history. Additional lab results were added in 2021 and planning is underway to make other information available from Netcare.

A primary care provider is a health care professional who provides a main point of contact with the health care system for Albertans. Currently, most Albertans access a family physician or nurse practitioner as their primary care provider. Some primary care providers keep electronic medical records (EMR) that are used to record patient visits and interactions. Efforts are currently underway to further the electronic integration of information between these EMRs and Alberta's Netcare system.

Recent efforts by AHS to streamline processes, create efficiencies and reduce red tape are being undertaken in alignment with the work and initiatives in the AHS Review implementation plan. Although slowed due to the pandemic, AHS continued to make progress in consolidating their clinical information systems by a phased roll out of Connect Care within all AHS facilities. Connect Care is a common clinical information system that houses all AHS medical records, prescriptions and care history at AHS facilities, including doctor's notes. Alberta Netcare integrates with Connect Care. Connect Care was launched in November 2019. Wave 2 was rolled out on October 24, 2020, and Wave 3 was launched on April 10, 2021. The remaining six waves of deployment are expected to be completed by 2023.

Currently, the ministry uses a legacy mainframe system to support critical capabilities to administer the Alberta Health Care Insurance Plan and support core business, such as claims processing, payment of health care providers and health care insurance for Albertans. The legacy mainframe system is not agile or flexible enough to support future models of care and emerging digital technology in the Canadian public health benefits management and claims processing domain.

The Enabling New Models of Care (ENMOC) initiative is currently underway to replace and redesign nine mainframe systems to reduce the risk to the reliability and functionality of the systems, and growing maintenance costs. The new technology will use automation to achieve business process efficiencies and increase the capacity of the ministry to better meet the needs of Albertans and care providers. In 2020-21, a vendor to support the ENMOC initiative was selected through a request for proposal process, with the contract agreement signed on June 24, 2020. Significant progress on development of the new systems is being made towards a target "go-live" date of November 2022.

Government is continuing work on moving to a more durable personal health card. At the same time, work is ongoing to improve renewal and validation processes to ensure continued eligibility for health services covered under the Alberta Health Care Insurance Plan. This modernization initiative is intended, in part, to address observations of Alberta's Auditor General on the integrity of the Alberta Health Care Insurance Plan.

1.6 Ensure Albertans are able to navigate the complaints process so that the voice of patients and caregivers leads to real improvements.

If Albertans have a concern or negative experience with the health system, it is important they are aware of what resources are available to help them work towards a resolution and how their valuable feedback can help improve the quality and safety of health services. The Alberta Health Advocate helps connect Albertans to the appropriate complaints resolution process. More information is available at alberta.ca/alberta-health-advocate.aspx.

In July 2020, the Minister of Health requested the Health Quality Council of Alberta (HQCA) undertake an independent review of the processes currently available for Albertans to voice their complaints or concerns.

The HQCA is responsible for promoting and improving patient safety, person-centred care, and health service quality on a province-wide basis. From August to December, 2020, the HQCA consulted with Albertans and various health system partners across the province to help understand the current state of the complaints and concerns management processes. The HQCA also looked at past work done in this area, and conducted a scan of select jurisdictions across Canada and internationally to review leading practices in complaints/concerns management.

In February 2021, the HQCA submitted a final report from its review to the Minister. The Department of Health is engaged with the HQCA on next steps to develop and implement improved processes.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
Delivering sustainable, high quality, patient-centred health care for all Albertans

- As planned in the Ministry of Health's 2020-23 Business Plan, the government took the first step towards improving Alberta's health care system complaints and concerns management processes by directing the HQCA to review Alberta's processes. The review also included identification of leading practices in other jurisdictions.
- A report of findings and recommendations is under review and development of improved processes are underway.

Performance Metrics

Performance Indicator 1.a:
Unplanned medical readmissions to hospital within 30 days of discharge

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
13.6%	13.6%	13.9%	13.7%	13.2% (preliminary)

Source: Alberta's Morbidity and Ambulatory Care Abstract Reporting System (MACAR)

The indicator tracks the percentage of medical patients with an unplanned readmission to hospital within 30 days of leaving the hospital. Results exclude hospital admissions for surgery, pregnancy, childbirth, mental health diseases and disorders, palliative care and cancer therapy. The desired result is to decrease the percentage of unplanned readmissions to hospital within 30 days of discharge.

Results Analysis

The preliminary 2020-21 result of 13.2 per cent is 0.5 percentage point lower than in 2019-20. The percentage of unplanned readmissions of patients recently hospitalized because of a medical condition has remained relatively stable over the past five years.

A lower percentage means fewer patients have been readmitted to hospital within one month of discharge. Although readmission may involve external factors, lower readmission rates are supported by discharge planning and continuity of services after discharge. Rates may also be impacted by the nature of the population served by a hospital facility, such as elderly patients or patients with complex health needs, or by the accessibility of post-discharge health care services in the community.

The Canadian Institute for Health Information ranked Alberta fifth out of 12 provinces/territories for this indicator in 2019-20. AHS continues to monitor hospital readmissions, and a range of initiatives have been undertaken to address the needs specific to each geographical health zone. For example, patients with multiple chronic conditions can now be linked to Community Health Navigators to assist them with system navigation, understanding information, locating community resources, and supporting self-management. Coordination of care is also improving because of recent enhancements to the health information system that enables electronic notification of primary care doctors when their patient is admitted or discharged from hospital.

Performance Indicator 1.b:
Median number of days hospital stay extended until home care services or supports were ready

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
16	12	8	8	9 (preliminary)

Source: Alberta Health Discharge Abstract Database (DAD)

This indicator tracks timely access to home care by counting the median number of days an Albertan remains in an acute care hospital when they no longer require this level of care and they are waiting for home care services or supports to be available to them for discharge. The median number of days is the mid-point between the minimum and maximum number of days a person's hospital stay was extended for this reason. A patient with instructions to return to their doctor or referral to a specialist (as part of a routine discharge plan) is not counted in this metric. The desired result is to decrease the number of days a hospital stay is extended until home care is ready.

Results Analysis

The preliminary 2020-21 median result of nine days is slightly higher than the 2018-19 and 2019-20 results of eight days.

A number of factors can explain an extended stay, including availability of services, and complexity of post-discharge needs that require more time to plan appropriate services at home. Other factors that can influence the indicator results include accessibility to comprehensive home care services, such as through Alberta's Intensive Home Care program, or client-related delays due to availability of a friend or family caregiver at home. The COVID-19 pandemic has impacted home care service delivery throughout the 2020-21 fiscal year, at times requiring adjustments to home care service levels in some regions of the province. Home care is a critical support for hospitals during a pandemic, and service adjustments in home care have partly been driven by AHS purposefully protecting capacity within home care to ensure clients can be safely discharged from hospitals and have their post-acute care managed at home.

Impacts to home care service delivery have also occurred due both to increased demand for home care and reduced staff availability – due to the COVID-19 pandemic and requirements under public health orders (e.g., many staff required time off due to illness or family obligations, or may have needed to restrict the number of locations in which they worked to protect clients and themselves). These impacts on home care demand and workforce availability may have been a factor in Alberta's slightly higher preliminary result for this indicator in 2020-21.

Performance Indicator 1.c:
Percentage of surgical procedure wait-times within national benchmarks

Surgery (national benchmark)	Prior Years' Results				2020-21 Actual
	2016-17	2017-18	2018-19	2019-20	
Hip replacement (benchmark 182 days)	80.2%	70.5%	68.5%	65.5%	51.6%[1]
Knee replacement (benchmark 182 days)	75.2%	64.6%	65.0%	61.5%	43.3%[2]
Cataract surgery (benchmark 112 days)	56.8%	53.3%	48.2%	45.1%	44.5%

Source: Alberta Health Services
Notes: [1]Hip replacement data include totals, partials, resurfacings, primaries and revisions for scheduled/elective cases.
[2]Knee replacement data include totals, partials, unicondylars, primaries and revisions for scheduled/elective cases.

This indicator tracks the percentage of selected common surgical procedures undertaken within established national benchmarks. The results are based on the time (in days) within which people had their surgical procedures performed in Alberta as planned. The wait time calculations do not include persons who received emergency surgical care. The desired result is to increase the percentage of surgical procedures meeting national benchmarks for wait times.

Results Analysis

The 2020-21 results for all three types of surgical procedure included in this indicator show a decline, meaning that fewer Albertans are receiving the surgical procedure within national benchmark wait times when compared to 2019-20 results. COVID-19 protocols have had a significant impact to surgical services throughout the province resulting in postponements throughout the fiscal year. This resulted in a reduced percentage of surgeries meeting national benchmarks in Alberta and in other provinces and territories.

Shorter wait times are expected in the future as the Alberta Surgical Initiative continues to be implemented over the next two years. Alberta's Surgery Strategic Clinical Network is also implementing initiatives to improve access and decrease wait times, reduce variation in clinical practice, and increase quality of surgical care provincewide.

Performance Measure 1.d:
Percentage of scheduled surgeries performed in chartered surgical facilities (formerly known as non-hospital surgical facilities)

Prior Years' Results				2020-21 Target	2020-21 Actual
2016-17	2017-18	2018-19	2019-20		
Not Available[1]	Not Available[1]	14%[2]	16%[2]	22%	19%

Source: Alberta Health Services Main Operating Room (OR) information system sources as extracted to OR data repository as of June 4, 2021. Sites that do not have OR information systems were not included.
Notes: [1]Results not available as this performance measure was developed after 2017-18. [2]Previously published results have been updated.

This indicator tracks the percentage of scheduled surgeries in Alberta that were performed in chartered surgical facilities (CSFs). Currently, 44 CSFs provide surgeries under contract with AHS. Most are in Edmonton and Calgary. All facilities must be accredited by the College of Physicians and Surgeons of Alberta and follow safety and quality standards. The desired result is to increase the percentage of scheduled publicly funded surgeries performed in CSFs.

Results Analysis

In the past year, accredited CSFs in Alberta provided 19 per cent of publicly funded scheduled surgeries, with 81 per cent of surgeries provided in hospitals. The 2020-21 result is three percentage points more than the 2019-20 result (16%) and three percentage points below the 2020-21 target (22%). Surgery volumes dropped due to COVID-19 first and second wave impacts in both CSFs and hospitals to preserve acute care bed capacity for COVID-19 patients. The Department and AHS worked together to utilize additional capacity in CSFs as part of a strategy to preserve surgical volumes in the province and aid in recovery from the pandemic backlog of surgeries. As a result, CSF volumes were maintained year-over-year, and the proportion of surgeries performed in CSFs in 2020-21 rose due to the drop in surgeries performed in hospitals, which is expected to continue into the early part of 2021-22.

A key goal of the Alberta Surgical Initiative is to have CSFs perform about 90,000 surgeries each year by 2023, up from the more than 40,000 surgeries they currently perform in a year. This will result in expanded surgical capacity and reduce wait times for less complex scheduled surgeries. Reporting on volumes enables a clearer picture of progress towards expanded capacity, while taking into account impacts of the COVID-19 pandemic. The volume of surgeries performed by CSFs are expected to increase in 2021-22 as new and expanded contracts are implemented.

Outcome Two: A safe, high quality health system that is sustainable into the future and provides the best care for each tax dollar spent

Key Objectives

2.1 Develop and implement strategies that close the gap in health outcomes and spending between Alberta and comparator provinces, bringing Alberta's health spending more in line with national norms by 2022-23.

Alberta has a strong public health system that is a leader in innovation. The health system faces challenges to keep it sustainable for future generations, including providing the very best health care for each tax dollar spent.

As a result of Alberta's ongoing response to the COVID-19 pandemic, the government is on track for historic levels of spending on health care, community and social services, continuing care supports, mental health funding and family supports. In *Budget 2020* the government's 2020-21 budget estimate for Health was $20.9 billion in operating costs (not including pandemic expenses) and $1.2 billion in capital investment. In 2020-21, Health spent $20.5 billion on operating expenses and $1.1 billion on capital investment. In addition, consolidated ministry expense related to the pandemic response was $1.5 billion in 2020-21.

Alberta continues to spend more per capita on health care than the Canadian average, but Alberta is not seeing better health outcomes commensurate with its level of spending. In order to deliver sustainable, person-centred, quality health care for all Albertans, meaningful ways to control costs must be realized and savings redirected to front-line patient care.

In 2020-21, operating expenses were $331 million lower than budget and $644 million lower than the 2019-20 Actual. The 2020-21 results reflect a number of factors. There were savings in physician compensation and development costs, with fewer patient visits and implementation of the new physician funding framework reducing fee-for-service billings; savings in acute care costs as the COVID-19 pandemic led to the cancellation of elective surgeries as well as fewer emergency room visits; and the pandemic also resulted in significantly fewer contracted home care hours provided through AHS. Savings in publicly funded drug benefit programs from the new Alberta Biosimilars Initiative, expansion of the Maximum Allowable Costing policy, and the March 2020 removal of non-senior dependants from the Seniors Drug program helped maintain program spending at 2019-20 levels.

2.2 Implement approved recommendations from the comprehensive review of Alberta Health Services.

A comprehensive performance review of AHS was conducted in 2019 to find efficiencies within the health delivery system in order to reinvest savings back into front-line care. The review included hearing directly from Albertans, including patients, staff and physicians working in AHS, as well as from key stakeholder groups including patient advocates, regulatory bodies and associations, municipalities and universities. Over 1,000 emails were received from Albertans and over 32,000 surveys were completed (front-line, physicians, and management/leadership). The report, released on February 3, 2020, is available at open.alberta.ca/publications/alberta-health-services-performance-review-summary-report.

The AHS Performance Review report identified 57 recommendations on how to create long-term sustainability for the health care delivery system. The review is part of the government's broader commitment to improve access and make the health system work better for Albertans. The government accepted the report's recommendations, with exceptions including no hospital closures and no consolidation of urban trauma centres.

In August 2020, AHS submitted a comprehensive implementation plan for the AHS Performance Review recommendations. The proposed implementation plan is available at open.alberta.ca/publications/ahs-performance-review-proposed-implementation-plan.

In October 2020, the government gave approval for AHS to proceed with 69 initiatives – 19 were approved as early initiatives in May 2020, and an additional 50 initiatives were approved in October to move forward. AHS realized over $80 million in savings in 2020-21 through these initiatives. A fact sheet outlining the initiatives identified to proceed is available at open.alberta.ca/publications/ahs-review-report-implementation-plan-initiatives.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
Delivering sustainable, high quality, patient-centred health care for all Albertans

- As planned in the Ministry of Health's 2020-23 Business Plan, the government approved next steps for implementation of approved recommendations arising from the AHS Performance Review.
- The government directed AHS to take a long-term and gradual approach to implementation, and to put patient care above all else. The government approved AHS to proceed with a portion of the actions identified in AHS' implementation plan, with no job losses for nurses and other front-line clinical staff.

The changes from implementing the approved 69 initiatives are expected to generate up to $600 million in annual savings once fully implemented (approximately over 10 years), which will be reinvested to front-line services. The list of approved initiatives includes: moving forward with virtual care options; initiatives related to outsourcing non-clinical services; consolidating regional dispatch operations; expanding surgical volumes and the use of chartered surgical facilities; managing physician expenditures; implementing Operational Best Practices; and optimizing back office operations.

Outsourcing AHS' remaining laundry services is underway. AHS currently contracts out 68 per cent of laundry, including all laundry for Calgary and Edmonton. Following a competitive RFP process (initiated in October 2020) and evaluation, K-Bro Linen Systems was selected to provide laundry services for AHS provincewide. The full transition to this third-party provider will allow for the reinvestment of health care dollars into direct patient care, eliminating the need to spend more than $38 million in capital upgrades that would otherwise be immediately necessary.

2.3 Improve the measuring, monitoring and reporting of health system performance to drive health care improvements.

Evidence-informed decisions are the basis of effective, quality health care in Alberta. The ministry continues to increase capacity for evidence-informed practice and policy through enhanced data sharing, research, innovation, health technology evidence reviews, and knowledge translation to implementation.

On March 5, 2020, the government announced plans to develop an enhanced data-sharing environment to store valuable provincial health and non-health data in a secure environment that will safeguard and protect personal information. This world-class health data warehouse will strengthen health analytics and drive research and innovation for health system improvement.

Data collected under Alberta's public health surveillance program is compiled, summarized, and presented on the Interactive Health Data Application (IHDA), which is available at ahw.gov.ab.ca/IHDA_Retrieval/. The IHDA contains many health statistics on a variety of health-related topics such as demographics, mortality, chronic and infectious disease, and children's health. This information helps inform development of service plans for Alberta's geographical health zones, which shape care for the communities within each zone, based on current and future needs of Albertans. A new health analytics website, which is available at healthanalytics.alberta.ca/health-analytics.html, allows for exploration of Alberta health data using interactive dashboards. The health analytics website topics include childhood immunization coverage, substance use surveillance, Alberta Surgery Initiative dashboard, and national health expenditures.

The ministry provided $2.1 million to the Institute for Health Economics and the Universities of Alberta and Calgary, for the collection and analysis of evidence to address opportunities to improve care and reduce unwarranted variation of care. Projects included evidence to inform a new care pathway for endoscopies that emphasizes procedures of high value; interventions for chronic low back pain; and technologies to improve the management of diabetes.

As previously reported, the ministry has established a $10 million Health Innovation Implementation and Spread Fund to support implementation of proven innovations in the health system, such as new health technologies, services or ways of providing care. A call for new project proposals was released in November 2019. Although competition was delayed due to the COVID-19 pandemic, in September 2020, four projects were selected for implementation. The four projects are each aimed at different aspects of health, including implementing elder friendly care in hospitals; reducing surgical wait times through a central access system for surgical consultation; making more widespread use of a care pathway for patients with respiratory failure; and enhancing screening for cardiovascular disease.

Ongoing collaboration among ministry partners, including the HQCA and AHS, aims to improve how the province measures and reports on patient and client experiences, which helps ensure patient needs are at the centre of health care improvements.

Protecting and improving the quality of health care in Alberta also requires capital investments. The *Budget 2020 Capital Plan* dedicated $2.5 billion over three years for capital investments in health care, including $863 million in 2020-21 for ongoing capital projects like the state-of-the-art Calgary Cancer Centre, the Grande Prairie Regional Hospital, and a number of continuing care capital projects. The plan also included new capital funding for the Alberta Surgical Initiative, the Rural Health Facilities Revitalization Program, renovations of the Peter Lougheed Centre in Calgary, and the Red Deer Regional Hospital Centre Renewal Project. The Northern Laboratory Equipment Upgrade Program provides upgraded and modernized lab equipment to help ensure people living in and around Edmonton and across northern Alberta will continue to have access to state-of-the-art diagnostic and treatment services. All of these new capital projects and programs are underway using capital funding from fiscal year 2020-21. In addition, $110 million was allocated to the capital maintenance and renewal program to allow for the preservation and maintenance of health facilities throughout the province. In the 2020-21 fiscal year, approximately $838 million was spent on health infrastructure and equipment.

2.4 Work with independent providers to develop long-term care and supportive living spaces in community and modernize the continuing care legislative framework to enable more integrated care.

Alberta is facing an increasing demand for facility-based continuing care spaces, due to an aging population combined with the rising prevalence of chronic conditions. Nearly 600,000 people are over the age of 65, and it is likely that more Albertans will need the increasing levels of support offered through home care and in long-term care and designated supportive living facilities to maintain their independence and quality of life.

Budget 2020 included $164 million in capital funding over three years to increase the number of continuing care spaces and upgrade facilities in priority communities across the province, including Indigenous communities, with $45.9 million spent in 2020-21. Government is committed to working with community, non-profit and independent providers to achieve this priority. In September 2020, the ministry identified 31 Alberta communities most in need of new continuing care spaces based on current and projected demand and supply, age of the population, and health care utilization. The identification of priority communities is only the first step in the roll out of the government's continuing care capital approach. It is expected that findings from the facility-based continuing care review will help inform implementation of future continuing care infrastructure decisions and projects.

To extend the operational life of the facilities, help improve residents' standard of living and help mitigate transmission of airborne diseases, $20 million was committed for modernizing selected AHS and AHS subsidiary-owned continuing care facilities through renovations to replace heating, ventilation and air conditioning systems, improve life safety systems or convert multiple occupancy rooms into single occupancy rooms.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
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- The government remains committed to ensuring the province's continuing care system provides Albertans with the services they need to support their quality of life and ability to age with independence and dignity.
- As planned in the Ministry of Health's 2020-23 Business Plan, the government is adding continuing care spaces in priority areas of the province by working with partners to add spaces in existing facilities without capital investment, as well as build new facilities and upgrade existing facility infrastructure.
- In 2020, the government invited the public and interest groups to participate in a review of Alberta's continuing care legislation and facility-based continuing care system. Proposed legislative changes, currently under development, are expected to be introduced in fall 2021.

The province announced several new investments in continuing care infrastructure in 2020-21. In May 2020, government committed $7.1 million to help build a new 75-space, stand-alone continuing care facility in the northwestern community of Hythe. In September 2020, government announced $16.9 million for new seniors housing to provide different levels of care and flexible options for seniors and people with disabilities in the Canmore area. The Bow River Seniors Lodge redevelopment will add 60 new housing units, with the designated supportive living units offering 24-hour on-site nursing care and specialized dementia care. In addition, the government contributed $10 million towards the $28.2 million Covenant Health St. Anne's Haven continuing care project in West Lethbridge. Construction began in November 2020 and the facility is expected to begin welcoming residents in the fall of 2022.

Construction is complete on the Willow Square Continuing Care Centre, addressing a long-time need in Fort McMurray and area. This new, $102 million state-of-the-art continuing care centre has capacity for 108 beds with additional space for 36 more beds to meet future needs. Work continues on the $379 million Gene Zwozdesky Centre at Norwood in Edmonton. The government recently awarded a contract for the new Bridgeland Continuing Care Centre in Calgary. The centre will be a combination of seniors' day programs and continuing care units. The contractors are now on site and expect to complete the project in late 2023. The total approved budget for this project is $130.5 million.

Alberta is also adding more continuing care spaces in existing facilities. This enables the province to add and develop continuing care spaces more quickly and cost-effectively. Expansion of the number of continuing care spaces was initially paused due to pandemic response priorities, but resumed on September 1, 2020, with a call for proposals from new and existing continuing care operators to add publicly funded spaces without additional capital funding. This initiative targeted communities across the province with the most pressing need for new spaces and included adding some immediately available capacity to prepare for the impact of COVID-19 on the acute care hospital system. Next steps for increasing continuing care capacity will be announced in 2021-22.

To ensure legislation continues to meet the needs of Albertans, a review of continuing care legislation was announced in February 2020. The development of new legislation focuses on supporting person-centred care and considers authority and responsibility for ensuring standards of care and services are met. In addition to findings from the facility-based continuing care review mentioned previously, 34 key stakeholders provided written submissions to help inform the development of new continuing care legislation.

2.5 Ensure the sustainability of publicly funded drug benefits to support the most vulnerable by prioritizing treatments that deliver the best health outcomes in the most cost-effective manner, and collaborate with other provinces to achieve more affordable coverage of prescription drugs.

Government spending on prescription drugs is one of the fastest growing costs in the health system, with Alberta spending considerably more on a per capita basis than most provinces.

Effective December 12, 2019, the Alberta government, under the Alberta Biosimilars Initiative, changed the funding of select biologic drugs for patients on provincial government-sponsored drug plans. Affected adult patients (except pregnant women) were advised they must switch to the biosimilar version of higher cost biologic medications, initially by July 1, 2020, which was later extended to January 15, 2021. An exception can be requested by a physician if there is a medical reason that prevents a patient from switching to a biosimilar drug. The initiative is ongoing and as new biosimilar biologic drugs

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- As planned in the Ministry of Health's 2020-23 Business Plan, government is taking action to ensure Albertans have access to cost-effective medications that help achieve optimal health outcomes.
- Alberta is an ongoing participant in the pan-Canadian Pharmaceutical Alliance, which undertakes initiatives aimed at reducing prescription drug costs.
- Alberta's Biosimilars Initiative relies on assessments by subject matter experts to provide critical, evidence-based advice to inform government decisions to move to clinically proven lower-cost alternatives.

are listed on the Alberta Drug Benefit List, patients using the originator brand name biologic will be required to switch to its biosimilar version. The initiative is currently saving an estimated $30 million per year; this is expected to increase to $54 million annually for 2022-23 and 2023-24.

Alberta continues working with other provinces and the federal government to monitor the global drug supply. On March 20, 2020, in response to drug supply issues, which arose due to the COVID-19 pandemic, the Government of Alberta, with support from the Alberta College of Pharmacy and the Alberta Pharmacists' Association, recommended that pharmacies have the discretion to provide a maximum 30-day supply of a medication. This interim measure helped drug manufacturers stabilize supply and meet increased demand. Government recommended relaxing this guidance starting June 15, 2020, to resume filling prescriptions as they normally would. However, for drugs that continue to remain in a critical supply shortage, pharmacies are encouraged to continue to apply their discretion and dispense a 30-day supply when appropriate.

Performance Metrics

Performance Indicator 2.a:
Provincial per capita spending on health care

Category	Prior Years' Results				2020-21[2]
	2016-17	2017-18	2018-19	2019-20 Forecast[1]	
Total - Nominal	$4,963	$5,096	$5,177	$5,151	Not available
Hospitals	$1,982	$1,988	$1,966	$1,926	Not available
Physicians	$1,146	$1,184	$1,203	$1,211	Not available
Drugs	$370	$365	$366	$381	Not available

Source: Canadian Institute for Health Information (CIHI), National Health Expenditure Trends (NHEX), 1975 to 2020; Statistics Canada, Demography Division (population estimates)
Notes: [1]There is a two-year lag in actual results. [2]The 2020-2021 forecast is not available due to COVID-related delays in the typical publication schedule.

This indicator is used to monitor the trend of financial resources used for health care for each person covered by Alberta's publicly funded health care system. The total provincial government per capita spending on health care includes spending by the Ministry of Health, including AHS and health-related spending by other government departments and agencies, and is a gauge of the overall success of cost containment initiatives. The desired result is the provincial per capita spending figure decreasing over time to close the gap between Alberta and comparator provinces of British Columbia (BC), Ontario (ON) and Quebec (QC).

Results Analysis

Government and health system partners, such as health professional colleges and associations, the pan-Canadian Pharmaceutical Alliance and AHS, work together to manage the three biggest health care costs – hospital services, physician compensation, and pharmaceuticals.

The 2019-20 forecast results show per capita provincial government health care spending was reduced in comparison to 2018-19 results. This decrease was the result of reduced Hospital spending; Physician and Drug spending had small increases. The 2020-2021 forecast is not

available from the Canadian Institute for Health Information (CIHI) due to COVID-related data uncertainties and delays.

The results provided in the following table of provincial health care spending show Alberta's total per capita health spending is more than its comparator provinces. Alberta also spends more than these three provinces (ON, BC, QC) on hospitals and physicians, and more than BC and QC on publicly funded pharmaceutical drugs. Alberta would save over $3.2 billion per year if the per capita rate was the average of the combined per capita rates of BC, ON and QC. While CIHI makes significant efforts to use consistent classifications and accounting across jurisdictions, service-level differences still exist, reducing data comparability.

2019-20 Per Capita Provincial Government Health Expenditure (Forecast[1])										
	AB[2]	**BC[2]**	SK[2]	MB[2]	**ON[2]**	**QC[2]**	NB[2]	NS[2]	PEI[2]	NL[2]
Total	**$5,151**	**$4,288**	$4,887	$4,790	**$4,360**	**$4,598**	$4,546	$5,091	$4,988	$6,533
Hospitals	**$1,926**	**$1,634**	$1,814	$1,863	**$1,467**	**$1,646**	$1,963	$2,163	$2,129	$2,551
Physicians	**$1,211**	**$975**	$985	$1,016	**$1,055**	**$929**	$874	$929	$950	$971
Drugs	**$381**	**$207**	$281	$256	**$394**	**$297**	$279	$324	$252	$298

Source: Canadian Institute for Health Information (CIHI), National Health Expenditure Trends (NHEX), 1975 to 2020 Statistics Canada, Demography Division (population estimates.
Notes: [1]There is a two-year lag in actual results. [2]Provinces: Alberta, British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador. **Comparator provinces**: Alberta, British Columbia, Ontario, Quebec**.**

When comparing expenditures with other Canadian provinces, there are opportunities to explore whether similar initiatives used in other provinces can help lower costs in Alberta. Over the past several years, Alberta has improved its efficiency and is seeing the benefits through a flattening of provincial per capita spending on health care and a reduction in the cost gaps with comparator provinces. The AHS Performance Review identified additional opportunities for AHS to reduce costs and improve health outcomes by using hospital resources more efficiently. The ministry is also pursuing opportunities to better align physician compensation arrangements, and, if appropriate align government-sponsored health benefit coverage to that of comparable provinces, as well as continue to reduce drug costs through the work of the pan-Canadian Pharmaceutical Alliance.

Performance Indicator 2.b: Cost of standard hospital stay

Prior Years' Results				2020-21 Actual
2016-17	**2017-18**	**2018-19**	**2019-20**	
$8,034	$8,045	$8,173	$7,992	Not available

Source: Canadian Institute for Health Information (CIHI): Canadian MIS Database (CMDB); Alberta Health Discharge Abstract Database (DAD)

This indicator is used to monitor the cost of a hospital stay after adjusting for differences in the acuity of patients a hospital serves, using nationally calculated adjustments. This standardization allows direct comparison across sites and jurisdictions of how efficiently and effectively acute care hospital services are provided. It does not compare quality or satisfaction for the services delivered.

The desired result is the cost of a standard hospital stay decreasing over time to close the gap between Alberta and comparator provinces.

Results Analysis

The prior years' results indicate that the cost of a standard hospital stay in Alberta has remained consistent around $8,000 for several years.

As shown in the following table, Alberta's hospital stay cost is higher than all other provinces and substantially higher than the comparator provinces of British Columbia (BC), Ontario (ON) and Quebec (QC).

2019-20 Cost of Standard Hospital Stay by Province									
AB[1]	**BC**[1]	SK[1]	MB[1]	**ON**[1]	**QC**[1]	NB[1]	NS[1]	PEI[1]	NL[1]
$7,992	$6,618	$7,493	$6,500	$5,642	$6,304	$5,702	$6,477	$6,687	$6,221

Source: Canadian Institute for Health Information
Notes: [1]Provinces: Alberta, British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador. **Comparator provinces**: Alberta, British Columbia, Ontario, Quebec**.**

When assessing whether Albertans are receiving good value for dollars spent on the publicly funded health system, it is important to also consider quality of care and health outcome indicators. AHS will be taking these factors into consideration when moving forward on implementing initiatives arising from the AHS Performance Review.

Performance Indicator 2.c: Alternate level of care days

Prior Years' Results				2020-21 Actual
2016-17	**2017-18**	**2018-19**	**2019-20**	
15.2%	17.2%	16.2%	15.3%	15.1% (preliminary)

Source: Alberta Health Discharge Abstract Database (DAD)

This indicator is defined as the percentage of all hospital inpatient days when a patient no longer requires the intensity of care in the hospital setting and the patient's care could be provided in an alternate setting in the community. Community settings that better meet the needs of these hospitalized patients include personal residences, continuing care facilities and rehabilitation facilities. The desired result is to decrease the percentage of hospital inpatient days where care could be provided in an alternate setting.

Results Analysis

The preliminary result for 2020-21 (15.1%) shows a modest improvement when compared to results for 2019-20 (15.3%), however, it is significantly lower than the 2017-18 and 2018-19 results (17.2% and 16.2% respectively).

The ministry is committed to reducing the time patients wait in hospital for the appropriate level of care. It is anticipated that Alberta's rate of alternate level of care days will continue to improve as

more continuing care spaces are opened and access to enhanced home care supports in all health zones is improved.

Performance Indicator 2.d: Facility-based beds in community settings

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
77.2%	77.5%	78.2%	78.5%	78.6%

Source: Alberta Health Services

This indicator tracks the percentage of facility-based spaces in a community setting (mental health and addiction, long-term care, designated supportive living and sub-acute care outside of acute care) as a proportion of all spaces (including both community facilities and acute care hospitals). The desired result is to increase the percentage of facility-based beds in a community setting.

Results Analysis

AHS is responsible for implementing operational contracts and annually reporting facility spaces in service. As of March 31, 2021, 78.6 per cent of facility-based spaces are outside of an acute care hospital setting. As shown in the table below, this result represents 31,290 spaces in the community. The percentage of spaces in the community is expected to rise as the government's investments expand capacity across the range of facility-based care available to Albertans.

Number of facility-based beds in community settings as of March 31, 2021		
Type	**2019-20**	**2020-21**
Addiction and Mental Health	2,785	2,840
Long-term care	15,665	15,800
Designated supportive living	11,853	11,916
Community palliative and hospice	256	257
Sub-acute in auxiliary hospitals	472	477
Total	31,031	31,290

Adding new continuing care spaces can reduce the number of people waiting in hospital for an appropriate space and/or decrease the amount of time people spend waiting, thereby improving an individual's quality of life, freeing-up hospital spaces for those who need them, and decreasing overall health system costs. Alberta is committed to ensuring the services provided in facility-based continuing care are responsive and appropriate – that means ensuring a mix between long-term care, designated supportive living and home care. Through the review of Alberta's facility-based continuing care system, the Alberta government is exploring all ways to meet the needs of Albertans who rely on continuing care services while maintaining a strong connection to the broader health care system.

The government is also making progress on adding facility-based addiction and mental health spaces in the community to expand options and increase access to care to support over 4,000 Albertans in their journey to recovery.

Performance Measure 2.e:
Annual rate of change of operational expenditures

Prior Years' Results				2020-21 Target	2020-21 Actual
2016-17	2017-18	2018-19	2019-20		
3.1%	2.7%	3.3%	2.0%[1]	0.0%	-2.8%

Source: Ministry Consolidated Statement of Revenue and Expenses as presented in the Financial Information section of the Ministry of Health Annual Report
Notes: [1]The 2019-20 result has been restated for comparability purposes.

This measure is defined as the year-over-year percentage change in the Ministry Total Expenses per published Statement of Revenue and Expenses, less infrastructure support and pandemic-related costs. It is used to monitor the trend of financial resources used for the Ministry of Health and is an indicator of fiscal sustainability and efficiency of the health system.

Results Analysis

The 2020-21 annual rate of change of operational expenditure was lower by 2.8 per cent. The pandemic created some downward pressure on operational expenditure mainly due to: reduced physician visits resulting in lower physician compensation and development costs; temporary suspension of scheduled surgeries and fewer emergency room visits resulting in lower acute care costs; fewer service hours provided resulting in lower home care costs. The 2020-21 results reflect savings in physician compensation from implementation of the new physician funding framework, as well as savings in publicly funded drug benefit programs from the new Alberta Biosimilars Initiative, expansion of the Maximum Allowable Costing policy, and the March 2020 removal of non-senior dependants from the Seniors Drug program.

The government is committed to improving the efficiency and effectiveness of the health system and supporting Albertans in maintaining their health and wellbeing. This includes implementing recommendations from the AHS Performance Review and examining best practices from other provinces to identify opportunities for improving health outcomes and redirecting savings to front-line services.

Outcome Three: Albertans have increased access to health care professionals and the mix of professionals that best meets their needs.

Key Objectives

3.1 Work with the Alberta Medical Association to manage spending growth and modernize physician funding models to improve quality of patient care and accountability for results.

Government recognizes that Alberta's health care workers are essential partners in the health system, and their foremost concern is the health of their patients. Physicians and their colleagues bring professionalism, deep expertise and compassion to addressing the health needs of Albertans.

After negotiation and consultation between the government and the Alberta Medical Association in 2019-20, the government introduced a new physician funding framework on March 31, 2020. The new framework aimed to avoid projected cost overruns in the physician funding budget, align benefit programs with those of comparable provinces, and improve services for patients. The framework also included the government's 11 consultation proposals based on appropriate patient care and use of the insured services budget. Eight of the proposals moved forward in 2020-21.

Government committed to monitoring the physician funding framework for effectiveness, and adjustments were made in consultation with the Alberta Medical Association to ensure effective patient care. Two initiatives – overhead and clinical stipends – remain under development with implementation expected December 31, 2021. One initiative – changes to the complex modifiers – was cancelled.
In addition, monitoring the physician funding framework provided the government with impetus to cancel the changes to the Business Cost Program; remove the cap on the Rural Remote Northern Program, to support physician recruitment and retention in rural and remote areas; and exempt several services from the daily patient visit cap, such as virtual care Health Service Codes, to ensure patient access.

Despite the pandemic, government continued consultations with the AMA and physicians. The Minister established the Physician Compensation Advisory Committee with physician and public representation, to provide input on the physician funding framework.

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Key Priority:
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- As planned in the Ministry of Health's 2020-23 Business Plan, the government consulted with the Alberta Medical Association and physicians on a physician funding framework.
- On February 26, 2021, government and the Alberta Medical Association announced a tentative agreement. The vote to ratify a tentative agreement was ultimately unsuccessful. Government and the AMA continue to work collaboratively on shared priorities that will improve patient care and also in reaching an agreement.

3.2 Develop and implement modernized, fiscally-sustainable distribution and funding models for health providers that support high quality care and collaborative practice within interdisciplinary team-based environments, including implementing provisions related to practitioner identification numbers to ensure the right number and distribution of physicians across the province.

The ministry collaborates with stakeholders on fiscally-sustainable compensation models for health providers, which support quality of care and collaborative practice, whether health care and advice is delivered virtually or in person. In 2020-21, the government invested over $231 million in Primary Care Networks, which involve physicians and other health care providers supporting delivery of team-based primary care in the community.

The fee-for-service (FFS) model is the most common payment model for physicians in Alberta. The amount paid to the physician for each service or procedure is set out in Alberta's Schedule of Medical Benefits. As part of the response to COVID-19 pandemic, in March 2020, the government released temporary billing codes for doctors providing virtual care. The new billing codes for virtual physician visits became permanent in June 2020. Albertans are able to connect with a doctor over the phone or through a secured video conference to receive medical consultations, assessments and mental health services without having to leave their home.

The ministry also worked with primary health care partners to implement telephone and electronic advice between primary care providers and specialists. The virtual care health service codes are being monitored continuously to evaluate their effectiveness and explore opportunities to enhance provision of care through virtual means.

Alberta and other jurisdictions also use physician compensation models that are different than the FFS model to allow for more comprehensive, patient-centred care, while providing physicians predictable funding. In Alberta these arrangements include Academic or Clinical Alternative Relationship Plans (ARPs), including a Blended Capitation Model (BCM).

A BCM arrangement pays a fee for a bundle of insured services for each person under the regular care of a physician, combined with FFS as necessary, for any additional services provided. Clinical ARPs pay clinicians for delivering a defined set of clinical services to a target population, for example, inner city populations who receive care from physicians participating in the Boyle McCauley Clinical ARP or Indigenous Albertans who receive care from the Indigenous Wellness Clinical ARP.

On March 31, 2020, a clinical ARP was established and later expanded to provide a compensation program for physicians volunteering to be redeployed to provide care to COVID 19 patients, including physicians staffing assessment centres and working in Alberta hospitals in response to the pandemic.

In July 2020, the government passed the *Alberta Health Care Insurance Amendment Act* to increase government's capacity to enter into contractual agreements or establish compensation arrangements with a range of organizations to provide insured health care services to Albertans, including Indigenous community organizations and AHS, as well as corporations. Before these amendments, the government could only enter into agreements or arrangements with physicians to provide insured services to Albertans.

These legislative amendments open up a number of possibilities to help modernize Alberta's health system with innovative arrangements that put Alberta patients and communities at the centre. The payments for physician services include administrative and operational expenses, thereby providing the opportunity to establish more efficient arrangements in new contracts, with fixed

business expenses spread over a broader group of physicians. In time, these arrangements will help the government achieve economies of scale to offset increasing cost pressures for physician services. These amendments will create opportunities for physicians to receive different types of compensation arrangements if they so choose, such as salaries and benefit plans from agreement partners who will take on the administrative and operational responsibilities related to delivering insured services. The goal is to have these new agreements and arrangements ready for fall 2021.

Government is committed to ensuring all Albertans, including those in rural, remote and small communities, have access to strong, publicly funded health services. Physicians are engaged to find ways to improve health care in rural communities and ensure rural Albertans have access to safe and high quality health care. In 2020-21, the government spent $90 million to address rural physician recruitment and retention, ensuring rural doctors are supported financially to remain in their communities. The Rural Remote and Northern Program was improved by removing the cap on the amount that eligible physicians can claim. On-call compensation rates for rural family medicine physicians were also increased. To encourage Albertans from rural communities to return to practice in their home communities, service guarantee agreements will be implemented for medical learners in exchange for financial incentives.

3.3 Improve Albertans' choice of health professionals by increasing access to nurse practitioners and midwives.

Workforce planning encompasses the entire health care workforce to ensure Alberta has the right mix of health professionals who can best meet Albertans' health care needs. The government is working closely with health care delivery stakeholders to manage the supply of current and future health human resources. This includes increasing the number of Nurse Practitioners (NPs) and midwives and lifting barriers that prevent Albertans from accessing services provided by these health professionals.

As of September 30, 2020, there were approximately 718 licensed NPs in Alberta. Post-graduate training enables NPs to assess, diagnose, treat, order diagnostic tests, prescribe medications, make referrals to specialists, and manage overall care. In 2020, the Nursing Homes General Regulation and the Nursing Homes Operation Regulation were modified to enable NPs to work to their full scope of practice to fulfill a primary care role in nursing homes.

Starting in July 2020, in addition to physicians, NPs are also authorized to complete driver medical examination forms, making these exams more accessible for drivers age 75 or older, commercial drivers, and medically-at-risk drivers.

A commitment to add 50 new NP full-time equivalents (FTE) in primary care networks (PCNs) was made in fall of 2019. Planning for the delivery of health services in primary care include the utilization of NPs in a variety of priority areas such as working with patients who do not have a regular primary care provider, participation in the opioid response, cancer screening, and increasing continuity of care. This is evident in the 2020-2023 health zone PCN service plans, which continue to be implemented; however, progress was delayed due to the shift in resource allocation to the COVID-19 pandemic response.

Of the 34 NP FTEs that have been approved for recruitment to date, 21 NP FTEs have been added to PCNs as of March 31, 2021 – this includes eight NP FTEs added in 2021. Thirteen NP FTEs are in various stages of recruitment, and planning is underway to fulfill the original commitment of 50 NPs, by adding the remaining 16 NP FTEs in fiscal year 2021-22.

All midwives in Alberta are contracted by AHS to provide services throughout Alberta. Beginning on April 1, 2020, AHS implemented a new billing structure enabling midwives to direct bill AHS. The

new billing structure provides a more flexible fee payment schedule, which supports more families to receive services. Midwives most often work in a small team of up to four midwives, allowing continuity of care for clients and a work/life balance for midwives.

3.4 Expand scopes of practice of other health professionals, reduce red tape and remove barriers that limit health care providers from working to their full scope of practice.

Regulatory colleges and government work together on expanding scopes of practice to meet patient needs in the context of an evolving health system. When the ministry is considering a proposal to expand the scope of practice for a profession, a detailed investigation to identify associated benefits and risks must be conducted, including consultations with key interest groups, such as the relevant professional colleges. This investigation ultimately helps the government determine the impact a scope expansion may have on both the profession and the entire health system, and in turn informs decisions on proposed regulatory changes.

Over the past year, the ministry explored a number of proposals to expand the scopes of practice of different health professions. Consultations were conducted with interests groups and the feedback is being reviewed to ensure any changes will improve the care Albertans receive. The ministry continues to work with regulatory colleges and interests groups to advance these proposals for decision in 2021-22.

Beginning April 1, 2021, physician assistants will become regulated health care professionals. Requirements include graduation from a program of study for physician assistants approved by the College of Physicians and Surgeons of Alberta, and successful completion of a registration examination approved by the college. Regulating the profession means that physician assistants will adhere to standards for competency, safety and ethics like other regulated health professionals in Alberta. It also enables these health professionals to work to their full scope of practice and allows their skills to be used in a greater capacity within the health system. A physician assistant works under the supervision of a physician and the support provided by a physician assistant frees a physician to spend more time with patients, particularly those with more complex health concerns.

The *Health Statutes Amendment Act, 2020 (No.2)*, which received royal assent on December 9, 2020, included amendments to establish the regulatory framework for health care aides to become a regulated health profession. The Act authorizes the College of Licensed Practical Nurses of Alberta as the governing college for the profession and allows for amendments to the Licensed Practical Nurses Profession Regulation to include the practice of health care aides. Work continues with the College to develop the amendments to establish the regulatory requirements to hold the profession to the same high standards as other health professionals.

3.5 Restructure and modernize the *Health Professions Act* to reduce red tape and improve regulatory effectiveness and efficiency.

Ongoing review of health legislation improves alignment of regulations, standards and legislation with current regulatory best practices, ensuring that regulation of health professionals is responsive to the changing needs of the health care system. In the context of health system legislation, red tape reduction means ensuring regulatory requirements protect the public interest, including health and safety, while not being overly burdensome, and at the same time reducing, where possible, administrative requirements imposed by legislation, regulations and associated policies, forms and guides.

The *Health Professions Act* provides a common regulatory framework for regulated health professions in Alberta. It allows health professions to self-regulate their profession, while being accountable to the government. The Act sets out standard processes for colleges relating to registration, continuing competence, complaints and discipline, and establishing a board that advises the Minister. The *Health Professions Act* now encompasses 29 health professional regulatory colleges, after the Acupuncturist Profession Regulation came into force on December 30, 2020.

In 2020-21, the ministry collaborated with a number of regulatory colleges regarding proposed amendments to standards of practice for their membership to ensure that health care providers are working to the highest standards and accountability. Review of the proposed amendments involves consultation within government and with regulatory colleges, professional associations, insurance providers, AHS, and other parties with an interest in health professional standards.

In 2020, the College and Association of Registered Nurses of Alberta (CARNA) proposed revisions to its Prescribing Standards for Nurse Practitioners standard of practice, and a related standard of practice, Medication Management Standards. The revisions support increased access to care for underserved populations and vulnerable groups, and align to amendments made by Health Canada to the Food and Drug Regulations under the *Controlled Drugs and Substances Act*, effective July 1, 2020. Amendments to the federal food and drug regulations modify restrictions on the health providers authorized to receive prescription drug samples and distribute them to patients. CARNA's council approved the revised Alberta standards in March 2021, thereby allowing NPs to receive prescription drug samples.

The ministry has also been working with the Alberta College of Pharmacy on potential changes to Alberta's Pharmacy and Drug Regulation in order to modernize requirements for licensees and ownership of community pharmacies.

In July 2020, Section 12 of the *Health Professions Act* was amended to give Albertans a stronger voice and greater role in professional oversight by requiring that 50 per cent of the voting members appointed to regulatory college councils, complaint review committees and hearing tribunals be members of the public. This is an increase from the previous requirement of 25 per cent. A series of public member appointments have been made and additional appointments to college councils remains a priority and will be completed as soon as possible.

The *Health Statutes Amendment Act, 2020 (No.2)* made a number of amendments including changes to the *Health Professions Act* to modernize the legislation and reduce red tape to ensure regulatory colleges can be more responsive to changes in the health care system. The amendments pertaining to regulatory colleges require the colleges to undertake significant operational changes, and an implementation plan is under development. Amendments include:

- Separating regulatory colleges from professional associations and allowing for the amalgamation of some smaller colleges; establishment of a public-facing, centralized online registry where Albertans will be able to search for a health provider, rather than having to search multiple websites; and improving colleges' ability to update continuing competence programs;
- Moving common provisions from professional regulations to the *Health Professions Act*, and allowing colleges to make changes via bylaws and standards of practice;
- Enabling colleges to address use of professional titles within standards of practice;
- Moving restricted activities from the *Government Organization Act* to the *Health Professions Act* and developing a restricted activity regulation; and,
- Provision such that the Minister of Health will approve professional regulations.

Performance Metrics

Performance Indicator 3.a:
Percentage of physicians participating in Alternative Relationship Plan payment models

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
13%	13%	13%	13%	13%

Source: Canadian Institute for Health Information (CIHI): National Physician Database (NPDB); Alternative Payment Information File for Alberta

This indicator tracks the percentage of physicians who participate in Alternative Relationship Plans (ARP), which is an arrangement that compensates physicians by a method other than fee-for-service. The intent is to increase the percentage as a way to diversify physician payments and achieve greater cost predictability for both physicians and government, and improve patient care.

Results Analysis

ARP payments as a percentage of total physician payments has remained at 13 per cent over the last five years. The ministry is developing strategies to increase physician interest and participation in ARPs, including streamlined application and approval processes.

Performance Indicator 3.b:
Percentage of Albertans who had access to a regular health care provider

Prior Years' Results				2020-21 Actual
2016	2017	2018	2019	
82.0%	83.6%	83.7%	85.1%	Not Available[1]

Source: Canadian Community Health Survey, Statistics Canada
Notes: [1]The 2020 Survey is expected to be released in the summer of 2021.

This indicator tracks the percentage of Albertans aged 12 or older who participated in the Canadian Community Health Survey and responded that they have a regular health care provider. The survey describes a regular health care provider as one health professional that a person regularly sees or talks to when a person needs care or health advice.

Results Analysis

Prior years' results show a small year-over-year improvement. In 2019, 85.1 per cent of Albertans had access to a regular health provider. Having a regular health care provider is important for early screening, prevention through health and wellness advice, diagnosis, and treatment of a health issue, as well as ensuring good continuity of care and connections to other health and social services. The desired result is to increase the percentage of Albertans who have access to a regular health care provider.

Increasing access to a regular health care provider is consistent with progress towards the following provincial primary health care goals:

- Timely access to appropriate primary care services delivered by a regular health care provider or team;
- Co-ordinated, seamless delivery of primary care services through a patient's "medical home" and integration of primary care with other levels of the health care system;
- Efficient delivery of high-quality, evidence-informed primary care services; and,
- Involvement of Albertans as active partners in their own health and wellness.

Alberta's Primary Care Networks are involved in a variety of initiatives that support provincial and health zone primary care goals, including adopting a "medical home" approach in their practices. This approach strengthens the connection between a patient and regular health care provider to improve access to care, chronic disease prevention and management, continuity of care, and innovations in primary health care including telemedicine and virtual care.

Performance Indicator 3.c:
Percentage of Licensed Practical Nurses relative to Registered Nurses

Prior Years' Results				2020-21 Actual
2016	2017	2018	2019	
36.5%	38%	40.0%	41.6%	Not Available[1]

Source: Canadian Institute for Health Information (CIHI)
Notes: [1]Results are expected to be available in winter 2021.

This indicator measures Licensed Practical Nurses (LPNs) relative to Registered Nurses (RNs), which includes Registered Psychiatric Nurses but excludes Nurse Practitioners. LPNs and RNs are different types of nursing professionals with different scopes of practice that align to their training. Decisions on health workforce employment and utilization are the responsibility of AHS and other employers.

The AHS Performance Review identified opportunities to optimize the skill mix and better leverage the various skill levels of RNs, LPNs and Health Care Aides to ensure efficiency and effectiveness of AHS' complement of nursing staff. The desired result is to increase the percentage of Licensed Practical Nurses relative to Registered Nurses.

Results Analysis

In 2019, 41.6 per cent of all licensed and registered nurses (excluding Nurse Practitioners) in Alberta were LPNs. This is consistent with the annual increase in the percentage of LPNs relative to RNs over the past five years in both Alberta and Ontario, as provided in the table on the right.

Table Legend

Source: Canadian Institute for Health Information (CIHI) Nursing in Canada, 2019 data tables.
Provinces: Alberta, British Columbia, Ontario, Quebec

Percentage of LPNs relative to RNs (Alberta and comparator provinces)				
	AB	BC	ON	QC
2015	34.2%	30.6%	42.6%	41.0%
2016	36.5%	30.1%	45.3%	39.5%
2017	38.0%	29.9%	47.1%	38.7%
2018	40.0%	30.1%	48.8%	38.6%
2019	41.6%	30.2%	50.8%	38.5%

Performance Indicator 3.d:
Percentage of Nurse Practitioners relative to Family Medicine Physicians

Prior Years' Results				2020 Actual
2016	2017	2018	2019	
8.4%	8.7%	9.6%	10.2%	Not Available[1]

Source: Canadian Institute for Health Information (CIHI)
Notes: [1]Results are expected to be available in winter 2021.

This indicator tracks the percentage of Nurse Practitioners (NPs) relative to Family Medicine Physicians. NPs are registered nurses with post-graduate degrees and advanced knowledge and skills. They are trained to assess, diagnose, treat, order diagnostic tests, prescribe medications, make referrals to specialists and manage overall care.

NPs often work closely with physicians and other health professions as part of a team. Some NPs work independently and manage their own clinics. Family medicine physicians include general practitioners, as well as family medicine specialists and emergency family medicine specialists certified by the College of Family Physicians of Canada. The desired result is to increase the percentage of Nurse Practitioners relative to Family Medicine Physicians.

Results Analysis

In 2019, the percentage of NPs relative to Family Medicine Physicians was 10.2 per cent, which is an increase over the previous year and consistent with the four-year trend. Although 2020 results are not yet available, Alberta is making progress on government's commitment, made in fall 2019, to add 50 new NP full-time equivalents (FTE) in primary care networks (PCN).

The government is encouraging an increase in the number of NPs in primary care settings through the PCN NP Support Program. Enabling NPs to provide care in community-based settings helps to achieve the five identified strategic outcomes for primary health care: access to primary health care; safety and quality of care; continuity of care; care transitions; and, person experience and outcomes. The ministry is working with the Nurse Practitioner Association of Alberta to understand implications of funding models on NP recruitment for primary care and to enable optimal NP scope of practice.

Performance Indicator 3.e:
Ambulatory Care Sensitive Condition (ACSC) hospitalization rate

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
360	351	341	330	251 (April – December)

Source: Numerator: Alberta Health Discharge Abstract Database (DAD); Denominator: Alberta Health Population Estimate
Notes: [1] Result for 2019-20 is updated.

This indicator measures the number of people (under 75 years of age) per 100,000 population who were hospitalized for health conditions known as ambulatory care sensitive conditions (ACSC), which include: grand mal status and other epileptic convulsions; chronic obstructive pulmonary

diseases; asthma; heart failure and pulmonary edema; hypertension; angina; and, diabetes. The desired result is to reduce the ACSC hospitalization rate.

Results Analysis

In 2020-21, preliminary results indicate 251 people (under 75 years of age) per 100,000 population were hospitalized for health conditions that are routinely treated outside of a hospital inpatient setting by a range of health professionals. This represents an improvement when compared to the 2019-20 result of 330 people per 100,000 population and continues the steady improvement shown over the past five years. The significant drop in hospital rates in 2020-21 when compared to 2019-20 is due in large part to lower utilization of inpatient services during the COVID-19 pandemic period. The number of overall inpatient discharges from March to December 2020 was 275,768, which is 36,636 fewer than the same period in 2019.

To enable interprovincial comparison, the Canadian Institute for Health Information (CIHI) uses a slightly different population estimate and resident criteria than Alberta. According to CIHI's most recent results the ACSC hospital rate in Alberta in 2019-20 was 312 hospitalizations per 100,000, which is slightly better than the national rate of 316 hospitalizations per 100,000. Among other provinces, British Columbia had the lowest rate in 2019-20 at 274 per 100,000, while Saskatchewan had the highest rate at 460 per 100,000.

While not all hospital admissions for ambulatory care sensitive conditions are avoidable, it is assumed that appropriate primary care could help prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. Optimizing management of these health conditions in the community, including primary health care settings, and support for people in managing their health conditions can contribute to both improved patient outcomes and reduced health care costs.

The ministry continues to focus on increasing access to care in the community and developing a coordinated approach across the continuum of care, to help people prevent and manage chronic health conditions and diseases and improve their quality of life. The ministry is working collaboratively with community partners to coordinate the planning and delivery of supports and services across the province in all AHS health zones. In addition, Alberta's Strategic Clinical Networks focus on specific areas of health such as cardiovascular health and stroke; diabetes, obesity and nutrition; and respiratory health, to implement clinical best practices and ensure consistent care across the province.

Outcome Four: Albertans are supported by accessible and coordinated mental health and addiction services and supports

Key Objectives

4.1 Informed by advice from the Mental Health and Addiction Advisory Council, develop and implement a new mental health and addictions strategy to improve access to recovery-oriented services.

Addiction and mental health services may be clinical or non-clinical. These services are delivered in various settings by a mix of public and private service providers – funded by government, philanthropic organizations, and by individuals through user fees in non-publicly funded sites or private insurance.

The government recognizes the COVID-19 pandemic is both a health and social crisis, and efforts are aimed at addressing both the immediate and long-term effects on the physical and mental health of Albertans. The government's addiction and mental health response involves multiple ministries and community partners to help people and communities meet their everyday emotional, psychological and social needs. Actions to support the transition to long-term recovery for those impacted by the COVID-19 pandemic will be integrated into Alberta's plan to establish a coordinated, recovery-oriented continuum of supports.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
Delivering sustainable, high quality, patient-centred health care for all Albertans

- As planned in the Ministry of Health's 2020-23 Business Plan, a report from the Mental Health and Addiction Advisory Council, which was delayed due to the pandemic, will be ready for release in the coming months.
- Recommendations from the report will inform government's next steps and provide a framework for transformative change to create a coordinated, recovery-oriented continuum of supports for people at risk of or suffering from addiction and mental health challenges.

Alberta's *Mental Health Services Protection Act* provides a foundation to ensure safe, quality addiction and mental health care. The Act requires that residential addiction treatment service providers are licensed by the province and outlines core requirements that must be met. In July 2020, the government implemented specific operational and outbreak standards for residential addiction treatment service facilities to help limit the spread of the COVID-19 virus, while allowing individuals to continue to receive treatment and overcome their addiction. This is in addition to ensuring mutual support groups, like Alcoholics Anonymous and Narcotics Anonymous, could continue as essential services during the pandemic.

In July 2019, a ruling by the Alberta Court of Queen's Bench found some sections of the *Mental Health Act* to be unconstitutional or incomplete. Following the court's decision, government launched a public engagement initiative to gather feedback to inform changes to the Act. The government passed the *Mental Health Amendment Ac*t in 2020.

Alberta's *Mental Health Act* allows for individuals with serious mental health disorders to be involuntarily detained in a designated facility for treatment or to receive mandatory treatment in the community. To address the court's ruling, the amendments change the definition of mental disorder so that only individuals who require and would benefit from mental health care can be detained. To safeguard patients' rights, amendments require hospitals to provide free and timely

access to medical records, and information about legal counsel and the Mental Health Patient Advocate. Facilities are also required to review forms more promptly, so patients are fully informed about why they are detained. Patients staying in a hospital for more than 30 days must be provided with a treatment plan, including criteria for release, so they know what to expect.

Other key changes in the amendment act include: updated criteria for admission to a designated facility for treatment or to receive mandatory treatment in the community; provisions allowing better access to care, including videoconferencing; cutting red tape by adjusting rules, including Mental Health Review Panel processes such as allowing patients more time to appeal a panel's decision; and expanding the role of the Mental Health Patient Advocate to better assist people. Further details of the amendment act are available at alberta.ca/strengthening-mental-health-care.aspx. Some amendments took effect upon royal assent on June 26, 2020, while the majority of changes came into force upon proclamation on September 30, 2020.

4.2 Expand access to a continuum of mental health and addiction services to provide a range of appropriate supports for individuals, families and communities.

Addiction and mental health supports are an important part of Alberta's health care system. Government is committed to expanding access to services across the province, and took action this past year to support Albertans in a variety of ways.

In April 2020, government committed $53.4 million for increased online, phone and in-person mental health and addiction recovery supports to make it easier for Albertans to access services from anywhere in Alberta during and after the COVID-19 pandemic. This included $21.4 million to improve access to phone and online supports with existing helplines, such as the Addiction Helpline and the Mental Health Helpline.

Alberta 211, a helpline that provides information and referrals to mental health and addiction services, was expanded provincewide in June 2020, which was ahead of schedule. Government funding is also supporting the work of Alberta 211 and its partners to develop a digital navigation and crisis support hub that will provide system navigation and seamless transfers to help lines such as local crisis lines in Edmonton and Calgary, Kids Help Phone, the family violence information line, and other phone and digital crisis supports. This work is progressing, but some aspects of hub development have been delayed, as partners focus on addressing significant increases in service demand stemming from the pandemic.

As part of overall funding, the government also committed $2.6 million to expand individual and group treatment to address family violence services for Indigenous, rural, and remote communities; $4.2 million to expand the addiction and mental health support available through Primary Care Networks; and $25 million for a new community grant program. This new grant program will enhance community mental health and addiction recovery supports for Albertans by providing funding for a total of 231 community projects, including projects for Indigenous communities, seniors, youth, and cultural groups who are negatively impacted by the pandemic.

Aside from pandemic-specific funding, government committed $500,000 to provide additional mental health supports to residents of northern Alberta who were affected by flooding that took place in May 2020. Funding enables qualified staff to provide psychiatric, nursing and social work support, as well as support recovery from addiction in Fort McMurray. Addiction and mental health staffing was also increased in Fort Vermilion to support residents.

The Government of Alberta continues to monitor suicide rates across the province during the pandemic in an effort to respond to the needs of citizens. Direct correlation between COVID-19 and provincial suicide rates is unclear. It does not appear that the pandemic has increased suicide

levels, however, investigations by the Office of the Chief Medical Examiner take time to complete and, as new information is available, these statistics can change. In 2020, there were a number of deaths by suicide in Medicine Hat, which presented a unique situation as a cluster of individuals known to each other contributed to this number. In 2020, the suicide rate in Medicine Hat was 15.9 per 100,000 as compared to a rate of 11.9 per 100,000 in the South Zone and 13.5 per 100,000 for the province as a whole. The cluster phenomenon is not new, and does take place from time to time in localized areas, requiring a targeted response. In response, the Canadian Mental Health Association Alberta Southeast Division received more than $220,000 from the Alberta government to support timely access to quality suicide prevention information, and awareness and training programs. As part of this funding, a variety of initiatives and resources for adults, youth and children are offered including Buddy Up, a suicide prevention campaign that encourages men to help each other and access services if they need them. As well, families already accessing bereavement supports through private counselling will receive support to continue accessing these services.

Government funding continued to support implementation of 12 community-based integrated mental health youth hubs, which are available through a combination of online and physical locations. These youth hubs provide support for youth aged 11-24 to access primary health care, addiction and mental health services, and community supports. These spaces and services, both physical and virtual, are designed to be youth-friendly and improve access to prevention and early intervention supports, and treatment and recovery services as required. The hub sites are at various stages of implementation and have had to make modifications due to pandemic impacts, such as initiating soft launches of youth hub services and shifting existing services to an online platform. All sites continue to make progress. In addition, government committed funding to support further development of six of these sites to become sites of excellence. This funding will also support a collaborative provincial governance structure for youth hubs, as well as research and evaluation of hub implementation to guide improvement. It is anticipated that the governance structure will be in place by early summer 2021.

In 2018, the government committed $15 million over three years ($5 million per year) through AHS to fund Honouring Life: Indigenous Youth Suicide Prevention – Aboriginal Youth and Communities Empowerment Strategy. As of December 2020, 49 communities/organizations were funded – comprised of First Nations communities (47 per cent), Metis Settlements (17 per cent), friendship centres (13 per cent) and other Indigenous organizations (23 per cent). This funding supports community capacity building to support youth health and well-being, including programs aimed at suicide prevention, life promotion, mental wellness, work experience, educational achievement, substance misuse, violence, and healthy lifestyle choices.

The provincial government also committed more than $3.4 million in 2020-21 to support Indigenous Albertans and communities to establish addiction and mental health services such as detox and addiction treatment, corrections transition, assessment of community opioid response needs and response planning, and equitable access initiatives. Using this funding, the Blood Tribe expanded safe withdrawal management site capacity from six beds to 24; the Aseniwuche Winewak Nation of Canada identified gaps in service that could hinder their clients in succeeding in recovery; and the Métis Nation of Alberta Association hired a community wellness advocate to support client navigation and links to services and supports.

4.3 Develop and implement balanced, compassionate opioid response strategies that support increased access to opioid treatment and recovery services for individuals and their families, including incorporating findings from the Supervised Consumption Services Review Committee into a full continuum of care.

Opioid use disorder remains a major challenge for Alberta and for the people it impacts. The government committed $40 million over four years to respond to the opioid crisis and support treatment and recovery services. This work includes the development and implementation of balanced and compassionate opioid response strategies, which support increased access to evidence-based treatment and recovery services for individuals and appropriate oversights to ensure the safety and protection of vulnerable people and the public.

In June 2020, the government committed an additional $1 million per year to expand access to the Virtual Opioid Dependency Program. The program uses telehealth technology to allow Albertans to access treatment on demand for opioid use disorder, as well as addiction counselling and other supports, including transitional services. Between April 1, 2020, and December 31, 2020, the program initiated 1,448 clients in treatment; accepted 1,842 clients transitioning from another care setting; transitioned 280 clients to other long-term settings; provided 888 same day (emergency) starts; and maintained treatment for 99 clients, while working to transition them to a physician in their local or home community.

In July 2020, the government announced $25 million to support the construction of recovery communities, which will play a critical role in supporting the health, wellness and long-term recovery of Albertans. Recovery communities, also known as therapeutic communities, are a form of long-term residential treatment for addiction, used in more than 65 countries around the world.

In addition, the government eliminated the $40-per-day user fee to access publicly funded residential addiction treatment, allowing more Albertans to receive the care they need without the barrier of cost.

The Alberta government also provided an additional $2 million per year to enhance the provision of additional psychosocial supports at AHS opioid dependency program clinics. These supports will allow clients to start to treat the social or psychological roots of addiction, in addition to receiving opioid agonist therapy (OAT), which helps manage withdrawal symptoms and provides other health benefits. An OAT Gap Coverage program was implemented in June 2020. The program covers the costs of medications to treat opioid use disorder for Albertans who are waiting to receive coverage through a supplementary health benefit plan. The program will cover the costs of medication for up to 120 days, which supports an Albertan while they apply for and receive supplementary health benefits to cover the ongoing costs.

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
Delivering sustainable, high quality, patient-centred health care for all Albertans

- As planned in the Ministry of Health's 2020-23 Business Plan, the government is focused on improving access for Albertans to recovery-oriented treatment and supports.
- In 2020-21, the government provided funding for: expanded access to the Virtual Opioid Dependency Program; enhanced psychosocial supports at AHS Opioid Dependency clinics; an Opioid Agonist Therapy Gap Coverage program; removal of the user fee for publicly funded residential addiction treatment; and establishment of two new overdose prevention sites – in Lethbridge and a temporary site in the Edmonton Convention Centre shelter.

The work of the Supervised Consumption Services Review Committee, in 2019-20, focused on engaging with Albertans to better understand the socio-economic impacts of supervised consumption sites on Alberta communities. The Committee also provided advice for how to mitigate these concerns. In 2020-21, the ministry began assessing each of the province's supervised consumption sites and overdose prevention sites to develop a plan to implement changes aimed at reducing negative socio-economic concerns, as well as improving the consistency and quality of services.

In August 2020, a new mobile overdose prevention site was established in Lethbridge, replacing the previous site in that city, while ensuring a seamless transition of services for clients. The new site, operated by AHS, is located outside the Alpha House Stabilization Centre and Shelter, which partners with the overdose prevention site to provide wrap-around supports to clients and facilitate referrals to other health and social services. In November 2020, a new temporary overdose prevention site was established at the Edmonton Convention Centre in association with the temporary Tipinawâw shelter to reduce the risk of overdose for shelter users. Between November 2020 and March 2021, the site, operated by Boyle Street Community Services, saw 7,496 visits from an average of 194 unique clients per month, and managed 124 drug related adverse events on site. The Edmonton Convention Centre shelter was closed on April 30, 2021.

Providing transparent and comprehensive data helps give a broad perspective on substance use in Alberta, supporting recovery-oriented care for Albertans experiencing addiction, and community planning. In December 2020, government launched the new online Alberta Substance Use Surveillance System, which provides up-to-date substance use data and is the most detailed and comprehensive reporting system in Canada. It replaces quarterly reporting, and helps the government make informed, strategic decisions about how best to support individuals needing to enter recovery. This online tool is available at alberta.ca/substance-use-surveillance-data.aspx.

During a particularly challenging year of overdose deaths, analysis of data indicated that a large portion of individuals who were dying due to overdose were doing so while in their own place of residence, a trend that has occurred since 2017. Work on an online tool to support this population called the Digital Overdose Response System, is underway, and aims to provide a solution for people who are not currently accessing existing measures, such as supervised consumption services. This tool is a critical component to Alberta's opioid response and will be launched in Calgary in summer 2021, with spread and scale to other parts of the province being informed by testing throughout the launch phase.

Performance Metrics

Performance Measure 4.a:
Unplanned mental health readmissions to hospital

Prior Years' Results				2020-21 Target	2020-21 Actual
2016-17	2017-18	2018-19	2019-20		
9.8%[1] (8.8%)[2]	9.6%[1] (8.8%)[2]	10.7%[1] (9.8%)[2]	10.7%[1] (11.4 %)[2]	(8.8%)[3]	11.8%[1] (April – December)

Source: Alberta Health Discharge Abstract Database (DAD)
Notes: [1]Prior years' results and 2020-21 results were calculated using new methodology adopted by the Canadian Institute for Health Information(CIHI). CIHI's new methodology expands the inclusion criteria to patients of any age discharged from acute care hospitals or psychiatric hospitals, whereas previously the patient population included only those aged 15 years or older discharged from acute care hospitals. This change reflects the increasing numbers of children and youth diagnosed with mental health issues

requiring hospitalization. [2]Prior years' results shown in brackets were calculated using previous methodology. [3]The 2020-21 target, was based on the previous methodology. Targets will be updated going forward.

This measure represents the proportion of non-elective (unplanned) readmissions to an acute care hospital in Alberta for selected mental illness within 30 days of a patient being discharged from a hospital stay for their mental illness. The measure excludes patients who have mental health disorders that require scheduled follow-up care.

Visits to facilities and programs not designated as acute inpatient care facilities (e.g., hospital emergency departments, urgent care centres, community clinics) are not included. The selected mental illnesses include substance use disorders; schizophrenia, delusional and non-organic psychotic disorders; mood/affective disorders; anxiety disorders; and disorders of adult personality and behavior.

Results Analysis

Available results for 2020-21 (April 1 – December 31, 2020) show that 11.8 per cent of those patients previously discharged from a hospital stay for mental illness had an unplanned mental health readmission within 30 days. This is higher than the results for each of the previous four years.

Unplanned readmissions within 30 days for mental health patients is used as an indicator of continuity of care and accessibility of care in the community. It should be noted, however, that readmission may involve other external factors including the nature of the population served by the facility and the nature of addiction and mental health issues. Frequent hospitalizations may be an indication there are challenges with appropriateness of care, medication access and use, and community supports. Readmissions may indicate a lack of follow-up care or transition to care in the community.

While not all readmissions can be avoided, monitoring readmissions can assist in planning appropriate follow-up care after hospitalization. Hospital care for people diagnosed with a mental illness typically aims to stabilize acute symptoms. Once stabilized the individual can be discharged, and subsequent care and support to prevent relapse or complications are offered through primary care and outpatient and community programs.

The government is committed to improving care in the community, so Albertans have access to services closer to home. Going forward, government will develop a recovery-oriented approach to addressing the addiction and mental health related needs of Albertans, which will improve access to care and continuity of care.

Performance Indicator 4.b:
Percentage of mental health emergency department visits with no mental health service in previous two years

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
28.7%	27.5%	26.2%	25.9%	24.8% (preliminary)

Source: Alberta Health Discharge Abstract Database (DAD); Alberta's physician claims database; Alberta Ambulatory Care Reporting System (AACRS); Provincial Population Registry

This indicator tracks the percentage of mental health/addiction-related emergency department (ED) visits where the patient had received no mental health/addiction services from a physician, or in a hospital or emergency department in the past two years. The desired result is a lower percentage.

Results Analysis

The preliminary result for 2020-21 shows that about a quarter of mental health ED visits (24.8%) were patients who had not received mental health/addiction services from either a physician, hospital, or emergency department in the past two years. This is a modest improvement compared to 2019-20 (25.9%), and is consistent with the improvement over the past four years.

First identification of a mental health issue in the emergency department may indicate a lack of access to services available in the community, especially early intervention and screening. The government is investing in initiatives to improve access to a range of addiction and mental health services and supports in the community.

Implementation of actions related to a new recovery-oriented provincial approach to address addiction and mental health issues will support continued improvement in this indicator, by ensuring Albertans experiencing a mental health issue have options other than emergency departments to help them improve their mental health. Initiatives to improve early identification and treatment include improving the capacity of primary care teams to assess and respond to addiction and mental health concerns within their practice. The government invested an additional $1.6 million into capacity building and training in 2020-21. The Mental Health Helpline was expanded in 2020-21 and continues to offer referrals to services.

Performance Indicator 4.c:
Number of emergency department visits due to alcohol or opioid use, per 100,000 population

Substance	Prior Years' Results				2020-21 Actual
	2016-17	2017-18	2018-19	2019-20	
Alcohol	948	936	940	926	765 (preliminary)
Opioids	184	209	213	190	198 (preliminary)

Source: Alberta Ambulatory Care database; Alberta Health Care Insurance Plan, End of Fiscal-Year (March 31) Adjusted Population Registry Files Statistics Canada; Canadian population, 2011

This indicator provides the number of visits to emergency departments (EDs) and urgent care centres related to use of alcohol and opioids per 100,000 population. The desired result is to decrease the number of emergency department visits due to alcohol or opioid use.

Results Analysis

The preliminary 2020-21 result (765 per 100,000 population) for ED/urgent care centre visits due to alcohol shows a significant improvement when compared to the 2019-20 result (926 per 100,000). However, it should be noted that the 2020-21 results are preliminary and are subject to change. The age group with the greatest per cent decrease in alcohol-related ED visits

from 2019-20 to 2020-21 was among 13 to 19 years, where ED visits decreased by 26 per cent (1,655 to 1,220 visits). The Ministry of Health and the Alberta Gaming, Liquor and Cannabis agency work collaboratively to implement the province's Alcohol Strategy, which aims to prevent and reduce alcohol-related harm by developing a culture of moderation. The issue of alcohol use is complex and misuse impacts costs associated with health care, criminal justice and lost productivity.

The preliminary 2020-21 result (198 per 100,000 population) for ED/urgent care centre visits due to opioid use are higher compared to the 2019-20 (190 per 100,000) and 2016-17 (184 per 100,000) results. These preliminary 2020-21 results reflect the ongoing challenge to find ways to best support those experiencing opioid use disorder.

Emergency department visits were lower overall in 2020 compared to 2019, and the COVID-19 pandemic was likely a major factor. From April to December of 2020, there were 1,296,558 ED visits compared to 1,768,995 during the same nine months in 2019, a decrease of more than 472,000 visits. It is unclear whether the pandemic had an impact on ED visits due to substance use.

Emergency department clinicians use a standardized and consistent evidence-based care pathway to ensure patients receive the best treatment required for their condition. Albertans can receive help through the Addiction Helpline (1-866-332-2322), a toll free, confidential service that provides support for those experiencing problems with alcohol, tobacco, other drugs, or gambling – including information and referral to services. The government is committed to improving access to a range of addiction and mental health services and supports.

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

Key Objectives

5.1 Prevent chronic conditions, injuries and infections by developing policies that reduce risk from environmental and individual risk factors.

The government protects the health and safety of Albertans by maintaining regulations, standards and guidelines for infection prevention and control, and environmental public health, including food safety, safe drinking water, recreational water, and personal services. Government is also responsible for implementing emergency response and recovery programs related to environmental public health. This includes the ongoing implementation of the Horse River Wildfire Environmental Public Health Recovery Monitoring Plan, which supports recovery from the 2016 Fort McMurray fire.

In 2020-21, the government maintained and updated online environmental public health data, as well as information to help Albertans reduce their exposure to risks. Examples include the "Should I Eat This Fish?" app and the Alberta Environmental Public Health Information Network website - /aephin.alberta.ca/. The Network serves as a hub for ongoing collection, integration, analysis, interpretation, and dissemination of environmental health and public health data and information.

The government spent over $672 million on population and public health initiatives in 2020-21, excluding pandemic response costs. This included funding for prevention of sexually transmitted and blood borne infections; prevention of injuries including falls, concussions and motor vehicle events; assistance for vulnerable pregnant and reproductive age women to access health and social supports; and comprehensive prevention initiatives to reduce the incidence of cancer in Alberta.

AHS public health programs provide health promotion as well as disease and injury prevention programs to individuals, high-risk groups and the broader community. Online resources provided by AHS and Alberta-based partner organizations are available at myhealth.alberta.ca/.

Chronic disease management (CDM) is an organized, proactive, multi-component, patient-centred approach to health care delivery that involves an integrated and coordinated system of supports. Implementation of CDM activities is shared between government and partners responsible for program delivery, including AHS, Primary Care Networks and individual clinicians.
In March 2020-21, the Provincial Primary Care Network Committee endorsed a set of recommendations for consideration by AHS and Primary Care Networks (PCNs). The recommendations were developed by a broad group of content experts and included patient representation. The recommendations will be actioned by Zone PCN Committees and AHS over the next five years, and are intended to support an integrated approach to chronic condition and disease prevention and management, so that individuals, families and communities in Alberta are supported to be as healthy as they can be.

To help support Albertans with diabetes, the government conducted a Health Technology Assessment in collaboration with the University of Calgary to review the clinical effectiveness and cost-effectiveness of several newer diabetes management technologies, including Continuous Glucose Monitors and Flash Glucose Monitors. An Expert Advisory Group, made up of clinicians and experts in diabetes management, provided feedback on the results of the assessment and government is currently considering the most suitable evidence-supported options to provide to Albertans.

Cancer prevention continues to be a government priority. Continued investments in cancer research aim to reduce the incidence and mortality from cancer. In 2020-21, $5.3 million was spent on cancer research projects, including two new projects related to developing an accelerated cancer diagnosis program, including optimizing follow-up times for colonoscopy tests and fecal immunochemical (FIT) tests, to support timely colon cancer screening. Continued support was also provided to Alberta's Tomorrow Project, which tracks the health status of participating Albertans to identify lifestyle and other factors that increase the risk of cancer and other chronic diseases, including the long-term effects of COVID-19.

In addition to research funding, approximately $20 million was provided in 2020-21 to support cancer prevention and screening initiatives to help reduce risk factors associated with cancer and other chronic disease. For example, projects supported Indigenous communities by increasing capacity to evaluate community risk factors and develop ways to support healthy living in their local areas. The government is also supporting a two-year research pilot program designed to improve access to cancer screening by including colon and cervical cancer screening techniques in a Mobile Mammography Unit. The pilot program will be assessed following its completion in 2022.

5.2 Develop strategies and strengthen legislation to help prevent and reduce the harms of tobacco, tobacco-like products and vaping.

In May 2020, the government released a report summarizing input received regarding the *Tobacco and Smoking Reduction Act*. The report, entitled "What we heard: Tobacco and Smoking Reduction Act review", is available at open.alberta.ca/publications. The public engagement took place from October 25 to December 4, 2019, and involved approximately 250 people in 41 consultation sessions and 9,628 online survey respondents. Highlights of participant responses included concern about the high rates of youth vaping in Alberta, and interest in establishing a provincial minimum age for vaping, and implementing photo ID requirements. Nearly 80 per cent of respondents agreed (or strongly agreed) that vaping should be prohibited anywhere smoking tobacco is prohibited, and 81 per cent believed that advertisements or promotion of vaping products should be prohibited in retail stores (which is the same as the restriction for tobacco products).

Government passed the *Tobacco and Smoking Reduction Amendment Act*, *2020*, in June 2020. The Act, which will be renamed the *Tobacco, Smoking and Vaping Reduction Act* after proclamation of the amendments, is available on the Alberta Queen's Printer website at qp.alberta.ca/. When proclaimed, the amendments will add enforceable restrictions on the possession, promotion, display, sale and use of vaping products, in alignment with tobacco laws. In addition, the amendments will introduce fines for violations of the new tobacco and vaping rules, prevent sales of tobacco and vaping products in vending machines and temporary locations, and expand the number of smoke-free and vape-free areas, especially at places frequented by children and youth. The government is continuing to work on additional initiatives to prevent and reduce the harms of tobacco and vaping products, such as reviewing specified penalties for violations of retailer vaping regulations.

5.3 Safeguard Albertans from communicable diseases through initiatives aimed at decreasing sexually transmitted and blood-borne infections, including syphilis and through immunization for vaccine-preventable diseases, such as influenza and measles.

Immunization helps individuals develop immunity to those infectious pathogens (bacteria and viruses) that can cause severe disease and death. Immunization is one of the world's most successful and cost-effective mechanisms for preventing disease and protecting the health of the population.

As part of Alberta's pandemic response, the Ministry of Health is responsible for implementation of the province's COVID-19 Immunization Program, ensuring the ethical, timely and effective distribution of vaccines across Alberta. Early indications that initial supplies of vaccines would be limited meant fostering a strong collaborative approach and identifying key populations for initial immunization. Alberta's COVID-19 Immunization Coordination Committee includes representatives from AHS; Indigenous Services Canada; the Alberta College of Pharmacy; the Alberta Pharmacists' Association; and physician representatives from primary care networks, the Alberta Medical Association and the provincial Indigenous Health Hub of AHS.

The government's COVID-19 Immunization Program was developed using many key information sources, including Alberta's Immunization Policy and guidance documents, Alberta's Pandemic Plan and Influenza Policy, and advice from Alberta Advisory Committee on Immunization. Guidance provided from the National Advisory Committee on Immunization, Canada's COVID-19 Immunization Plan and other federal planning documents were also considered during the development of the Alberta COVID-19 Immunization Program Plan.

Following the approval of the Pfizer vaccine by Health Canada on December 9, 2020, the first doses arrived in Alberta in mid-December and were administered soon after to health care workers crucial to supporting vulnerable Albertans and caring for critically ill patients. Following approval of the Moderna vaccine by Health Canada on December 23, 2020, its roll out began in late December to residents of long-term care facilities and designated supportive living facilities, including six First Nations sites, and First Nations and Métis peoples aged 65 years or older. A phased roll out to more Albertans continued from January to March, 2021, targeting all Albertans over the age of 65, workers who support those in seniors' residences, health care workers in acute care settings and First Nations, Métis and Inuit over the age of 50.

On March 3, 2021, Alberta extended the period between first and second doses of COVID-19 vaccine for first appointments booked after March 10, 2021. The 16-week timeline for second doses brought Alberta in line with British Columbia and other jurisdictions. As of March 31, 2021, 533,699 Albertans had received their first dose of two doses of vaccine required and 101,298 Albertans had been fully vaccinated with two doses.

Beginning in October each year, the government continues to offer, free of charge, annual influenza immunizations to Albertans six months of age or older. The influenza immunization program has many partners, including pharmacists and physicians, to increase the accessibility of influenza vaccine. AHS and most immunization partners moved to an appointment-based model to accommodate COVID-19 public health measures. For the 2020-21 influenza season, AHS focused its influenza immunization service delivery on children under five years of age and their families to ensure necessary resources were allocated to support the ongoing COVID-19 pandemic response.

The influenza immunization program, combined with the public health measures to help reduce transmission of COVID-19 (wearing a mask, physical distancing, washing hands frequently), likely contributed to Alberta not recording any lab-confirmed cases of influenza as of March 31, 2021. Results of the influenza immunization program for high-risk groups, specifically seniors (aged 65 or older) and residents of long-term care facilities are given under performance metric 5.a.

Immunization to prevent measles is part of the routine childhood immunization program in Alberta. Measles is one of the vaccine-preventable diseases of highest priority for government. It is highly contagious and can result in serious complications, particularly in young children. When a measles case is confirmed, case and contact follow-up is required. Results for the childhood immunization program are provided under performance metric 5.b.

Over the past number of years, sexually transmitted infections, such as chlamydia, gonorrhea, and syphilis have been an ongoing public health concern in Alberta. Alberta's Chief Medical Officer of Health declared a provincial syphilis outbreak in July 2019, due to a rapid increase in syphilis cases. Government released the "Alberta Sexually Transmitted Infections and HIV 2019" report in July 2020. The report, which is available at open.alberta.ca/publications, shows that while chlamydia and HIV have stayed stable, gonorrhea and infectious syphilis rates continue to increase and are at outbreak levels. Work is underway to enhance prenatal, infectious, and congenital syphilis case management, including testing and treatment.

Government funding for sexually transmitted and blood borne infection (STBBI) services dates back to the 1990s as a response to the HIV epidemic. Since then, services and programs have evolved and expanded from primarily HIV prevention and care to a broader spectrum of STBBI-related issues, including prevention, education, health promotion, support for continued care, and linkage to mainstream health and social services. To reflect this broader scope, in January 2021 a call for proposals for STBBI prevention and wrap-around supports was circulated to over 250 STBBI interest groups and other community-based organizations involved in similar work. Funded services will be focused on a continuum of care to address syphilis, HIV, Hepatitis C, and other STBBI.

Specifically, government funded activities may include: prevention and control services (sexual health education, distribution of safer sex supplies, prevention messaging and education, and referrals to addiction services as appropriate); stigma awareness; provider education; access or referral to STBBI testing and treatment services; referrals to other health and social services; individual, group and peer led STBBI counselling; and other services to support people living with STBBI.

The call for proposals for STBBI prevention and wrap-around supports resulted in six applications for grant funding within Alberta's five geographical health zones. Five applications were accepted – two in the North Zone and one each in the Edmonton, Central and Calgary Zones. Services for the South Zone are being transitioned to AHS.

5.4 Improve the health and well-being of women and children by supporting initiatives that foster maternal-infant health and early childhood development.

Maternal, infant and child health care is delivered by physicians, midwives and AHS, either through facilities or through specific programs. Maternal-infant health initiatives foster healthy birth outcomes, including healthy birth weights, Fetal Alcohol Spectrum Disorder prevention, and support for overall maternal and infant health. In 2020-21, Alberta invested over $2 million on six programs that support vulnerable pregnant women in accessing prenatal care (also known as antenatal care) and other health, social and cultural supports.

The Maternal Newborn Child & Youth Strategic Clinical Network supports various initiatives including the antenatal care pathway, and providing clinicians, particularly in rural communities with up-to-date information, standards of care and decision-making tools. In December 2020, the syphilis subsection of Alberta's antenatal care pathway was updated to support early identification and treatment of pregnant patients with syphilis to prevent transmission of this infection to their baby. Preventing congenital syphilis avoids severe consequences for the baby, such as hydrocephalus, sensorineural hearing loss, musculoskeletal deformity, learning challenges, or death.

Future work of this Strategic Clinic Network will focus on developing and implementing standardized pregnancy pathways, identifying strategies to improve access to perinatal care (before and after birth) for rural and remote communities and marginalized populations, and

facilitating care of obstetrical and neonatal patients in the most appropriate health care setting, according to the level of presenting risk.

5.5 Engage with Indigenous communities and the federal government to improve access for Indigenous Albertans to high quality health services that support improved health outcomes.

The Alberta government is responsible for providing publicly funded health care and services for all Albertans, including First Nations, Métis, and Inuit. In addition, the federal government provides specific programs and services for on-reserve First Nations.

The Alberta government recognizes that Indigenous peoples in Alberta experience poorer health outcomes than non-Indigenous Albertans. As part of Alberta's work to improve health outcomes and access to health services for Indigenous peoples, two new protocol agreements and a memorandum of understanding were signed in 2020. These agreements provide a framework for continued collaboration between the provincial government and First Nations in Alberta.

The protocol agreements support meaningful discussion, information sharing, and the exploration of issues of mutual concern. The Stoney Nakoda-Tsuut'ina Tribal Council Protocol Agreement, signed in October 2020, commits both parties to engage in discussions on the following key priority areas identified by the council: health, economic growth, education, family services, and housing. The Protocol Agreement between the Government of Alberta and the Confederacy of Treaty Six First Nations for Discussions on Matters of Mutual Concern was signed in December 2020. The agreement creates a framework to work together on the following issues: land and resources, health care, education, justice, economic development, and culture and tourism.

In February 2021, the Alberta government signed a memorandum of understanding (MOU) with Siksika Nation that supports work to improve health outcomes and services for Siksika Nation members. The MOU establishes a process for ongoing assessment of Siksika Nation health needs and issues, and identifies realistic activities to resolve them. The MOU is the first agreement in Alberta to include the use of the Blackfoot language. The agreement

Actions that Support the Priorities of the Government of Alberta Strategic Plan

Key Priority:
Making life better for Albertans

Objective:
Partnering with Indigenous peoples to pursue opportunities – towards community well-being, improved access to health care, and participation in business opportunities in the healthcare sector.

- As planned in the Ministry of Health's 2020-23 Business Plan, the Government of Alberta is committed to addressing the health needs of Indigenous peoples in Alberta, including working with the federal government and other partners to streamline how Indigenous peoples access health services, and ensuring that health services are culturally appropriate.
- In 2020-21, agreements between the Government of Alberta and several Indigenous organizations were signed to provide a foundation for continued collaboration.
- Ongoing discussion and collaboration resulted in better access to health care through the Alberta Indigenous Virtual Care Clinic program and the Indigenous Alternative Relationship Payment program, which provides funding for primary care physicians.
- The provincial government also provided funding to support needs assessments and development of business cases for future health-related business opportunities for Indigenous communities.

also acknowledges Siksika Nation Elders' Guiding Principles and seeks to combat racism and bring about positive and transformative change in health care for Siksika Nation.

The Alberta government works very closely with the Blackfoot Confederacy to identify and resolve health system gaps, and improve health outcomes. Alberta and the Blackfoot Confederacy are working to establish a health work plan to address needs.

The Alberta government continued working with the Métis Nation of Alberta (MNA) on health concerns for Métis Albertans, meeting several times with the MNA in 2020-21 to discuss priorities, including COVID-19 and mental health supports, and public health.

In support of International Day of the World's Indigenous Peoples on August 9, 2020, and the theme of COVID-19 and Indigenous Peoples' Resilience, the government recognized the efforts of Indigenous communities across Alberta to keep their residents safe. This included setting up checkpoints and isolation centres, among other actions.

In 2020-21, the Government of Alberta supported innovation in health service delivery in Indigenous communities through initiatives including:

- Alberta Indigenous Virtual Care Clinic, offering First Nations, Métis and Inuit patients access to same-day primary care services through a secure telephone/video system.
- The Indigenous Alternative Relationship Payment program, which funds primary care physicians for services in Indigenous communities and improves the availability of pediatric, obstetric, and psychiatric care.

In 2020-21, the Government of Alberta provided funding for:

- Indigenous communities to support their business case development and needs assessments to determine continuing care needs of their community and membership.
- The Chartered Surgical Facilities Capacity Grant Program, which provided six First Nations in Alberta with funding to develop competitive submissions for AHS' Chartered Surgical Facility Call for Proposals.

The provincial government also upholds "Jordan's Principle" commitments, by working with the federal government and the First Nations Health Consortium to ensure First Nations children do not experience denials or delays when accessing publicly funded health, education, and social supports.

Performance Metrics

Performance Measure 5.a:
Percentage of seniors aged 65 or older and long-term care facility residents immunized for influenza

Population	Prior Years' Results				2020-21 Target	2020-21 Actual
	2016-17	2017-18	2018-19	2019-20		
Seniors aged 65 or older	62%	60%	61%	61%	68%	63%
Residents of long-term care facilities	89%	89%	87%	88%	95%	86%

Source: Alberta Health Services; Alberta Health's weekly pharmacists data; First Nations and Inuit Health Branch, Indigenous Services Canada, Alberta Region

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

Results Analysis

In 2020-21, 63 per cent of Alberta's seniors received immunization against influenza, which is a higher percentage than the results in the four prior years and five per cent below the target (68%). In 2020-21, 86 per cent of residents in long-term care facilities received immunization, which is two per cent below the 2019-20 result (88%) and nine percentage points below the target (95%) for these Albertans.

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. More than 1.65 million doses of influenza vaccine were administered during the 2020-21 influenza season, covering just over 37 per cent (33 per cent in 2019-20) of Alberta's population. This is the highest population-based influenza immunization rate achieved to date since the universal influenza program was established in 2009.

The 2020-21 Influenza Immunization Policy (IIP) has an added objective of increasing influenza immunization coverage rates for targeted populations, including individuals 65 years of age or older. Influenza immunization service delivery is shifting to prioritize high-risk populations, which is now defined in the 2020-21 IIP, which is available at open.alberta.ca/publications/alberta-influenza-immunization-policy. Access to influenza vaccine continues to increase with over 1,400 pharmacies now offering provincially funded vaccine.

In order to better protect residents of long-term care aged 65 or older, in 2020-21 the federal government procured an influenza high-dose vaccine for use in all long-term care facilities across Canada that offers better protection for the most vulnerable Albertans.

The ministry is working with health practitioners in all health zones to ensure a consistent approach to reporting influenza immunization and adverse events following immunization to the

Provincial Immunization Repository (Imm/ARI) as per the new reporting requirements outlined in Alberta's Immunization Regulation.

Performance Measure 5.b:

Children by age two immunized for DTaP-IPV-Hib (diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza type b) and for MMR (measles, mumps, rubella)

Immunization	Prior Years' Results				2020-21 Target	2020 Actual
	2016	2017	2018	2019		
Diphtheria, tetanus, pertussis, polio, Hib	77%	77%	78%	79%	95%[1]	78%
Measles, mumps, rubella	88%	88%	88%	88%	95%[1]	88%

Source: Alberta Health Care Insurance Plan (AHCIP) Quarterly Population Registries; Immunization/Adverse Reactions to Immunization (Imm/ARI)
Notes: [1]National targets.

This indicator reports the percentage of children in Alberta who by two years of age have received the required immunization for the following vaccine preventable diseases: diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza type b, measles, mumps and rubella.

Results Analysis

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

In 2020, by age two, 78 per cent of Albertans had received immunization with DTaP-IPV-Hib vaccine and 88 percent had received immunization with MMR vaccine. These immunization rates are both lower than the national target of 95 per cent for both vaccines.

Provincial immunization rates for both vaccines for this age group of children have remained stable over the past five years. Vaccine hesitancy can contribute to lower rates of immunization and is related to a general lack of understanding about vaccines, perceived risk of serious adverse events related to injections, and lack of appreciation for the severity of vaccine preventable diseases. Accessing vaccine services can also be a barrier.

AHS has implemented five of the seven recommendations of the Canadian Pediatric Society to increase immunization levels, including the development of a provincial immunization registry, proactive reminders for parents, enhanced immunization clinic hours, and an augmented school-based immunization program.

The ministry is working with health practitioners in all health zones to ensure a consistent approach to disease outbreak reporting, notification, and management.

Performance Indicator 5.c:
Infant mortality rate per 1,000 live births for First Nations peoples in Alberta, compared to non-First Nations

Infant Population[1]	Prior Years' Results				2020 Actual
	2016	2017	2018	2019	
First Nations	7.1	9.2	10.8	8.0	9.2
Non-First Nations	3.7	4.3	4.4	3.9	4.5

Source: Alberta Vital Statistics Death File (infant deaths); Newborn Metabolic Screening Database (live births); First Nations Status Registry (excludes Métis Albertans)
Notes: [1]Infants less than one year of age.

This indicator compares the infant mortality rate for the First Nations population to that of the non-First Nations population in Alberta. The infant mortality rate provides the rate of death of 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. The desired result is to reduce the gap between infant mortality rates for First Nations and non-First Nations populations by reducing infant mortality rates for First Nations peoples.

Results Analysis

There is a significant gap in the infant mortality rate for the First Nations population in Alberta in comparison to the non-First Nations population. Infant mortality rates are based on relatively small numbers that result in annual fluctuations, making trends over time difficult to interpret. Compared to 2019, the infant mortality rate for First Nations peoples is higher in 2020 and it remains higher compared to 2016, while the rate for non-First Nations people is higher in 2020 compared to any of the previous four years.

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

To address the health status gaps between First Nations and non-First Nations populations in Alberta, the ministry is committed to respectfully engaging with First Nations leadership and First Nations people in the design, delivery and stewardship of health services. Engagement and coordination processes with Confederacy of Treaty 6, Treaty 8 First Nations of Alberta, Blackfoot Confederacy and the Stoney Nakoda-Tsuut'ina Tribal Council build upon the foundation of reconciliation and relationships. Separate processes have been established with the Métis Nation of Alberta, and Metis Settlements General Council to understand the health needs and priorities of Métis in Alberta.

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

Performance Indicator 5.d:
Life Expectancy at birth – First Nations, non-First Nations

Population	Prior Years' Results				2020 Actual
	2016	2017	2018	2019	
First Nations	71.2	71.0	70.9	70.3	66.8
Non-First Nations	82.2	82.1	82.3	82.8	81.9

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

This indicator compares the life expectancy of First Nations peoples to that of non-First Nations peoples 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. It only takes into account the length of life and not quality of life. The desired result is to reduce the gap between the life expectancy for First Nations and non-First Nations peoples by improving life expectancy for First Nations peoples.

Results Analysis

In 2020, the gap in life expectancy between First Nations and non-First Nations populations in Alberta was 15 years. Overall mortality rates in 2020 increased significantly from 2019, with rates increasing more in younger Albertans under 65 years of age, particularly First Nations. While deaths directly attributed to COVID-19 affected life expectancy in 2020, increased numbers of deaths from substance misuse among younger Albertans, especially First Nations, had a more significant impact on life expectancy. 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 populations in Alberta over time. This data clearly shows that more needs to be done to address health disparities for Indigenous peoples.

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

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

In addition, the ministry was involved with the Treaty 8 Protocol Agreement Health Table, Blackfoot Confederacy Protocol Agreement, Métis Nation of Alberta Framework Agreement, and the Metis Settlements General Council Long-Term Governance and Funding Arrangement. Progress is being made in several key areas including strengthened immunization information sharing; coordination of actions through an Indigenous Integration Committee; and collaboration with the

Métis Nation of Alberta and Metis Settlements General Council to develop health status information to identify community health needs and future planning. Furthermore, work under the Protocol Agreements is focused on increasing collaboration across all government ministries to identify and address the gap in health outcomes of Alberta First Nations people and non-First Nations people.

Performance Indicator 5.e:
Percentage of Albertans who smoke cigarettes

Prior Years' Results				2020-21 Actual
2016-17	2017-18	2018-19	2019-20	
16.6%	15.3%	15.6%	12.9%	Not available[1]

Source: Alberta Community Health Survey
Notes: [1]Typically, results are available in the fall.

This indicator tracks the percentage of Albertans aged 18 or older who took part in the Alberta Community Health Survey and indicated that they smoke cigarettes daily or occasionally at the present time. The desired result is to decrease the percentage of Albertans who smoke cigarettes daily or occasionally.

Results Analysis

The survey results for 2019-20 show that 12.9 per cent of Albertans aged 18 or older currently smoke cigarettes daily or occasionally. This is a 2.7 percentage point drop when compared to the previous year.

The government recognizes the health harms of cigarette smoking and tobacco products. In addition, the increase in vaping, particularly by youth, is a significant emerging health concern. The review of Alberta's *Tobacco and Smoking Reduction Act*, which commenced in 2019, provided government with an opportunity to assess the effectiveness of the current legislative framework and consider options to further protect Albertans.

Public education remains an important tool to discourage the use of tobacco and vaping products. A variety of information, tips, tools and resources are available through the AlbertaQuits website (albertaquits.ca) to raise awareness about smoking and vaping, and to support a decrease in the percentage of Albertans who smoke cigarettes daily or occasionally. These supports are particularly important during the pandemic because infected individuals who smoke or vape are at higher risk of developing more severe COVID-19 symptoms.

Performance Measure and Indicator Methodology

Performance Indicator 1.a:
Unplanned medical readmissions to hospital within 30 days of discharge

Methodology

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

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

Denominator: Total number of medical patients discharged.

- Inclusion Criteria: Residents of Alberta covered by the Alberta Health Care Insurance Plan; discharge from an acute care hospital, within a reporting period.
- Exclusion Criteria: Admissions where patients died in hospital; admissions from March 2 to March 31; transfers (admitted within 6 hours of discharge from another hospital, or 6-12 hours after transfer from or to an acute care facility); newborn, still birth, cadaver admissions; non-acute care admissions; pediatric (less than 20 years of age), surgery, obstetrics, palliative care, mental health admission.

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

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

$$\text{Risk-adjusted rate} = \frac{\text{observed cases}}{\text{expected cases}} \times \text{Alberta rate}$$

The methods used by Alberta and CIHI differ only in that Alberta applies the Alberta Rate instead of the Canada Rate. Using the Alberta rate allows for timely reporting and calculation of results for sub-populations.

Source

Alberta's Morbidity and Ambulatory Care Abstract Reporting System (MACAR).
Note: Data in MACAR is then provisioned to the ministry's Business Intelligence warehouse. It is also submitted to CIHI's Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) datasets.

Performance Indicator 1.b:
Median number of days hospital stay extended until home care services or supports were ready

Methodology	
The indicator measures the median (50th percentile) number of days patients spend in an inpatient acute care hospital bed when they don't need acute care, also known as alternate level of care (ALC), before they are discharged to home care. • Inclusion Criteria: Records from acute care hospitals in Alberta; patients discharged to home or a home setting with home care services available to the patient; sex recorded as male or female; and, records with a valid ALC length of stay greater than 0. • Exclusion Criteria: Records with admission category of cadaveric donor or stillbirth.	
Median # days =	The mid-point on the distribution curve of the # days spent in hospital in ALC before discharged with home care available.
Source	
Alberta Health Discharge Abstract Database (DAD).	

Performance Indicator 1.c:
Percentage of surgical procedure wait-times within national benchmarks

Methodology

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

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

RTT Date = The date that the surgeon determines the patient is ready for the surgical intervention. The RTT Date excludes patient delays or voluntary waits.

Treatment Date = The date the treatment (surgical procedure) took place.

RTT Wait time = Treatment (surgical procedure) Date minus RTT Date

National RTT wait time benchmarks:
- Hip replacement national benchmark is 182 days
- Knee replacement national benchmark is 182 days
- Cataract surgery national benchmark (for first eye) is 112 days.

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

Source

Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, and Manual Data Collection).

Performance Measure 1.d:
Percentage of scheduled surgeries performed in chartered surgical facilities (formerly known as non-hospital surgical facilities)

Methodology

Numerator: Total Main Operating Room cases completed in chartered surgical facilities (CSFs).

Denominator: Total Main Operating Room cases completed in CSFs and hospitals.

Emergency surgeries and pregnancy terminations are excluded from the calculation.

$$\text{Percentage} = \frac{\text{total \# surgeries performed in CSFs under contract with AHS}}{\text{total \# surgeries in CSFs and hospitals from April 1 to Mar 31}} \times 100$$

Source

Alberta Health Services Main Operating Room (OR) information system sources as extracted to OR data repository as of June 4, 2021. Sites that do not have OR information systems were not included.

Performance Indicator 2.a:
Provincial per capita spending on health care

Methodology

Health expenditure includes any type of expenditure for which the primary objective is to improve or prevent the deterioration of health status.

Data is extracted annually from provincial and 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 and territorial government department annual reports and annual statistical reports when available, as well as information provided by provincial and territorial government department officials.

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

As part of the preparation of the NHEX report, the Canadian Institute for Health Information estimates of provincial and territorial government health expenditures were submitted to provincial and territorial departments of health for review. The 2020-2021 forecast is not available from CIHI due to COVID-related data uncertainties and delays.

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

Source

Canadian Institute for Health Information (CIHI), National Health Expenditures Trends (NHEX), 1975 to 2020. Statistics Canada, Demography Division (population estimates).

Performance Indicator 2.b:
Cost of standard hospital stay

Methodology

The Cost of standard hospital stay (CSHS) is constructed as a ratio. CSHS is comparable across provinces since data for the Canadian MIS Database (CMDB) and Discharge Abstract Database (DAD) are submitted by provinces according to national standards.

Numerator: Total inpatient costs captured from all areas of a hospital. As a full-cost indicator, the CSHS includes not only direct expenses incurred in the provision of care (e.g., nursing compensation, drugs, meals, etc.) but also the indirect operational expenses (e.g., finance, administrative services). The costs are retrieved from the CMDB, which contains financial and statistical operations information from hospitals and regional health authorities across Canada.

Note: The CSHS calculation excludes physician compensation. Physician compensation within the hospital environment is treated and reported differently across jurisdictions due to varying provincial and territorial policies. It has been removed from the CSHS calculation for better comparability across jurisdictions.

Denominator: The sum of all acute care weighted cases, or Resource Intensity Weights (RIWs). To arrive at this number, each inpatient case is weighted by an RIW factor indicating the expected resource intensity of the stay. All RIWs are relative to the average typical inpatient case, which is assigned an RIW of 1.0. For example, a patient with an RIW of 2.0 would be expected to require twice as many resources during his or her hospital stay as the average typical inpatient. The RIW calculated for each stay takes into account a patient's age, disease status, comorbidities, and types of interventions received. Data required for the denominator is retrieved from the DAD, which captures administrative, clinical and demographic information about patients when they are discharged from the hospital.

$$\text{Cost of a standard hospital stay} = \frac{\text{Total inpatient costs}}{\text{Total acute inpatient weighted cases}}$$

Source

Canadian Institute for Health Information (CIHI): Canadian MIS Database (CMDB) and Alberta Health Discharge Abstract Database (DAD).

Performance Indicator 2.c:
Alternate level of care days

Methodology

Alternative Level of Care (ALC) days are recorded at any point during the hospital stay for patients covered by the publicly funded Alberta Health Care Insurance Plan.

- Inclusion Criteria: Records from acute care hospitals in Alberta; sex recorded as male or female; and, records with a valid ALC length of stay greater than 0.
- Exclusion Criteria: Records with admission category of cadaveric donor or stillbirth.

$$\text{Percentage} = \frac{\text{\# of days as an inpatient in hospital classified as ALC days}}{\text{total \# of inpatient days in hospital.}} \times 100$$

Source

Alberta Health Discharge Abstract Database (DAD).

Performance Indicator 2.d:
Facility-based beds in community settings

Methodology

Facility-based beds in the community as a proportion of all beds.

Numerator: Number of facility-based beds in a community setting.

- Inclusion Criteria:
  - Long-Term Care (Auxiliary and Nursing Home)
  - Designated Supportive Living (DSL3, DSL4, DSL4D)
  - Community Palliative and Hospice (outside hospitals)
  - Sub-Acute in Long-Term Care (Auxiliary Hospitals)
  - Addiction and Mental Health (Addiction Treatment, Community Mental Health, stand-alone psychiatric facilities)

Denominator: Number of facility-based beds in a community setting and number of beds in acute care hospitals.

$$\text{Percentage} = \frac{\text{\# facility-based beds in a community setting}}{\text{\# facility-based beds in a community setting + \# acute care beds}} \times 100$$

Source

Alberta Health Services.

Performance Measure 2.e:
Annual rate of change of operational expenditures

Methodology
Calculation of percentage growth in ministry operational expenses when compared to operational expenses in the previous fiscal year. Operational expenses is defined as the Ministry of Health total expenses per published Statement of Revenue and Expenses less infrastructure support and COVID-19 pandemic expenses.
$\text{Percentage} = \frac{\text{total 2020/21 operational expenses} - \text{total 2019/20 operational expenses}}{\text{total 2019/20 operational expenses}} \times 100$
Source
Ministry Consolidated Statement of Revenue and Expenses as presented in the Financial Information section of the Ministry of Health Annual Report.

Performance Indicator 3.a:
Percentage of physicians participating in Alternative Relationship Plan payment models

Methodology
Alternative Relationship Plans (ARPs) are arrangements to compensate physicians by methods other than fee-for-service. Information comes from the Canadian Institute for Health Information – National Physician Database (NPDB). NPDB data is derived from physicians' billings, including fee codes, which provincial and territorial health insurance programs submit. Claims data and associated physician data are submitted quarterly, usually within six months of the end of the fiscal quarter. The ARP payment data is derived from payments made to ARP programs through the Claims Assessment System in the specified fiscal year.
$\text{Percentage} = \frac{\text{\$ physician payments made under an ARP}}{\text{\$ physician payments}} \times 100$
Source
Canadian Institute for Health Information (CIHI) - National Physician Database (NPDB); Alternative Payment Information File for Alberta.

Performance Indicator 3.b:
Percentage of Albertans who had access to a regular health care provider

Methodology

Statistics Canada's Canadian Community Health Survey (CCHS) is a cross-sectional survey that collects information related to health status, health care utilization, and health determinants for the Canadian Population (including regional and provincial levels).

- Inclusion Criteria: Population age 12 and older.
- Exclusion Criteria: Persons living on Indigenous reserves or settlements, full-time members of the Canadian Forces, institutionalized population (i.e., those who live in an institutional collective dwelling, such as a hospital, a nursing home or a prison; residents under care or custody, such as patients or inmates), and children age 12-17 living in foster care.

Population estimates are based on weighted survey responses to reflect the total population. The results of the survey are based on a 95% confidence interval.

$$\text{Percentage} = \frac{\text{\# survey respondents who reported having a regular health care provider}}{\text{\# survey respondents}} \times 100$$

Source

Canadian Community Health Survey, Statistics Canada.

Performance Indicator 3.c:
Percentage of Licensed Practical Nurses relative to Registered Nurses

Methodology

Prior to 2019, data pertaining to registered nurses (RNs) reported by the Canadian Institute for Health Information (CIHI) included Nurse Practitioners (NPs). In the 'Nursing in Canada, 2019 data tables', CIHI separated NP counts from RN counts. In calculation of the percentage of licensed practical nurses (LPNs) relative to RNs, the current methodology excludes NPs.

Nurse supply refers to those nurses who are eligible to practice in the given year, including those employed and those not employed at the time of registration. Note that secondary registrants (also known as interprovincial duplicates) are excluded from provincial nurse supply counts.

$$\text{Percentage} = \frac{\text{\# LPN supply}}{\text{\# RN supply + \# registered psychiatric nurse supply}} \times 100$$

Source

Canadian Institute for Health Information (CIHI).

Performance Indicator 3.d:
Percentage of Nurse Practitioners relative to Family Medicine Physicians

Methodology

Numerator: Nurse Practitioner (NP) supply refers to all NPs who are eligible to practice in the given year, including those employed and those not employed at the time of registration. Note that secondary registrants (also known as interprovincial duplicates) are excluded from provincial NP supply counts.

Denominator: Family medicine physicians include general practitioners, as well as family medicine specialists and emergency family medicine specialists who are certificants of the College of Family Physicians of Canada.

$$\text{Percentage} = \frac{\text{\# nurse practitioner supply}}{\text{\# family medicine physicans}} \times 100$$

Source

Canadian Institute for Health Information (CIHI).

Performance Indicator 3.e:
Ambulatory Care Sensitive Condition (ACSC) hospitalization rate

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 relating to: grand mal status and other epileptic convulsions; chronic obstructive pulmonary diseases; acute lower respiratory infection (only included when there is a secondary diagnosis code of J44); asthma; heart failure and pulmonary edema; hypertension; angina; and, diabetes; and gender specified as male or female.
  Age is determined as of discharge date. Only people deemed as “Alberta resident” (as defined by the Ministry of Health) will be included. This includes people that are homeless and people from Lloydminster, discharged from an acute care hospital.
- Exclusion Criteria: Individuals 75 years of age or older; deaths; stillbirths and newborns; cases with a specified cardiac procedure; and, records where the fiscal year was omitted.

Denominator: The total end-of-fiscal year population younger than age 75. The population is age-adjusted using the 2011 Canada Census.

The overall age-standardized rate is obtained by first calculating crude rates for each age group multiplied by its corresponding age groups weight (derived from the 2011 Canadian Census). The sum across all age groups for the year is the age-standardized ACSC.

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

Source

Numerator: Alberta Health Discharge Abstract Database (DAD); Denominator: Alberta Health population estimate.

Performance Measure 4.a:
Unplanned mental health readmissions to hospital

Methodology

The patient population consists of patients of any age.

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 is included. In this way, episodes of care are identified with the reporting facility identified as the final discharging facility. Only discharges from general or psychiatric hospitals are included.

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

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

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

Crude Readmission Rate (CRR):

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

Risk Adjusted Rate (RAR):

The observed number of cases is the actual count of readmissions to a hospital. The expected number of cases is based on the sum of the probabilities of readmissions to a hospital. Coefficients from the Canadian Institute for Health Information used for calculating the probability of readmissions were from logistic regression models on the following independent variables – age, sex, multiple previous admissions for a selected mental illness (two or more) during the past 12 months, discharges against medical advice, substance use related disorder, schizophrenia, anxiety disorder, and personality disorder. The 2018-19 Canadian Average Rate (12.9%) is used for the risk adjustment calculation.

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

Source

Alberta Health Discharge Abstract Database (DAD).

Performance Indicator 4.b:
Percentage of mental health emergency department visits with no mental health service in previous two years.

Methodology

This indicator examines first-contact visits to an emergency department (ED) for mental health conditions. The calculation includes the number of mental health-related ED visits (per 100 mental health ED visits) for those patients, aged 15 or older, where the patient had received no mental health services from a physician, or in a hospital or emergency department in the preceding two years.

Data is sourced from ministry databases pertaining to physician billing claims data and hospital discharge abstracts, and the National Ambulatory Care Reporting System. Current fiscal year results are reported as preliminary to allow for all provincial reporting to be completed.

$$\text{\# visits (per 100 mental health ED visits)} = \frac{\text{\# individuals treated in an ED for a mental health reason for the first time in two years}}{\text{\# individuals treated in an ED for a mental health reason}} \times 100$$

Source

Alberta Health Discharge Abstract Database (DAD), Alberta Ambulatory Care Reporting System (AACRS), Alberta physician claims database, Provincial Population Registry.

Performance Indicator 4.c:
Number of emergency department visits due to alcohol or opioid use, per 100,000 population

Methodology

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

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. Emergency visit rates based on all diagnostic fields were used. For alcohol use, the following ICD10 codes were selected: F10 (mental and behavioral disorders due to use of alcohol) and T51 (toxic effects due to alcohol). For opioid use the following ICD10 codes were selected: F11 (opioid related disorders), T400 (poisoning by, adverse effect of and underdosing of opium), T401 (poisoning by and adverse effect of heroin), T402 (poisoning by, adverse effect of and underdosing of other opioids), T403 (poisoning by, adverse effect of and underdosing of methadone), T404 (poisoning by, adverse effect of and underdosing of other synthetic narcotics), and T406 (poisoning by, adverse effect of and underdosing of other and unspecified narcotics).

The date of birth in the fiscal year population registry file is used to calculate the age of the individual as of March 31 each year.

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

Age-standardized rate of visits:

$$\text{Rate} = \sum_{i=\text{first age group}}^{\text{last age group}} \frac{\text{\# ED visits (alcohol or opioids) in age group}}{\text{Alberta pop'n in that age group}} \times \frac{\text{reference pop'n in age group}}{\text{total reference population}} \times 100{,}000$$

Source

Alberta Ambulatory Care database; Alberta Health Care Insurance Plan, End-of-fiscal year (March 31) adjusted Population Registry Files Statistics Canada; Canadian population, 2011.

Performance Indicator 5.a:
Percentage seniors aged 65 or older and long-term care facility residents immunized for influenza

Methodology

Seniors aged 65 or over:

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

Residents of long-term care (LTC) facilities:

$$\text{Immunization rate} = \frac{\text{\# of LTC residents on Dec 15, 2020, who received one vaccine dose during the period October 1 – December 15, 2020}}{\text{\# of LTC residents on Dec 15, 2020}} \times 100$$

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

Source

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

Denominator: For seniors, the denominator is the ministry's population estimates, based on mid-year registration population estimates. For residents of long-term care facilities the denominator is the number of residents as of December 15, 2020, provided by Alberta Health Services.

Performance Indicator 5.b:
Children by age two immunized for DTaP-IPV-Hib (diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza type b), and for MMR (measles, mumps, rubella)

Methodology

Using data from the Alberta Health Care Insurance Plan population registries, children in Alberta are followed through time (i.e., from date of birth to study end date). Exclusions include individuals leaving Alberta, individuals who died, individuals who do not belong to the study period, First Nations individuals, and residents of Lloydminster.

Coverage rates are based on a birth cohort and reported at age two. Once established, the population-based birth cohort is linked to Imm/ARI using the Unique Lifetime Identifier to get immunization information.

Calculation: Childhood immunization coverage is calculated using a survival analysis (time-to-immunization) method based on the specified population-based birth cohort. The analysis measures the probability that the child will receive required vaccines by age two.

Source

Alberta Health Care Insurance Plan (AHCIP) Quarterly Population Registries; Immunization/Adverse Reactions to Immunization (Imm/ARI).

Performance Indicator 5.c:
Infant mortality rate per 1,000 live births for First Nations peoples in Alberta, compared to non-First Nations

Methodology

Infant deaths are identified from the Alberta Vital Statistics Death file, while live births are identified from the Newborn Metabolic Screening Database. Infants are defined as less than one year of age (birth to 364 days).

$$\text{Infant mortality rate} = \frac{\text{\# of infant deaths during a calendar year}}{\text{\# of live births during a calendar year}} \times 1{,}000$$

Source

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

Performance Indicator 5.d:
Life expectancy at birth – First Nations, Non-First Nations

Methodology

Life expectancy is calculated using the commonly-used "period" life table methodology. A detailed description of the methodology used to convert age-sex specific death rates into life expectancy at birth can be found in Appendix 3 of the ministry's Chronic Disease Projections Methodology, 2008. open.alberta.ca/publications/9780778566175.

Source

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

Performance Indicator 5.e:
Percentage of Albertans who smoke cigarettes

Methodology

The Alberta Community Health Survey is a telephone-based survey aimed to collect data on specific determinants of health among Albertans 18 years and older.

The smoking indicator is based on the following survey question: “At the present time, do you smoke cigarettes: i) Daily, ii) Occasionally, or iii) not at all”?

Sampling Methodology:
Goal of sampling frame is to have high-quality geographically representative estimates

- Telephone (cell phone and land line) or web-based survey among Albertans 18 years and older.
- Cell phone sampling with geographic specificity began halfway through the 2014 cycle.
- A web-based survey (January 2017 onwards) was available to those who did not elect to do the telephone survey.
- Sample size in 2016-2017 to 2019-20 was 6410, 6474, 6716 and 4372, respectively.

The percentage of cigarette smokers is estimated by tabulating a weighted proportion of those that responded as daily or occasional cigarette smokers and based on a confidence interval of 95%.

Geographic assignment is based on the postal code of residence reported by the respondent.
The geographic areas are obtained by linking the postal code with the Postal Code Translator File.

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

Source

Alberta Community Health Survey (ACHS).

Financial Information

Table of Contents

Reporting Entity and Method Consolidation

The consolidated ministry financial information is prepared in accordance with Canadian Public Sector Accounting Standards.

The reporting entity is the Ministry of Health, for which the Minister of Health is accountable. The accounts of the Department of Health are fully consolidated with Alberta Health Services (AHS) and Health Quality Council of Alberta on a line-by-line basis.

Accounts of entities that are consolidated by AHS are listed in note 2a (i) and (ii) of AHS consolidated financial statements.

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

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

Ministry of Health

Ministry Financial Highlights

Statement of Revenues and Expenses (unaudited)

Year ended March 31, 2021

(in thousands)

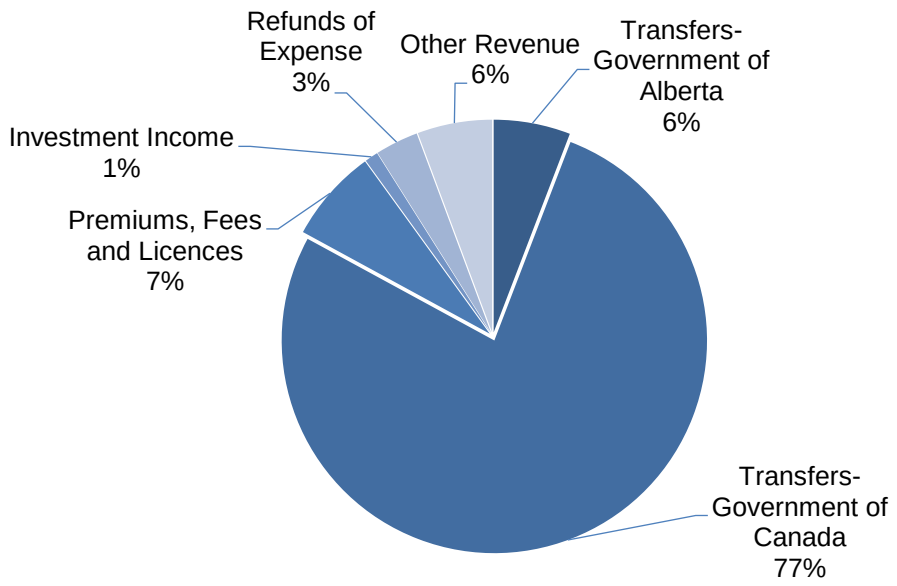
	2021		2020	Change from	
	Budget	Actual	Actual	Budget	2020 Actual
Revenues			(Restated)		
Government Transfers					
Government of Alberta	$ 417,000	$ 384,118	$ 425,845	$ (32,882)	$ (41,727)
Government of Canada	5,024,060	5,086,298	4,815,833	62,238	270,465
Premiums, Fees and Licences	566,001	467,373	572,658	(98,628)	(105,285)
Investment Income	65,020	63,644	80,269	(1,376)	(16,625)
Refunds of Expense	170,105	215,914	222,414	45,809	(6,500)
Other Revenue	399,121	374,218	472,103	(24,903)	(97,885)
Ministry Total	6,641,307	6,591,565	6,589,122	(49,742)	2,443
Inter-Ministry Consolidation Adjustments	(447,800)	(410,249)	(458,438)	37,551	48,189
Adjusted Ministry Total	6,193,507	6,181,316	6,130,684	(12,191)	50,632
Expenses - Directly Incurred					
Ministry Support Services	62,579	60,141	61,902	(2,438)	(1,761)
Physician Compensation and Development	5,417,275	5,052,755	5,456,359	(364,520)	(403,604)
Drugs and Supplemental Health Benefits	2,227,467	2,334,570	2,335,872	107,103	(1,302)
Population and Public Health	660,510	658,568	640,212	(1,942)	18,356
Acute Care	4,055,418	4,011,309	4,150,743	(44,109)	(139,434)
Continuing Care	1,164,000	1,154,098	1,163,433	(9,902)	(9,335)
Ambulance Services	532,000	522,607	527,041	(9,393)	(4,434)
Community Care	1,494,000	1,465,796	1,475,178	(28,204)	(9,382)
Home Care	717,000	660,350	716,023	(56,650)	(55,673)
Diagnostic, Therapeutic & Other Patient Services	2,452,482	2,496,384	2,493,967	43,902	2,417
Administration	489,760	495,871	492,031	6,111	3,840
Support Services	2,250,000	2,214,027	2,267,016	(35,973)	(52,989)
Information Technology	719,787	686,941	660,838	(32,846)	26,103
Research and Education	94,579	106,753	127,253	12,174	(20,500)
Debt Servicing	16,000	15,349	14,755	(651)	594
Infrastructure Support	96,631	25,844	9,727	(70,787)	16,117
Cancer Research and Prevention Investment	15,410	7,632	2,449	(7,778)	5,183
COVID-19 Pandemic Response	500,000	1,497,587	25,837	997,587	1,471,750
Ministry Total	22,964,898	23,466,582	22,620,636	501,684	845,946
Inter-Ministry Consolidation Adjustments	(258,530)	(304,469)	(276,146)	(45,939)	(28,323)
Adjusted Ministry Total	22,706,368	23,162,113	22,344,490	455,745	817,623
Adjusted Annual Deficit	$ (16,512,861)	$ (16,980,797)	$ (16,213,806)	$ (467,936)	$ (766,991)

Ministry of Health

Revenue and Expense Highlights

Revenues

Consolidated Revenues (prior to inter-ministry consolidation adjustments)



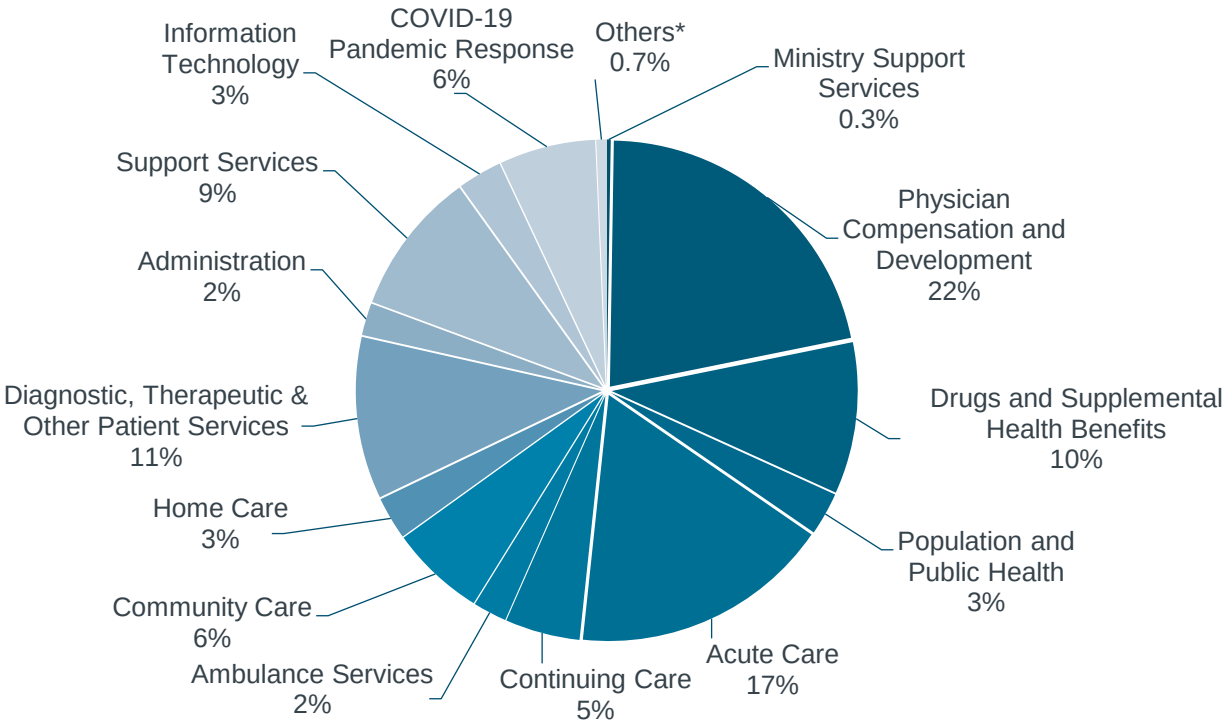
Actual revenue was lower than the budget by $50 million and increased by $2 million over prior year mainly due to:

- Premiums, Fees and Licenses as a result of COVID 19 pandemic travel restrictions which reduced volume of health care services billable to other Canadian jurisdictions and non-residents of Canada, and lower than anticipated activity involving services billable to the Workers Compensation Board.
- Other Revenue reported a decrease from prior year mainly due to suspension of parking fees in the first half of the year and lower traffic at retail food services sites due to the COVID 19 pandemic.
- This was partially offset by an increase in federal transfers for COVID-19 Border Testing Pilot Program, Pan-Canadian Virtual Care Response, and transfer of Personal Protective Equipment.

Ministry of Health

Expenses

Consolidated Expenses (prior to inter-ministry consolidation adjustments)



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

Actual expenses was higher than the budget by $502 million and increased by $846 million over prior year mainly due to:

- Expenses incurred for COVID-19 Pandemic Response measures including one-time payments for Critical Worker Benefits.
- Drugs and Supplemental Health Benefits exceeded the budget due to higher utilization of high cost cancer drugs; unbudgeted utilization of cancer drugs received at no cost; and significant enrollment growth in the Seniors Drug program.
- This was partially offset by Physician Compensation and Development due to lower fee-for-service claims; Acute Care due to temporary suspension of elective surgeries and decrease in emergency room visits; and Home Care due to reduced provision of home care services as a result of COVID-19.

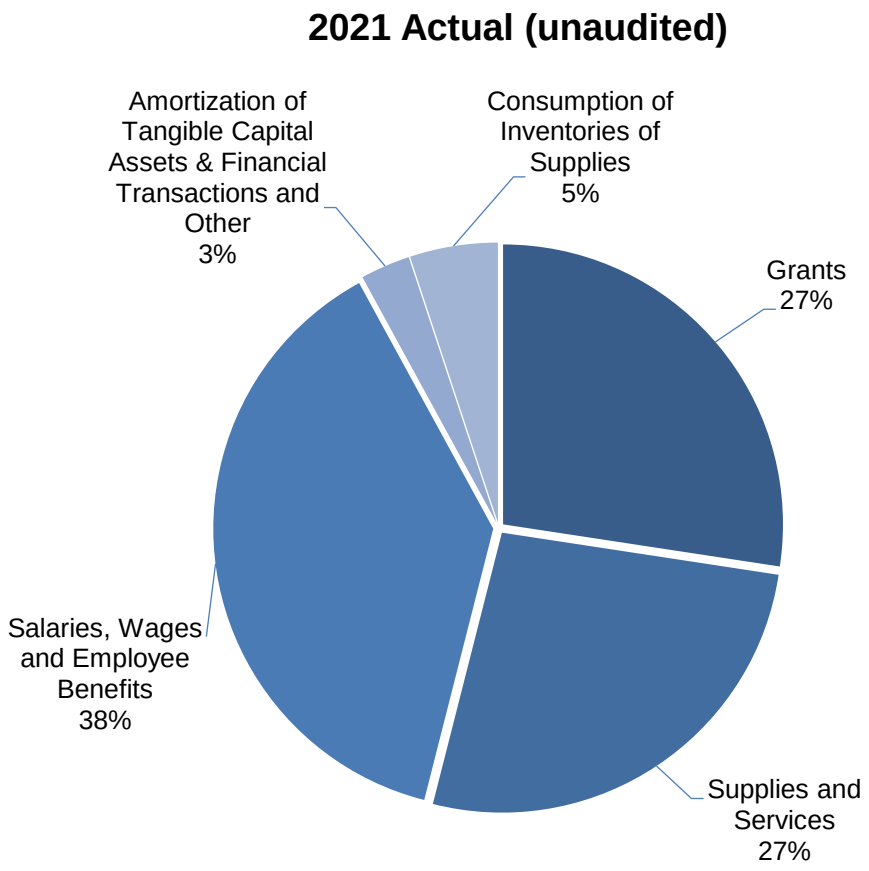
Ministry of Health

Expenses – Directly Incurred Detailed by Object (unaudited)

(in thousands)

	2021		2020
	Budget	Actual	Actual (Restated)
Grants	$ 7,251,800	$ 6,431,184	$ 6,694,349
Supplies and Services	5,776,426	6,233,190	5,801,136
Salaries, Wages and Employee Benefits	8,420,510	8,935,114	8,630,395
Amortization of Tangible Capital Assets	604,522	571,957	557,249
Consumption of Inventories of Supplies	893,500	1,192,872	844,955
Financial Transactions and Other	18,140	102,265	92,552
	$ 22,964,898	$ 23,466,582	$ 22,620,636

Ministry of Health



- Ministry expenses incurred were primarily for Grants, Supplies and Services, and Salaries, Wages and Employee benefits, which accounted for 92% of the total expenses.
- Salaries, Wages, and Employee benefits totaled 38% ($8.9 billion) of the expenses primarily for delivery and provision of health services.
- Grants comprised 27% ($6.4 billion) of the expenses primarily for Physician Compensation and Development, and Drugs and Supplemental Health benefits. Other grant expenses includes restricted funding to support organization and communities through grant programs, and funding for out-of-province health services.
- Supplies and services resulted in 27% ($6.2 billion) of the expenses mainly attributed to contracts with voluntary and private health service providers, contract payments to physicians for referred-out services, purchased services, and home support contracts.
- Amortization of tangible capital assets ($572 million), consumption of inventories of supplies ($1.2 billion), and financial transactions and other expenses ($102 million) comprises the residual ministry expenses.

Ministry of Health

COVID-19 Pandemic Response

Year ended March 31, 2021

The World Health Organization declared a global health emergency in January 2020 and in March 2020, it declared the spread of COVID-19 as a global pandemic. Government of Alberta declared a state of public health emergency on March 17, 2020 following which mandatory health measures were declared.

Following are some of the initiatives undertaken by the Government to address the pandemic:

- Distribution of more than 40 million free non-medical masks with the help of drive-thru restaurants to Albertans.
- Funding increase to support the addiction and mental health needs of Albertans.
- Operation of accessible assessment and treatments centres, including significantly higher laboratory testing.
- Funding to support operators of continuing care, supportive living, residential addiction and mental health treatment centres for increased operating costs associated with the pandemic.
- Critical Worker Benefit of one-time payment to recognize Alberta's critical workers, including healthcare workers in continuing care and addiction and mental health settings.
- Participated in a pilot program with the federal government that offered international travellers entering Alberta (at the Coutts land border crossing and Calgary International Airport) rigorous testing and monitoring.
- Developed and launched Alberta-specific contact tracing application, ABTraceTogether, first jurisdiction in North America to use this technology.
- Expanded services offered through MyHealth Records, which included access to COVID-19 lab test results for adults and parents/guardians of minors, and the addition of virtual care services.

Ministry of Health

Supplemental Financial Information

Tangible Capital Assets (unaudited)

Year ended March 31, 2021

(in thousands)

	2021							2020
	Land	Buildings [1]	Land Improvements	Equipment	Computer Hardware and Software	Leasehold Assets	Total	Total
Estimated Useful Life	Indefinite	10-70 years	5-40 years	3-20 years	3-15 years	Term of Lease		
Historical Cost [2]								
Beginning of year	$116,926	$12,134,288	$ 105,581	$ 2,603,702	$ 2,203,763	$ 279,286	$ 17,443,546	$ 16,497,205
Asset reclassification				22,882		(22,882)	-	-
Additions [3]	-	709,921	4,822	155,058	224,046	1,353	1,095,200	1,077,352
Disposals, including write-downs	(86)	(1,954)	(380)	(53,857)	(14,024)	-	(70,301)	(131,011)
	116,840	12,842,255	110,023	2,727,785	2,413,785	257,757	18,468,445	17,443,546
Accumulated Amortization								
Beginning of year	-	4,652,880	72,051	2,025,144	1,581,733	199,826	8,531,634	8,065,487
Asset reclassification				12,152		(12,152)	-	-
Amortization expense	-	293,082	3,258	149,764	116,536	9,317	571,957	557,249
Effect of disposals	-	(1,249)	(380)	(53,115)	(11,313)	-	(66,057)	(91,102)
	-	4,944,713	74,929	2,133,945	1,686,956	196,991	9,037,534	8,531,634
Net Book Value at March 31, 2021	$116,840	$ 7,897,542	$ 35,094	$ 593,840	$ 726,829	$ 60,766	$ 9,430,911	
Net Book Value at March 31, 2020	$116,926	$ 7,481,408	$ 33,530	$ 578,558	$ 622,030	$ 79,460		$ 8,911,912

[1] Buildings include parking lots.

[2] Historical cost includes work-in-progress at March 31, 2021 totaling $1,526,168 (2020 - $1,770,125).

[3] Additions include total contributed capital assets of $543,751 (2020 - $523,196) consisting of $543,417 from Ministry of Infrastructure (2020 - $523,196) and $334 from other sources (2020 - $nil).

Ministry of Health

Portfolio Investments

Year ended March 31, 2021

(in thousands)

	2021		2020	
	Book Value	Fair Value	Book Value	Fair Value
Cash held for investing purposes	$ 119,313	$ 119,313	$ 112,072	$ 112,072
Interest bearing securities:				
Money market securities	818,910	818,910	38,076	38,076
Fixed income securities	783,671	786,460	888,059	902,690
	1,602,581	1,605,370	926,135	940,766
Equities:				
Canadian equities	43,885	54,802	47,368	44,554
Global equities	300,789	410,961	329,990	345,112
	344,674	465,763	377,358	389,666
Real estate pooled funds	40,342	40,623	40,267	40,837
Total Portfolio Investments	$ 2,106,910	$ 2,231,069	$ 1,455,832	$ 1,483,341

The following is a breakdown of portfolio investments:

	2021		2020	
	Cost	Fair Value	Cost	Fair Value
Operating	$ 2,031,242	$ 2,155,401	$ 1,380,394	$ 1,407,903
Endowments	75,668	75,668	75,438	75,438
Total Portfolio Investments	$ 2,106,910	$ 2,231,069	$ 1,455,832	$ 1,483,341

Financial Statements of Other Reporting Entities

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Alberta Health Services

Financial Statements

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Management Responsibility for Financial Reporting

The accompanying consolidated financial statements for the year ended March 31, 2021 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]

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

[Original Signed By Colleen Purdy]

Colleen Purdy, CPA, CMA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 1, 2021

Independent Auditor's Report

Auditor General OF ALBERTA

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

Report on the Consolidated Financial Statements

Opinion

I have audited the consolidated financial statements of Alberta Health Services (the Group), which comprise the consolidated statement of financial position as at March 31, 2021, and the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and notes to the consolidated financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Group as at March 31, 2021, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

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

Other information

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

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

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

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

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

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

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

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

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

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

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

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

- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

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

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

June 1, 2021
Edmonton, Alberta

Alberta Health Services

Consolidated Statement of Operations

Year ended March 31, 2021

(thousands of dollars)

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31			
	2021		2020
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 12,600,000	$ 12,756,769	$ 12,598,000
One-time base operating (Note 26)	-	145,566	-
Other operating	1,292,000	2,480,646	1,290,302
Recognition of expended deferred capital revenue	61,000	76,407	61,354
Other government transfers (Note 4)	427,000	461,929	434,768
Fees and charges	520,000	419,895	532,250
Ancillary operations	134,000	63,485	129,129
Donations, fundraising, and non-government contributions (Note 5)	161,000	184,870	195,980
Investment and other income (Note 6)	179,000	199,519	226,752
TOTAL REVENUES	**15,374,000**	**16,789,086**	**15,468,535**
Expenses:			
Continuing care	1,175,000	1,318,533	1,176,468
Community care	1,537,000	1,666,107	1,525,789
Home care	717,000	680,119	716,561
Acute care	4,876,000	5,221,569	5,065,807
Ambulance services	535,000	542,463	530,662
Diagnostic and therapeutic services	2,454,000	2,719,600	2,539,566
Population and public health	349,000	754,294	357,117
Research and education	352,000	333,133	344,634
Information technology	643,000	626,792	597,005
Support services (Note 7)	2,270,000	2,330,557	2,287,205
Administration (Note 8)	466,000	492,247	473,544
TOTAL EXPENSES (Schedules 1 and 3)	**15,374,000**	**16,685,414**	**15,614,358**
ANNUAL OPERATING SURPLUS (DEFICIT)	**-**	**103,672**	**(145,823)**
Accumulated surplus, beginning of year	1,132,000	1,132,601	1,278,424
Accumulated surplus, end of year (Note 20)	**$ 1,132,000**	**$ 1,236,273**	**$ 1,132,601**

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

Alberta Health Services

Consolidated Statement of Financial Position

As at March 31, 2021

(thousands of dollars)

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31	2021 Actual	2020 Actual
Financial Assets:		
Cash and cash equivalents	$ 477,148	$ 538,778
Portfolio investments (Note 10)	2,231,069	1,472,195
Accounts receivable (Note 11)	665,415	610,571
	3,373,632	2,621,544
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,932,777	1,611,914
Employee future benefits (Note 13)	760,786	711,995
Unexpended deferred operating revenue (Note 14)	641,469	405,951
Unexpended deferred capital revenue (Note 15)	165,111	108,823
Debt (Note 17)	455,659	481,551
	3,955,802	3,320,234
NET DEBT	**(582,170)**	**(698,690)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	9,355,263	8,855,960
Inventories for consumption (Note 19)	563,928	127,298
Prepaid expenses, deposits, and other non-financial assets	209,366	211,480
	10,128,557	9,194,738
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	9,546,387	8,496,048
Expended deferred revenue (Note 16)	8,254,337	7,359,615
NET ASSETS	**1,292,050**	**1,136,433**
Net Assets is comprised of:		
Accumulated surplus (Note 20)	1,236,273	1,132,601
Accumulated remeasurement gains	55,777	3,832
	$ 1,292,050	**$ 1,136,433**

Contractual Obligations and Contingent Liabilities (Note 21)
Impact of COVID-19 (Note 26)

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

Approved by the Alberta Health Services Board:

[Original Signed By David Weyant]

David Weyant, Q.C.
Board Chair

[Original Signed By David Carpenter]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

Alberta Health Services

Consolidated Statement of Change in Net Debt

Year ended March 31, 2021

(thousands of dollars)

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31			
	2021		2020
	Budget (Note 3)	Actual	Actual
Annual operating surplus (deficit)	$ -	$ 103,672	$ (145,823)
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18):			
Purchased tangible capital assets	(611,000)	(455,920)	(502,732)
Leased tangible capital assets	-	(63,214)	(30,751)
Contributed tangible capital assets	(627,000)	(543,751)	(523,196)
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	586,000	563,582	581,723
Effect of other changes:			
Net increase in expended deferred capital revenue	591,000	467,277	434,497
Net increase in expended deferred operating revenue	-	427,445	-
Net decrease (increase) in inventories for consumption	50,000	(436,630)	(20,789)
Net decrease (increase) in prepaid expenses, deposits and other non-financial assets	30,000	2,114	(43,758)
Net remeasurement gains (losses) for the year	17,000	51,945	(30,637)
Decrease (increase) in net debt for the year	**36,000**	**116,520**	**(281,466)**
Net debt, beginning of year	(698,000)	(698,690)	(417,224)
Net debt, end of year	**$ (662,000)**	**$ (582,170)**	**$ (698,690)**

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

Alberta Health Services

Consolidated Statement of Remeasurement Gains and Losses

Year ended March 31, 2021

(thousands of dollars)

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2021		2020
	Budget (Note 3)	Actual	Actual
Unrestricted unrealized gains (losses) attributable to:			
Derivatives	$ -	$ (1,245)	$ 539
Portfolio investments	38,000	82,973	(5,933)
Amounts reclassified to the Consolidated Statement of Operations:			
Portfolio investments	(21,000)	(29,783)	(25,243)
Net remeasurement gains (losses) for the year	**17,000**	**51,945**	**(30,637)**
Accumulated remeasurement gains, beginning of year	4,000	3,832	34,469
Accumulated remeasurement gains, end of year (Note 10)	**$ 21,000**	**$ 55,777**	**$ 3,832**

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

Alberta Health Services

Consolidated Statement of Cash Flows

Year ended March 31, 2021

(thousands of dollars)

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2021 Actual	2020 Actual
Operating transactions:		
Annual operating surplus (deficit)	$ 103,672	$ (145,823)
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	563,582	581,723
Recognition of expended deferred capital revenue	(385,639)	(404,405)
Contributed inventories for consumption	107,460	-
Recognition of expended deferred operating revenue	(67,930)	-
Gain on disposal of portfolio investments	(36,946)	(28,057)
Change in employee future benefits	48,791	23,499
Decrease (increase) in:		
Accounts receivable related to operating transactions	(54,844)	(243,849)
Inventories for consumption	(436,630)	(20,789)
Prepaid expenses, deposits, and other non-financial assets	2,114	(43,758)
Increase (decrease) in:		
Accounts payable and accrued liabilities	281,460	98,823
Unexpended deferred operating revenue	235,518	(47,268)
Expended deferred operating revenue	387,915	-
Cash provided by (applied to) operating transactions	748,523	(229,904)
Capital transactions:		
Purchased tangible capital assets	(455,920)	(502,732)
Cash applied to capital transactions	(455,920)	(502,732)
Investing transactions:		
Purchase of portfolio investments	(2,339,784)	(2,686,092)
Proceeds on disposals of portfolio investments	1,669,801	3,490,385
Cash (applied to) provided by investing transactions	(669,983)	804,293
Financing transactions:		
Restricted capital contributions received	366,649	300,533
Unexpended deferred capital revenue returned	(1,196)	(4,398)
Proceeds from debt	-	157,000
Principal payments on debt	(25,892)	(23,091)
Payments on obligations under capital leases	(22,327)	(23,814)
Net (repayment) receipt of life lease deposits	(1,484)	281
Cash provided by financing transactions	315,750	406,511
(Decrease) Increase in cash and cash equivalents	**(61,630)**	**478,168**
Cash and cash equivalents, beginning of year	538,778	60,610
Cash and cash equivalents, end of year	**$ 477,148**	**$ 538,778**

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

Alberta Health Services

Notes to the Consolidated Financial Statements

For the year ended March 31, 2021
(thousands of dollars)

Note 1 Authority, Purpose and Operations

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

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

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

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

The AHS consolidated financial statements include the revenues and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care.

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 and the financial directives issued by Alberta Health (AH).

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

(i) Controlled Entities

AHS controls the following three entities:

- Alberta Precision Laboratories Ltd. - provides medical diagnostic services throughout Alberta. AHS owns 100% of the Class A voting shares.
- CapitalCare Group Inc. - manages continuing care programs and facilities in the Edmonton area. AHS owns 100% of the Class A voting shares.
- Carewest - manages continuing care programs and facilities in the Calgary area. AHS owns 99% of the Class A voting shares, and 1% of the Class A voting shares are held in trust for the benefit of AHS by an employee of AHS.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

- Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation
American Friends of the Calgary Health Trust Foundation (inactive)
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (operating as Calgary Health Foundation)
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)

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

  The LPIP has a fiscal year end of December 31, 2020. Significant transactions occurring between this date and March 31, 2021 have been recorded in these consolidated financial statements.

- Queen Elizabeth II Hospital Child Care Centre

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

(ii) Government Partnerships

AHS proportionately consolidates its 50% interests in Primary Care Network (PCN) partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 23).

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.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 24).

(iv) Other

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

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

(b) Revenue Recognition

Revenue is recognized in the year 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. Unallocated costs comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

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Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) Government Transfers

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

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

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

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

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

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

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

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

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

(iii) Transfers and Donations related to Land

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

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

Fees and charges, ancillary operations, and other income are recognized in the year that goods are delivered or services are provided by AHS. Amounts received for which goods or services have not been provided by year end are recorded as deferred revenue.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(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 portfolio investments are sold. When realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses from restricted transfers or donations are deferred until recognized according to the provisions within the individual funding agreements.

(c) Expenses

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

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

(d) Financial Instruments

Financial instruments comprise financial assets and liabilities. Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Liabilities are present obligations of AHS to others arising from past transactions or events occurring before the year end, the settlement of which is expected to result in the future sacrifice of economic benefits.

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
Portfolio investments	Measured at fair value with unrealized changes in fair values recognized in the Consolidated Statement of Remeasurement Gains and Losses or deferred revenue until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable, accrued vacation pay, accounts payable and accrued liabilities and debt	Measured at amortized cost.

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to portfolio 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 portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of portfolio investments are accounted for using trade date accounting.

(e) Cash and Cash Equivalents

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

(f) Inventories For Consumption

Purchased inventories for consumption are valued at lower of cost (defined as moving average cost) and replacement cost. Contributed inventories for consumption are recorded at fair value when such value can reasonably be determined. Inventories for consumption are assessed for obsolescence annually and write-downs are recorded in the Consolidated Statement of Operations.

(g) Tangible Capital Assets

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

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

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

	Useful Life
Facilities and improvements	10-70 years (2020 – 10-40 years)
Equipment	3-20 years
Information systems	3-15 years
Building service equipment	5-40 years
Land improvements	5-40 years

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

Tangible capital assets are written down to their net recoverable amount when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. Write-downs are recorded as expenses in the Consolidated Statement of Operations.

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

(h) Employee Future Benefits

(i) Defined Benefit Pension Plans

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

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

Supplemental Executive Retirement Plan (SERP)

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

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

(ii) Defined Contribution Pension Plans

Group Registered Retirement Savings Plans (GRRSPs)

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Supplemental Pension Plan (SPP)

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

(iii) Other Benefit Plans

Accumulating Non-Vesting Sick Leave

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

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

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

Other Benefits

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

(i) Liability for Contaminated Sites

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

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Foreign Currency Translation

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

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

(k) Reserves

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

(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. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences could require adjustment in subsequent reporting years.

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

(m) Future Accounting Changes

The following accounting standards and guideline are applicable in future years:

- **PS 3280 – Asset Retirement Obligations (effective April 1, 2022)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset.
- **PS 3400 – Revenue (effective April 1, 2023)**
  PS 3400 provides guidance on how to account for and report revenue, and specifically, it differentiates between revenue arising from exchange and non-exchange transactions.
- **PSG-8 – Intangible Assets (effective April 1, 2023)**
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets.

AHS is currently assessing the impact of these standards and guideline on future consolidated financial statements.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 3 Budget

The 2020-21 annual budget was submitted to the Minister on February 3, 2020 and was included as part of the Minister's published budget submission that was approved by the Legislative Assembly on March 17, 2020.

Note 4 Other Government Transfers

	Budget	2021	2020
Recognition of expended deferred capital revenue	$ 282,000	$ 275,022	$ 308,581
Restricted operating	105,000	154,063	92,152
Unrestricted operating	40,000	32,844	34,035
	$ 427,000	**$ 461,929**	**$ 434,768**

Other government transfers include $384,161 (2020 – $425,845) transferred from the Province of Alberta, $77,768 (2020 – $8,923) from government entities outside the Province of Alberta and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	Budget	2021	2020
Unrestricted operating	$ 3,000	$ 12,162	$ 3,940
Restricted operating (Note 14)	122,000	138,268	157,289
Recognition of expended deferred capital revenue (Note 16 (a))	36,000	34,210	34,470
Endowment contributions	-	230	281
	$ 161,000	**$ 184,870**	**$ 195,980**

Note 6 Investment and Other Income

	Budget	2021	2020
Investment income	$ 65,000	$ 63,660	$ 80,243
Other income:			
Province of Alberta (Note 22)	31,000	23,369	28,077
AH	11,000	12,520	12,562
Other [(i)]	72,000	99,970	105,870
	$ 179,000	**$ 199,519**	**$ 226,752**

(i) The Other balance of $99,970 (2020 - $105,870) mainly relates to recoveries for services provided to third parties.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 7 Support Services

	Budget	2021	2020
Facilities operations	$ 882,000	$ 927,997	$ 905,659
Patient health records, food services, and transportation	429,000	440,661	436,326
Housekeeping, laundry, and linen	217,000	231,855	220,500
Materials management	169,000	196,806	177,684
Support services expense of full-spectrum contracted health service providers	150,000	162,745	152,542
Ancillary operations	103,000	88,705	97,099
Fundraising expenses and grants awarded	49,000	46,861	48,635
Other	271,000	234,927	248,760
	$ 2,270,000	**$ 2,330,557**	**$ 2,287,205**

Note 8 Administration

	Budget	2021	2020
General administration	$ 213,000	$ 234,448	$ 220,679
Human resources	115,000	114,337	114,865
Finance	75,000	73,480	74,969
Communications	25,000	27,986	24,771
Administration expense of full-spectrum contracted health service providers	38,000	41,996	38,260
	$ 466,000	**$ 492,247**	**$ 473,544**

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.

The COVID-19 pandemic and the measures taken to contain the virus continue to impact the market as a whole. The situation is dynamic and the ultimate duration and magnitude of the impact on the economy and the financial effect on AHS is not known at this time.

In order to earn financial returns at an acceptable level of market risk, the consolidated investment portfolio is governed by investment bylaws and policies with clearly established target asset mixes. The target assets range between 0% 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 3.10% (2020 – 3.24%) 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 unexpended deferred operating revenue of $50,016 (2020 – $28,877).

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 9 Financial Risk Management (continued)

(i) Price Risk

Price risk relates to the possibility that equity portfolio investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity portfolio investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $49,592 or 2.21% of total portfolio investments (March 31, 2020 – $42,045 or 2.84%).

(ii) Interest Rate Risk

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

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

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

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $52,994 (March 31, 2020 – $53,634).

Interest bearing securities have the following average maturity structure:

	2021	2020
0 – 1 year	58%	9%
1 – 5 years	20%	47%
6 – 10 years	10%	19%
Over 10 years	12%	25%

	Average Effective Market Yield	
Asset Class	2021	2020
Money market instruments	0.20%	0.83%
Fixed income securities	1.35%	2.03%

(iii) Foreign Currency Risk

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 9 Financial Risk Management (continued)

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, 2021, investments in non-Canadian equities represented 13.1% (March 31, 2020 – 18.4%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. AHS holds US dollar forward contracts to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2021, AHS held derivatives in the form of forward contracts for future settlement of $8,000 (2020 – $12,000). The fair value of these forward contracts as at March 31, 2021 was $8 (2020 – $1,253) and is included in portfolio investments (Note 10).

(b) Credit Risk

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

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

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

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2021. The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2021	2020
Investment Grade (AAA to BBB)	96%	89%
Unrated	4%	11%
	100%	**100%**

(c) Liquidity Risk

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 10 Portfolio Investments

	2021		2020	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 119,313**	**$ 119,313**	**$ 112,072**	**$ 112,072**
Interest bearing securities:				
Money market securities	818,910	818,910	38,076	38,076
Fixed income securities	786,459	783,669	891,544	876,913
	1,605,369	**1,602,579**	**929,620**	**914,989**
Equities:				
Canadian equity investments	54,802	43,885	44,554	47,368
Canadian equity funds	83,912	65,759	66,937	73,807
Global equity funds	327,050	235,030	278,175	256,183
	465,764	**344,674**	**389,666**	**377,358**
Real estate pooled funds	**40,623**	**40,342**	**40,837**	**40,267**
	$ 2,231,069	**$ 2,106,908**	**$ 1,472,195**	**$ 1,444,686**

	2021	2020
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,176,259	$ 1,426,388
Portfolio investments in equity instruments that are quoted in an active market	54,802	44,554
Derivatives	8	1,253
	$ 2,231,069	**$ 1,472,195**

Included in portfolio investments is $227,688 (2020 – $233,282) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* (Alberta). Endowment principal included in portfolio investments amounts to $75,668 (2020 – $75,438).

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

	2021	2020
Accumulated remeasurement gains	$ 55,777	$ 3,832
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	68,384	23,677
	$ 124,161	**$ 27,509**

Alberta Health Services

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(thousands of dollars)

Note 10 Portfolio Investments (continued)

Fair Value Hierarchy

	2021			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 119,313	$ -	$ -	$ 119,313
Interest bearing securities:				
Money market securities	-	818,910	-	818,910
Fixed income securities	-	734,874	51,585	786,459
Equities:				
Canadian equity investments	54,802	83,912	-	138,714
Global equity funds	-	327,050	-	327,050
Real estate pooled funds	-	-	40,623	40,623
	$ 174,115	**$ 1,964,746**	**$ 92,208**	**$ 2,231,069**
Percent of total	8%	88%	4%	100%

	2020			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ 112,072	$ -	$ -	$ 112,072
Interest bearing securities:				
Money market securities	-	38,076	-	38,076
Fixed income securities	-	816,331	75,213	891,544
Equities:				
Canadian equity investments	44,554	66,937	-	111,491
Global equity funds	-	278,175	-	278,175
Real estate pooled funds	-	-	40,837	40,837
	$ 156,626	**$ 1,199,519**	**$ 116,050**	**$ 1,472,195**
Percent of total	11%	81%	8%	100%

Reconciliation of Investments classified as level 3

	2021		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 75,213	$ 40,837	$ 116,050
Purchases	1,828	74	1,902
Sales	(24,045)	-	(24,045)
Loss (gain) included in the Consolidated Statement of Remeasurement Gains and Losses	1,708	(288)	1,420
Transfers out	(3,119)		(3,119)
End of year	**$ 51,585**	**$ 40,623**	**$ 92,208**

	2020		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 164,738	$ -	$ 164,738
Purchases	4,763	40,268	45,031
Sales	(94,716)	-	(94,716)
Loss included in the Consolidated Statement of Remeasurement Gains and Losses	447	569	1,016
Transfers out	(19)	-	(19)
End of year	**$ 75,213**	**$ 40,837**	**$ 116,050**

Alberta Health Services

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Note 11 Accounts Receivable

	2021			2020
	Gross	Allowance for Doubtful Accounts	Net	Net
AH operating transfers receivable	$ 317,233	$ -	$ 317,233	$ 268,119
Other capital transfers receivable	74,409	-	74,409	62,716
Patient accounts receivable	104,341	34,490	69,851	99,976
Drugs rebates receivable	59,731	-	59,731	60,624
AH capital transfers receivable	55,822	-	55,822	40,707
Other operating transfers receivable	17,540	-	17,540	21,667
Other accounts receivable	71,230	401	70,829	56,762
	$ 700,306	**$ 34,891**	**$ 665,415**	**$ 610,571**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2020, the total allowance for doubtful accounts was $35,016.

Note 12 Accounts Payable and Accrued Liabilities

	2021	2020
Payroll payable and related accrued liabilities	$ 796,747	$ 611,513
Trade accounts payable and accrued liabilities	713,204	636,041
Provision for unpaid claims[(a)]	214,611	208,830
Obligations under capital leases[(b)]	144,877	103,990
Other liabilities	63,338	51,540
	$ 1,932,777	**$ 1,611,914**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $338,379 (2020 – $305,843). Of these amounts, $11,518 (2020 – $13,002) comprise life lease deposits received from tenants of certain AHS' long term care facilities, amounts payable to AI of $97,050 (2020 – $109,150) related to a project funded by debt.

(a) Provision for unpaid claims is an estimate of liability claims against 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 1.90% (2020 – 2.25%) plus a provision for adverse deviation, based on actuarial estimates.

(b) Obligations under capital leases include a site lease with the University of Calgary, vehicle leases, obligations related to a clinical information system, site leases for ambulance services and a community care service facility.

The obligations will be settled between 2021 and 2039 and have an implicit interest rate payable ranging from 0.92% to 5.07% (2020 – 1.93% to 5.07%).

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Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 12 Accounts Payable and Accrued Liabilities (continued)

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

Year ended March 31	Minimum Contract Payments
2022	$ 34,643
2023	21,627
2024	10,372
2025	9,434
2026	8,462
Thereafter	88,625
	173,163
Less: interest	(28,286)
	$ 144,877

Note 13 Employee Future Benefits

	2021	2020
Accrued vacation pay	$ 626,599	$ 582,819
Accumulating non-vesting sick leave[(a)]	130,745	124,652
SERP/SPP pension plans	3,442	4,524
	$ 760,786	**$ 711,995**

(a) Accumulating Non-Vesting Sick Leave

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

	2021	2020
Funded status – deficit	$ 149,885	$ 153,419
Unamortized net actuarial (loss) gain	(19,140)	(28,767)
Accrued benefit liability	**$ 130,745**	**$ 124,652**

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

	2021	2020
Estimated average remaining service life	13 years	13 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	18.30%
Discount rate – beginning of year	2.14%	3.51%
Discount rate – end of year	1.77%	2.14%
Rate of compensation increase per year	2020-21	2019-20
	0.25%	0.75%
	2021-22	2020-21
	0.25%	0.75%
	Thereafter	Thereafter
	2.25%	2.75%

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Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 47% (2020-46%) of the total membership in LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

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

(ii) LAPP Surplus

The LAPP carried out an actuarial valuation as at December 31, 2019 and these results were then extrapolated to December 31, 2020.

	December 31, 2020	December 31, 2019
LAPP net assets available for benefits	$ 53,599,237	$ 50,520,461
LAPP pension obligation	48,637,900	42,607,200
LAPP surplus	**$ 4,961,337**	**$ 7,913,261**

The 2021 and 2020 LAPP contribution rates are as follows:

Calendar 2021		Calendar 2020	
Employer	**Employees**	**Employer**	**Employees**
9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	8.39.% of pensionable earnings up to the YMPE and 12.84% of the excess	9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	8.39% of pensionable earnings up to the YMPE and 12.84% of the excess

(c) Pension Expense

	2021	2020
Local Authorities Pension Plan	$ 536,504	$ 547,168
Defined contribution pension plans and group RRSPs	43,561	45,029
Other pension plans	4,417	2,473
	$ 584,482	**$ 594,670**

Alberta Health Services

Notes to the Consolidated Financial Statements

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Note 14 Unexpended Deferred Operating Revenue

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

	2021				2020
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 115,061	$ 25,019	$ 265,871	$ 405,951	$ 453,219
Received or receivable during the year, net of repayments	3,051,861	48,361	141,468	3,241,690	1,493,467
Unexpended deferred operating revenue returned	(4,170)	(56)	(690)	(4,916)	(14,134)
Restricted investment income	153	2,031	10,833	13,017	13,128
Transferred from unexpended deferred capital revenue [(ii)]	4,499	40,680	1,486	46,665	32,253
Transferred to expended deferred operating revenue	(789,166)	-	-	(789,166)	-
Recognized as revenue	(2,079,395)	(86,133)	(138,268)	(2,303,796)	(1,539,743)
Miscellaneous other revenue recognized	(154)	178	(12,707)	(12,683)	(13,565)
	298,689	**30,080**	**267,993**	**596,762**	**424,625**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	1,507	(519)	43,719	44,707	(18,674)
Balance, end of year	**$ 300,196**	**$ 29,561**	**$ 311,712**	**$ 641,469**	**$ 405,951**

[(i)] The balance at March 31, 2021 for other government includes $677 (2020 – $1,007) of unexpended deferred operating revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta, see Note 22.

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

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Notes to the Consolidated Financial Statements

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Note 14 Unexpended Deferred Operating Revenue (continued)

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

	2021				2020
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 10,038	$ 3,505	$ 175,335	$ 188,878	$ 176,891
COVID-19 pandemic response and Support (Note 26)	108,040	-	374	108,414	-
Support services	1,298	383	56,487	58,168	62,622
Physician revenue and alternate relationship plans	47,842	374	-	48,216	36,684
Addiction and mental health	41,379	3,753	765	45,897	35,127
Cancer prevention, screening and treatment	43,704	11	1,676	45,391	6,473
Primary Care Networks	21,095	-	-	21,095	24,778
Promotion, prevention and community	16,081	1,022	259	17,362	3,929
Long term care partnerships	-	17,304	-	17,304	15,093
Others less than $10,000	9,121	190	13,049	22,360	20,677
	298,598	**26,542**	**247,945**	**573,085**	**382,274**
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	1,598	3,019	63,767	68,384	23,677
	$ 300,196	**$ 29,561**	**$ 311,712**	**$ 641,469**	**$ 405,951**

Note 15 Unexpended Deferred Capital Revenue

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

	2021				2020
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 37,670	$ 4,637	$ 66,516	$ 108,823	$ 128,394
Received or receivable during the year	247,143	115,609	50,562	413,314	332,786
Unexpended deferred capital revenue returned	(1,196)	-	-	(1,196)	(4,398)
Transferred to expended deferred capital revenue	(204,524)	(75,359)	(29,282)	(309,165)	(315,706)
Transferred to unexpended deferred operating revenue[(ii)]	(4,499)	(40,680)	(1,486)	(46,665)	(32,253)
Balance, end of year	**$ 74,594**	**$ 4,207**	**$ 86,310**	**$ 165,111**	**$ 108,823**

[(i)] The balance at March 31, 2021 for other government all relates to the Province of Alberta, see Note 22.
[(ii)] The transfer is mainly comprised of restricted capital funding of approved expenditures that did not meet the definition of a tangible capital asset.

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Note 15 Unexpended Deferred Capital Revenue (continued)

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

	2021	2020
AH		
COVID-19 related projects and equipment	$ 29,380	$ -
Continuing Care Beds	20,000	-
Information systems	4,214	11,118
Medical Equipment Replacement Upgrade Program	322	1,457
Diagnostic equipment	216	18,189
Other equipment	20,462	6,906
Total AH	**74,594**	**37,670**
Other government		
Facilities and improvements	4,207	4,637
Total other government	**4,207**	**4,637**
Donors and non-government		
Equipment	74,540	59,809
Facilities and improvements	11,764	6,707
COVID-19 related projects and equipment	6	-
Total donors and non-government	**86,310**	**66,516**
	$ 165,111	**$ 108,823**

Note 16 Expended Deferred Revenue

	2021	2020
Expended deferred capital revenue[a]	$ 7,826,892	$ 7,359,615
Expended deferred operating revenue[b]	427,445	-
	$ 8,254,337	**$ 7,359,615**

(a) Expended deferred capital revenue

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

	2021				2020
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 459,415	$ 6,698,991	$ 201,209	$ 7,359,615	$ 6,925,118
Transferred from unexpended deferred capital revenue	204,525	75,358	29,282	309,165	315,706
Contributed tangible capital assets	-	543,418	333	543,751	523,196
Less: amounts recognized as revenue	(76,407)	(275,022)	(34,210)	(385,639)	(404,405)
Balance, end of year	**$ 587,533**	**$ 7,042,745**	**$ 196,614**	**$ 7,826,892**	**$ 7,359,615**

[i] The balance includes $5 of expended deferred capital revenue received from government entities outside the Province of Alberta (2020 – $20). The remaining balance relates to the Province of Alberta, see Note 22.

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Notes to the Consolidated Financial Statements

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Note 16 Expended Deferred Revenue (continued)

(b) Expended deferred operating revenue

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

	2021			2020
	AH	Other Government[(i)]	Total	Total
Balance, beginning of year	$ -	$ -	$ -	$ -
Transferred from unexpended deferred operating revenue	789,166	-	789,166	-
Contributed inventories for consumption	-	107,460	107,460	-
Less: amounts recognized as revenue	(401,251)	(67,930)	(469,181)	-
Balance, end of year	**$ 387,915**	**$ 39,530**	**$ 427,445**	**$ -**

[(i)] The balance relates to contributions received from a government entity outside the Province of Alberta (2020 – $ nil)

The balance at March 31, 2021 of expended deferred operating revenue pertains to purchased or contributed but unused COVID-19 supplies of $417,201 (2020 - $ nil) (Note 19) and a related prepayment of $10,244 (2020 - $nil).

Note 17 Debt

	2021	2020
Debentures [(a)]:		
Parkade loan #1	$ 20,257	$ 23,447
Parkade loan #2	20,334	22,984
Parkade loan #3	28,493	31,338
Parkade loan #4	116,390	124,680
Parkade loan #5	28,498	30,388
Parkade loan #6	20,559	21,576
Parkade loan #7	45,388	47,479
Parkade loan #8	155,200	157,000
Energy savings initiative loan	20,540	22,336
Other	-	323
	$ 455,659	**$ 481,551**

(a) In November 2019, *the Reform of Agencies, Boards and Commissions and Government Enterprises Act, 2019* (Bill 22) received Royal Assent in the Legislative Assembly of Alberta. This legislation included the new *Local Authorities Capital Financing Act* allowing for the dissolution of the Alberta Capital Finance Authority (ACFA) and the transfer of ACFA's operations to the Province of Alberta.

Alberta Treasury Board and Finance (TBF), on behalf of the Province, became responsible for the administration of ACFA's lending program effective November 1, 2020 following dissolution of ACFA on October 31, 2020.

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

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Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 17 Debt (continued)

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

AHS is in compliance with all performance requirements relating to its debentures as at March 31, 2021

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

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Parkade loan #8	December 2059	3.6010%
Energy savings initiative loan	December 2030	2.4160%
Other	March 2021	4.6000%

(b) As at March 31, 2021, AHS has access to a $220,000 (2020 - $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, 2021, AHS has $nil (2020 - $nil) draws against this facility.

AHS also has access to a $33,000 (2020 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2021, AHS has $3,772 (2020 – $4,687) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit as at March 31, 2021.

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

Year Ended March 31	Principal	Interest	Total
2022	26,666	17,866	44,532
2023	27,811	16,721	44,532
2024	29,008	15,524	44,532
2025	30,258	14,274	44,532
2026	31,565	12,967	44,532
Thereafter	310,351	131,906	442,257
	$ 455,659	**$ 209,258**	**$ 664,917**

During the year, the total interest related to debt was $18,827 (2020 – $15,864). Accrued interest at March 31, 2021 amounted to $3,006 (2020 - $3,153).

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Note 18 Tangible Capital Assets

Cost	2020	Additions[a]	Transfers	Disposals/write-downs[b]	2021
Facilities and improvements	$ 9,645,300	$ -	$ 874,506	$ (1,954)	$ 10,517,852
Work in progress	1,744,688	875,266	(1,127,112)	-	1,492,842
Equipment	2,623,616	162,205	(7,147)	(53,851)	2,724,823
Information systems	1,827,799	25,414	175,590	(14,010)	2,014,793
Building service equipment	840,122	-	78,034	-	918,156
Land[c]	116,926	-	-	(86)	116,840
Leased facilities and improvements	255,393	-	1,307	-	256,700
Land improvements	105,581	-	4,822	(380)	110,023
	$17,159,425	**$ 1,062,885**	**$ -**	**$ (70,281)**	**$ 18,152,029**

Accumulated Amortization	2020	Amortization Expense	Effect of Transfers	Disposals/write-downs[b]	2021
Facilities and improvements	$ 4,175,901	$ 245,717	$ -	$ (1,250)	$ 4,420,368
Work in progress	-	-	-	-	-
Equipment	2,034,711	149,694	-	(53,109)	2,131,296
Information systems	1,356,789	104,110	-	(11,297)	1,449,602
Building service equipment	476,980	47,366	-	-	524,346
Land[c]	-	-	-	-	-
Leased facilities and improvements	187,033	9,192	-	-	196,225
Land improvements	72,051	3,258	-	(380)	74,929
	$ 8,303,465	**$ 559,337**	**$ -**	**$ (66,036)**	**$ 8,796,766**

Cost	2019	Additions[a]	Transfers	Disposals/write-downs[b]	2020
Facilities and improvements	$ 9,401,390	$ 1,867	$ 244,882	$ (2,839)	$ 9,645,300
Work in progress	1,625,941	909,759	(763,719)	(27,293)	1,744,688
Equipment	2,561,156	106,152	3,591	(47,283)	2,623,616
Information systems	1,474,803	17,073	389,281	(53,358)	1,827,799
Building service equipment	729,544	-	110,662	(84)	840,122
Land[c]	116,823	133	-	(30)	116,926
Leased facilities and improvements	229,874	21,695	3,830	(6)	255,393
Land improvements	94,188	-	11,473	(80)	105,581
	$16,233,719	**$ 1,056,679**	**$ -**	**$ (130,973)**	**$ 17,159,425**

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Note 18 Tangible Capital Assets (continued)

Accumulated Amortization	2019	Amortization Expense	Effect of Transfers	Disposals/write-downs	2020
Facilities and improvements	$ 3,915,175	$ 263,455	$ -	$ (2,729)	$ 4,175,901
Work in progress	-	-	-	-	-
Equipment	1,933,533	147,466	-	(46,288)	2,034,711
Information systems	1,320,894	77,772	-	(41,877)	1,356,789
Building service equipment	434,531	42,533	-	(84)	476,980
Land[(c)]	-	-	-	-	-
Leased facilities and improvements	179,731	7,308	-	(6)	187,033
Land improvements	68,851	3,280	-	(80)	72,051
	$ 7,852,715	**$ 541,814**	**$ -**	**$ (91,064)**	**$ 8,303,465**

	Net Book Value	
	2021	2020
Facilities and improvements	$ 6,097,484	$ 5,469,399
Work in progress	1,492,842	1,744,688
Equipment	593,527	588,905
Information systems	565,191	471,010
Building service equipment	393,810	363,142
Land[(c)]	116,840	116,926
Leased facilities and improvements	60,475	68,360
Land improvements	35,094	33,530
	$ 9,355,263	**$ 8,855,960**

(a) Additions

Additions include total contributed tangible capital assets of $543,751 (2020 – $523,196) consisting of $543,417 from AI (2020 – $523,196) and $334 from other sources (2020 – $nil). Also included in additions is $45,525 (2020 - $nil) (Note 26) of COVID-19 related tangible capital assets. Capital lease additions amounted to $63,214 (2020 – $30,751).

(b) Write-Downs

Write-downs include work in progress of $nil (2020 - $22,615)

(c) Leased Land

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

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

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Note 18 Tangible Capital Assets (continued)

(d) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes equipment, information systems and facilities with a cost of $258,813 (2020 – $192,092) and accumulated amortization of $56,357 (2020 – $43,354).

Note 19 Inventories for consumption

Included in the March 31, 2021 inventory balance is $417,201 (2020 - $nil) (Note 26) of COVID-19 supplies such as personal protective equipment (PPE) and rapid test kits.

Note 20 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2021					2020
	Unrestricted Surplus	Invested in Tangible Capital Assets[a]	Endowments[b]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[c]	Total	Total
Balance, beginning of year	$ 34,417	$ 940,370	$ 75,438	$ 82,376	$ 1,132,601	$ 1,278,424
Annual operating surplus (deficit)	103,672	-	-	-	103,672	(145,823)
Net investment in tangible capital assets	14,807	(14,807)	-	-	-	-
Transfer of insurance equity requirements and foundations surpluses	(1,574)	-	-	1,574	-	-
Transfer of endowment contributions	(230)	-	230	-	-	-
Balance, end of year	**$ 151,092**	**$ 925,563**	**$ 75,668**	**$ 83,950**	**$ 1,236,273**	**$ 1,132,601**

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Note 20 Accumulated Surplus (continued)

(a) Invested in Tangible Capital Assets

The accumulated surplus invested in tangible capital assets represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus.

Reconciliation of invested in tangible capital assets:

	2021	2020
Tangible capital assets (Note 18)	$ 9,355,263	$ 8,855,960
Less funded by:		
Expended deferred capital revenue (Note 16 (a))	(7,826,892)	(7,359,615)
Debt (Note 17)	(455,659)	(481,551)
Unexpended debt	9,246	42,568
Obligations under capital leases (Note 12b)	(144,877)	(103,990)
Life lease deposits (Note 12)	(11,518)	(13,002)
	$ 925,563	**$ 940,370**

(b) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity. Transfers of endowment contributions from unrestricted surplus include $230 (2020 - $281) of contributions received in the year (Note 5).

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

Insurance equity requirements comprise surpluses of $20,912 (2020 - $28,237) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $63,038 (2020 - $54,139) related to donations received by AHS' Controlled Foundations without external restrictions attached.

Note 21 Contractual Obligations and Contingent Liabilities

(a) Contractual Obligations

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of those contracts or agreements are met.
The estimated aggregate amount payable for the unexpired terms of these contractual obligations are as follows:

Year ended March 31	Services[(i)]	Other[(ii)]	Operating Lease	Capital Projects	Total
2022	$ 3,361,378	$ 494,204	$ 62,635	$ 223,898	$ 4,142,115
2023	1,601,636	291,095	55,084	32,442	1,980,257
2024	1,192,785	169,780	45,978	2,331	1,410,874
2025	938,482	107,136	38,349	-	1,083,967
2026	811,574	70,342	28,136	-	910,052
Thereafter	7,803,650	101,449	97,951	-	8,003,050
March 31, 2021	**15,709,505**	**1,234,006**	**328,133**	**258,671**	**17,530,315**
March 31, 2020	**$ 14,162,596**	**$ 1,167,818**	**$ 297,858**	**$ 211,492**	**$ 15,839,764**

(i) Service obligations mainly relate to contracts with third parties for the provision of long-term care and home care services.
(ii) Other obligations mainly relate to contracts with third parties for maintenance, information technology services, software, equipment, acquisitions, and procurement of medical supplies and food.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 21 Contractual Obligations and Contingent Liabilities (continued)

(b) Contingent Liabilities

i. Legal Claims

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, 2021, 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 314 legal claims (2020 – 262 claims) related to conditions in existence at March 31, 2021 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 258 claims have $728,811 in specified amounts and 56 have no specified amounts (2020 – 222 claims with $498,678 of specified claims and 40 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

ii. Collective Agreements

AHS currently has 19 (2020 – nil) collective agreements that have expired and are currently under negotiation at March 31, 2021. The outcome of these negotiations is not determinable at this time and no accrual has been made in the consolidated financial statements.

Note 22 Related Parties

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

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

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 22 Related Parties (continued)

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

	Revenues[a]		Expenses	
	2021	2020	2021	2020
Alberta Advanced Education	$ 55,415	$ 56,092	$ 182,453	$ 191,053
Alberta Infrastructure[c]	319,155	343,065	252	222
Other ministries[d]	35,040	58,326	57,497	29,794
Total for the year	**$ 409,61**	**$ 457,483**	**$ 240,202**	**$ 221,069**

	Receivable from		Payable to	
	2021	2020	2021	2020
Alberta Advanced Education[b]	$ 6,115	$ 6,545	$ 32,561	$ 33,967
Alberta Infrastructure[c]	43,834	25,477	97,050	109,150
Other ministries[d]	8,395	12,128	459,148	488,080
Balance, end of year	**$ 58,344**	**$ 44,150**	**$ 588,759**	**$ 631,197**

(a) Revenues with Province of Alberta ministries include other government transfers of $384,161 (2020 – $425,845), (Note 4), other income of $23,369 (2020 – $28,077) (Note 6), and fees and charges of $2,080 (2020 – $3,561).

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

(c) The transactions with AI relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $44,614 (2020 – $35,271) and recognition of expended deferred capital revenue of $274,541 (2020 – $307,794) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Not included in the table above but included in total amounts disclosed in Note 18(a) is the transfer of land and other tangible capital assets from AI of $543,417 (2020 – $523,196).

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

At March 31, 2021, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $28,884 (2020 – $24,012) related to unexpended deferred operating revenue (Note 14), $4,207 (2020 – $4,637) related to unexpended deferred capital revenue (Note 15) and $7,042,740 (2020 – $6,698,971) related to expended deferred capital revenue (Note 16 (a)).

Contingent liabilities in which AHS has been jointly named with other government entities within the Province of Alberta are disclosed in Note 21.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 23 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.

	2021	2020
Financial assets (portfolio investments, accounts receivable, other assets)	$ 67,275	$ 74,273
Liabilities (trade accounts payable, unexpended deferred operating revenue)	67,275	74,273
Accumulated surplus	$ -	$ -
Total revenues	$ 260,508	$ 260,975
Total expenses	260,508	260,975
Annual surplus	**$ -**	**$ -**

Note 24 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority representation on the HBTA governance board. The HBTA is a formal 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.

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

	2021	2020
Financial assets	$ 108,516	$ 128,181
Liabilities	17,698	17,486
Net financial assets	$ 90,818	$ 110,695
Non-financial assets	12	4
Net assets	**$ 90,830**	**$ 110,699**

AHS has included in prepaid expenses $57,179 (2020 – $74,828) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2021, AHS paid premiums of $431,569 (2020 – $407,512) which is approximately 98% (2020 – 98%) of the total premiums received by the HBTA.

(b) Other Trust Funds

AHS holds funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to appropriate the funds or to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2021, the balance of funds held in trust by AHS for research and development is $100 (2020 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2021, the balance of these funds is $1,595 (2020 – $1,390). These amounts are not included in the consolidated financial statements.

AHS and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. As at March 31, 2021, there are $30,329 in plan assets (2020 - $29,181). These amounts are not included in the consolidated financial statements.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 25 Segment Disclosure

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

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

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

Segments include:

(a) Continuing care

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

(b) Community care

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

(c) Home care

Home care is comprised of home nursing and support.

(d) Acute care

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

(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) Diagnostic and therapeutic services

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

(g) Population and public health

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

(h) Research and education

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

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 25 Segment Disclosure (continued)

(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) 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.

(k) Administration

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

Note 26 Impact of COVID-19

The World Health Organization declared the novel strain of coronavirus, COVID-19, a global pandemic and recommended containment measures worldwide. On March 17, 2020, a state of public health emergency was declared in Alberta with various public health measures implemented across the province throughout the year.

AHS continues to support Albertans with contact tracing, testing and treatment required in the response against COVID-19. AHS is working with the Province on deployment of the COVID-19 vaccine program as vaccine doses are received from AH.

The pandemic continues to impact AHS in many areas, including:

- The provision of personal protective equipment for the overall safety of Albertans. AHS continues to enter into significant purchase commitments to secure essential supplies required for the delivery of healthcare services. At the direction of the Minister, AHS also acquired personal protective equipment to provide to other provinces;
- Increases in funding provided to third party service providers, including long term care providers which have been significantly impacted by COVID-19;
- The operation of assessment and treatments centers, including significantly higher laboratory testing relating to COVID-19;
- Increasing capacity at acute care sites for treatment of COVID-19 cases as a result of increased demand for hospital supplies and equipment;
- Delays or deferrals of certain health care related services;
- Programs such as the critical worker benefit, which provide one-time payments to support front line workers;
- Redeployment of parts of the AHS workforce as the organization responded with measures such as contact tracing and testing, and health link support;
- Vaccine deployment initiatives including staffing and operational and information technology costs relating to the setup of various vaccination facilities;
- Temporary suspension of parking fees at all sites for patients and staff;
- Delays in the implementation of certain information systems initiatives; and
- Receiving donated ventilators, supplies and personal protective equipment as Albertans came together to assist in the response to COVID-19.

Alberta Health Services

Notes to the Consolidated Financial Statements

(thousands of dollars)

Note 26 Impact of COVID-19 (continued)

In order to support COVID -19 initiatives, AHS received contributions totaling approximately $2,042,730 during the year which were utilized as follows:

- $817,213 for incremental operating expenditures arising from activities performed by AHS as described above;
- $896,626 relating mainly to the purchase and contributions received of inventory items, of which $417,201 remained on hand as at March 31, 2021 (see Note 19);
- $145,566 for lost revenue resulting from reduced out of province and out of country patient billings, parking, self-pay medical fees, retail food services and rent abatements; and
- $45,525 in the acquisition of tangible capital assets (see Note 18(a)).

The remaining unexpended contributions have been included in unexpended deferred operating revenue of $108,414 (see Note 14(b)) and unexpended deferred capital revenue of $29,386 (see Note 15(b)) and will be utilized in the next fiscal year.

As Alberta progresses through the response to COVID-19, AHS continues to closely monitor the impacts of COVID-19 on its operations. Overall, as the response is ongoing and an end to the pandemic is indeterminable, the related financial and operational impacts of the pandemic cannot be reliably estimated at this time.

Note 27 Corresponding Amounts

Certain amounts have been reclassified to conform to 2021 presentation.

Note 28 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 1, 2021 and submitted to the Minister for approval.

Alberta Health Services

Schedule 1 - Consolidated Schedule of Expenses by Object

For the year ended March 31

(thousands of dollars)

	2021		2020
	Budget (Note 3)	Actual	Actual
Salaries and benefits	$ 8,315,000	$ 8,836,269	$ 8,530,683
Contracts with health service providers	2,805,000	3,078,611	2,823,741
Contracts under the Health Care Protection Act	28,000	21,828	20,041
Drugs and gases	501,000	592,640	560,661
Medical supplies	584,000	652,304	581,490
Other contracted services	1,341,000	1,368,110	1,319,640
Other[a]	1,214,000	1,572,070	1,196,379
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	586,000	563,582	581,723
	$ 15,374,000	**$ 16,685,414**	**$ 15,614,358**
(a) Significant amounts included in Other are:			
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[i]	$ 81,000	$ 439,087	$ 86,877
Equipment expense	217,000	237,216	223,174
Utilities	114,000	129,022	115,577
Building rent	116,000	128,496	126,387
Building and ground expenses	124,000	95,966	85,683
Minor equipment purchases	47,000	74,794	51,922
Food and dietary supplies	77,000	69,530	80,855
Insurance and liability claims	39,000	58,180	42,439
Office supplies	51,000	57,701	60,311
Fundraising and grants awarded	49,000	47,323	52,298
Telecommunications	36,000	34,339	39,983
Travel	49,000	22,473	39,809
Licenses, fees and memberships	19,000	21,116	21,650
Education	18,000	8,325	11,893
Other	177,000	148,502	157,521
	$ 1,214,000	**$ 1,572,070**	**$ 1,196,379**

[i] Includes PPE, such as procedural masks, N95's, gowns, face shields and goggles, as well as other COVID-19 supplies such as hand sanitizers, disinfecting wipes and other cleaning supplies

Alberta Health Services

Schedule 2 - Consolidated Schedules of Salaries and Benefits
Schedule 2A – Board Remuneration

For the year ended March 31, 2021

(thousands of dollars)

	Term	2021 Committees	2021 Remuneration	2020 Remuneration
Board Chairs[f]				
David Weyant	Since Aug 20, 2019	AOC, ARC, CEC, FC, GC, HRC, QSC	$ 71	$ 43
Linda Hughes	Nov 27, 2015 to Aug 19, 2019	-	-	26
Board Members				
Dr. Sayeh Zielke (Vice Chair)	Since Sep 28, 2020	ARC, CEC, FC, GC, HRC, QSC	21	-
Dr. Brenda Hemmelgarn (Vice Chair)	Nov 27, 2015 to Jan 22, 2021	CEC (Chair), FC, QSC	36	49
Deborah Apps	Since Jan 19, 2021	CEC, FC, QSC	6	-
David Carpenter	Since Nov 27, 2015	ARC (Chair), FC (Chair), HRC	37	34
Heather Crowshoe	Nov 3, 2016 to Nov 2, 2019	-	-	17
Tony Dagnone	Since Jan 19, 2021	FC, HRC, QSC	8	-
Richard Dicerni	Nov 27, 2015 to Aug 31, 2020	FC, HRC (Chair)	10	28
Sherri Fountain	Since Jan 19, 2021	AOC, FC, GC (Chair), HRC	8	-
Linda Hughes	Aug 20, 2019 to Sep 30, 2019	-	-	1
Stephen Mandel	Since Sep 25, 2019	AOC (Chair), CEC, FC, QSC	32	16
Heidi Overguard	Since Sep 25, 2019	AOC, CEC, FC, GC, HRC (Chair)	33	17
Natalia Reiman	Since Jan 19, 2021	CEC, FC, GC, HRC	8	-
Hugh Sommerville	Nov 27, 2015 to Jan 25, 2021	ARC, FC, GC (Chair)	24	32
Marliss Taylor	Nov 27, 2015 to Oct 24, 2019	-	-	18
Brian Vaasjo	Since Aug 20, 2019	AOC, ARC, FC, GC	32	19
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	33	32
Vicki Yellow Old Woman	Since Sep 28, 2020	ARC, CEC (Chair), FC, GC, HRC	19	-
Board Committee Participants[g]				
Dr. Brian Postl	Since Jan 1, 2018	QSC	3	2
Gord Winkel	Since Nov 27, 2015	QSC	3	2
Total Board			**$ 384**	**$ 336**

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

Alberta Health Services

Schedule 2B – Executive Salaries and Benefits

For the year ended March 31

(thousands of dollars)

	2021						
For the Current Fiscal Year	FTE [a]	Base Salary [b,h]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer[i]	0.57	$ 121	$ -	$ 25	$ 146	$ -	$ 146
Ronda White – Chief Audit Executive[j,s]	1.00	277	1	75	353	-	353
Dr. Verna Yiu – President and Chief Executive Officer[k,t]	1.00	574	-	119	693	-	693
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[l,s]	1.00	464	-	73	537	-	537
Dr. Ted Braun – VP and Medical Director, Clinical Operations[s]	1.00	397	-	92	489	-	489
Mauro Chies – VP, Cancer Care Alberta and Clinical Support Services[s]	1.00	330	-	81	411	-	411
Sean Chilton – VP, People, Health Professions and Information Technology[m,s]	1.00	330	1	68	399		399
Tina Giesbrecht – General Counsel[n,s]	0.43	109	3	30	142	-	142
Todd Gilchrist – VP, People[o,u]	0.57	255	-	39	294	-	294
Deb Gordon – VP and Chief Operating Officer, Clinical Operations[s]	1.00	370	-	135	505	-	505
Robert Hawes – Interim VP, Corporate Services and Chief Financial Officer[p,v]	0.27	96	9	4	109	-	109
Dr. Mark Joffe – VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[q,w]	1.00	450	33	44	527	-	527
Colleen Purdy – VP, Corporate Services and Chief Financial Officer[r,s]	0.75	301	-	90	391	-	391
Dr. Kathryn Todd – VP, Provincial Clinical Excellence[q,w]	1.00	289	14	47	350	-	350
Colleen Turner – VP, Community Engagement and Communications[s]	1.00	330	-	72	402	-	402
Total Executive	**12.59**	**$ 4,693**	**$ 61**	**$ 994**	**$ 5,748**	**$ -**	**$ 5,748**

Alberta Health Services

Schedule 2B – Executive Salaries and Benefits (continued)

For the year ended March 31

(thousands of dollars)

	2020						
For the Prior Fiscal Year	FTE [a]	Base Salary [b,h]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Andrea Beckwith-Ferraton – Chief Ethics and Compliance Officer	1.00	$ 212	$ 3	$ 37	$ 252	$ -	$ 252
Ronda White – Chief Audit Executive	1.00	278	1	56	335	-	335
Dr. Verna Yiu – President and Chief Executive Officer	1.00	576	-	78	654	-	654
CEO Direct Reports							
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	1.00	465	-	88	553	-	553
Dr. Ted Braun – VP and Medical Director, Clinical Operations	1.00	399	-	61	460	-	460
Mauro Chies – VP, CancerControl Alberta and Clinical Support Services	1.00	331	-	55	386	-	386
Sean Chilton – VP, Health Professions and Practice and Information Technology	1.00	331	-	64	395	-	395
Todd Gilchrist – VP, People	1.00	452	1	72	525	-	525
Deb Gordon – VP and Chief Operations Officer, Clinical Operations	1.00	372	-	65	437	-	437
Robert Hawes – Interim VP, Corporate Services and Chief Financial Officer	0.08	34	3	2	39	-	39
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	0.95	353	-	57	410	-	410
Dr. Mark Joffe – VP and Medical Director, Cancer Control Alberta, Clinical Support Services and Provincial Clinical Excellence	1.00	451	34	42	527	-	527
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	0.92	357	1	51	409	557	966
Dr. Kathryn Todd – VP, Provincial Clinical Excellence	1.00	291	15	45	351	-	351
Colleen Turner – VP, Community Engagement and Communications	1.00	332	-	70	402	-	402
Total Executive	**13.95**	**$ 5,234**	**$ 58**	**$ 843**	**$ 6,135**	**$ 557**	**$ 6,692**

Alberta Health Services

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 amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Schedule 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.

	2021			2020			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2020	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2021
Andrea Beckwith-Ferraton - Chief Ethics and Compliance Officer	$ 4	$ -	$ 4	$ 6	$ 25	$ 7	$ 32
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	35	-	35	36	326	66	392
Dr. Ted Braun - VP and Medical Director, Clinical Operations							
SERP	-	11	11	-	206	12	218
SPP	27	-	27	28	189	43	232
Mauro Chies - VP, Cancer Care Alberta and Clinical Support Services	19	-	19	20	138	30	168
Sean Chilton - VP, People, Health Professions and Information Technology	19	-	19	20	198	35	233
Tina Giesbrecht - General Counsel	10	-	10	11	64	17	81
Todd Gilchrist - VP, People	19	-	19	34	191	(191)	-
Deb Gordon - VP and Chief Operating Officer, Clinical Operations							
SERP	-	36	36	(1)	642	41	683
SPP	23	-	23	25	219	36	255
Robert Hawes - Interim VP, Corporate Services and Chief Financial Officer[v]	-	-	-	-	-	-	-
Dr. Mark Joffe - VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[w]	-	-	-	-	-	-	-
Colleen Purdy - VP, Corporate Services and Chief Financial Officer	20	-	20	-	-	20	20
Dr. Kathryn Todd - VP, Provincial Clinical Excellence[w]	-	-	-	-	-	-	-
Colleen Turner - VP, Community Engagement and Communications	19	-	19	20	150	33	183
Ronda White - Chief Audit Executive	12	-	12	13	118	21	139
Dr. Verna Yiu - President and Chief Executive Officer	48	-	48	49	203	66	269

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plan's assets. AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.

Alberta Health Services

Footnotes to the Consolidated Schedules of Salaries and Benefits

For the year ended March 31

(in thousands)

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.

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

d. Other non-cash benefits include:
   - Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Schedule 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
   - Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

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

Board and Board Committee Participants

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

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

Executive

h. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2021, the number of work days at AHS is 261 (2020 – 262 work days).

i. As a result of restructuring, the incumbent ceased to be a direct report to the Board effective October 26, 2020.

j. The incumbent received a vacation payout of $16 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.

k. 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.

l. The incumbent received a vacation payout of $35 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 received vacation payouts totaling $26 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.

n. As a result of restructuring, the incumbent became a direct report to the President and Chief Executive Officer effective October 26, 2020.

o. The incumbent held the position until October 23, 2020 at which time the incumbent left AHS. At this time, the incumbent received a vacation payout of $49 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

p. The term of the temporary position ended July 8, 2020.

Alberta Health Services

Footnotes to the Consolidated Schedules of Salaries and Benefits (continued)

For the year ended March 31

(in thousands)

q. 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.

r. The incumbent was appointed to the position effective July 1, 2020.

Termination Obligations

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

t. 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.

u. Based on the provision of the applicable SPP, the following outlines the benefits received by the incumbent who terminated employment with AHS within the 2020-21 fiscal period. As a result of this termination, the incumbent is entitled to the benefits accrued to them up to the date of termination. For participants of SPP, the benefit includes the account balances as at March 31, 2020 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year.

Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
May 4, 2015	$219,030	Once	November 2020

v. There is no severance associated with the temporary position.

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

Alberta Health Services

Schedule 3 - Consolidated Schedule of Segment Disclosures

For the year ended March 31

(thousands of dollars)

	2021								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 330,419	$ 930,329	$ -	$ 8,301	$ 5,679	$ 9,293	$ 31,942	$ 2,570	$ 1,318,533
Community care	693,825	836,030	-	4,427	3,549	59,099	68,546	631	1,666,107
Home care	339,150	215,509	-	194	9,716	86,642	28,867	41	680,119
Acute care	3,084,131	406,462	21,828	546,778	339,940	556,025	200,813	65,592	5,221,569
Ambulance services	311,550	172,407	-	2,001	4,878	1,499	31,427	18,701	542,463
Diagnostic and therapeutic services	1,665,709	300,123	-	25,632	246,237	313,965	117,549	50,385	2,719,600
Population and public health	437,911	15,572	-	2,668	32,663	31,650	233,510	320	754,294
Research and education	188,877	2,161	-	96	1,993	120,234	19,653	119	333,133
Information technology	302,708	18,285	-	-	7	28,092	175,120	102,580	626,792
Support services	1,113,775	164,706	-	2,541	7,406	130,816	591,618	319,695	2,330,557
Administration	368,214	17,027	-	2	236	30,795	73,025	2,948	492,247
Total	**$ 8,836,269**	**$ 3,078,611**	**$ 21,828**	**$ 592,640**	**$ 652,304**	**$ 1,368,110**	**$ 1,572,070**	**$ 563,582**	**$ 16,685,414**

Alberta Health Services

Schedule 3 - Consolidated Schedule of Segment Disclosures (continued)

For the year ended March 31 (continued)

(thousands of dollars)

	2020								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Care Protection Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 321,316	$ 806,123	$ -	$ 7,881	$ 4,533	$ 5,802	$ 28,489	$ 2,324	$ 1,176,468
Community care	698,728	698,918	-	4,445	3,451	52,003	67,693	551	1,525,789
Home care	338,741	257,699	-	187	9,308	88,298	22,244	84	716,561
Acute care	3,022,568	388,383	20,041	511,365	356,465	562,803	148,107	56,075	5,065,807
Ambulance services	305,282	173,494	-	2,018	3,945	1,472	27,322	17,129	530,662
Diagnostic and therapeutic services	1,595,207	289,472	-	24,473	188,168	286,529	106,626	49,091	2,539,566
Population and public health	305,676	14,620	-	7,704	4,809	10,225	13,825	258	357,117
Research and education	189,530	3,495	-	103	1,364	124,776	25,217	149	344,634
Information technology	298,101	735	-	-	29	40,667	166,852	90,621	597,005
Support services	1,102,401	152,542	-	2,481	9,167	115,228	541,106	364,280	2,287,205
Administration	353,133	38,260	-	4	251	31,837	48,898	1,161	473,544
Total	**$ 8,530,683**	**$ 2,823,741**	**$ 20,041**	**$ 560,661**	**$ 581,490**	**$ 1,319,640**	**$ 1,196,379**	**$ 581,723**	**$ 15,614,358**

Health Quality Council of Alberta

Financial Statements

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Management Responsibility for Financial Reporting

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

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

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

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

On behalf of the Health Quality Council of Alberta.

[Original signed by Charlene McBrien-Morrison]

Acting Chief Executive Officer
Charlene McBrien-Morrison
May 31, 2021

[Original signed by Jessica Wing]

Director, Financial Services
Jessica Wing
May 31, 2021

Independent Auditor's Report

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

Auditor General OF ALBERTA

Report on the Financial Statements

Opinion

I have audited the financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2021, and the statements of operations, change in net financial assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2021, and the results of its operations, its changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

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

Other information

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

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

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

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

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

May 31, 2021
Edmonton, Alberta

Health Quality Council of Alberta

Statement of Operations

Year ended March 31, 2021

(*thousands of dollars*)

	2021		2020
	Budget	Actual	Actual
	(Note 4)		
Revenues			
Government transfers			
Alberta Health - operating grant	$ 7,560	$ 7,560	$ 6,560
Investment income	25	5	27
Other revenue	-	20	25
	7,585	7,585	6,612
Expenses (Schedule 1)			
Administration	2,318	1,681	2,111
Health system analytics	2,881	2,477	2,596
Health system improvement	2,300	884	1,425
Communication	1,013	672	946
Ministerial assessment/study	-	18	79
Minister’s priorities	-	674	-
	8,512	6,406	7,157
Annual operating surplus (deficit)	(927)	1,179	(545)
Accumulated operating surplus, beginning of year	2,168	1,222	1,767
Accumulated operating surplus, end of year	$ 1,241	$ 2,401	$ 1,222

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

Health Quality Council of Alberta

Statement of Financial Position

As at March 31

(*thousands of dollars*)

	2021	2020
Financial Assets		
Cash	$ 2,193	$ 1,017
Accounts receivable	18	30
	2,211	1,047
Liabilities		
Accounts payable and other accrued liabilities (Note 6)	624	686
Employee future benefits (Note 7)	21	134
Deferred lease inducements (Note 8)	74	111
	719	931
Net Financial Assets	1,492	116
Non-Financial Assets		
Tangible capital assets (Note 9)	769	936
Prepaid expenses	140	170
	909	1,106
Net Assets	2,401	1,222
Net Assets		
Accumulated operating surplus (Note 11)	$ 2,401	$ 1,222

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

(*thousands of dollars*)

	2021		2020
	Budget	**Actual**	**Actual**
Annual operating surplus (deficit)	$ (927)	$ 1,179	$ (545)
Acquisition of tangible capital assets (Note 9)	(43)	(127)	(44)
Amortization and write down of tangible capital assets (Note 9)	296	294	296
Decrease (Increase) in prepaid expenses	-	30	(88)
Increase (Decrease) in net financial assets in the year	(674)	1,376	(381)
Net financial assets, beginning of year	116	116	497
Net financial assets, end of year	$ (558)	$ 1,492	$ 116

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

Health Quality Council of Alberta

Statement of Cash Flows

Year ended March 31

(*thousands of dollars*)

	2021	2020
Operating Transactions		
Annual operating surplus (deficit)	$ 1,179	$ (545)
Non-cash items:		
Amortization and write down of tangible capital assets (Note 9)	294	296
Amortization of deferred lease inducements (Note 8)	(37)	(36)
(Decrease) Increase in employee future benefits (Note 7)	(113)	13
	1,323	(272)
Decrease in accounts receivable	12	30
Decrease (Increase) in prepaid expenses	30	(88)
(Decrease) in accounts payable and other accrued liabilities (Note 6)	(62)	(71)
Cash provided by (applied to) operating transactions	1,303	(401)
Capital Transactions		
Acquisition of tangible capital assets (Note 9)	(127)	(44)
Cash (applied to) capital transactions	(127)	(44)
Increase (Decrease) in cash	1,176	(445)
Cash at beginning of year	1,017	1,462
Cash at end of year	$ 2,193	$ 1,017

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

Health Quality Council of Alberta

Notes to the Financial Statements

March 31, 2021

(*thousands of dollars*)

Note 1 AUTHORITY

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

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

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

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES

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

(a) Reporting Entity

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

(b) Basis of Financial Reporting

Revenues

All revenues are reported on the accrual basis of accounting. 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.

Health Quality Council of Alberta

Notes to the Financial Statements

(thousands of dollars)

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

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

Valuation of Financial Assets and Liabilities

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

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

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

Financial Assets

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

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

Cash

Cash comprises cash on hand and demand deposits.

Accounts Receivable

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

Liabilities

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

Health Quality Council of Alberta

Notes to the Financial Statements

(thousands of dollars)

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

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

Deferred Lease Inducements

Deferred lease inducements represent amounts received for leasehold improvements and the value of a rent-free period. Lease inducements are deferred and amortized on a straight-line basis over the term of the related lease and the amortization is recognized as a reduction of rent expense for the year.

Employee Future Benefits

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

Non-Financial Assets

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

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

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

Tangible Capital Assets

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

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

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

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

Health Quality Council of Alberta

Notes to the Financial Statements

(*thousands of dollars*)

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.

Note 3 FUTURE CHANGES IN ACCOUNTING STANDARDS AND GUIDELINE

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

- PS 3280 Asset Retirement Obligations (effective April 1, 2022)
  This standard provides guidance on how to account for and report liabilities for retirement of tangible capital assets.
- PS 3400 Revenue (effective April 1, 2023)
  This standard provides guidance on how to account for and report on revenue, and specifically, it differentiates between revenue arising from exchange and non-exchange transactions.
- PSG-8 Intangible Assets (effective April 1, 2023)
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets.

The HQCA has not adopted these standards and guideline. Management is currently assessing the impact of these standards and guideline on the financial statements.

Health Quality Council of Alberta

Notes to the Financial Statements

(*thousands of dollars*)

Note 4 BUDGET

The HQCA's 2020-2021 operating budget with a budgeted deficit of ($927) was approved by the Board of Directors on January 22, 2020 and submitted to the Ministry of Health.

Note 5 FINANCIAL RISK MANAGEMENT

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

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

(a) Interest rate risk

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

(b) Liquidity risk

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

(c) Price risk

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.

(d) Credit risk

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

Note 6 ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Included in accounts payable and accrued liabilities is $58 (2020 - $160) of funds held on behalf of the partners of PROactive: Partners in Professionalism initiative to cover expenses which the HQCA will incur on their behalf.

Health Quality Council of Alberta

Notes to the Financial Statements

(*thousands of dollars*)

Note 7 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 $374 for the year ended March 31, 2021 (2020 - $388).

At December 31, 2020, the Local Authorities Pension Plan reported a surplus of $4,961,337 (2019 – surplus of $7,913,261).

As a result of the COVID-19 outbreak, declared a global pandemic on March 11, 2020, global financial markets and world economies have experienced significant volatility. Given the extent of the crisis, and varying levels of response and recovery of countries across the globe, additional uncertainty remains and will continue to exist with regards to fair value measurement of the pension plan's investments.

The Supplementary Executive Retirement Plan (SERP) payable at year ended March 31, 2021 is $21 (2020 - $134). A payment of $119 (2020 - $0) has been made to plan member at retirement. The current year contribution related to this plan is $6 (2020 - $13).

Note 8 DEFERRED LEASE INDUCEMENTS

The HQCA received a 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.

	2021	2020
Lease inducements - rent free periods	$ 209	$ 209
Less accumulated amortization	(135)	(98)
	$ 74	$ 111

Health Quality Council of Alberta

Notes to the Financial Statements

(thousands of dollars)

Note 9 TANGIBLE CAPITAL ASSETS

	2021				2020
	Office Equipment	Computer Hardware & Software	Leasehold improvements	Total	Total
Estimated useful life	10 years	5 years	5-10 years		
Historical Cost					
Beginning of year	$ 401	$ 819	$ 1,013	$ 2,233	$ 2,227
Additions	-	127	-	127	44
Disposals, including write-downs	(6)	(14)	-	(20)	(38)
	395	932	1,013	2,340	2,233
Accumulated Amortization					
Beginning of year	249	403	645	1,297	1,039
Amortization expense	32	139	123	294	294
Effect of disposals, including write-downs	(6)	(14)	-	(20)	(36)
	275	528	768	1,571	1,297
Net book value at March 31, 2021	$ 120	$ 404	$ 245	$ 769	
Net book value at March 31, 2020	$ 152	$ 416	$ 368		$ 936

Health Quality Council of Alberta

Notes to the Financial Statements

(*thousands of dollars*)

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 three years and thereafter are as follows:

Year ended March 31	Total lease payments
2021 - 22	$ 479
2022 - 23	479
2023 - 24	-
Thereafter	-
	$ 958

Note 11 ACCUMULATED OPERATING SURPLUS

Accumulated operating surplus is comprised of the following:

	2021				2020
	Investment in Tangible Capital Assets[(a)]	Internally Restricted Surplus[(b)]	Unrestricted Surplus (Deficit)	Total	Total
Balance, April 1, 2020	$ 936	$ 286	$ -	$ 1,222	$ 1,767
Annual operating surplus (deficit)	-	-	1,179	1,179	(545)
Net investments in capital assets	(167)	-	167	-	-
Transfers, prior year restricted	-	(286)	286	-	-
Transfers, current year restricted	-	1,632	(1,632)	-	-
Balance, March 31, 2021	$ 769	$ 1,632	$ -	$ 2,401	$ 1,222

(a) Investment in tangible capital assets equals to net book value of internally funded tangible capital assets. These assets are restricted and are not available for any other purpose.

Health Quality Council of Alberta

Notes to the Financial Statements

(thousands of dollars)

Note 11 ACCUMULATED OPERATING SURPLUS (CONT'D)

(b) The internally restricted surplus represents amounts set aside by the Board for future purposes. Those amounts are not available for other purposes without the approval of the Board. Internally restricted surplus based on the business plan is summarized as follows:

	2021	2020
Engage	$ 750	$ -
Assess	450	-
Improve	432	-
Experience surveys	-	218
FOCUS on Healthcare	-	50
Ministerial assessments and studies	-	18
	$ 1,632	$ 286

Note 12 APPROVAL OF THE FINANCIAL STATEMENTS

The financial statements were approved by the HQCA Board of Directors on May 31, 2021.

Health Quality Council of Alberta

Schedule 1 – Expenses – Detailed by Object

Year ended March 31

(*thousands of dollars*)

	2021		2020
	Budget	Actual	Actual
Salaries and benefits	$ 4,557	$ 4,088	$ 3,979
Supplies, services and other	3,659	2,024	2,884
Amortization of tangible capital assets (Note 10)	296	294	294
	$ 8,512	$ 6,406	$ 7,157

Health Quality Council of Alberta

Schedule 2 – Salary and Benefits Disclosure

Year ended March 31

(*thousands of dollars*)

	2021				2020
	Base Salary [1]	Other Cash Benefits [2]	Other Non-Cash Benefits [3]	Total	Total
Board of Directors-Chair	$ -	$ 24	$ -	$ 24	$ 19
Board of Directors-Members	-	41	-	41	54
Chief Executive Officer [4]	50	153	7	210	298
Acting Chief Executive Officer [4]	173	5	14	192	-
Executive Director [4]	37	-	4	41	218
	$ 260	$ 223	$ 24	$ 508	$ 589

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include honoraria for board members and vehicle allowance, flexible spending allowance, Supplementary Executive Retirement Plan payments and vacation payouts to employees. There were no bonuses paid in 2020/2021.

(3) Other non-cash benefits include: employer's portion of all employee benefits and contributions or payments made on behalf of employees, including pension, Supplementary Executive Retirement Plan, health care benefits, dental coverage, vision coverage, out of country medical benefits, group life insurance, accidental disability and dismemberment insurance, employee assistance program, Canadian Pension Plan, Employment Insurance and fair market value parking.

(4) The Chief Executive Officer retired effective June 11, 2020. The Executive Director assumed the role of Acting Chief Executive Officer effective June 12, 2020. The Executive Director position has been vacant since June 12, 2020.

Health Quality Council of Alberta

Schedule 3 – Related Party Transaction

Year ended March 31

(*thousands of dollars*)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Government of Alberta's Consolidated Financial Statements. Related parties also include key management personnel and close family members of those individuals in the HQCA. The HQCA and its employees paid or collected certain taxes and fees set by regulation for premiums, licenses and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The HQCA had the following transactions with related parties recorded in the Statement of Operations and the Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2021	2020
Revenues		
Grants	$ 7,560	$ 6,560
Other	6	6
	$ 7,566	$ 6,566
Expenses		
Other services	$ 54	$ 114
Receivable from related parties	$ -	$ 1
Payable to related parties	$ 18	$ 29

Other Financial Information

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Department of Health

Statement of Credit or Recovery (unaudited)

Year ended March 31, 2021
(in thousands)

	2021				
	Authorized	Actual Revenue Recognized	Unearned Revenue	Total Revenue Received / Receivable	(Shortfall) / Excess
Expense Amounts					
Support Programs					
Other Support Programs [(a)]	$ 1,000	$ -	$ -	$ -	$ (1,000)
	$ 1,000	$ -	$ -	$ -	$ (1,000)

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

Department of Health

Lapse/Encumbrance (unaudited)

Year ended March 31, 2021
(in thousands)

Expense Vote by Program Operating Expense		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Over Expended/ (Unexpended)
1	**Ministry Support Services**						
1.1	Minister's Office	$ 745	$ (20)	$ -	$ 725	$ 1,080	$ 355
1.2	Associate Minister's Office	395	(9)	-	386	569	183
1.3	Deputy Minister's Office	1,553	-	-	1,553	1,302	(251)
1.4	Strategic Corporate Support	41,648	-	-	41,648	42,071	423
1.5	Policy Development and Strategic Support	16,023	-	-	16,023	12,772	(3,251)
1.6	Health Advocates' Office	1,965	-	-	1,965	1,490	(475)
		62,329	(29)	-	62,300	59,284	(3,016)
2	**Alberta Health Services**						
2.1	Continuing Care	1,123,000	-	-	1,123,000	1,123,000	-
2.2	Community Care	1,254,000	-	-	1,254,000	1,254,000	-
2.3	Home Care	688,000	(23,733)	-	664,267	664,267	-
2.4	Acute Care	3,680,000	96,151	-	3,776,151	3,776,151	-
2.5	Ambulance Services	465,000	-	-	465,000	465,000	-
2.6	Diagnostic and Therapeutic Services	2,373,351	34,000	-	2,407,351	2,407,351	-
2.7	Population and Public Health	330,000	11,000	-	341,000	341,000	-
2.8	Health Workforce Education and Research	81,000	28,000	-	109,000	109,000	-
2.9	Information Technology	484,000	(42,000)	-	442,000	442,000	-
2.10	Support Services	1,634,000	55,000	-	1,689,000	1,689,000	-
2.11	Administration	488,000	-	-	488,000	488,000	-
		12,600,351	158,418	-	12,758,769	12,758,769	-
3	**Physician Compensation and Development**						
3.1	Program Support	8,065	18	-	8,083	7,404	(679)
3.2	Physician Remuneration	4,505,992	(270,414)	-	4,235,578	4,194,603	(40,975)
3.3	Physician Development	174,851	(20)	-	174,831	174,766	(65)
3.4	Physician Benefits	341,132	11,643	-	352,775	270,823	(81,952)
		5,030,040	(258,773)	-	4,771,267	4,647,596	(123,671)

Department of Health

Lapse/Encumbrance (Unaudited) (Continued)

Year ended March 31, 2021
(in thousands)

Expense Vote by Program Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Over Expended/ (Unexpended)
4 Drugs and Supplemental Health Benefits						
4.1 Program Support	$ 49,000	$ -	$ -	$ 49,000	$ 48,473	$ (527)
4.2 Outpatient Cancer Therapy Drugs	234,600	32,900	-	267,500	279,873	12,373
4.3 Outpatient Specialized High Cost Drugs	122,100	7,573	-	129,673	126,992	(2,681)
4.4 Seniors Drug Benefits	517,369	98,631	-	616,000	613,417	(2,583)
4.5 Seniors Dental, Optical and Supplemental Health Benefits	138,746	(18,746)	-	120,000	113,239	(6,761)
4.6 Non-Group Drug Benefits	223,877	123	-	224,000	222,073	(1,927)
4.7 Non-Group Supplemental Health Benefits	900	-	-	900	798	(102)
4.8 Assured Income for the Severely Handicapped Health Benefit	247,825	(13,825)	-	234,000	232,500	(1,500)
4.9 Child Health Benefit	31,352	(4,352)	-	27,000	25,267	(1,733)
4.10 Adult Health Benefit	234,000	(32,000)	-	202,000	198,249	(3,751)
4.11 Alberta Aids to Daily Living	170,000	(3,000)	-	167,000	155,948	(11,052)
4.12 Pharmaceutical Innovation and Management	108,243	6,757	-	115,000	112,892	(2,108)
	2,078,012	74,061	-	2,152,073	2,129,721	(22,352)
5 Addiction and Mental Health						
5.1 Program Support	3,591	-	-	3,591	3,218	(373)
5.2 Addiction and Mental Health	116,935	-	-	116,935	116,774	(161)
	120,526	-	-	120,526	119,992	(534)
6 Primary Health Care						
6.1 Program Support	3,258	-	-	3,258	3,025	(233)
6.2 Primary Health Care	242,900	-	-	242,900	231,388	(11,512)
	246,158	-	-	246,158	234,413	(11,745)
7 Population and Public Health						
7.1 Program Support	13,424	-	-	13,424	11,306	(2,118)
7.2 Immunization Support	2,121	-	-	2,121	1,870	(251)
7.3 Community-Based Health Services	53,168	-	-	53,168	52,577	(591)
7.4 Research and Support Programs	15,450	-	-	15,450	13,723	(1,727)
7.5 Palliative Care	5,000	-	-	5,000	3,275	(1,725)
	89,163	-	-	89,163	82,751	(6,412)
8 Allied Health Services	116,700	(5,869)	-	110,831	109,526	(1,305)
9 Human Tissue and Blood Services	180,000	-	-	180,000	185,253	5,253

Department of Health

Lapse/Encumbrance (Unaudited) (Continued)

Year ended March 31, 2021
(in thousands)

Expense Vote by Program Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Over Expended/ (Unexpended)
10 Support Programs						
10.1 Program Support	$ 8,780	$ -	$ -	$ 8,780	$ 8,288	$ (492)
10.2 Health Quality Council of Alberta	7,559	-	-	7,559	7,560	1
10.3 Protection for Persons in Care	2,100	-	-	2,100	1,374	(726)
10.4 Monitoring, Investigations and Licensing	7,720	-	-	7,720	6,855	(865)
10.5 Health System Projects	3,160	-	-	3,160	128	(3,032)
	29,319	-	-	29,319	24,205	(5,114)
11 Out-of-Province Health Care Services						
11.1 Program Support	6,872	-	-	6,872	5,988	(884)
11.2 Out-of-Province Health Care Services	144,800	-	-	144,800	126,683	(18,117)
	151,672	-	-	151,672	132,671	(19,001)
12 Information Technology						
12.1 Program Support	7,257	-	-	7,257	6,476	(781)
12.2 Development and Operations	72,230	4,000	-	76,230	69,356	(6,874)
	79,487	4,000	-	83,487	75,832	(7,655)
13 Cancer Research and Prevention Investment	25,000	-	-	25,000	21,532	(3,468)
15 COVID-19 Pandemic Response	500,000	1,638,210	-	2,138,210	2,063,464	(74,746)
Capital Grants						
14 Infrastructure Support						
14.1 Continuing Care Beds	92,131	(76,000)	-	16,131	15,445	(686)
	92,131	(76,000)	-	16,131	15,445	(686)
Capital Payments to Related Parties						
14 Infrastructure Support						
14.1 Continuing Care Beds	4,500	25,900	-	30,400	30,400	-
14.2 External Information Systems Development	5,748	-	-	5,748	4,051	(1,697)
14.3 Equipment for Cancer Corridor Projects	3,469	(3,469)	-	-	-	-
14.4 Medical Equipment Replacement and Upgrade Program	30,000	-	-	30,000	30,000	-
14.5 Clinical Information System	110,000	-	-	110,000	97,000	(13,000)
14.6 Northern Laboratory Equipment	9,000	-	-	9,000	9,000	-
14.7 Alberta Surgicial Initiative Capital Program	13,593	(6,787)	-	6,806	6,806	-
14.8 Rural Alberta Health Facilities Capital Program	5,000	-	-	5,000	5,150	150
15 COVID-19 Pandemic Response	-	77,043	-	77,043	75,135	(1,908)
	181,310	92,687	-	273,997	257,542	(16,455)
Credit or Recovery (Shortfall)	-	-	(1,000)	(1,000)	-	1,000
Total	$ 21,582,198	$ 1,626,705	$ (1,000)	$ 23,207,903	$ 22,917,996	$ (289,907)
(Lapse)/Encumbrance						$ (289,907)

Department of Health

Lapse/Encumbrance (Unaudited) (Continued)

Year ended March 31, 2021
(in thousands)

		Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Over Expended/ (Unexpended)
Capital Investment Vote by Program							
Department Capital Acquisitions							
12	**Information Technology**						
12.2	Development and Operations	$ 33,230	$ -	$ -	$ 33,230	$ 32,189	$ (1,041)
Total		$ 33,230	$ -	$ -	$ 33,230	$ 32,189	$ (1,041)
(Lapse)/Encumbrance							$ (1,041)
Financial Transactions Vote by Program							
Inventory Acquisition							
4	**Drugs and Supplemental Health Benefits**						
4.3	Outpatient Specialized High Cost Drugs	$ 9,000	$ -	$ -	$ 9,000	$ 6,756	$ (2,244)
7	**Population and Public Health**						
7.2	Immunization Support	61,221	-	-	61,221	53,386	(7,835)
Total		$ 70,221	$ -	$ -	$ 70,221	$ 60,142	$ (10,079)
(Lapse)/Encumbrance							$ (10,079)

[1] As per "Expense Vote by Program", "Capital Investment Vote by Program" and "Financial Transactions Vote by Program" page 118 to 120 of 2020-2021 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. An encumbrance is incurred when, on a vote by vote basis, the total of actual disbursements in the prior year exceed the total adjusted estimate.

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

Department of Health

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

Year ended March 31, 2021
(in thousands)

	2021	2020
Write-Offs		
Medical Claim Recoveries	$ 969	$ 2,914
Pharmaceuticals and Health Benefits	18,463	916
Other Receivables	451	456
Total Write-offs [(1)]	$ 19,883	$ 4,286

[(1)] There were no remissions or compromises during the year.

The above statement has been prepared pursuant to Section 23 of the Financial Administration Act. The statement includes all remissions, compromises and write-offs made or approved during the fiscal year.

Ministry of Health

Year ended March 31, 2021
(in thousands)

Payments Based on Agreements (unaudited)

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

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

	2021	2020
Other Provincial and Territorial Governments	$ 235,135	$ 323,290

Accounts receivable includes $24,065 (2020 - $33,551).

Trust Funds under Administration (unaudited)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements.

At March 31, 2021, the Health Benefit Trust of Alberta reported fund balance of $90,830 (2020 - $110,699). At March 31, 2021, balance of trust funds held for others is $1,695 (2020 - $1,490).

The Ministry and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. At March 31, 2021, there are $30,329 in plan assets (2020 - $29,181).

Annual Report Extracts and Other Statutory Reports

Public Interest Disclosure (Whistleblower Protection) Act

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

32 (1) every chief officer must prepare a report annually on all disclosures that have been made to the designated officer of the department, public entity or office of the Legislature for which the chief officer is responsible.

(2) The report under subsection (1) must include the following information:

(a) the number of disclosures received by the designated officer, the number of disclosures acted on and the number of disclosures not acted on by the designated officer;

(b) the number of investigations commenced by the designated officer as a result of disclosures;

(c) in the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations made or corrective measures taken in relation to the wrongdoing or the reasons why no corrective measure was taken.

(3) The report under subsection (1) must be included in the annual report of the department, public entity or office of the Legislature if the annual report is made publicly available.

There were no disclosures of wrongdoing for the Department of Health between April 1, 2020 and March 31, 2021.

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.