Alberta

Freedom To Create. Spirit To Achieve.

Health and Wellness

Annual Report
2010-2011

Government of Alberta

For further information

For additional copies of this document contact:

Alberta Health and Wellness
Communications
22nd floor, 10025 Jasper Avenue
Edmonton, Alberta T5J 1S6
Phone: (780) 427-7164
Fax: (780) 427-1171
E-mail: ahinform@health.gov.ab.ca

You can find this document on the Alberta Health and Wellness website – www.health.alberta.ca

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Health and Wellness

Annual Report 2010 – 2011

Preface

Public Accounts 2010/2011

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Government Accountability Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 24 ministries.

The annual report of the Government of Alberta contains Ministers' accountability statements, the consolidated financial statements of the Province and *The Measuring Up* report, which compares actual performance results to desired results set out in the government's business plan.

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

- **the financial statements of entities making up the ministry including the Department of Health and Wellness, and provincial agencies for which the Minister is responsible,**
- **other financial information as required by the *Financial Administration Act* and *Government Accountability Act*, either as separate reports or as a part of the financial statements, to the extent that the ministry has anything to report.**

For financial information relating to Alberta Health Services, which is accountable to the Minister of Alberta Health and Wellness, please visit the Alberta Health Services website at www.albertahealthservices.ca.

Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2011, was prepared under my direction in accordance with the *Government Accountability Act* and the government's accounting policies. All of the government's policy decisions as at June 15, 2011 with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original signed by]

Gene Zwozdesky
Minister of Health and Wellness

Message from the Minister

As Minister of Health and Wellness (AHW), my mandate this past year was clear: build the best-performing, publicly funded health care system in Canada. Working with Alberta Health Services (AHS), we made significant progress towards achieving that goal.

The first milestone was Budget 2010, which marked the first year of a 5-year funding commitment to AHS. The funding commitment provides 6 per cent operating increases in each of the first 3 years, and 4.5 per cent increases in each of the final 2 years. This 5-year funding — the first of its kind in Canada — provides AHS with a stable, predictable funding platform to enhance long-range planning.

The second major milestone was the release of *Becoming the Best: Alberta's 5-Year Health Action Plan*. Our 5-Year Health Action Plan sets a clear course for the health system. The plan is supported by 50 accompanying performance measures, and is one of the most aggressive plans to reduce wait times and increase access anywhere in Canada.

The performance measures include: reduced wait times for hip surgery; quicker access to radiation oncologists for cancer patients; faster treatment at emergency departments; more continuing care spaces; and a greater emphasis on wellness to keep Albertans healthy.

Improving access to services

To improve access to important health services, a number of surgery and diagnostic imaging blitzes were launched in the spring of 2010. These blitzes provided thousands of Albertans with access to more cancer, heart, cataract and hip/knee replacement surgeries, plus MRI and CT scans.

Building on the success of those blitzes, a permanent addition of 5,000 more surgeries was announced in December of 2010. The total number of surgeries performed in Alberta will increase to 253,000 annually.

In October, AHW and AHS took steps to reduce pressures in hospital emergency departments by introducing new overcapacity protocols. We also opened more hospital beds and more continuing care spaces to help reduce emergency department wait times. Some great improvements have been made, but more work is needed to bring those wait times down further.

Care for seniors

In 2010/2011, we expanded continuing care and supportive living options for seniors by adding over 1,000 new spaces. Our plan over 5 years is to add more than 5,000 continuing care spaces in Alberta. We also launched a 2-year, $1.9 million pilot project to test technologies to better support seniors to remain in their homes longer.

Putting a priority on wellness and advancing care

Several initiatives to promote wellness and advance specialized care were undertaken over the year. In December, I hosted Alberta's first-ever Action on Wellness forum to encourage collaboration between workplaces, industries and private sectors for wellness activities, including school-based mental health programs. At this forum, I also announced $19 million for school-based mental health programs.

Our $42.5 million investment in stroke treatment and prevention is also paying real dividends. In February, an evaluation of Alberta's Provincial Stroke Strategy (which was introduced in 2005) indicated that fewer Albertans are dying because of stroke and they are gaining timely action to stroke treatment.

Other important developments included 100 new addiction treatment beds, a new meningitis immunization program for Grade 9 students and $1 million for a three-year observational study on the safety and effects of venous procedures (Zamboni treatment) for Albertans with multiple sclerosis.

Investing in health infrastructure

Our Government invested $2.5 billion dollars in health infrastructure projects and maintenance. The 2010 – 13, 3-year Health Capital Plan included 22 health infrastructure projects in 15 medium-sized cities/towns and rural communities, as well as significantly expanded cancer treatment capacity in Edmonton and Calgary.

Health Legislation

In November, I introduced the *Alberta Health Act*, which was subsequently passed by the Legislative Assembly and reflected more than a year-long consultation with Albertans about our publicly funded health system. The new *Alberta Health Act* requires: AHW to establish a Health Charter that sets out principles and responsibilities within the health system; a Health Advocate to resolve citizen concerns with the health system as they relate to the health charter; and, the provision for continued public input in the development of health regulations under the Act.

Moving forward from a strong foundation

These are just a few of the many great accomplishments during 2010/2011. They are the result of the great work of many front-line professionals, health care providers and colleagues. I look forward to another year of collaboration and inspiration that draws on their talents, expertise, patience, spirit and dedication. I also want to thank Albertans in general for their passion and commitment when speaking out and providing feedback on health issues. Together, I know we can build the best-performing publicly funded health care system in Canada.

[Original signed by]

Gene Zwozdesky
Minister of Health and Wellness

Management's Responsibility for Reporting

For financial reporting purposes, the Ministry of Health and Wellness annual report includes the financial statements of Department of Health and Wellness, Alberta Health Services, the Health Quality Council of Alberta, the Alberta Cancer Foundation, and the Calgary Health Trust.

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 business plans, annual report, quarterly reports and other financial and performance reporting.

Responsibility for the integrity and objectivity of the consolidated financial statements and performance results for the ministry rests with the Minister of Alberta Health and Wellness. Under the direction of the Minister, I oversee the preparation of the ministry's annual report, including consolidated financial statements and performance results. The consolidated financial statements and the performance results, of necessity, include amounts that are based on estimates and judgments. The consolidated financial statements are prepared in accordance with the Canadian public sector accounting standards. The performance measures are prepared in accordance with the following criteria:

- Reliability — Information agrees with the underlying data and the sources used to prepare it.
- Understandability and Comparability — Current results are presented clearly in accordance with the stated methodology and are comparable with previous results.
- Completeness — Performance measures and targets match those included in Budget 2010.

As Deputy Minister, in addition to program responsibilities, I establish and maintain 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 of Alberta under ministry administration,
- provide Executive Council, the President of Treasury Board, the Minister of Alberta Finance and Enterprise, and the Minister of Alberta Health and Wellness information needed to fulfill their responsibilities; and
- facilitate preparation of ministry business plans and annual reports required under the *Government Accountability Act*.

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

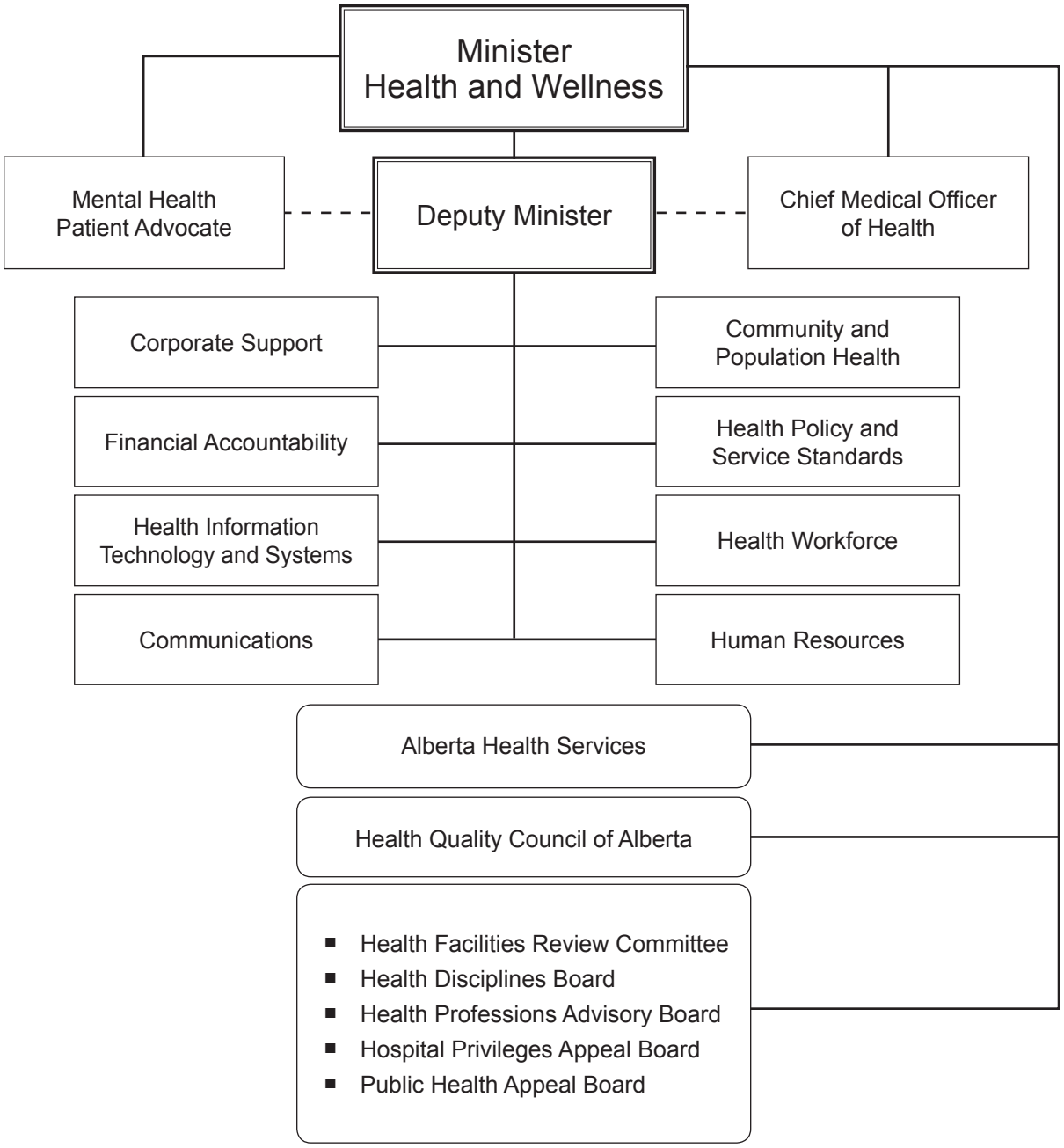
[Original signed by]

Jay G. Ramotar
Deputy Minister
Alberta Health and Wellness
June 15, 2011

Ministry Overview

Ministry of Health and Wellness Organization

(For the year ended March 31, 2011)



The ministry's focus and role is strategic in developing policy, setting standards and regulations, ensuring accountability, and pursuing innovations on behalf of Albertans. Alberta Health Services delivers health services in response to direction received from the ministry. Alberta Health Services' specific plans for delivering health services, and its priorities for the health system, can be found in its Strategic Direction Plan, which can be accessed at www.albertahealthservices.ca.

Vision, Mission and Core Businesses

Vision: *Healthy Albertans in a Healthy Alberta.*

The achievement of this vision is everybody's responsibility. The Ministry of Alberta Health and Wellness plays a leadership role in achieving this vision through our mission, core businesses and goals.

Mission: *Health and Wellness sets policy and direction to lead, achieve and sustain a responsive, integrated and accountable health system.*

The ministry fulfills this mission through two core businesses, each of which is supported by corresponding business plan goals.

Core Business 1: Leadership and governance.

Goal 1 — Health system accountability.

Goal 2 — Public assurance.

Goal 3 — A sustainable health system.

Goal 4 — Healthy living and optimal well-being.

Core Business 2: Effective and innovative health care.

Goal 5 — Appropriate access to services across the continuum of care.

Goal 6 — Health workforce utilization and efficiency.

Goal 7 — Excellence through research, innovation and technology.

Results Analysis

Auditor General's Report

AUDITOR GENERAL *Alberta*

Review Engagement Report

To the Members of the Legislative Assembly

I have reviewed the performance measures identified as "Reviewed by Auditor General" in the *Ministry of Health and Wellness' 2010-11 Annual Report*. These performance measures are the responsibility of the Ministry and are prepared based on the following criteria:

- Reliability – Information agrees with the underlying data and with sources used to prepare it.
- Understandability and Comparability – Current results are presented clearly in accordance with the stated methodology and are comparable with previous results.
- Completeness – Performance measures and targets match those included in Budget 2010.

My review was made in accordance with Canadian generally accepted standards for review engagements and, accordingly, consisted primarily of enquiry, analytical procedures and discussion related to information supplied to my Office by the Ministry. My review was not designed to provide assurance on the relevance of these performance measures.

A review does not constitute an audit and, consequently, I do not express an audit opinion on the performance measures.

Based on my review, nothing has come to my attention that causes me to believe that the "Reviewed by Auditor General" performance measures in the Ministry's 2010-11 Annual Report are not, in all material respects, presented in accordance with the criteria of reliability, understandability, comparability, and completeness as described above. However, my review was not designed to provide assurance on the relevance of these performance measures.

[Original signed by Merwan N. Saher]

Auditor General

June 3, 2011

Edmonton, Alberta

Performance Measures Summary Table

Note: The measures reported in this Table are consistent with the published Ministry 2010 – 13 Business Plan; however, a number of these measures or targets have been superseded by measures subsequently published by the Government of Alberta in November 2010 and linked to the 5-Year Health Action Plan. For a full listing of this Plan's measures, please see http://www.health.alberta.ca/documents/Health-Performance-Measures-2010.pdf

Core Businesses/Goals/Performance Measures		Prior Years' Results				Target	Current Actual
Core Business 1: Leadership and governance							
1.	**Health system accountability**						
1.a	Public rating of health system overall: Percentage rating the health care system as either "excellent" or "good"	55% 2007	60% 2008	63% 2009	65% 2010	**70%**	64% 2011
1.b*	Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year	52% 2004	58% 2006	60% 2008	61% 2010	**63%**	67% 2011
2.	**Public assurance**						
2.a*	Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	13% 2004	13% 2006	10% 2008	9% 2010	**10%**	12% 2011
2.b	Incidence of serious complaints: Percentage of Albertans reporting a serious complaint about any health care services personally received in Alberta within the past year	15% 2004	14% 2006	13% 2008	13% 2010	**12%**	15% 2011
2.c	Influenza immunization: Percentage of Albertans who have received the recommended seasonal influenza immunization:***						
	• Seniors aged 65 years and over	62% 2006/07	60% 2007/08	58% 2008/09	56% 2009/10	**75%**	59% 2010/11
	• Children aged 6 to 23 months	52% 2006/07	64% 2007/08	43% 2008/09	16% 2009/10	**75%**	25% 2010/11
	• Residents of long term care facilities	93% 2006/07	94% 2007/08	95% 2008/09	91% 2009/10	**95%**	90% 2010/11
2.d	Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)						
	• Chlamydia	317 2006	329 2007	344.7 2008	379.3 2009	**340**	356.1 2010
	• Gonorrhea	65 2006	64 2007	60.8 2008	43.8 2009	**55**	32.5 2010
	• Syphilis	6.6 2006	7.3 2007	7.0 2008	7.7 2009	**7.0**	4.5 2010
	Congenital Syphilis: Rate per 100,000 births (live and still born)	8.9 2006	12.3 2007	5.9 2008	13.6 2009	**8**	4.0 2010
3.	**A sustainable health system**						
3.a	Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta	25.7% 2006	29.3% 2007	32.8%% 2008	35.1% 2009	**36%**	38.8% 2010
4.	**Healthy living and optimal well-being**						
4.a	Health Link Alberta						
	• Percentage of Albertans who are aware of Health Link Alberta	67% 2007	71% 2008	71% 2009	76% 2010	**75%**	79% 2011
	• Percentage of Albertans who have used Health Link Alberta within the past year	37% 2007	33% 2008	37% 2009	36% 2010	**45%**	34% 2011

Core Businesses/Goals/Performance Measures		Prior Years' Results				Target	Current Actual
4.b	Self-reported health status: Percentage of Albertans reporting "excellent", "very good", or "good" health						
	• 18 to 64 years	87% 2007	88% 2008	89% 2009	88% 2010	**90%**	88% 2011
	• 65 years and over	78% 2007	84% 2008	84% 2009	88% 2010	**85%**	77% 2011
4.c	Body Mass Index: Percentage of Albertans age 18 and over who are overweight or obese**						
	• Overweight	35% 2003	36% 2005	34% 2007	34% 2008	**33%**	36% 2009
	• Obese	16% 2003	16% 2005	19% 2007	18% 2008	**17%**	19% 2009
4.d	Smoking: Prevalence of smoking**						
	• Alberta youth aged 12 to 19 years	14% 2003	11% 2005	12% 2007	11% 2008	**10%**	13% 2009
	• Young adults aged 20 to 24 years	37% 2003	33% 2005	30% 2007	26% 2008	**25%**	25% 2009
4.e	Regular heavy drinking: Prevalence of regular, heavy drinking among young Albertans**	38% 2003	38% 2005	40% 2007	40% 2008	**30%**	40% 2009
Core Business 2: Effective and innovative health care							
5.	**Appropriate access to services across the continuum of care**						
5.a	Continuing care:						
	Number of persons waiting in an acute care hospital bed for continuing care	---	645 2007/08	754 2008/09	707 2009/10	**400**	471 2010/11
	Number of persons waiting in the community for continuing care	---	---	1,065 2008/09	1,039 2009/10	**975**	1,110 2010/11
5.b	Wait time for children's mental health services: Percent of children receiving "scheduled" mental health treatment within 30 days***	---	---	78% 2008/09	75% 2009/10	**85%**	81% 2010/11
5.c	Wait time for heart surgery (coronary artery bypass graft): 90th percentile wait time in weeks						
	• Urgency Level 1 (urgent)	4 2006/07	2 2007/08	2 2008/09	2 2009/10	**≤1 week**	2 2010/11
	• Urgency Level 2 (less urgent)	18 2006/07	14 2007/08	20 2008/09	21 2009/10	**6 weeks**	6 2010/11
	• Urgency Level 3 (elective)	34 2006/07	26 2007/08	18 2008/09	17 2009/10	**26 weeks**	24 2010/11
5.d	Wait time for hip replacement surgery: 90th percentile wait time in weeks	43 2006/07	36 2007/08	36 2008/09	35 2009/10	**26 weeks**	39 2010/11
5.e	Wait time for knee replacement surgery: 90th percentile wait time in weeks	53 2006/07	49 2007/08	46 2008/09	49 2009/10	**26 weeks**	49 2010/11
5.f	Wait time for cataract surgery: 90th percentile wait time in weeks	32 2006/07	28 2007/08	30 2008/09	42 2009/10	**16 weeks**	47 2010/11
5.g	Wait time for all other elective surgical procedures: 90th percentile wait time in weeks	22 2006/07	23 2007/08	25 2008/09	25 2009/10	**22 weeks**	26 2010/11
5.h	Emergency department length of stay: 90th percentile wait time in hours***						
	• Minor or uncomplicated cases	---	---	5.6 2008/09	5.3 2009/10	**4.5 hours**	5.3 2010/11
	• Complex cases	---	---	16.2 2008/09	15.0 2009/10	**11 hours**	15.0 2010/11

Core Businesses/Goals/Performance Measures		Prior Years' Results				Target	Current Actual
5.i	Public rating of access to emergency department services: Percentage rating ease of actually obtaining emergency department services needed for self or a close family member as "very easy" or "easy"	50% 2004	48% 2006	51% 2008	55% 2010	**60%**	59% 2011
6.	**Health workforce utilization and efficiency**						
6.a	Access to primary care providers: Percentage of Albertans reporting they have a personal family doctor	85% 2004	81% 2006	81% 2008	82% 2010	**83%**	84% 2011
6.b*	Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network**	---	---	55% 2008/09	60% 2009/10	**80%**	--- 2010/11
6.c	Physicians linked to Primary Care Networks: Percentage of family physicians linked to Primary Care Networks**	---	---	55% 2008/09	53% 2009/10	**57%**	--- 2010/11
7.	**Excellence through research, innovation and technology**						
7.a	Alberta Netcare: Number of care providers accessing Alberta Netcare	22,918 2006/07	29,110 2007/08	34,200 2008/09	39,866 2009/10	**45,229**	--- 2010/11
7.b	Physician utilization of electronic medical records: Percentage of community physicians using the Electronic Medical Record in their clinic	45% 2006/07	45% 2007/08	46% 2008/09	46% 2009/10	**57%**	53% 2010/11

* **Indicates Performance Measures that have been reviewed by the Office of the Auditor General**
The performance measures indicated with an asterisk were selected for review by ministry management based on the following criteria established by government:

- Enduring measures that best represent the goal and mandated initiatives.
- Measures for which new data is available.
- Measures that have well established methodology.

** **Note:** Measure 4.c. Body Mass Index: Percentage of Albertans age 18 and over who are overweight or obese — Results for 2010/11 are not available as of June 30, 2011.

Measure 4.d. Smoking: Prevalence of smoking — Result for 2010/11 is not available as of June 30, 2011.

Measure 4.e. Regular heavy drinking: Prevalence of regular, heavy drinking among young Albertans — Result for 2010/11 is not available as of June 30, 2011.

Measure 6.b. Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network — Result for 2010/11 is not available as of June 30, 2011.

Measure 6.c. Physicians linked to Primary Care Networks: Percentage of family physicians linked to Primary Care Networks — Result for 2010/11 is not available as of June 30, 2011.

Measure 7.a. Alberta Netcare: Number of care providers accessing Alberta Netcare. During 2010/11, some older systems that provided reporting for this measure were retired and replaced with a new system. The methodology to gather the counts under the new system is being revised. As a result, data available for 2010/11 is not comparable to prior years and, therefore, is not reported in this year's annual report.

*** **Note:** Measure 2.c Influenza immunization — In order to meet 2010/11 reporting deadlines, results for influenza immunization of seniors and children aged 6 to 23 months are based on data up to March 31, 2011, which is earlier than the end of the seasonal influenza immunization season.

Measure 5.b Wait time for children's mental health services — In order to meet 2010/11 reporting deadlines, result is based on data for the first three quarters of the 2010/11 fiscal year, not full fiscal year data. Caution is required in comparing results across years.

Measure 5.h Emergency department length of stay — Result is based on data for the first three quarters of the 2010/11 fiscal year, rather than full fiscal year data. Caution is required in comparing results across years.

For more detailed information, see the Performance Measures — Data Sources and Methodology section of the annual report, pages 57 to 70.

Goal 1: Health system accountability

Linked to Core Business 1 — Leadership and governance

Albertans expect a high standard for health services and it is the responsibility of the government to ensure that the system is accountable for results. Being accountable for the health system means monitoring performance and measuring results, providing quality services for Albertans, and evaluating the effectiveness of programs in the interests of continuous service improvement and enhanced health system outcomes. The ministry acknowledges that effective partnerships are key to evaluating, planning, and providing access to a broad range of quality health services while ensuring effective governance and quality standards are met, and best practices are used throughout the health system. The ministry also recognizes the importance of maintaining and building upon its own organizational capacity to lead, govern and deliver the ministry's mission and to effectively respond to future challenges.

Achievements

Strategy 1.1 **Continued implementation of the new provincial Framework for Emergency Medical Services.**

- A single set of provincial emergency medical services (EMS) medical control protocols were developed, approved and implemented across all EMS in Alberta. This ensures all EMS in Alberta are following current, evidence based clinical guidelines which has improved consistency and quality across the province.
- Operation of the fixed wing air Medevac program was transferred from Alberta Health and Wellness to Alberta Health Services. This has created an integrated ground and air ambulance system and enables efficiencies and coordination of patient transports within the province.

Strategy 1.2 **Review service optimization findings with Alberta Health Services and develop new strategies for enhancing the performance and sustainability of programs in acute, primary and continuing care.**

- The department conducted a service optimization review in 2008 to improve access, quality and sustainability of the health system. As Alberta Health and Wellness (AHW) and Alberta Health Services (AHS) continue to collaborate toward improving Alberta's health care system, the findings from the service optimization review continue to provide valuable data allowing for improved coordination of policy directions and strategies between AHW and AHS.

Strategy 1.3 **Clarify and strengthen accountability relationships, roles and mutual responsibilities between Health and Wellness and Alberta Health Services.**

- A new *Alberta Health Act* (unproclaimed) received Royal Assent in December 2010, and provides principles to guide the health system, requirements to establish a health charter and a health advocate, as well as provisions for public input into the regulations proposed for the Act.

- In December 2010, the collaboratively developed Mandate and Roles Document was signed by the Minister and Alberta Health Services to reflect a common understanding of their respective roles, responsibilities and accountabilities.

Strategy 1.4 **Develop and implement policy, monitoring processes and the performance reporting framework to ensure effective governance and accountability of the health system.**

- The Government of Alberta, in conjunction with Alberta Health Services (AHS), released *Becoming the Best: Alberta's 5-year Health Action Plan* in November 2010. The plan provides Albertans clear direction on what they can expect from their health care system over the next 5 years. *Becoming the Best* provides the detailed targets the province and AHS will use to drive further improvements in the health care system, and is organized under five core areas:
  - Improve access and reduce wait times;
  - Provide more options for continuing care;
  - Strengthen primary health care;
  - Be healthy, stay healthy; and
  - Build one health system.

- The Government of Alberta release of *Alberta's 5-year Health Action Plan* also referenced a set of 50 supporting performance measures and targets to support the planned strategies and help Alberta achieve the ultimate goal of becoming the best performing publicly-funded health system in Canada. These measures and targets are included in the Alberta Health Services Health Plan and Quarterly Performance Reports, both key public accountability documents that provide a monitoring process and performance reporting framework for reporting progress.

Strategy 1.5 **Provide recommendations to build an updated and flexible legislative framework to better reflect Alberta's emerging health issues.**

- The department engaged in public and stakeholder consultations over the summer of 2010 to gather input on new health legislation for Alberta. These consultations resulted in the *Putting People First: Recommendations for an Alberta Health Act* report. The *Alberta Health Act* (unproclaimed) received Royal Assent in December, 2010. The Act provides principles to guide the health system, a requirement to establish a health charter and a health advocate as well as provisions for public input on any regulations proposed for the Act.

Key Performance Measures and Results

Measure 1.A Public rating of health system overall

This measure identifies Albertans' rating of the health care system and the quality of medical services it provides.

Several factors may contribute to public rating of the health system, including perceived ease of access to family physicians and medical specialists, wait times for health care services for oneself or family members, the quality of health care services experienced, and the perceived responsiveness of the health system to individual and community needs.

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and older found that 64 per cent rated the health system overall as excellent or good, which does not meet the 2010/2011 target of 70 per cent. However, compared to prior years the 2010/2011 result is not statistically different from public ratings of the health system in 2009 and 2010.

Public rating of health system overall

	2007	2008	2009	2010	2011	Target 2010/2011
Public rating of health system overall: Percentage rating the health care system as either "excellent" or "good"	55%	60%	63%	65%	64%	70%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Measure 1.B Satisfaction with health care services received

Listening and responding to Albertans to continuously improve the quality and safety of Alberta's health system is the mission of the Health Quality Council of Alberta (HQCA). This mission is realized through the HQCA's legislated mandate to survey Albertans on their experience with the health system. The information is vital in identifying Albertans' views and perceptions about the quality, safety and performance of the publicly funded health care system. It informs stakeholders (AHS, AHW and health professionals) responsible for health care service delivery about Albertans' experiences with the services received and the impact of those experiences on the overall ratings of the health system.

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and older found that 67 per cent were satisfied or very satisfied with health care services received, up from 61 per cent in 2010. This result exceeds the 2010/2011 target of 63 per cent.

Satisfaction with health care services received

	2004	2006	2008	2010	2011	Target 2010/2011
Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year	52%	58%	60%	61%	67%	63%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Goal 2: Public assurance

Linked to Core Business 1 — Leadership and governance

Albertans need safe and efficient access to health care programs and services that meet their needs and protect them from disease and injury. In addition to supporting safe and healthy communities through promotion, protection and prevention services, emergency preparedness and response plans are developed to deal with disease outbreaks and other public health threats. Public assurances are also provided, through a legislative framework, that health providers comply with legislative standards, that risks are managed or mitigated, and that quality is ensured through continuous performance monitoring.

Achievements

Strategy 2.1 **Introduce a patient safety framework to support the continuous and measureable improvement of patient safety in Alberta.**

- The Health Quality Council of Alberta, in conjunction with Alberta Health and Wellness, released the Patient Safety Framework for Albertans. The framework aims to guide, direct and support the continuous and measurable improvement of patient safety in Alberta. It provides organizations and individuals providing health services with a comprehensive and systems-based approach to the provision of safe care based on fundamental principles of patient safety which will remain relevant as the healthcare system continuously evolves.

Strategy 2.2 **Improve the health system's capacity to prevent, prepare and respond to public health risks.**

- The Health Quality Council of Alberta completed their review of the provincial pandemic H1N1 2009 influenza response on December 30, 2010. The findings of the review are being incorporated into provincial pandemic planning to ensure that future pandemics receive the benefit of past experience to improve our capacity to deal with a future pandemic.
- The 2008 Single Use Standards for single use medical devices were updated in March 2011. Updating the standards ensures province-wide understanding of, and compliance with, Infection Prevention and Control Standards.
- As part of the Alberta Immunization Strategy, work was completed on strengthening partnerships with community providers such as pharmacists. This resulted in vaccines being delivered through approved pharmacists to clients in the community.
- Two vaccine changes were made to Alberta's Immunization Program this year. The Pneumococcal Conjugate vaccine, 13 serotypes was launched July 2010 and a combined Measles, Mumps, Rubella and Varicella vaccine was launched in September 2010 for one year old children. These changes will improve protection in children against invasive pneumococcal disease and will reduce the number of injections provided to children six years of age and younger.

- In addition, on February 1, 2011, the ministry launched a province-wide immunization program to protect adolescents from meningococcal disease. This immunization program is offered to as many as 40,000 students in Grade 9 through school-based clinics. The vaccine protects against four different strains of meningococcal disease and is now part of the annual immunization program offered to Alberta adolescents.

Strategy 2.3 **Build public confidence and strengthen the public's trust in the health system by enhancing our consolidated and integrated compliance function.**

- The department continued to work collaboratively with the Health Facilities Review Committee, Alberta Health Services and Alberta Seniors and Community Supports to enhance the consolidated and integrated compliance function which oversees compliance with Continuing Care Health Standards, the Infection Prevention and Control Standards and Emergency Health Services standards and legislation.

Strategy 2.4 **Develop and implement a health impact assessment.**

- Work was done on the Health Impact Assessment for Public Policy (HIAPP) Model, which will assist policy developers across government to consider the impact of their proposed policies on the health of Albertans. The health impact assessment model and tools will be released and implemented in 2011/2012.

Strategy 2.5 **Develop and implement a provincial surveillance strategy.**

- Government is funding the Métis Nation of Alberta Association (MNAA) $250,000 over two years to enable the MNAA to better monitor the health of the Métis living in Alberta. This work will be undertaken by a new public health surveillance unit recently established by the MNA and the unit will work in collaboration with Alberta Health and Wellness. This initiative will enable information to be compiled about the types of health issues and services being used by Métis and to monitor health trends over time.

Strategy 2.6 **Develop and implement a provincial environmental public health strategy.**

- Work was initiated on the Environmental Public Health Strategy and a high level implementation plan is under development. The strategy supports the pillar of health protection and sets forth directions and goals for a comprehensive approach to protect Albertans from potential hazards in natural and built environments.

Strategy 2.7 **Review and consult on the *Public Health Act.***

- The department initiated a review of the *Public Health Act* to identify and develop recommendations for potential revisions. The purpose is to update the Act and ensure it reflects changes in the health system and ensure public health officials have the necessary tools to protect the health of Albertans and respond to emerging health issues.

Strategy 2.8 **Develop and begin implementation of a strategy to reduce prevalence of antibiotic-resistant organisms.**

- The department is supporting Alberta Health Services in updating the Bugs and Drugs Handbook and in the development of an electronic application for the Handbook to be distributed to professionals across Alberta.
- The Antimicrobial Resistance Framework was reviewed to confirm core evidence-informed areas that require extensive consultation and action, including stewardship of antibiotics, surveillance and key linkages to infection prevention and control.

Key Performance Measures and Results

Measure 2.A Patient Safety

Albertans deserve a safe health care system that they can rely on whenever and wherever they receive health services. The performance measure on patient safety assesses Albertans' perception of receiving and reporting unexpected harm while receiving health services in Alberta within the past year.

On September 20th, 2010 the Minister and HQCA released the Patient Safety Framework for Albertans. The Framework guides, directs and supports the continuous and measurable improvement of health care safety in Alberta.

The Framework outlines key principles and building blocks and identifies strategic initiatives for organizations and health care providers to facilitate and support an environment where the safest care possible can be given. Included in the framework are strategies addressing reporting and learning from adverse events, and informing and disclosure.

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and older found that 12 per cent of Albertans reported unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year, up from 9 per cent in 2010. This result does not meet the 2010/2011 target of 10 per cent.

The attention from the release of the Framework in 2010 and provincial standardization of informing and disclosure may have increased the percentage of Albertans reporting unexpected harm. Further analysis is necessary in order to guide future decisions and to gain an understanding of what has occurred. Though it may be impossible to eliminate unexpected harm entirely, it is feasible to continually learn and improve systems and processes in order to minimize it. Alberta Health Services has a multi-pronged strategy to identify and learn more about unexpected harm in an effort to minimize it.

Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year

	2004	2006	2008	2010	2011	Target 2010/2011
Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	13%	13%	10%	9%	12%	10%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Measure 2.B Incidence of serious complaints

The information patients provide through the concerns/complaints process is an aspect of a patient feedback mechanism. From a health provider point of view, receiving patient complaints promotes a culture of reporting and accountability (HQCA, 2007).

On September 20, 2010 the Minister and HQCA released the Patient Safety Framework for Albertans. The Framework guides, directs and supports the continuous and measurable improvement of health care safety in Alberta. Building a Patient Safety Culture is central to the framework. In building the culture, avenues for receiving and acting on commendations and concerns about the quality of care received are vital.

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and older found that 15 per cent reported a serious complaint about health care services personally received in the past year in Alberta, up from 13 per cent in 2010. This result does not meet the 2010/2011 target of 12 per cent.

Receiving complaints is an inevitable part of any business or organization and the information provided through this process is an important aspect of improving the quality improvement process. Reporting or lodging a complaint is often related to the ease of the process, follow-up received on a previous concern such as patient access to health services, or harm that may have resulted from an adverse event.

Alberta Health Services (AHS) is committed to quality improvement and takes patient concerns very seriously. If you have a concern about services received, there are a number of ways you can tell AHS staff. You can:

- talk to your local health care provider directly about the concern, or involve the program manager or supervisor to help reach a resolution; or
- contact the Patient Relations Department, by telephone: 1-877-753-2170 (Red Deer and North) or 1-877-957-9771 (south of Red Deer) and online.

To further assist patients, AHS has appointed a Patient Concerns Officer (PCO) to assist is the review process and uphold a patient's right to express their concerns with health services. The PCO can be contacted at any time during a concern resolution, and will provide assistance no matter which option, as identified above, is chosen. The Patient Concerns Officer can be contacted by telephone at 1-866-561-7578.

Incidence of serious complaints

	2004	2006	2008	2010	2011	Target 2010/2011
Incidence of serious complaints: Percentage of Albertans reporting a serious complaint about any health care services personally received in the past year in Alberta	15%	14%	13%	13%	15%	12%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Measure 2.C Influenza immunization

Influenza has a significant seasonal impact on the health of Albertans and tends to be most severe among older Albertans, residents of long term care facilities, young infants, and those with certain chronic conditions. Influenza illness can cause significant morbidity and mortality in these populations and those ill can quickly fill acute care hospitals and emergency departments. Alberta Health and Wellness introduced a universal influenza immunization program in the fall of 2009 in order to improve immunization rates for high risk groups.

Targets were not met in 2010/2011 for this performance measure. Despite AHS' increased efforts to improve immunization rates, there are some human behaviour aspects that cannot be controlled:

- Immunization is not mandatory in Alberta; therefore, individuals make their own decisions on whether to be immunized or not;
- Some Albertans incorrectly felt that the previous year's pandemic H1N1 vaccine still provided protection for this influenza season; and
- Influenza "fatigue" may have also played a role, where Albertans just had enough of influenza immunization promotion activities.

Influenza immunization rates varied across AHS Zones, with Calgary achieving the highest rate (62.2 per cent among seniors; 36.9 per cent among children 6 to 23 months) and the North achieving the lowest rate (48.8 per cent among seniors; 16 per cent among children 6 to 23 months).

Improved uptake for seniors and children six to 23 months of age can be attributed to the vaccine arriving on time, improved access of the vaccine by community partners and Alberta Health Services (AHS), central reporting of immunization data in AHS, and the universal influenza immunization program.

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

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Seniors aged 65 years and over	62%	60%	58%	56%	59%	75%
Children aged 6 to 23 months	52%	64%	43%	16%	25%	75%
Residents of long term care facilities	93%	94%	95%	91%	90%	95%

Source: Alberta Health Services; Alberta Health and Wellness, Interactive Health Data Application Population Estimates 2010.

***Note:** Results for 2010/11 are current as of March 31, 2011. Caution should be used in comparing the 2010/11 result for children aged 6 to 23 months with results from prior years, due to changes in the methodology used to calculate the percentage of children aged 6 to 23 months who have received the recommended seasonal influenza immunization.

Measure 2.D

Sexually transmitted infections

Sexually transmitted infections are an important focus for public health surveillance. The diseases resulting from these infections are widespread, have potentially severe or even lethal effects, and carry high social and economic costs.

Syphilis, in particular, is a serious bacterial infection that is passed from an infected person to an uninfected person during intimate sexual contact. Syphilis often does not cause any symptoms in the early stages, or if there are symptoms many are indistinguishable from those of other diseases. This means someone can transmit syphilis without any knowledge they are infected. Left untreated, the infection can progress to affect the entire body causing severe damage to the brain, heart, blood vessels and bones. It can eventually lead to death. Syphilis transmission can occur from an infected pregnant woman to her unborn child. Untreated, the outcome of the pregnancy may be profoundly affected. Approximately 40 per cent of babies will die either through miscarriage, stillbirth or within a few days of birth.

Through a grant from Alberta Health and Wellness (AHW), Alberta Health Services (AHS) established a team of 13 prevention coordinators who work with communities and schools to prevent sexually transmitted infections, including syphilis. Two of the prevention coordinators were dedicated solely for the prevention of congenital syphilis.

Through the Universal Prenatal Syphilis Rescreening Program, introduced in April 2009, all women receiving prenatal care are now tested for syphilis three times during their pregnancy. This enhanced program has identified newly infected women among those who earlier tested negative and provides screening for those who were not tested previously. This program may have led to a reduction in the number of cases of babies born with congenital syphilis and a reduction in transmission of syphilis by pregnant women.

AHW provided funding to AHS to support the Teaching Sexual Health Website. The teaching sexual health website www.teachingsexualhealth.ca is an innovative, curriculum based website developed by educators and heath professionals to assist teachers in their work teaching sexual health including sexually transmitted infections and HIV.

AHW provides funding to community based HIV organizations through the Alberta Community HIV Fund (ACHF). In 2010/2011, AHW contributed $3,015,000 to the ACHF.

Alberta rates for chlamydia, gonorrhea, and infectious syphilis exceeded the national rates in 2009. Alberta continues to have the highest rates for syphilis in the country. The final results for 2010/2011 are not available — the rates below are interim results.

To address the STI rates in Alberta, the Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy and Action Plan 2011 – 2016 is being developed.

Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)

	2006	2007	2008	2009	2010	Target 2010/2011
Chlamydia: Rate of newly reported infections (per 100,000 population)	317	329	344.7	379.3	356.1	340
Gonorrhea: Rate of newly reported infections (per 100,000 population)	65	64	60.8	43.8	32.5	55
Syphilis: Rate of newly reported infections (per 100,000 population)	6.6	7.3	7.0	7.7	4.5	7.0

Source: Alberta Health and Wellness. CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection).

Congenital syphilis: Rate per 100,000 births (live and still born)

	2006	2007	2008	2009	2010	Target 2010/2011
Congenital Syphilis: Rate per 100,000 births (live and still born)	8.9	12.3	5.9	13.6	4.0	8

Source: Alberta Health and Wellness. CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection).

Goal 3: A sustainable health system

Linked to Core Business 1 — Leadership and Governance

The cost of delivering health care continues to rise at a rapid pace. Health care services must be preserved and enhanced through a reaffirmation of shared responsibility to assure accessible, sustainable and affordable high quality care for all Albertans. The ministry will continue to encourage effective and innovative approaches to enhance the capacity and utilization of the health system to alleviate escalating health care costs and demands. This includes consideration of the pricing strategies for pharmaceuticals, procurement strategies, and development of models for alternate funding sources. The ministry acknowledges that health care in Alberta is a resource maintained in the public interest, and made possible through collective action, collaborative approaches and prudent choices.

Achievements

Strategy 3.1 **Lead the capital planning process based on service and community needs.**

- Phase One of the Government of Alberta's 2010 – 13 Health Capital Plan was announced in July 2010, which included 22 facility projects in 15 communities. These projects reflect more than $1.4 billion in total provincial support. Phase One also includes an additional $1 billion for facility maintenance, facility transition initiatives, and technology and equipment purchases and replacement. Highlights from Phase One of the Health Capital Plan include:
  - $200 million total provincial support for redevelopment of the Medicine Hat Regional Hospital and will include renovations to create additional ambulatory treatment space.
  - $108 million to build a new health centre in Edson. The health centre will be built on a new site to provide health care services and programs to meet the needs of the community, including acute care, emergency and outpatient services.
  - $90 million to build a new health centre in High Prairie to replace the existing complex and the J.B. Wood Nursing Home. The new High Prairie Health Centre will be built on a new site and will include a wide range of health services such as acute care, continuing care and community health programs.
  - $520 million to build a new regional hospital in Grande Prairie, which will include a state-of-the-art cancer centre.
- Phase Two of the Government of Alberta's 2010 – 13 Health Capital Plan was announced in December 2010, and provided $1.3 billion over 3 years for new and previously announced projects in Edmonton and Calgary. The Plan focused on increased capacity to support faster access to cancer care and other key health services.

Strategy 3.2 **Implement the *Alberta Pharmaceutical Strategy* to improve drug coverage for Albertans, a single government-sponsored drug plan and more timely and transparent drug review process.**

- The Minister's Expert Committee on Drug Evaluation and Therapeutics developed an expedited review process for interchangeable drugs and to facilitate more timely review of drugs for addition to the Drug Benefit List.
- A product listing agreement (PLA) framework for patented drugs was implemented to facilitate access to new therapies. The PLA framework will support listing of patented drugs on the Drug Benefit List through negotiation of better pricing, focused utilization management or support of Alberta-based health research.

Strategy 3.3 **Implement a new generic pricing policy for community drugs and a new reimbursement model for pharmacists.**

- As part of the Alberta Pharmaceutical Strategy, the price of new generic drugs was reduced to 45 per cent of the similar brand name drug, which took effect on April 1, 2010.
- Work on new practice and reimbursement models for community pharmacies continued throughout the year, building on the learnings from the Professional Practice Models Initiative undertaken by the Alberta Pharmacists' Association. When complete, the new model will support pharmacists practicing to their full scope and continued access to pharmacist services for Albertans in remote areas of the province.

Strategy 3.4 **Develop a budgetary allocation and economic evaluation framework to respond to evolving priorities and ensure value for money.**

- The department worked with Alberta Health Services (AHS) regarding activity-based funding implementation for Alberta's nursing homes and auxiliary hospitals. AHS began a phased in approach of activity-based funding into long-term care services on April 1, 2010. The department continues to collaborate with AHS on this funding model.
- Clinical Risk Group data was been incorporated into the Health Human Resource Forecasting and Simulation Models (e.g. Family Physician and Nursing models) to ensure that the projected demand for health professionals reflect the actual — and future — disease profiles and health status of Albertans. Disease profiles and health status are the key determinants of health needs and health resource utilization.

Key Performance Measures and Results

Measure 3.A Generic drug spending in Alberta

The cost of prescription drugs continues to be an important component of healthcare to Albertans. The Government of Alberta is implementing the Alberta Pharmaceutical Strategy to make drug coverage for Albertans more accessible, sustainable and affordable.

Generic drugs are significantly less expensive than the brand equivalents. Within the Alberta Pharmaceutical Strategy, Government continues to implement changes to reduce the costs of prescription drugs for all Albertans — initiatives like limiting the price of generics provide a direct cost reduction.

Within the framework of on going implementation of the Alberta Pharmaceutical Strategy, an affordability measure for Albertans is the generic per cent of total prescription cost dispensed in community pharmacies. Essentially, pharmaceutical drugs become more affordable as a larger share of Albertans' pharmacy dollars go to generic drugs.

The target for 2010 was exceeded by 2.8 per cent. The most likely cause is that a heavily used drug, Lipitor, went generic in July 2010. This has resulted in the acceleration of the actual result compared to the target.

Generic drug spending in Alberta

	2006	2007	2008	2009	2010	Target 2010/2011
Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta	25.7%	29.3%	32.8%	35.1%	38.8%	36%

Source: IMS Brogan Inc.

Goal 4: Healthy living and optimal well-being

Linked to Core Business 1 — Leadership and governance

A healthier population can be realized and a more effective and sustainable health system can be attained by building a strong foundation for public health. The ministry will focus on health and wellness promotion, including mental health, as well as chronic disease and injury prevention to improve the health of Albertans. Health and Wellness will work with various partners and stakeholders to encourage the integration of health promotion and disease and injury prevention, including addiction and mental health, with other health care services and non-health care sectors. The ministry continues to encourage Albertans to make wise choices about their health, wellness and quality of life. In addition, the ministry will also focus on policies and programs that support government and communities in encouraging healthy behaviours and lifestyle choices.

Achievements

Strategy 4.1 **Develop a mechanism to support the wellness agenda.**

- To support the wellness of Albertans, work was initiated on Healthy Alberta: A Wellness Framework for Albertans 2011 – 2021. This framework will be used by the Government of Alberta and stakeholders to guide the development of policies that promote wellness in Alberta. Looking at the next 10 years, the framework will help Albertans improve their health by focusing on improving healthy behaviours and reducing the incidence of chronic disease and injury.

Strategy 4.2 **Provide Albertans with health information to support their health.**

- A new program, supported by $3.96 million in Safe Communities grant funding from the Alberta government over 3 years, is being delivered to children and youth at Alexis Nakota Sioux Nation and Maskwacis Cree Communities that teaches positive lifestyle choices and build resistance to high-risk behaviours. The chosen program, LifeSkills©, is an internationally-developed, evidence-based program, for substance abuse and violence prevention.
- The Minister of Alberta Health and Wellness hosted a Wellness Forum in December 2010 with over 250 Forum participants from the business community, public and private industry, service providers, academia and government attending the event. The purpose of the Wellness Forum was to establish a commitment to action on wellness from multiple stakeholders in the province. This was accomplished through sharing of current research and innovation, new emerging topics, identifying solutions and a roundtable exercise to establish a commitment to action from all participants.

- Healthy Eating ToolKit — In support of Workplace Wellness — The Healthy Eating Toolkit was launched March 14, 2011 to assist employees and employers in making healthy food choices, the easy choices to make at home, at work and during active times with family and friends. The kit consists of the following on-line resources: Alberta Nutrition Guidelines for Adults, the Healthy U Food Checker, Eat Smart Meet Smart, How to Choosewell at Work — An Employers Guide and Moving Toward a Healthy U-Your Personal LogBook.
- The Alberta Nutrition Guidelines for Children and Youth low literacy resources were completed in March 2011. These easy-to-read literacy resources support implementation of the nutrition guidelines in childcare, schools and recreation community centres.
- Alberta Nutrition Guidelines for Adults were released in March 2011. These guidelines provide simple, easy-to-follow guidance on how to make healthier food and beverage choices.
- The Healthy U Food Checker was launched on March 14, 2011. The Food Checker is an on-line application that will assist the user to compare the nutrition criteria from a nutrition facts table to find out if a food or beverage choice is a listed as “choose most often”, “choose sometimes” or “choose least often” according to the Alberta Nutrition Guidelines.

Strategy 4.3 Promote wellness and childhood resiliency, ensuring alignment with multi-sectoral initiatives

- Healthy Kids Alberta! — an Action Plan for 2011 – 2014 was developed. This action plan links the priorities, actions and resources of multiple ministries together into a comprehensive and focused effort. This initiative not only stimulates innovative approaches through cross-sector collaboration, but also enables more widespread leadership and streamlines the coordination of approaches to policy and program development in the four focus areas of achieving healthy weights, supporting healthy birth outcomes, enhancing early childhood development, and building resiliency.

Strategy 4.4 Develop policies and strategies for enhancing health and safety and for reducing the risk of disease and injury.

- The Office of the Chief Medical Officer of Health completed and released a report entitled *The Syphilis Outbreak in Alberta*, in December 2010. The report outlined the spread of syphilis across the province and its impacts, and outlined strategies for controlling the spread of syphilis in Alberta.

Strategy 4.5 Develop policies to improve mental health and prevent and reduce the harm associated with substance abuse and gambling.

- Two additional residential addiction treatment beds were opened in 2010/2011 at the Aventa Addiction Treatment for Women bringing the total of Safe Communities beds to 82 in the province. Aventa is a residential treatment facility for women which offers four-week intensive day treatment and residential treatment programs that include individual and group counseling, information sessions, and life skills training geared to women's specific needs.
- Under the Safe Communities initiatives, a capital plan for 100 new detoxification, residential treatment, and/or concurrent addiction and mental health treatment beds was completed. In February 2011, Alberta Health and Wellness and Alberta Justice and Attorney General announced target dates for new beds opening by 2012 in Fort McMurray and 2013 in Medicine Hat.

Key Performance Measures and Results

Measure 4.A Health Link Alberta

Health Link Alberta is a 24 hour a day, 7 day a week nurse telephone advice and health information services that is available to Albertans from anywhere in the province by dialing: Calgary 403-943-5465; Edmonton 780-408-5465; or toll-free (1-866-408-5465). Highly trained registered nurses provide advice and information about health symptoms or concerns that an individual person or a family member may be experiencing. Health Link can also assist Albertans to locate appropriate services and health information.

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and older found that 79 per cent were aware of Health Link Alberta, up from 76 per cent in 2010. This result exceeds the 2010/2011 target of 75 per cent. Of those Albertans that were aware of Health Link Alberta, 34 per cent had used the service in the past year. The use has been relatively consistent over time.

Health Link Alberta

	2007	2008	2009	2010	2011	Target 2010/2011
Percentage of Albertans who are aware of Health Link Alberta	67%	71%	71%	76%	79%	75%
Percentage of Albertans who have used Health Link Alberta within the past year	37%	33%	37%	36%	34%	45%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Measure 4.B Self reported health status

Self reported health is an indicator of overall health status which compares a person's health to other persons in his or her age group. This measure refers to a person's health in general — not only the absence of disease or injury, but also physical, mental and social well being. It is accepted across Canada as an indicator of population health.

The Ministry has supported the following significant policy initiatives and strategies in 2010/2011 so as to promote and improve population health in Alberta for adults:

- A Wellness Forum, December 1 to 3, 2010
- Alberta Nutrition Guidelines for Adults
- The Healthy U Food Checker
- Eat Smart Meet Smart Resources
- Healthy U Website www.healthyalberta.com
- Alberta Food for Health Award — A Premier's Award
- Premier's Award for Healthy Workplaces
- The Alberta Health Check™ Restaurant Program
- Communities ChooseWell

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans found that 88 per cent of those aged 18 to 64 reported excellent, very good or good health, which is unchanged from 2010 and just under the target of 90 per cent. For those aged 65 years and over, 77 per cent reported excellent, very good or good health, an 11 per cent decrease from 2010 which is under the target of 85 per cent.

Self reported health status: percentage of Albertans reporting "excellent", "very good" or "good" health

	2007	2008	2009	2010	2011	Target 2010/2011
18 to 64 years	87%	88%	89%	88%	88%	90%
65 years and over	78%	84%	84%	88%	77%	85%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

MEASURE 4.C

Body Mass Index

Chronic diseases such as cardiovascular disease, cancer and diabetes are the leading causes of morbidity and mortality in Alberta. Many chronic diseases are associated with overweight and obesity. For example, persons who are overweight or obese are at risk for high blood pressure, Type 2 diabetes, coronary artery disease, stroke, respiratory problems and some cancers. Having a Body Mass Index (BMI) that falls into a normal range is associated with the least amount of health risk. Being overweight or obese in early childhood significantly increases the likelihood of being overweight or obese in adolescence and adulthood, with all the attendant health problems that ensue.

The ministry has supported the following policy initiatives and programs to promote healthy living and healthy weight in Alberta's adult population:

- Alberta Nutrition Guidelines for Adults were released in March 2011. These guidelines provide simple, easy-to-follow guidance on how to make healthier food and beverage choices.
- The Healthy U website supports and encourages Albertans to lead healthier lifestyles by providing them with access to information on healthy eating and active living.
- The Healthy U Food Checker was launched on March 14, 2011; it is an on-line application that will assist the user to compare the nutrition criteria from a Nutrition Facts Table to find out if a food or beverage choice is a Choose Most Often, Choose Sometimes or Choose Least Often according to the Alberta Nutrition Guidelines.
- How to Choosewell at Work — An Employers Guide was developed to assist employers develop workplace health promotion initiatives to support their employees make healthy eating choices and be physically active.
- Moving Toward a Healthy U — Your Personal LogBook provides information about healthy eating and active living and includes tools to chart goals and progress toward achieving them.
- The Communities ChooseWell initiative, managed by the Alberta Recreation and Parks Association, was launched in December 2010. It enables, supports and recognizes communities that promote active living and healthy eating. Alberta Tourism, Parks and Recreation's link to municipalities across the province serves to connect the health and wellness and recreation and parks sectors to realize a shared vision of community wellness.

The percentage of overweight adults has remained stable from 2003 to 2009. The percentage of obese adults increased slightly between 2005 and 2007 and then remained stable between 2007 and 2009. Given the short time frame assessed in these measures, it is reasonable to have minimal changes observed between years.

Body Mass Index

	2003	2005	2007	2008	2009	Target 2010/2011
Percentage of Albertans age 18 and over who are: Overweight	35%	36%	34%	34%	36%	33%
Obese	16%	16%	19%	18%	19%	17%

Source: Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

Measure 4.D Smoking

Tobacco use is the leading cause of preventable disease and death in Alberta. With over 3,000 Albertans dying from tobacco-related illnesses each year, tobacco reduction is a top priority for this Government.

The performance measures listed are important indicators for measuring the success of the Alberta Tobacco Reduction Strategy (ATRS). The self-reported smoking prevalence rate in youth aged 12 – 19 has remained stable over the 2003 – 2009 period. There was a slight increase in smoking rates from 2008 to 2009; however, the increase was not statistically significant and could be the result of statistical variability within the process or measurement of the Canadian Community Health Survey.

Alberta Health Services and Alberta Health and Wellness have implemented several initiatives in 2010/2011 related to tobacco reduction in the youth population, as follows:

- School-based programs will continue to be provided throughout the province.
- Alberta Health Services has started to develop and test an evidence based integrated health system tobacco cessation and prevention model for pediatric patients (ages 0 – 17) and their families.
- The *Alberta Tobacco Reduction Strategy* is in the process of being renewed. The new strategy will focus on youth tobacco prevention, cessation, and protection.

The 2009 CCHS data for the 20-24 year old age group indicates that the performance target for the 2010/2011 year has been achieved. A variety of initiatives were put in place during 2010/2011 to assist in reducing tobacco rates in the province, as follows:

- Health professional training was offered throughout Alberta to enhance cessation services. Over 1300 health professionals have been trained as of 2010/2011.
- AlbertaQuits Groups offered a group cessation counselling program for adults. The program was expanded in the 2010/2011 from 7 to 20 sites.
- In 2010/2011 a total of 17 grants were funded, which included projects that focused on tobacco cessation, protection, and prevention. In addition, there were 4 grants that focused on students at post-secondary campuses.
- A policy was developed that makes all Alberta Health Services owned or leased property across the province smoke-free.
- The Provincial Tobacco Reduction Advisory Committee was reformed in April 2010.

Smoking: prevalence of smoking among Alberta youth and young adults

	2003	2005	2007	2008	2009	Target 2010/2011
Prevalence of smoking Alberta youth 12 to 19 years	14%	11%	12%	11%	13%	10%
Young adults 20 to 24 years	37%	33%	30%	26%	25%	25%

Source: Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

Measure 4.E Regular, heavy drinking

Albertans drank more per capita (9.4 litres), than the national average (8.2 litres) of absolute alcohol in 2008/2009. Alberta ranks second (behind the Yukon) in per capita consumption when provinces and territories are compared.

Drinking heavily over a long period of time can lead to serious health problems such as stomach ulcers, sexual problems, liver disease, brain damage, and many kinds of cancer. Excessive drinking is often responsible for financial, legal and family problems.

Further, Alberta has some unique challenges that need to be addressed:

- Alberta has one of the youngest populations in Canada and alcohol and drug use tends to be highest among the youth and young adult population.
- Alberta has high disposable income.
- The legal drinking age in Alberta is 18.

Prevalence of heavy drinking is a significant issue in Alberta and has not met performance targets for several years. In the Fall 2010, the National Alcohol Strategy Advisory Committee approved new National Low Risk Drinking Guidelines. The recently finalized Alberta Alcohol Strategy Action Plan has prioritized the introduction of these guidelines in Alberta so that Albertans are informed about their alcohol consumption and are educated on how to drink with low-risk.

Regular, heavy drinking: Prevalence of regular, heavy drinking among young Albertans

	2003	2005	2007	2008	2009	Target 2010/2011
Prevalence of regular, heavy drinking among young Albertans	38%	38%	40%	40%	40%	30%

Source: Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

Goal 5: Appropriate access to services across the continuum of care

Linked to Core Business 2 — Effective and innovative health care

Albertans require appropriate access to the right service in the right place and at the right time, through broad strategic policies such as *Vision 2020, Continuing Care Strategy, Pharmaceutical Strategy*, and the *Primary Health Care Strategy*. Within this context, strong collaboration and partnerships are required to improve the coordination of care and thereby more effectively serve the needs of Albertans and integrate health programs and services offered to Albertans. The ministry strives to maintain and further support Alberta Health Services in delivering accessible quality health care to all Albertans including the right services for an aging population, and the right mental health services.

Achievements

Strategy 5.1 **Continue to implement the *Continuing Care Strategy* which will provide Albertans with more options and choices to receive health services to "age in the right place."**

- Alberta Health and Wellness allocated $37.5 million in 2010/2011 to Alberta Health Services to enhance services for seniors and those with disabilities so that more Albertans can receive care in their homes and communities. This includes enhancing home care and supportive living, providing assistance for individuals to transition from facility care back to home or community living, and introducing support programs for emergency departments to support seniors to return to the community with enhanced home care services.
- In 2010/2011, 1,166 new and upgraded spaces were added to Alberta's continuing care system to address the needs of an aging population. New construction or renovations involving 13 facilities were initiated across 11 Alberta communities. The spaces support the Government of Alberta's *Continuing Care Strategy: Aging in the Right Place* and span the spectrum of continuing care facilities that include supportive living, designated assisted living and long-term care spaces.
- The province initiated a new 'Neighbours Helping Neighbours' initiative. The program, which was launched in Edmonton and Jasper, partners volunteers with seniors or those with disabilities to help them with everyday tasks and keep them connected with their communities. The municipalities will work with community stakeholders such as community leagues, seniors' centres, local businesses and church or volunteer groups to deliver the program.
- A pilot project was implemented in Grande Prairie and Medicine Hat to field test and evaluate a limited number of promising market-ready assistive technologies that are designed to increase safety for seniors who live alone in their homes. If successful, these technologies would be considered as an integral component in the delivery of continuing care home care services.

Strategy 5.2 **Support clients in accessing and navigating the health system through guiding of the development and implementation of a patient navigator model.**

- The department initiated a project to develop policy, and design a model, for health system patient navigation. Patient navigation is an approach that links patients with access to a comprehensive range of services in a coordinated fashion. Patient navigation creates alignment of and collaboration among care sectors and service areas to facilitate patients accessing the right services, at the right time, by the right provider.

Strategy 5.3 **Implement targeted strategies to improve access to health services.**

- New province-wide protocols were launched to reduce peak pressures in emergency departments and other parts of the health system during periods of high patient volume. The overcapacity protocols build on current practices by setting new targets that, when reached, trigger immediate actions to reduce emergency department wait times through the movement of admitted patients out of the emergency department on an as needed urgent basis.
- A new radiation therapy site in the Lethbridge Cancer Centre opened in June 2010. The new centre is intended to make it easier for residents of Alberta to obtain radiation therapy in a timely manner and closer to home. In addition, the External Beam Radiation Treatment Access Policy and Directive was approved in 2010 to ensure that the wait time benchmark for patients to receive radiation treatment is met.
- An evaluation of the Alberta Provincial Stroke Strategy (APSS) was completed in February 2011. The evaluation showed that since establishment in 2005, APSS has made significant gains in improving access to stroke treatment and prevention across Alberta. The result is improved outcomes for patients and better stroke prevention and care for Albertans, which translates to fewer people ending up in emergency departments and hospitals.

Strategy 5.4 **Develop and implement provincial policies and strategies to address addiction and mental illness.**

- In the fall of 2010, the Solicitor General, the Minister of Public Security and the Minister of Health and Wellness approved the *Alberta Alcohol Strategy*. The Strategy is co-led by Alberta Health and Wellness, the Gaming and Liquor Commission and Alberta Health Services. The primary goal of the Strategy is to prevent and reduce harm associated with alcohol use in Alberta.
- Work was initiated and is progressing on the Alberta Addiction and Mental Health Strategy. The Strategy is co-led by Alberta Health and Wellness and Alberta Health Services and will set the direction and agenda for the delivery, policy, legislation and standards for addiction and mental health services for Alberta for the next five years.

Strategy 5.5 **Develop a care in the community strategy involving an enhanced primary care model and more coordinated health and social support systems.**

- One of the key strategies of *Becoming the Best: Alberta's 5-Year Health Action Plan*, is to strengthen primary health care. The goal of this strategy is for Albertans to have access to primary health care when they need it, where they need it, from the appropriate provider. Some of the key objectives of the actions contained in the strategy are to: better connect Albertans to family doctors and other healthcare providers, provide information, help Albertans manage chronic disease, and improve the quality and delivery of primary health care. Targets have been committed to with key deliverables targeted for completion by March 2012.

Key Performance Measures and Results

Measure 5.A **Continuing care: Number of persons waiting in an acute care hospital bed or waiting in the community for continuing care placement**

The number of persons waiting in an acute care hospital bed indicates the number of acute care beds that are being occupied by non-acute patients. The number of persons waiting in the community for continuing care indicates how many people are waiting in the community for continuing care spaces. Both measures also indicate unmet demand for continuing care spaces and beds, including those in long-term care facilities such as nursing homes and auxiliary hospitals, or higher level supportive living environments such as designated enhanced living (level 3) or designated assisted living (level 4).

Continuing care clients are not defined by age, diagnosis or the length of time they may require service, but by their need for community-based care.

Continuing care differs from acute care, as services are usually ongoing rather than episodic in nature and needs are beyond what could be addressed through primary care alone.

On November 30, 2010, Alberta Health and Wellness and Alberta Health Services (AHS) announced *Becoming the Best: Alberta's Five Year Health Action Plan*. The Plan includes a strategy to improve continuing care. The strategy to improve continuing care includes adding continuing care spaces, increasing and enhancing home care, using technology, increasing caregiver support and enhancing care coordination as goals for the next five years.

Alberta Health and Wellness has allocated $37.5 million in 2010/2011 to AHS to enhance and strengthen home care so that more Albertans can receive care in their homes and communities. Over the past year, AHW and AHS have been working in partnership to reduce the number of persons waiting for continuing care while in acute care through a number of strategies such as expanding home care and building new supportive living capacity.

In 2010/2011, the target of 400 individuals waiting for continuing care placement while in an acute care facility was not met. However, there was a significant decrease (33 per cent) in the number of persons waiting in hospital for continuing care, compared to the number of people waiting in 2009/2010.

In 2010/2011, the target of 975 individuals waiting for continuing care placement while in the community was not met. There was a small increase in the number of persons waiting in the community for continuing care, compared to 2009/2010. This is due to the impacts of the aging population on the demand for continuing care service, as demand for continuing care services for those individuals who are waiting in the community is still considerable, and continues to rise with the aging of the baby boomers.

Continuing care

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Number of persons waiting in an acute care hospital bed for continuing care	645	754	707	471	400
Number of persons waiting in the community for continuing care	---	1,065	1,039	1,110	975

Source: Alberta Health Services.

Measure 5.B Wait time for children's mental health services

According to the National Institute of Mental Health, nearly one half of mental illnesses begin by age 14. While some children get seen immediately, especially those in crisis, there are still children who wait longer than they should. Providing reasonable access to needed health service is a major objective and a defining attribute of the publicly funded health system. Longer waits affect health status and quality of life and result in more costly health services.

The 2004 Provincial Mental Health Plan indicates that children and adolescents are priority populations for mental health service enhancements and children's mental health is one of six priority access areas in Alberta. The Postl report (*Final Report of The Federal Advisor on Wait times — Health Canada, 2006*) suggests that Federal, Provincial and Territorial governments should address children's wait times due to the fact that the issues they face in their youth as they develop may have an effect on their lifetime health.

In August 2008, the *Children's Mental Health Plan for Alberta: Three Year Action Plan* was released by Alberta Health and Wellness. This Action Plan was further supported in Goal 5 of *Vision 2020* as a key action to be undertaken. The two goals in the Action Plan are to improve access to children's mental health services and address the mental health needs of children and youth at risk. Strategy 1.1 of Goal 1 is to implement access standards for children's mental health services for emergent care (within 24 hours), urgent care (within two weeks) and scheduled visits (within 30 days). Monitoring wait-times is a key outcome measure of improving access to services.

Actions completed to date: A total of 39 Mental Health Capacity Building projects have been implemented through the province with a total of 11 sites funded through the Children's Mental Health Plan (CMHP). All CMHP Strategies have been implemented. These initiatives are designed to enhance access to mental health services in schools and communities across the province. Seventy per cent of the positions being recruited have been filled thus far. Partnerships have been established between Alberta Health Services (AHS) and stakeholder organizations that provide services to at-risk youth and young adults 12 to 24. Mentoring and training of staff in stakeholder organizations ongoing. Subsequent actions planned: Continue with the implementation of the CMHP, including recruitment. Mentoring needs of current contracted partner organizations to be identified. Knowledge exchange and sharing activities are to continue.

As of December 2010, AHS did not meet the target of 85 per cent of referred children receiving a face-to-face assessment within 30 days of referral.

Wait time for children's mental health services

	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Wait time for children's mental health services: per cent of children receiving "scheduled" mental health treatment within 30 days	78%	75%	81%	85%

Source: Alberta Health Services. Alberta Regional Mental Health Information System (ARMHIS) and Meditech (Lethbridge) of Alberta Health Services.

Measure 5.C Wait time for heart surgery (coronary artery bypass graft) — 90th percentile wait time in weeks, by urgency level

Coronary artery bypass graft (CABG) surgery is indicated for patients with significant narrowing and blockages of the heart arteries (coronary artery disease). CABG surgery creates new routes around narrowed and blocked arteries, allowing sufficient blood flow to deliver oxygen and nutrients to the heart. Cardiovascular disease is a major concern for Canadians as it costs $7.6 billion for health care costs (direct costs), and $14.6 billion for indirect costs resulting from lost economic productivity due to disability or death.

The wait time target of less than 1 week for Urgency Level I was not met. However, Alberta Health Services was close to meeting it, with a reported performance of 2 weeks. The target of 6 weeks for Urgency Level II patients was met, while the target of 26 weeks for Urgency Level III patients was exceeded. Alberta Health Services implemented an improved triage and booking process for urgent cases in December 2010. Wait time definitions have also been refined and standardized between Calgary and Edmonton to ensure accurate and consistent reporting of data.

Wait time for heart surgery (CABG) by urgency level: 90th percentile wait time in weeks

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Heart surgery (CABG)						
• Urgency Level I	4	2	2	2	2	<1 week
• Urgency Level II	18	14	20	21	6	6 weeks
• Urgency Level III	34	26	18	17	24	26 weeks

Sources: Alberta Health Services. Mazankowski Wait List database (Edmonton); Velos database (Calgary) for Q1 to Q3, 2010/11; APPROACH database for Q4, 2010/11.

Note: Results are restated for all prior years due to changes in methodology. Calculation of results is now based on data for the entire fiscal year, not data 90 days prior to the last day of March.

Measure 5.D Wait time for hip replacement surgery
Measure 5.E Wait time for knee replacement surgery

Hip replacement surgery is the second most common joint replacement surgery in Alberta specifically, and North America in general. Providing reasonable and timely access to hip replacement surgery is a major objective and a defining attribute of the publicly funded health system in Alberta. Longer waits for necessary hip replacements affect health status and quality of life and result in more costly health services.

In 2010/2011, 90 per cent of patients received hip replacement surgery within 39 weeks from the decision to treat. The wait time increased from the previous year, and was significantly longer than the national benchmark of 26 weeks.

Knee replacement surgery is the most common joint replacement surgery in Alberta specifically, and North America in general. Typically the procedure is undertaken for patients with a condition of osteoarthritis and occurs with greatest frequency in those aged 60 and older. In Alberta, 80 per cent of the patients undergoing elective surgery for knee replacement since 2003 have been over 60 years of age. Given the rapidly aging population in the province, the incidence and importance of this procedure can be expected to increase markedly over the foreseeable future.

In 2010/2011, 90 per cent of patients received knee replacement surgery within 49 weeks from the decision to treat. The wait time is the same result achieved as in 2009/2010, and is significantly longer than the national benchmark of 26 weeks. Currently over 70 per cent of Alberta patients receive knee replacement surgery within 26 weeks.

Alberta Health Services has undertaken a number of actions in 2010 to improve access to hip and knee replacement surgery, including:

- Establishing a provincial plan for hip and knee replacements to look at backlog and identify areas for increased volume;
- Undertaking a provincial surgical blitz in the summer of 2010 (an additional 130 hip replacements and an additional 195 knee replacements);
- Implementing the Hip Arthroplasty Care Pathway and the Knee Arthroplasty Care Pathway across Alberta in August, 2010;
- Opening the new McCaig Tower at the Foothills Medical Centre to expand surgical capacity and offer specialized, patient-centred orthopedic care (first phase opened in October 2010);
- Opening of the new Orthopedic Surgery Centre in the Royal Alexandra Hospital in Edmonton, a new 56 bed, 4 operating room facility built with the specific purpose of providing high volume throughput, improved efficiency and decreased length of stay for joint replacements.

Wait times for hip replacement surgery and knee replacement surgery: 90th percentile wait times in weeks

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Hip replacement surgery	43	36	36	35	39	26 weeks
Knee replacement surgery	53	49	46	49	49	26 weeks

Sources: Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

Measure 5.F Wait time for cataract surgery

One of the leading causes of visual impairment in North America is cataracts. Cataracts have been identified in about 50 per cent of persons between 65 and 74 years of age, and in about 70 per cent of those over the age of 75 years. Surgical removal of the lens, the only currently available treatment for cataract-associated vision loss, is capable of restoring visual function in 90 per cent of cases. Cataract surgery is the most common surgery in Alberta and one of the major concerns for timely treatment for residents of the province.

In 2010/2011, 90 per cent of patients received scheduled cataract surgery (first eye) within 47 weeks from the decision to treat. The wait time increased from 42 weeks in 2009/2010, and is significantly longer than the national benchmark of sixteen weeks.

Alberta Health Services expanded the number of cataract surgeries provincially in 2010/2011. The impact of these additional procedures on equalizing wait times in the province was monitored. The majority of long patient waits were experienced in Calgary, which has the highest backlog of patients. Alberta Health and Wellness and Alberta Health Services are investigating the wait times and wait list process.

Wait time for cataract surgery: 90th percentile wait time in weeks

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Cataract surgery	32	28	30	42	47	16 weeks

Source: Alberta Health and Wellness. Alberta Wait Times Reporting, Business Intelligence Environment (BIE).

Measure 5.G Wait time for all other elective surgical procedures

The wait time for all other elective surgical procedures covers surgical services to virtually all body systems, and collectively accounts for 77 per cent of the elective surgical procedures contained and reported from the Alberta Wait Times Reporting system. This measure reflects the wait times of the majority of Albertans that seek surgery.

In 2010/2011, 90 per cent of patients received other elective surgical procedures within 26 weeks from the decision to treat. The wait time increased from the previous year, and it exceeds the 2010/2011 performance target of 22 weeks. Currently there is no national benchmark for wait times for these surgeries.

Alberta Health Services is undertaking a transformational improvement program focused on improving access and reducing wait times. Additional surgeries were also undertaken in the first quarter (April to June) surgical blitz to reduce the backlog of patients waiting for surgery, and additional surgical volume investments are being planned.

Wait time for all other elective surgical procedures: 90th percentile wait time in weeks

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
All other elective surgical procedures	22	23	25	25	26	22 weeks

Sources: Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

Measure 5.H Emergency department length of stay

The emergency department (ED) length of stay (LOS) is the time from when a patient is triaged until they are discharged or enter the hospital (leave the ED).

Patients with a more serious initial assessment (CTAS 1, 2, or 3) are classified as complex cases as they are more likely to require more tests, complexity of care, waits for consults or surgery, or admission to an available hospital bed. Patients with a less serious initial assessment (CTAS 4 or 5) are classified as minor/uncomplicated cases. CTAS is the Canadian Triage Acuity Scale developed by the Canadian Association of Emergency Physicians.

Unlike how other health services are organized, emergency departments have unique characteristics. The majority of visits to EDs are unscheduled and involve immediate assessment. At times, decisions about treatment need to be made very rapidly and actions taken. While not all emergency departments are organized in the same way, most have an intake area where patients who arrive on their own (that is, not in an ambulance) register. During this time, patients are assessed or triaged by qualified health professionals and may be assigned severity scores, which have associated clinical urgency recommendations. If patients arrive by ambulance, the registration process may differ slightly, but the severity of the patient's condition is still assessed.

The length of time that a patient spends in the emergency room from triage through provider assessment and treatment is an important indicator for the public that may be seeking care at a particular facility. There are important demographic differences and patient expectations between urban and rural emergency room patients. Wait times to access emergency department services may affect patients' overall experiences of care in emergency departments.

In 2010/2011, 90 per cent of patients assessed as minor or uncomplicated cases were discharged from the emergency department within 5.3 hours, which is longer than the performance target of 4.5 hours. Ninety per cent of patients assessed as complex cases were admitted to hospital from the emergency department in 15.0 hours, which is also longer than the performance target of 11 hours. Performance results for ED LOS in 2010/2011 are the same performance results achieved in 2009/2010.

There is significant variance in wait times in EDs across the province, with the longest waits being experienced in the 14 high volume facilities in Edmonton, Calgary, Red Deer, Lethbridge, Grande Prairie and Fort McMurray. Wait times in emergency departments of lower volume facilities are substantially shorter.

In December 2010, Alberta Health Services introduced "over capacity" protocols and escalation plans to manage periods of peak pressures in EDs. Alberta Health Services is also introducing process improvement efforts, having EDs work collaboratively with other sectors to help patients avoid unnecessary (avoidable) ED visits and return home with appropriate services so as to minimize return visits. Following the introduction of the protocols, AHS reported that:

- 66 per cent of patients were discharged from high volume EDs within 4 hours, up from 62 per cent before the protocols, and
- 42 per cent of patients were admitted from high volume EDs within 8 hours, up from 39 per cent before the protocols.

Emergency department length of stay: 90th percentile wait time in hours

	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Emergency department length of stay • Minor or uncomplicated cases	5.6	5.3	5.3	4.5 hours
• Complex cases	16.2	15.0	15.0	11 hours

Sources: Alberta Health Services. Alberta Ambulatory Care Reporting System (AACRS) data and AHS Ambulatory Care Reporting System (NACRS) data.

Measure 5.I Public rating of access to emergency department services

Albertans get emergency and urgent care services in many different ways. Hospital emergency departments see the majority of patient emergencies in Alberta and access to services has become an issue. Ensuring equitable and timely access to emergency services is essential.

Excessive wait times for care can result in treatment delays for individual patients and reduced efficiency in the flow of patients.

The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and older found that 59 per cent rated access to emergency departments as easy or very easy, up from 55 per cent in 2010, and just under the target of 60 per cent (the confidence interval around the result is within the target).

In response to long wait times and public concerns, Alberta Health Services has undertaken a multi-pronged strategy to improve access to emergency departments, and these actions reflect its improved performance:

- implementing "over capacity" protocols (as of December 17, 2010) to manage periods of peak pressures;
- establishing and reporting on performance measures for patients admitted within 8 hours and patients discharged within 4 hours;
- introducing process improvements projects in different sites;
- new treatment rooms in some emergency departments;
- new medical assessment units;
- new hospital beds; and
- new continuing care beds.

Public rating of access to emergency department services

	2004	2006	2008	2010	2011	Target 2010/2011
Percentage rating ease of actually obtaining emergency department services needed for self or a close family member as 'very easy" or "easy"	50%	48%	51%	55%	59%	60%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Goal 6: Health workforce utilization and efficiency

Linked to Core Business 2 — Effective and innovative health care

A strong health workforce is key to maintaining a strong health system. Through various collaborations and partnerships, the ministry assures the provision of quality health care services by matching workforce supply to demand. Efficient, effective and innovative patient care models can be achieved by leveraging health workforce resources and optimizing utilization of education, skills and experience. Well managed retention initiatives will increase workforce satisfaction and staff retention, as well as overall productivity and system effectiveness.

Achievements

Strategy 6.1 **Ensure there is an appropriately regulated, adequate supply of health care workers with the right skills and competencies.**

- Drafting of an amendment to the Pharmacy Profession Regulation was completed to include pharmacy technicians as a regulated health profession. The regulation will give pharmacy technicians the authority to dispense, compound and sell drugs; and compounding blood products under the direction of pharmacist. Regulating pharmacy technicians will provide Albertans with improved access to pharmacy services. Pharmacy technicians will focus on prescription preparation and dispensing of drugs, while pharmacists will focus on providing more comprehensive patient care such as medication management, immunization, and patient counseling.

Strategy 6.2 **Develop and maintain compensation models to support effective and efficient ways to offer sustainable health services.**

- A new three-year agreement with the United Nurses of Alberta was finalized in June 2010 which put in place agreement surrounding wage grids for registered nurses as well as commitments to nurse recruitment and hiring.
- An Agreement in Principle was reached with the Alberta Medical Association and Alberta Health Services in March 2011 for the provision of physician services in Alberta. The Agreement in Principle contains the structure for a number of strategic task forces that will be used to help guide important physician policy in the future.
- A new three-year agreement was reached with the Alberta Association of Optometrists for the provision of services under the seniors' and children's programs as well as for medically necessary procedures covered by the province.
- In 2010/2011 there were 9 Academic Alternate Relationship Plans (ARPs) in Alberta, involving 10 academic programs with approximately 750 academic physicians as of March 31, 2011. This is an increase of 25 academic physicians since March 31, 2010. Participating physicians are primarily specialists and academic family physicians working in Edmonton and Calgary.

- During 2010/2011, four additional Clinical Alternate Relationship Plans (ARPs) were implemented, bringing the total number of clinical ARPs in Alberta to 47, involving approximately 900 physicians. Physicians in Clinical ARPs are compensated in a manner other than fee-for-service, thus allowing them to manage patient care differently. The purpose of Clinical ARPs is to promote innovation in clinical service delivery while enhancing recruitment and retention of physicians, team-based approach to service delivery, access to health services for Albertans, patient satisfaction, and value for money.
- An evaluation of the Clinical Alternate Relationship Program (ARP) was completed in December 2010. The evaluation examined the program's impact and assessed how it measured up to its defined goals, which are to provide innovation in clinical service and enhance physician recruitment and retention, a team based approach to care, access to services, patient satisfaction and value for money. The evaluation provided evidence that clinical ARPs have been successful in advancing the use of multidisciplinary teams and increasing access to care.
- The Rural Remote Northern Program, which is a component of the Clinical Stabilization Initiative, aims to recruit and retain physicians in under-serviced communities in Alberta, and to provide Albertans with equitable health services. This program compensates physicians practicing in eligible rural, remote, and/or northern communities a fee premium on all insured services provided. The program has been successful in recruiting/retaining approximately 910 physicians (flat fee) and approximately 2,100 physicians (variable fee premium) in under-serviced communities and improving access to care.
- Government development a funding mechanism so that pharmacists could be compensated for their influenza immunization services. This is part of improving access to this vaccine resulting in improving immunization rates and decreasing influenza transmission in Alberta.

Strategy 6.3 **Continue to develop and expand innovative, sustainable and patient-centered service delivery models that improve access to health services.**

- Seven new Primary Care Networks (PCNs) were launched in 2010/2011. Athabasca PCN was launched on April 1, 2010, Cold Lake PCN and Vegreville PCN were launched on July 1, 2010, Wetaskiwin PCN and Vermilion PCN were launched on September 1, 2010, Grande Prairie PCN was launched on October 1, 2010 and Lloydminster PCN was launched on January 1, 2011. As of March 31, 2011 there were 39 PCNs operating in the province, which included more than 2,216 family physicians providing primary health care to over 2.5 million Albertans.

Strategy 6.4 **Enhance capacity for training health care workers and improve education and training programs.**

- The Health Workforce Action Plan funded 18 University of Alberta and 13 University of Calgary medical students to live in rural Alberta communities for their 9-month clinical clerkships, increasing the likelihood that they will choose Family Medicine residencies in rural Alberta.
- The Alberta International Medical Graduate (IMG) program assessed 142 IMGs and matched 47 to Alberta residencies. International medical graduates bring their skills and training and after a period of time in residency training to gain experience in the Canadian health system, will be able to enter the workforce.

Strategy 6.5 **Support workforce efficiency improvements to optimize workflow and utilization of full scopes of practice.**

- More family physicians have enrolled in the Access Improvement Measures (AIM) program which assists physicians and teams in reducing wait times for patient visits and improve access to health care for Albertans. The program has also expanded to include specialists. To date, 150 primary care clinics and 79 specialty and/or regional programs involving 770 general practitioners, 434 specialists and 1,043 allied health providers have or are currently participating in AIM.

Key Performance Measures and Results

Measure 6.A Access to primary care providers

Primary health care refers to the care a patient receives from a doctor or a health-care team when first entering the health system. In addition to doctors, primary health care providers include professionals such as nurses, pharmacists, dieticians, counselors and rehabilitation therapists.

This measure describes the percentage of Albertans that report having access to a primary care physician. The Health Quality Council of Alberta (HQCA) 2011 survey of Albertans age 18 and over found that 84 per cent reported that they have a personal family doctor, up from 82 per cent in 2010. This result exceeds the target of 83 per cent.

Access to primary care providers: percentage of Albertans reporting that they have a personal family doctor

	2004	2006	2008	2010	2011	Target 2010/2011
Access to primary care providers: Percentage of Albertans reporting they have a personal family doctor	85%	81%	81%	82%	84%	83%

Source: Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

Measure 6.B Access to primary care through Primary Care Networks

Primary Care Networks (PCNs) are the key strategy to support the implementation of primary health care (PHC) services in Alberta. In the document, *Becoming the Best: Alberta's 5-Year Health Action Plan 2010 – 2015*, released in November 2010, the continued development and expansion of PCNs is described as a key strategy to improving quality, access and sustainability for the health system overall.

Although PHC services are also provided outside of PCNs, PCNs are the only province wide, comprehensive, PHC service delivery model. Albertans enrolled within PCNs are provided access to multi-disciplinary, integrated and coordinated care.

According to research conducted by the Canadian Institute for Health Information (CIHI) access to a broad spectrum of services, including health promotion and disease prevention (offered by PCNs), as well as comprehensive, multi-disciplinary and coordinated care are markers of health care service delivery excellence.

Given that most family practices at this time are closed or accept a very limited number of new patients, the increase in the number of Albertans enrolled within a PCN is directly related to the registration of individual physicians with existing PCNs and the establishment of new PCNs. In 2009/2010 an additional 290 physicians registered with existing PCNs. This resulted in an additional 159,278 Albertans being enrolled. Also in 2009/2010, two new PCNs were established. This resulted in the addition of 47 new physicians and an additional 49,538 enrolled Albertans. As a result, the 2009/2010 target established in the *Health and Wellness Business Plan 2009 – 2012* of 55 per cent was exceeded. However, it is noted that the higher target (80 per cent) set for 2010/2011 in the 2010 – 2013 business plan was not met. Further development of PCNs and enrollment of Albertans to current PCNs is dependent on an increase in the voluntary participation of physicians in Primary Care Networks.

Access to primary care through Primary Care Networks

	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network	55%	60%	---	80%

Source: Alberta Health and Wellness. Claims Assessment System (CLASS) (numerator); Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator).

Note: Result for 2010/2011 was not available as of June 30, 2011.

Measure 6.C Physicians linked to Primary Care Networks

Primary Care Networks (PCNs) are the key strategy to support the implementation of primary health care (PHC) services in Alberta. In networks, physicians work closely with other health care professionals to enhance the primary health care services they are able to provide to Albertans.

PCNs are voluntary partnerships between groups of family physicians and Alberta Health Services. In the document, Becoming the Best: Alberta's 5-Year Health Action Plan 2010 – 2015, released in November 2010, the continued development and expansion of PCNs is described as a key strategy to improving quality, access and sustainability for the health system overall. Primary health care refers to the care a patient receives from a doctor or a health-care team when first entering the healthcare system.

This measure indicates the proportion of family physicians enrolled in PCNs. Although the 2010/2011 target of 57 per cent was not met, an additional 290 physicians were registered with existing PCNs. As well, an additional 47 new physicians were registered with two new PCNs which were established in 2009/2010.

The increase in the number of physicians linked within a PCN is directly related to the registration of individual physicians to existing PCNs and the establishment of two new PCNs. Further development of PCNs and enrollment in current PCNs is based on the voluntary participation of physicians.

Physicians linked to Primary Care Networks

	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Physicians linked to Primary Care Networks: Percentage of family physicians linked to a Primary Care Network	55%	53%	---	57%

Source: Alberta Health and Wellness. Claims Assessment System (CLASS). Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator).

Note: Result for 2010/2011 was not available as of June 30, 2011.

Goal 7: Excellence through research, innovation and technology

Linked to Core Business 2 — Effective and innovative health care

The pursuit of excellence in Alberta's health system is an ongoing process that is accelerated through the efforts of scientists, program evaluators, information specialists and others involved in building upon the foundation for the health system of the future. The ministry promotes a culture of innovation to support programs and mechanisms required to maximize capacity and optimize the critical role research and technology play in improving health care in Alberta. Integrated systems for sharing information combined with a new health research strategy will leverage knowledge and support innovative programs and services needed to improve health care diagnostics and treatments.

Achievements

Strategy 7.1 **Coordinate and lead the continued adoption of automated information systems, electronic health records and technology by health care providers.**

- Phase 1 of the Personal Health Portal, branded MyHealth.Alberta.ca, was completed and publicly launched in May 2011. MyHealth Alberta will offer valuable health information on over 8750 health topics and a number of tools that can help Albertans make important decisions about their health.
- Access to Alberta's electronic health records portal (Alberta Netcare) continued to be rolled out across the province. The Alberta Netcare portal is integrated with the Calgary Clinical Information System which enabled 2600 users to access the provincial electronic health record.
- The Provincial Provider Site Registry, which already includes information on sites that are providing health services in Alberta, was expanded to include information on organizations that provide health care services for quick and accurate reference for users of Netcare.

Strategy 7.2 **Implement a health research and innovation strategy that will provide strategic focus to health research investment and encourage translation of knowledge.**

- *Alberta's Health Research and Innovation Strategy* (AHRIS) was released on August 26, 2010. The strategy was co-developed by Alberta Health and Wellness and Alberta Advanced Education and Technology in consultation with more than 150 stakeholders through numerous workshops, forums and one-on-one interviews. This strategy is shaping the business planning processes of key health research organizations including Alberta Innovates Corporations, Alberta Health Services and health research programs at post-secondary institutions.

Strategy 7.3 **Collaborate with Alberta Health Services to review and recommend the introduction and further integration of new and existing technologies to improve service and manage public costs.**

- Twelve health technology assessments were completed in 2010/2011. Assessment of new and existing health technologies continues to ensure that the introduction or funding of these services is based on sound clinical evidence.
- In 2010/2011, work was initiated to enhance the Alberta Health Technologies Decision Process by developing three key areas of the process: technology reassessment, access with evidence development and post-policy implementation review.
- The Alberta Health System 2011 – 2016 IT Plan was developed, which serves as a companion document to the 5-Year Health Action Plan to set the strategic direction for IT developments over the next 5 years for Alberta Health and Wellness, Alberta Health Services and their stakeholders. The province's investment in IT is focused on supporting the operation, growth and transformation of the health system.

Strategy 7.4 **Develop a comprehensive data strategy to enhance clinical care and research initiatives (including Health and Wellness and Alberta Health Services data).**

- Business Definitions and guiding principles for the Alberta Healthcare Data Repository (AHDR) were developed. The repository is intended to unite under a single governance model and technical infrastructure, data holdings of high interest to analysts, decision-makers and researchers in Alberta's health care system. The repository will contain a comprehensive collection of administrative, registry, clinical health, survey and other health information.

Key Performance Measures and Results

Measure 7.A **Alberta Netcare: Number of care providers accessing Alberta Netcare**

Alberta Netcare (Alberta's electronic health record — EHR) is a clinical information network that links community physicians, pharmacists, hospitals, and other authorized health care professionals across the province. Netcare lets health care practitioners view health information such as patient allergies, prescriptions and lab tests electronically. As more health providers access the system, more consistent and improved treatment decisions will result. The measure was introduced to ensure accuracy and relevance of data used for tracking toward deployment and uptake goals and will be reviewed annually to ensure continued relevance in attainment.

Alberta Netcare: Number of care providers accessing Alberta Netcare

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Number of care providers accessing Alberta Netcare	22,918	29,110	34,200	39,866	---	45,229

Source: Alberta Health and Wellness, Information Management Branch. Electronic Health Record (EHR) applications: Pharmaceutical Information Network (PIN); Lab Test Results History (LTRH); Person's Directory (PD); Alberta Netcare Portal 2004.

Note: The overall number of users accessing Alberta Netcare continues to increase. During 2010/11, some older systems that provide reporting for this measure were retired and replaced with a new system. The methodology to gather the counts under the new system is being revised. As a result, data available for 2010/11 is not comparable to prior years and, therefore, is not reported in this year's annual report.

Measure 7.B Physician utilization of electronic medical records

This performance measure quantifies the adoption rate of electronic medical record (EMR) technology in physician practices. EMR technology supports best practice care delivery and helps community physicians provide improved primary care services to Albertans.

The percentage of Alberta's community physicians who use an EMR system in their clinic increased 7 per cent in fiscal 2010/2011. As of March 31, 2011, a total of 2,576 community physicians, or 53 per cent of Alberta's 4,820 practicing community physicians, have adopted an EMR system. EMR technology supports best practice care delivery and helps community physicians provide improved primary care services to Albertans.

Physician utilization of electronic medical records

	2006/ 2007	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	Target 2010/2011
Physician utilization of electronic medical records: Percentage of community physicians using the Electronic Medical Record in their clinic	45%	45%	46%	46%	53%	57%

Sources: Alberta Medical Association (AMA) membership database (MSIS); POSP funding and enrolment database (iPOSP); Alberta Health Services (AHS) Lab destinations per physician.

Changes to Performance Measures Information

New or Changed Performance Measures in the 2010/2011 Annual Report:

- Satisfaction with health care services received: percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year.
- Influenza immunization: percentage of Albertans who have received the recommended seasonal influenza immunization (seniors aged 65 and over; children aged 6 to 23 months; residents of long term care facilities).
- Sexually transmitted infections: rate of newly reported infections (per 100,000 population) (chlamydia; gonorrhea; syphilis).
- Congenital syphilis: rate per 100,000 births (live and still born).
- Generic drug spending in Alberta: community dispensed percentage of generic prescription drugs in Alberta.
- Body mass index: percentage of Albertans age 18 and over who are overweight or obese.
- Continuing care: number of persons waiting in an acute care hospital bed for continuing care; number of persons waiting in the community for continuing care.
- Wait time for children's mental health services: per cent of children receiving "scheduled" mental health treatment within 30 days.
- Wait time for cataract surgery: 90th percentile wait time in weeks.
- Wait time for all other elective surgical procedures: 90th percentile wait time in weeks.
- Emergency department length of stay: 90th percentile wait time in hours (1) minor or uncomplicated cases; (2) complex cases.
- Access to primary care providers: percentage of Albertans reporting they have a personal family doctor.
- Physicians linked to Primary Care Networks: percentage of physicians linked to Primary Care Networks.
- Physician utilization of electronic medical records: percentage of community physicians using the Electronic Medical Record in their clinic.

Key Performance Measures discontinued in the 2011 – 2014 Business Plan:

- Public rating of health system overall: percentage rating the health care system as either “excellent” or “good”.
- Incidence of serious complaints: percentage of Albertans reporting a serious complaint about any health care services personally received in Alberta within the past year.
- Congenital syphilis: rate per 100,000 births (live and still born).
- Health Link Alberta: percentage of Albertans who are aware of Health Link Alberta. Percentage of Albertans who have used Health Link Alberta within the past year.
- Self-reported health status: percentage of Albertans reporting “excellent”, “very good”, or “good” health (18 to 64 years; 65 years and over).
- Regular, heavy drinking: prevalence of regular, heavy drinking among young Albertans.
- Wait time for children’s mental health services: per cent of children receiving “scheduled” mental health treatment within 30 days.
- Wait time for heart surgery (coronary artery bypass graft): 90th percentile wait time in weeks by urgency level.
- Wait time for all other elective surgical procedures: 90th percentile wait time in weeks.
- Emergency department length of stay: 90th percentile wait time in hours (minor or uncomplicated cases; complex cases).
- Public rating of access to emergency department services: percentage rating ease of actually obtaining emergency department services needed for self or a close family member as “very easy” or “easy”.
- Access to primary care providers: percentage of Albertans reporting they have a personal family doctor.
- Physicians linked to Primary Care Networks: percentage of physicians linked to Primary Care Networks.

New or Changed Performance Measures in the 2011/2012 Annual Report:

- None.

Performance Measures — Data Sources and Methodology

Data Sources

1.a. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

1.b. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2004, 2006, 2008, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

2.a. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2004, 2006, 2008, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

2.b. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2004, 2006, 2008, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

2.c. Alberta Health Services; Alberta Health and Wellness, Interactive Health Data Application Population Estimates 2010.

2.d. Alberta Health and Wellness. CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection).

3.a. IMS Brogan, Canadian Compuscript; Alberta Health and Wellness, Health Workforce Division, Pharmaceutical Funding and Guidance Branch.

4.a. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

4.b. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2007, 2008, 2009, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

4.c. Statistics Canada. Canadian Community Health Survey (CCHS), Alberta Share file (2003, 2005, 2007, 2008, 2009).

4.d. Statistics Canada. Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009). For the 12 to 19 age group, 2009 CCHS results are published by Statistics Canada in Table 105-0501 Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2007 boundaries) and peer group, occasional, CANSIM (database). For the 20 to 24 age group, the 2009 results are calculated using the Alberta Share File of the 2009 Canadian Community Health Survey.

4.e. Statistics Canada, Canadian Community Health Survey (CCHS) (2003, 2005, 2007, 2008, 2009).

5.a. Alberta Health Services. Stratahealth Pathways (Calgary and Edmonton Zones); Meditech (North, Central and South Zones).

5.b. Alberta Health Services. Alberta Regional Mental Health Information System.

5.c. Alberta Health Services. Mazankowski Wait List database (Edmonton); Velos database (Calgary) for Q1 to Q3, APPROACH for Q4, 2010/2011.

5.d. Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

5.e. Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

5.f. Alberta Health and Wellness. Alberta Wait Times Reporting; Business Intelligence Environment.

5.g. Alberta Health and Wellness. Alberta Wait Times Reporting; Business Intelligence Environment.

5.h. Alberta Ambulatory Care Reporting System (AACRS) data and Alberta Health Services Ambulatory Care Reporting System (NACRS) data.

5.i. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2004, 2006, 2008, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

6.a. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2004, 2006, 2008, 2010). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

6.b. Alberta Health and Wellness. Claims Assessment System (CLASS) (numerator) as at March 31, 2010; Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator) as of March 31, 2010.

6.c. Alberta Health and Wellness. Claims Assessment System (CLASS) (numerator) as at March 31, 2010; Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator) as of March 31, 2010.

7.a. Alberta Health and Wellness, Health Information and Technology Systems Division, Information Management Branch. Electronic Health Record (EHR) applications:

- Pharmaceutical Information Network (PIN)
- Lab Test Results History (LTRH)
- Person's Directory (PD), and
- Alberta Netcare Portal 2004.

7.b. Alberta Medical Association (AMA) membership database (MSIS); Physician Office System Program (POSP) funding and enrolment database (iPOSP); Alberta Health Services (AHS) lab destinations per physician.

Methodology

1.a Public rating of health system overall: Percentage rating the health system as either "excellent" or "good"

This measure identifies Albertans' rating of the health care system and the quality of medical services it provides. Results are based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011).

To assess public rating of the health system overall, Albertans 18 years of age and over are asked, "Thinking broadly about Alberta's health care system and the quality of medical services it provides, how would you describe it overall? Would you say it is excellent, good, fair, or poor"? The total percentage of survey respondents who rate the health system overall as excellent or good is calculated and reported.

In February and March of 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 1,193 respondents answered the question on rating the health care system and the quality of medical services it provides. Results are reliable within ±2.7 per cent, 19 times out of 20.

1.b Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year

This result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). This measure is defined as the total percentage of respondents who responded "satisfied" or "very satisfied" to the question:

"Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, to what degree are you satisfied or dissatisfied with the services you have received?"

In February and March of 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 950 respondents answered the question on satisfaction with health care services personally received in Alberta within the past year. Results are reliable within ±3.0 per cent, 19 times out of 20.

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

The result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). This measure is defined as the percentage of survey respondents who answered "yes" to the question:

"To the best of your knowledge, have you, or has a member of your immediate family experienced UNEXPECTED HARM while receiving healthcare in Alberta WITHIN THE PAST YEAR?"

In 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 948 respondents

answered the question on experiencing unexpected harm while receiving health care in Alberta. Results are reliable within ±2.1 per cent, 19 times out of 20.

2.b Incidence of serious complaints: Percentage of Albertans reporting a serious complaint about any health care services personally received in Alberta within the past year

The result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). This measure identifies Albertans' self-reports of serious complaints about any health care services personally received in the past year in Alberta. Data are collected through a telephone survey of randomly selected Alberta households. In February and March of 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 957 respondents answered the question,

"Have you had a SERIOUS complaint about any health care services you have received in Alberta in the past year?"

The total percentage of respondents who answered "yes" to this question is calculated and reported. Results are reliable within ±2.2 per cent, 19 times out of 20.

2.c Influenza immunization: Percentage of Albertans who have received the recommended seasonal influenza immunization

(1) Seniors aged 65 and over

(2) Children aged 6 to 23 months

(3) Residents of long term care facilities

Numerator data was manually collected in each zone on the seasonal influenza NCR data collection form. Information was aggregated by each zone and sent centrally for inclusion into the provincial report. Numerators represent immunizations delivered by Alberta Health Services, Community Providers and First Nations. Denominator data was retrieved from Alberta Health and Wellness' (AHW) Interactive Health Data Application Population Estimates which is based on mid-year (June 30) registration population estimates. First Nations communities are also included in the Denominator. Alberta residents living in Lloydminster are not present in either the numerator or denominator.

Seniors' immunization rate includes all persons 65 years and older in Alberta who have received one dose of influenza vaccine in the 2010/2011 season. Rates for children aged 6 – 23 months in 2009/2010 and 2010/2011 are calculated as "dose 2 of 2 + Annual". Prior to 2009/2010 this rate was calculated as "Doses 1 of 1 + Annual". In order to meet the timelines for the Ministry of Health and Wellness Annual Report, results for seniors and children aged 6 to 23 months are current as of March 31, 2011, which is earlier than the end of the seasonal influenza immunization season.

The rate for LTC residents are representative of a snapshot immunization rate in the LTC population on December 15th, 2010. It is necessary to define the immunization rate in this way due to the high turnover in this population. Using the total number of LTC residents immunized in 2010/2010 instead of a snapshot may result in a coverage rate of over 100 per cent.

2.d Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)

- **Chlamydia**
- **Gonorrhea**
- **Syphilis**

Congenital syphilis, rate per 100,000 births (live and still born)

Results for this measure are based on data from Alberta Health and Wellness' CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection) database, which provides the number of newly reported cases of sexually transmitted infection, by type of infection, in a given calendar year, and the Alberta Health and Wellness' Business Intelligence Environment, which provides the mid-year population in a given calendar year.

Calculation of Sexually Transmitted Infection Rates

$$\text{The sexually transmitted infection rate} = \left(\frac{\text{Number of newly reported cases in given calendar year}}{\text{Mid-year population of given calendar year}} \right) \times 100{,}000$$

$$\text{Congenital syphilis rate} = \left(\frac{\text{Number of newly reported cases in given calendar year}}{\text{Number of births (live and still born) of given calendar year}} \right) \times 100{,}000$$

3.a Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta

This measure compares empirical data for retail (customer) expenditure of generic drugs versus brand name prescription drugs in Alberta.

The data source is IMS Brogan, Canadian CompuScript, as analyzed and reported by the Pharmaceutical Funding and Guidance Branch, Alberta Health and Wellness. *The Canadian CompuScript Audit* measures the number of prescriptions dispensed by Canadian retail pharmacies. Product information is presented according to therapeutic class, and for each product the following data elements are collected: manufacturer, form, strength, new vs. refill prescription, prescription size and price, transaction location, transaction date, MD number (if available), third-party payer (if available), and authorized repeats. The *CompuScript* sample is drawn from IMS Brogan's panel of over 5,700 pharmacies, which represents more than 70% of all retail pharmacies in Canada; over 5,200 stores are used for the audit including chain and independent pharmacies. Sample data collected are then used to project estimates for each province, and provincial totals are added to provide a national estimate.

Regarding methodology changes since 2005, the new CompuScript Next Generation (G2) was introduced in January 2008, with 3 years of restated back data (January 2005 forward) in order to maintain accurate trending of results..

For totals for Generics and totals for Brands, the sampling error for Alberta is approximately ±3% to ±5% for Total Brand, and ±5% to ±7.5% for Total Generics. On an individual product

basis, the vast majority of Brand products (top 300) have a sampling error of ±5% to ±7.5%, and the top 300 Generics have a sampling error of ±10% to ±15%. The margin of error is higher for Generics due to the stocking incentives that specific pharmacies/chains have with drug manufacturing companies.

The result is calculated as the quotient of the numerator and the denominator, defined as follows:

Numerator: Is the estimated value of generic manufactured prescription drugs dispensed from Alberta retail pharmacies (includes markups and professional fees).

Denominator: Is the total (generic and brand manufactured) estimated value of manufactured drugs dispensed from Alberta retail pharmacies (includes markups and professional fees).

4.a Health Link Alberta:

- **Percentage of Albertans who are aware of Health Link Alberta**
- **Percentage of Albertans who have used Health Link Alberta within the past year**

The result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). This measure is defined as the percentage of survey respondents who answer "yes" to the question,

"Alberta has a province-wide service called "Health Link" which provides Albertans with toll-free access to nurse advice and general health and services information, 24-hours a day, 7 days a week. Were you aware of the Health Link service before today?"

Those respondents who are aware of Health Link Alberta are then asked, "Have you called Health Link within the past year?"

In February and March of 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 1,213 respondents answered the question on awareness of Health Link Alberta. Results are reliable within ±2.3 per cent, 19 times out of 20. A total of 948 respondents answered the question on use of Health Link Alberta in the past year. Results are reliable within ±3.0 per cent, 19 times out of 20.

4.b Self-reported health status: Percentage of Albertans reporting "excellent", "very good", or "good" health

- **18 to 64 years**
- **65 years and over**

This measure identifies self-reported health status among adult Albertans, by age group. How people rate their own health is affected by a variety of factors including personal experiences with chronic disease, disability, acute illness and mental health.

The result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). To assess self-reported health status, Albertans 18 years of age and over are asked:

"In general, compared with other people your age, would you say your health is excellent, very good, good, fair, or poor?"

In February and March of 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%.

Among these households, 1,028 people age 18 to 64 years responded to the question on self-reported health status. Results for this age group are reliable within ±2.00 per cent, 19 times out of 20. A total of 182 Albertans age 65 years and over responded to the question on self-reported health status. Results for this age group are reliable within ±6.1 per cent, 19 times out of 20.

4.c Body mass index: Percentage of Albertans age 18 and over who are overweight or obese

- **Overweight**
- **Obese**

The Canadian Community Health Survey (CCHS) includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's height and weight, from which the Body Mass Index (BMI) is calculated using the international standard. The survey population includes Canadians age 12 years and over. Results for overweight and obese are for respondents aged 18 years and over only.

Respondents to the survey are asked the questions:

"The next questions are about height and weight. How tall are you without shoes on?" and "How much do you weigh?"

In 2009, the sample for Alberta was 5,152 respondents. Among those respondents, 4,390 answered the questions on height and weight. Results for this measure are reliable within ±2.5 per cent, 19 times out of 20.

4.d Smoking: Prevalence of smoking

- **Alberta youth aged 12 to 19 years**
- **Young adults aged 20 to 24 years**

This measure is defined as the percentage of Alberta youth 12 to 19 years, and young adults 20 to 24 years, who report that they smoke daily or occasionally.

The Canadian Community Health Survey (CCHS) includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's smoking habits. If respondents answer "yes" to the question, "In your lifetime, have you smoked a total of 100 or more cigarettes (about 4 packs), then respondents are then asked the question: "At the present time, do you smoke cigarettes daily, occasionally or not at all?"

Responses to this question, analyzed by the age group of the respondent, provide the results reported on the current prevalence of smoking among these age groups.

For results among Alberta youth 12 to 19 years: Among those respondents, 674 people from Alberta aged 12 – 19 answered the questions on smoking. Results are reliable within ± 4 per cent, 19 times out of 20.

For results among young adults 20 to 24 years: In 2009, the sample for Alberta was 5,152 respondents. A total of 329 people aged 20 – 24 answered the questions on smoking. Results are reliable within ± 7 per cent, 19 times out of 20.

4.e Regular, heavy drinking: Prevalence of regular, heavy drinking among young Albertans

This measure identifies the prevalence of regular, heavy drinking among young Albertans. Regular, heavy drinking is defined as the consumption of five or more alcoholic drinks on one occasion, 12 or more times a year for Albertans 15 to 29 years of age.

The data source is the Canadian Community Health Survey (CCHS) which includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's drinking habits.

Respondents to the survey were asked the question:

"How often in the past 12 months have you had 5 or more drinks on one occasion?"

In 2009, the sample for Alberta was 5,152 respondents. Among those respondents, 991 people aged 15 to 29 years answered the question on the frequency of drinking. Results are reliable within ±5 per cent, 19 times out of 20.

5.a Continuing care:

- **Number of persons waiting in an acute care hospital bed for continuing care**
- **Number of persons waiting in the community for continuing care**

The result for this measure is based on submissions from representatives from each of the five geographic Alberta Health Services (AHS) Zones. These AHS Zones are responsible for submitting the number of persons waiting in an acute care hospital bed for continuing care placement to AHS Health System Compliance and Accountability on a monthly basis. This information is submitted to Alberta Health and Wellness on a quarterly basis.

The measure is calculated as the arithmetic sum of persons waiting for continuing care placement in the five geographic AHS zones in all acute care facilities in Alberta as of March 31st in a given fiscal year.

5.b Wait time for children's mental health services: Percent of children receiving "scheduled" mental health treatment within 30 days

This measure is defined as per cent of children under 18 years of age who have been referred for non-urgent mental health services and have had a face to face assessment with a mental health therapist within a thirty day period from the date of referral. The data source is the Alberta Regional Mental Health Information System (ARMHIS) of Alberta Health Services.

Note: In order to meet 2010/2011 Annual Report deadlines, the result for 2010/2011 is based on data for the first three quarters of the 2010/2011 fiscal year, not full fiscal year data. Caution is required in comparing results across years.

5.c Wait time for heart surgery (coronary artery bypass graft): 90th percentile wait time in weeks

This measure is defined as the 90th percentile wait time (in weeks) from the date of cardiac catheterization to the date of coronary artery bypass graft (CABG) surgery. When a cardiac catheterization is not performed, the wait time start date is the date of alternate imaging. If no imaging is performed, the wait time begins at referral to surgery. The calculation uses Alberta Health Services' records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care. Patients whose urgency rating changed during their wait time for CABG surgery are not included in wait time calculations.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date – decision date

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

5.d Wait time for hip replacement surgery: 90th percentile wait time in weeks

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Health Services (AHS) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date – decision date

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

5.e Wait time for knee replacement surgery: 90th percentile wait time in weeks

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Health Services (AHS) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date – decision date

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

5.f Wait time for cataract surgery: 90th percentile wait time in weeks

This wait time for cataract surgery is the 90th percentile wait time (in weeks) from the decision to treat date to the treatment date (first eye). The calculation uses Alberta Health Services (AHS) records of persons served from April 1 to March 31 of the reporting fiscal year. When cataract surgery is required for a patient's both eyes, only the wait time for surgery on the first eye is included in the wait time calculations.

A percentile is defined as a point on a rank-ordered scale, found by sorting a group of observations in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. The 90th percentile wait time is the observed wait time that is equal to or greater than 90 per cent of other observations.

*Each observation is the wait time, computed as:

$$\text{Weeks wait} = \frac{\text{treatment date} - \text{decision date}}{7}$$

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.for each wait listed cataract surgery case recorded in the Alberta Wait Times Reporting (AWTR) meeting specified inclusion/exclusion criteria. For the ministry 2010/2011 Annual Report, data were obtained from the AWTR on April 22, 2011 and the result calculated using the fiscal year period of April 1, 2010 to March 31, 2011. Prior years' results have been recalculated using the fiscal year period of April 1 to March 31 so as to be consistent with the time period used for calculating the result for 2010/2011.

5.g Wait time for all other elective surgical procedures: 90th percentile wait time in weeks

The wait time for all other elective surgical procedure is the 90th percentile wait time (in weeks) from the date of the decision to treat to the date of surgery. All other elective surgical procedures include all elective surgical procedures other than coronary artery bypass surgery, hip replacement surgery, knee replacement surgery, and cataract surgery.

A percentile is defined as a point on a rank-ordered scale, found by sorting a group of observations in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. The 90th percentile wait time is the observed wait time that is equal to or greater than 90 per cent of other observations.

*Each observation is the wait time, computed as:

$$\text{Weeks wait} = \frac{\text{treatment date} - \text{decision date}}{7}$$

for each wait listed cataract surgery case recorded in the Alberta Wait Times Reporting (AWTR) meeting specified inclusion/exclusion criteria. For the ministry 2010/2011 Annual Report, data were obtained from the AWTR on April 22, 2011 and the result calculated using the fiscal year period of April 1, 2010 to March 31, 2011. Prior years' results have been recalculated using the fiscal year period of April 1 to March 31 so as to be consistent with the time period used for calculating the result for 2010/2011.

5.h Emergency department length of stay: 90th percentile wait time in hours

(1) Minor or uncomplicated cases

(2) Complex cases

The Emergency Department (ED) length of stay (LOS) is the time from when a patient is triaged until they are discharged or enter the hospital (leave the ED). Patients with a more serious initial assessment (CTAS 1, 2, or 3) or requiring admission to hospital are classified as complex cases as they are more likely to require more tests, complexity of care, waiting for consults or surgery, or admission to an available bed. Patients without a serious initial assessment (CTAS 4 or 5) and that are not admitted are classified as minor/uncomplicated cases.

The 14 Sites reported are those highest in terms of patient volume (annual visits greater than 40,000 in 2006/2007) and therefore identified as improvement targets regarding waiting times in Emergency.

These sites include:

1. University of Alberta Hospitals (Edmonton) (including Stollery Children's Hospital)
2. Misericordia Community Hospital (Edmonton)
3. Royal Alexandra Hospital (Edmonton)
4. Grey Nuns Community Hospital (Edmonton)
5. Sturgeon Community Hospital (Edmonton)
6. Northeast Community Health Centre (Edmonton)
7. Foothills Medical Centre (Calgary)
8. Rockyview General Hospital (Calgary)
9. Peter Lougheed Centre (Calgary)
10. Alberta Children's Hospital (Calgary)

11. Northern Lights Regional Health Centre (Fort McMurray)
12. Red Deer Regional Hospital (Red Deer)
13. Queen Elizabeth II Hospital (Grande Prairie)
14. Chinook Regional Hospital (Lethbridge)

Note: In order to meet 2010/2011 Annual Report deadlines, the result for 2010/2011 is based on data for the first three quarters of the 2010/2011 fiscal year, not full fiscal year data. Caution is required in comparing results across years.

5.i Public rating of access to emergency department services: Percentage rating ease of actually obtaining emergency department services needed for self or a close family member as "very easy" or "easy"

The result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). To assess public rating of access to emergency department services, Albertans were asked:

"How difficult or easy was it to actually obtain the emergency department services you or your close family member needed most recently?"

In February and March of 2011, data were collected through a telephone survey of 1,215 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 286 respondents answered the question on the ease of access to obtain emergency department services. Results are reliable within ±5.7 per cent, 19 times out of 20.

6.a Access to primary care providers: Percentage of Albertans reporting they have a personal family doctor

The result for this measure is based on the Health Quality Council of Alberta *Provincial Survey about Health and the Health System in Alberta* (2011). To assess access to general practitioners, Albertans 18 years of age and over are asked:

"Do you currently have a personal family doctor who you see for most of your health care needs? I'm speaking of a family doctor and not a specialist."

In February and March of 2011, data were collected through a telephone survey of 1,125 randomly selected Alberta households. The overall response rate for the survey was 34%. A total of 1,125 respondents answered the question on rating the health care system and the quality of medical services it provides. Results are reliable within ±2.1 per cent, 19 times out of 20.

6.b Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network

The result of this measure is based on the number of patients enrolled in a Primary Care Network (PCN). Patients are considered to be enrolled in a PCN when they are assigned to a physician/nurse practitioner/pediatrician registered to a PCN. There are 4 steps used to assign a patient to a physician:

Step 1: Patients who have seen one physician/nurse practitioner/pediatrician only are assigned to that physician/nurse practitioner.

Step 2: Patients who have seen more than one physician, but one physician is predominant, and then assigns the patient to that physician.

Step 3: Patients who have seen multiple physicians the same number of times are assigned to the physician who did the physical exam last.

Step 4: Patients who have seen multiple physicians the same number of times and had no physical examination done are assigned to the physician who saw the patient last.

These 4 steps are part of the four-cut methodology.

The number of patients linked to a PCN is calculated by the payments issued to the program, which is associated with the providers within the PCN. The payments to the PCN are identified by the payments the providers receive through the Claims Assessment System (CLASS). CLASS is an application that collects process claims transactions for physicians of multiple disciplines for fee-for-service items. A schedule of medical benefits is associated with each medical discipline and provides information on compensation for physician services. The calculation of the percentage of Albertans enrolled in a PCN is based on the number of enrollees (numerator) divided by number of total population covered in the province (denominator). The denominator is the number of Albertans registered with a Personal Health Number (PHN). The 2009/2010 number of Albertans registered with a PHN was used to calculate the 2009/2010 result, based on the 2009/2010 Health and Wellness Alberta Health Care Insurance Plan Statistical Supplement.

6.c Physicians linked to Primary Care Networks: Percentage of family physicians linked to Primary Care Networks

The result for this measure is the percentage of family physicians registered to a Primary Care Network, as a proportion of all eligible family physicians registered in the province. The calculation is based on the number of physicians registered in Primary Care Networks according to the Alberta Health and Wellness Claims Assessment System (CLASS), divided by number of family physicians registered under the Alberta Health Care Insurance Plan (AHCIP) in the province through CLASS.

7.a Alberta Netcare: Number of care providers accessing Alberta Netcare

This measure counts the number of distinct accesses to the EHR by authorized health care providers within the time frame of the annual reporting period. The Provincial EHR, called Alberta Netcare, is a system of inter-functional applications delivered and operated by multiple public and private organizations.

All data used to generate the performance measure is first automatically collected within the databases of the various EHR applications -specifically the Pharmaceutical Information Network (PIN), Lab Test Results History (LTRH), Person's Directory (PD) and Alberta Netcare Portal 2004. Any time a user accesses reads or updates an auditable data record in the EHR applications, an audit record of that access is recorded in that application's database. To generate the EHR performance measure reports, the audit records from the EHR applications that were generated in the appropriate time period are copied from the various applications' databases into a singe reporting database. This dedicated database is maintained and managed through CGI. The CGI's Application Maintenance Services (AMS) team has access and executes the data extraction/copy script. A series of four automated data analysis scripts are run in the appropriate sequence, which perform the appropriate calculations and summaries on the collected raw audit data and writes the results to separate results tables. The final reports are generated directly from the data in the results tables without any alterations or transformations.

All scripts used to generate the reports are triggered by a designated person on the AMS team. The scripts contain all the connection information for all the databases involved. The AMS personnel run the scripts in the correct sequence without needing to manually connect to the databases. The report generation scripts are all stored in the Concurrent Version System (CVS) source code repository. As changes are made to the reporting CVS tracks all versions of the scripts including the user who made the change and the date and time that the change was committed. Only AMS personnel with a valid user id and password are allowed to make changes to the scripts stored in the CVS repository. Some AMS developers are granted read-only access to production databases in order to execute service requests from AHW. Only the AMS database administrators are granted write access to production databases.

Audit records are not accessible (even for viewing) by the end users of the EHR applications. The report generation scripts are always run on an internal server that is only accessible by designated AMS and MO personnel. The report generation scripts do not alter the original audit data in any way. The numbers generated by the scripts are aggregates derived from the audit records of the EHR applications. The aggregation process is completely automated to ensure the integrity of the data.

7.b Physician utilization of electronic medical records: Percentage of community physicians using the electronic medical record in their clinic

This performance measure quantifies the adoption rate of electronic medical record (EMR) technology in physician practices.

The number of community physicians enrolled in the Physician Office Support Program (POSP) that are using an EMR in their clinic is reported as a proportion of the total number of community physicians that are potentially eligible to be enrolled in POSP.

Calculation of Results:

1. Numerator:
   a) The number of POSP grant-funded physicians that were using an EMR plus the total number of physicians who have implemented an EMR from a qualified vendor (achieved Milestone 3/Go-Live).
   b) Note: POSP has changed from grant funding to invoice-based reimbursement. Going forward, the assumption will be that physicians who received grant funding will continue to use EMRs unless POSP is notified otherwise. This assumption will be substantiated with periodic reviews by POSP.
2. Denominator:
   a) An extract from the AMA database provides all members and staff positions. Staff, non-physicians and deceased members are removed based on AMA charge codes.
   b) Physicians who do not have a work or home address in Alberta are removed. The address is contained in the data from the AMA database.
   c) Non-community based physicians are removed based on:
      i) Specialty: The specialties are identified as physicians who do not provide primary care to patients in a clinical setting as their point of care is in a hospital or research facility.
      ii) Lab results: Physicians whose lab results are sent only to an AHS facility or military facility.
   d) Physicians who have previously engaged with POSP and are known to be working in an academic facility are removed.
   e) Final denominator value: 4,820 physicians.

Financial Information

MINISTRY FINANCIAL HIGHLIGHTS

REVENUES

The Fiscal Plan documents such as the Budget and quarterly forecasts report on a different scope than the audited Consolidated Ministry Financial Statements in the Annual Report. The scope of the Consolidated Ministry Financial Statements includes the revenue, expense, assets and liabilities of Crown-controlled Schools, Universities, Colleges and Hospitals (SUCH) sector entities. For Health and Wellness, this includes Alberta Health Services, Health Quality Council of Alberta, Calgary Health Trust, and Alberta Cancer Foundation.

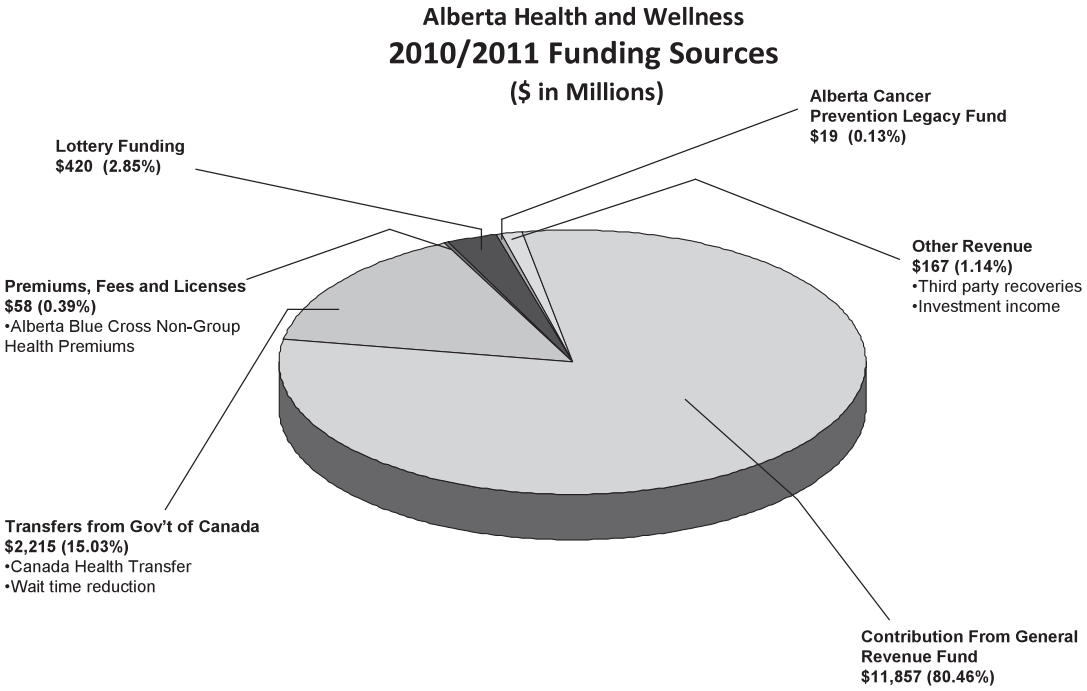
The following tables reflect the same scope of reporting as Budget 2010 and the 2010/2011 quarterly fiscal updates and also includes the net impact of SUCH sector entities as a single line item.

Revenues			(in thousands)
	2011		2010
	Budget	Actual	Actual
Internal Government Transfers	$ 445,497	$ 439,247	$ 413,908
Transfers from the Government of Canada	2,072,451	2,215,114	2,329,159
Premiums, Fees and Licences	104,290	58,035	42,567
Other Revenue	110,454	167,171	120,155
Total Revenue (Fiscal Plan Basis)	2,732,692	2,879,567	2,905,789
Alberta Health Services and Other Health Sector Entities	-	1,772,602	1,897,001
Total Revenue (Ministry Consolidated Financial Statement Basis)	$ 2,732,692	$ 4,652,169	$ 4,802,790

Major sources of revenue for SUCH sector entities include other government contributions, donations, fees and charges, ancillary operations, and investments.

A discussion of the main sources of revenue on a fiscal plan basis for 2010/2011 is below. Additional detail on the Ministry's revenues can be found in Schedules 1 and 3 of the Ministry's Consolidated Financial Statements.

Revenue decreased by $26 million from fiscal 2009/2010 to $2.9 billion. The decrease was primarily due to a decrease of $114 million in the transfers from the Government of Canada, and a $3 million decrease from the Alberta Cancer Prevention Legacy Fund. Partially offsetting this was a $30 million increase from refund of prior year expenditures, a $28 million increase in lottery funding, a $16 million increase from Alberta Blue Cross Non-Group Health Premiums, and a $17 million increase from miscellaneous revenue sources including Infoway Canada for investment in information technology initiatives such as the Electronic Health Record and Diagnostic Imaging.



Total – $14.7 Billion

EXPENSES

Expenses			(in thousands)
	2011		2010
	Budget	Actual	Actual
Total Expense (Fiscal Plan Basis)	15,030,486	14,736,333	12,838,155
Alberta Health Services and Other Health Sector Entities	-	571,253	1,606,404
Total Expense (Ministry Consolidated Financial Statement Basis)	$ 15,030,486	$ 15,307,586	$ 14,444,559

SUCH sector expenses relate directly to these entities operating expenses and include items such as, salaries and wages, medical and surgical supplies, drugs and gases, contracts with health service providers, and amortization of buildings and other assets.

A discussion of the program operating expenses on a fiscal plan basis for 2010/2011 is below. Additional detail on the Ministry's expenses can be found in Schedules 2 and 3 of the Ministry's Consolidated Financial Statements.

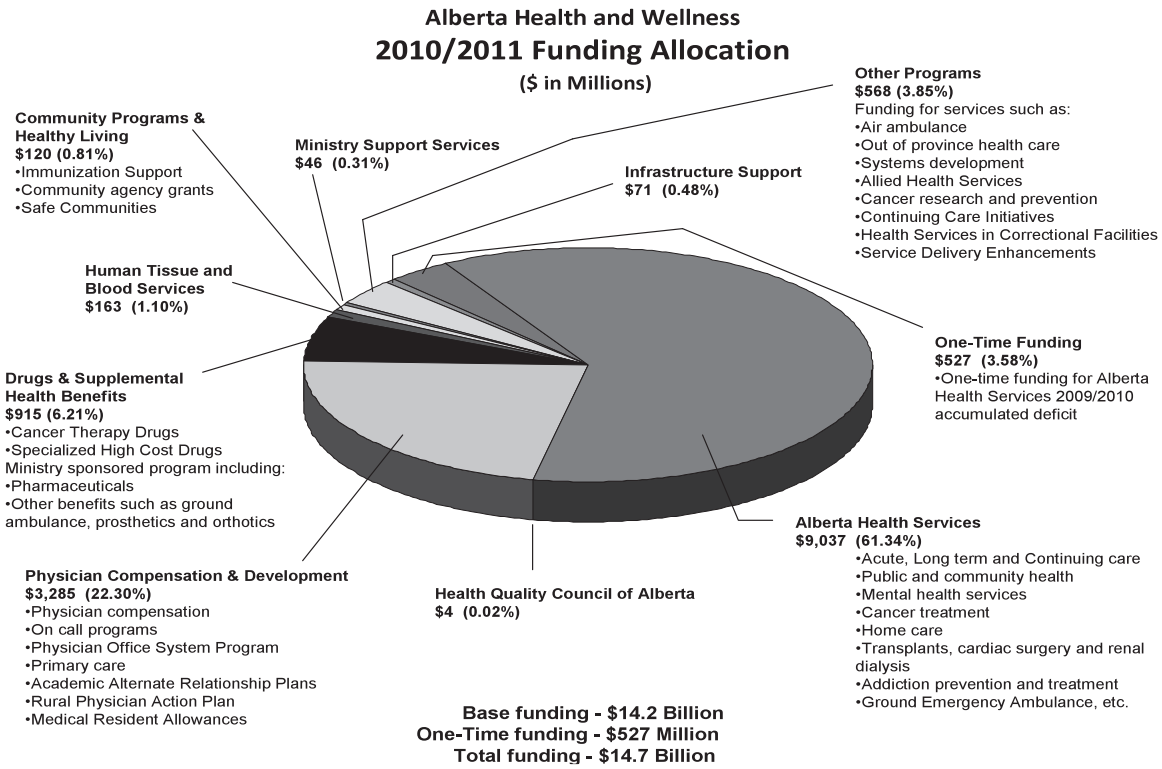
Several health system cost drivers contributed to the increased spending of almost 15 per cent over 2009/2010 amounts, including Alberta's growing and aging population, health sector wage inflation, drug costs, new technologies and rising expectations for health services. In addition, one-time funding of $527 million was provided to address the 2009/2010 accumulated deficit of Alberta Health Services (AHS).

As part of the government's five year funding commitment to AHS, a 6 per cent ($512 million) increase was provided in 2010/2011 to AHS' base operating funding. The 2010/2011 base operating funding for AHS originates from its 2009/2010 operating base of $7.7 billion. The 2009/2010 amount was revised by $812 million to reflect current costs, bringing the adjusted base to $8.5 billion, to which the 6 per cent increase was added. In total, $9.6 billion of the Health and Wellness budget for 2010/2011 was provided to AHS for operational support of the health system and to address the 2009/2010 accumulated deficit of $527 million.

Physician Compensation and Development received almost $3.3 billion in funding for costs such as physician fee-for-services, physician office automation, and specialist on call services. The continued operation and expansion of Primary Care Networks, Alternate Relationship Plans, and residency training positions were also supported.

$915 million has been provided for prescription drugs, ambulance services and other health benefits for Albertans. Included in the $915 million is funding for cancer therapy drugs and specialized high cost drugs.

$972 million was provided to support allied health professionals, such as oral surgeons, optometrists and podiatrists, and to support vaccination programs, provision for blood and blood products, continuing care initiatives, health services in correctional facilities, infrastructure support, additional post-secondary health workforce spaces, and service delivery enhancements.


Alberta Health and Wellness
2010/2011 Funding Allocation
($ in Millions)
Other Programs
$568 (3.85%)
Funding for services such as:
•Air ambulance
•Out of province health care
•Systems development
•Allied Health Services
•Cancer research and prevention
•Continuing Care Initiatives
•Health Services in Correctional Facilities
•Service Delivery Enhancements
Community Programs & Healthy Living
$120 (0.81%)
•Immunization Support
•Community agency grants
•Safe Communities
Ministry Support Services
$46 (0.31%)
Infrastructure Support
$71 (0.48%)
Human Tissue and Blood Services
$163 (1.10%)
One-Time Funding
$527 (3.58%)
•One-time funding for Alberta Health Services 2009/2010 accumulated deficit
Drugs & Supplemental Health Benefits
$915 (6.21%)
•Cancer Therapy Drugs
•Specialized High Cost Drugs
Ministry sponsored program including:
•Pharmaceuticals
•Other benefits such as ground ambulance, prosthetics and orthotics
Alberta Health Services
$9,037 (61.34%)
•Acute, Long term and Continuing care
•Public and community health
•Mental health services
•Cancer treatment
•Home care
•Transplants, cardiac surgery and renal dialysis
•Addiction prevention and treatment
•Ground Emergency Ambulance, etc.
Physician Compensation & Development
$3,285 (22.30%)
•Physician compensation
•On call programs
•Physician Office System Program
•Primary care
•Academic Alternate Relationship Plans
•Rural Physician Action Plan
•Medical Resident Allowances
Health Quality Council of Alberta
$4 (0.02%)
Base funding - $14.2 Billion
One-Time funding - $527 Million
Total funding - $14.7 Billion

Financial Information

Ministry of Health and Wellness

Consolidated Financial Statements

March 31, 2011

Ministry of Health and Wellness

Consolidated Financial Statements

March 31, 2011

Consolidated Financial Statements
March 31, 2011

AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Members of the Legislative Assembly

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of the Ministry of Health and Wellness, which comprise the consolidated statement of financial position as at March 31, 2011, and the consolidated statements of operations and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Ministry as at March 31, 2011, and the results of its operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher]

Auditor General

June 10, 2011

Edmonton, Alberta

Consolidated Statement of Operations

Year Ended March 31, 2011

(in thousands)

	2011	2010 (Restated - Note 3)
Revenues (Schedule 1)		
Internal Government Transfers	$ 1,094,347	$ 1,216,317
Transfers from Government of Canada	2,215,114	2,329,159
Premiums, Fees and Licences	687,714	640,759
Investment Income	62,761	35,827
Other Revenue	592,233	580,728
	4,652,169	4,802,790
Expenses - Directly Incurred (Note 2b(iv) and Schedules 2,3 & 5)		
Physician Compensation and Development	3,176,218	2,896,925
Drugs and Supplementary Health Benefits	735,146	711,243
Community Programs and Healthy Living	368,175	398,431
Support Programs	292,512	239,818
Facility Based Patient Care	4,416,359	4,243,426
Community Based & Home Care	1,191,825	1,062,603
Diagnostic,Therapeutic & Other Patient Services	2,412,488	2,332,977
Research and Education	150,434	146,049
Health Service Delivery Support	1,527,218	1,412,109
Administration & Support Services	809,432	816,414
Other	199,091	156,915
Valuation Adjustments	28,688	27,649
	15,307,586	14,444,559
Write-down of Tangible Capital Assets / Inventory	(7,976)	(14,880)
Net Operating results	$ (10,663,393)	$ (9,656,649)

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

Consolidated Statement of Financial Position

As at March 31, 2011
(in thousands)

	2011	2010 (Restated - Note 3)
ASSETS		
Cash	$ 508,511	$ 1,701,626
Portfolio Investments (Schedule 6)	2,014,300	544,945
Accounts Receivable (Note 4)	574,550	271,067
Tangible Capital Assets (Note 5)	6,799,128	6,270,111
Inventory	120,250	127,115
Prepaid Expenses	62,686	56,488
	$ 10,079,425	$ 8,971,352
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 6)	$ 1,961,254	$ 1,757,929
Deferred Revenue (Note 7)	672,742	1,172,343
Notes, Debentures and Mortgages (Note 8)	336,299	275,704
	2,970,295	3,205,976
NET ASSETS		
Net Assets at Beginning of Year	5,765,376	5,112,271
Net Operating Results	(10,663,393)	(9,656,649)
Net Financing provided from General Revenues	12,007,147	10,309,754
Net Assets at End of Year (Note 11)	7,109,130	5,765,376
	$ 10,079,425	$ 8,971,352

Contractual Obligations and Contingent Liabilities (Notes 9 and 10)

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

Consolidated Statement of Cash Flows

Year Ended March 31, 2011
(in thousands)

	2011	2010 (Restated - Note 3)
Operating Transactions		
Net Operating Results	$ (10,663,393)	$ (9,656,649)
Non-cash items:		
Valuation Adjustments	28,688	42,500
Amortization of Tangible Capital Assets and Consumption of Inventory (Schedule 2)	1,143,946	1,159,273
Write-down of Tangible Capital Assets / Inventory	7,976	14,880
Other Non-cash items	(751)	-
(Gain) on disposal of Portfolio Investments	(22,716)	(6,526)
	(9,506,250)	(8,446,522)
(Increase) in Accounts Receivable	(313,882)	(16,059)
(Increase) in Prepaid Expenses	(6,198)	(9,134)
Increase / (Decrease) in Accounts Payable and Accrued Liabilities	185,036	(333,113)
(Decrease) in Deferred Revenue	(499,601)	(687,557)
Cash (applied to) Operating Transactions	(10,140,895)	(9,492,385)
Capital Transactions		
Acquisition of Tangible Capital Assets	(1,014,763)	(1,075,689)
Purchase of Inventory	(658,560)	(746,281)
Cash (applied to) Capital Transactions	(1,673,323)	(1,821,970)
Investing Transactions		
Purchase of Portfolio Investments	(7,485,980)	(398,048)
Proceeds on sale of Portfolio Investments	6,039,341	472,809
Cash (applied to) provided by Investing Transactions	(1,446,639)	74,761
Financing Transactions		
Net Financing provided from General Revenues	12,007,147	10,309,754
Principal payments of Notes, Debentures and Mortgages	(12,565)	(14,411)
Proceeds from Notes, Debentures and Mortgages	73,160	88,830
Cash provided by Financing Transactions	12,067,742	10,384,173
(Decrease) in Cash	(1,193,115)	(855,421)
Cash, Beginning of Year	1,701,626	2,557,047
Cash, End of Year	$ 508,511	$ 1,701,626

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

Notes to the Consolidated Financial Statements

March 31, 2011

Note 1 Authority and Purpose

The Minister of Health and Wellness (Minister) has been designated responsibilities for various Acts by the *Government Organization Act*. To fulfill these responsibilities, the Minister administers the organizations listed below. The authority under which each organization operates is also listed. Together these organizations form the Ministry of Health and Wellness (Ministry).

Department of Health and Wellness	*Government Organization Act*
Alberta Health Services	*Regional Health Authorities Act*
Health Quality Council of Alberta	*Regional Health Authorities Act*
Calgary Health Trust	*Regional Health Authorities Act*
Alberta Cancer Foundation	*Regional Health Authorities Act*

The purpose of the Ministry is to maintain and improve the health of Albertans by providing increased access to quality health care and improve the efficiency and effectiveness of health care service delivery. The Ministry is also engaged in inter-ministerial initiatives to effectively address challenges to the health and well-being of the population.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

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

(a) Reporting Entity and method of consolidation

The reporting entity is the Ministry of Health and Wellness, for which the Minister of Health and Wellness is accountable. These financial statements include the accounts of the following entities:

Department of Health and Wellness
Alberta Health Services (AHS)
Health Quality Council of Alberta (HQCA)
Calgary Health Trust
Alberta Cancer Foundation

The accounts of the above entities are consolidated on line-by-line basis after adjusting them to a basis consistent with the accounting policies described below. Revenue and expense transactions, capital, investing, and financing transactions, and related asset and liability balances between the consolidated entities have been eliminated.

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

(a) Reporting Entity and method of consolidation (continued)

The threshold for recognizing inter-entity transactions among SUCH (Schools, Universities, Colleges and Hospitals) sector entities and between SUCH sector entities and other government controlled entities is $1,000,000 for particular transaction types and balances. Transactions involving school boards are subject to a $100,000 threshold for particular transaction types and balances.

The Ministry has entered into various partnerships with one or more partners outside the reporting entity to establish Primary Care Networks. The Ministry has also entered into a partnership with the University of Alberta to establish the Northern Alberta Clinical Trials Centre. The Ministry and its partners share, on an equitable basis, the significant risks and benefits associated with operating the partnership. The Ministry's 50 per cent interests in these partnerships are included in these financial statements under the proportionate consolidation method. The Ministry includes its proportionate share of assets, liabilities, revenues and expenses on a line-by-line basis, after conforming the accounting policies and eliminating its proportionate share of the balances and transactions with the partnerships.

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided or used for purposes specified by year end are recorded as unearned revenue or included in accounts payable and accrued liabilities.

(ii) Internal Government Transfers

Internal government transfers are transfers between entities within the government reporting entity where the entity making the transfer does not receive any goods or services directly in return. Restricted internal government transfers are reported as liabilities and included in deferred revenue until the transfer is used for the purposes specified. Unrestricted internal government transfers are recognized in revenue when received. Transfer of tangible capital assets work-in-progress is recognized as revenue as costs are incurred and work-in-progress reported by the Department of Infrastructure.

(iii) Transfers from Government of Canada

Transfers from Government of Canada are recognized as revenues when authorized by federal legislation or federal/provincial agreements, eligibility criteria, if any, are met and a reasonable estimate of the amounts can be made. Overpayments relating to Canada Health Transfers entitlements and other transfers received before revenue recognition criteria have been met are included in either accounts payable and accrued liabilities or unearned revenue.

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

(b) Basis of Financial Reporting (continued)

(iv) Expenses

Directly Incurred

Directly incurred expenses are those costs for which the Ministry has primary responsibility and accountability for.

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

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

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Incurred by Others

Services contributed by other entities in support of the Ministry's operations are not recognized and are disclosed in Schedule 4 and 5.

(v) Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial assets of the Ministry are limited to cash and financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Assets acquired by right are not included. Tangible capital assets of the Ministry are recorded at historical cost which includes all amounts directly attributable to the acquisition, construction, development or betterment of the asset. The costs of tangible capital assets built on behalf of the Ministry by the Department of Infrastructure are recorded as costs are incurred and work-in-progress reported by the Department of Infrastructure. Tangible capital assets are amortized on a straight-line basis over the estimated useful life of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

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

(b) Basis of Financial Reporting (continued)

Inventory is valued at the lower of cost and net realizable value. Cost is determined on a first-in, first-out basis.

(vi) Liabilities

Liabilities are recorded to the extent that they represent present obligations as a result of events and transactions occurring prior to the end of the fiscal year. The settlement of liabilities will result in sacrifice of economic benefits in the future.

(vii) Net Assets

Net assets represent the difference between the carrying value of assets held by the Ministry and its liabilities.

(viii) Valuation of Financial Assets and Liabilities

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

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

Public fixed-income securities and equities are valued at the average of the latest bid and ask prices.

The fair value of long term debt is an approximation of its fair value to the holder.

(ix) Contracted Health Service Operators

To account for the full extent of the Ministry's responsibility for the provision of health services in Alberta, fees and charges earned by the contracted health service operators for designated services are recorded as revenue. An equivalent amount is recorded as contracted health services expense. Also, grants paid to contracted health services operators are reclassified as program expense.

(x) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of Canada Health Transfer. The nature of uncertainty for Canada Health Transfers can arise from changes in the base allocations which are primarily a result of updated personal and corporate tax information or from new entitlement with little historical experience.

Note 3 Reporting Changes
(in thousands)

As a result of transfer of responsibility for programs between the Ministry of Health and Wellness, the Ministry of Infrastructure, Ministry of Service Alberta and Ministry of Solicitor General and Public Security, the comparatives for 2009/2010 have been restated as if the Ministry had always been assigned with its current responsibilities.

The following is a summary of the effect of the reporting changes on the 2009/2010 financial statements:

	March 31, 2010				
		Reporting Changes			
	As Previously Reported	Transfers to Infrastructure (1)	Transfers to Service Alberta (2)	Transfer from Solicitor General (3)	As Restated
Revenues	$ 4,074,147	$ 728,643	$ -	$ -	$ 4,802,790
Expenses	14,447,762	(512)	(1,946)	14,135	14,459,439
Net Operating Results	(10,373,615)	729,155	1,946	(14,135)	(9,656,649)
Net Transfers From General Revenues	10,405,155	(107,590)	(1,946)	14,135	10,309,754
Net Assets (Liabilities) at March 31, 2009	6,580,434	(1,468,163)	-	-	5,112,271
Net Assets (Liabilities) at March 31, 2010	$ 6,611,974	$ (846,598)	$ -	$ -	$ 5,765,376

(1) Responsibility for the Health Facilities Infrastructure capital projects was transferred from the Department of Health and Wellness to the Department of Infrastructure. As a result, capital grants paid by Alberta Health and Wellness during the years ended March 31, 2009 and 2010 have been recorded as revenue, if spent or deferred revenue, if unspent.

(2) Responsibility for the Alberta Health Care Insurance Plan registration services was transferred from the Department of Health and Wellness to the Department of Service Alberta.

(3) Responsibility for the delivery of health services in correctional facilities transferred from the Department of Solicitor General and Public Security to the Department of Health and Wellness.

Note 4 Accounts Receivable
(in thousands)

	2011			2010
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 507,794	$ (27,072)	$ 480,722	$ 260,972
Other Receivable	93,828	-	93,828	10,095
Total	$ 601,622	$ (27,072)	$ 574,550	$ 271,067

Accounts receivable are unsecured and non-interest bearing.

Note 5 Tangible Capital Assets
(in thousands)

	2011							2010
	Land	Buildings [1] 10-40 years	Land Improvements 5-25 years	Equipment 2-20 years	Computer Hardware and Software 3-10 years	Leasehold Assets Term of Lease	Total	Total
Historical Cost [2]								
Beginning of year	$ 106,330	$ 7,192,297	$ 63,577	$ 1,571,233	$ 1,010,608	$ 162,195	$ 10,106,240	$ 9,098,432
Additions	2,500	590,878	409	203,151	202,964	14,861	1,014,763	1,075,689
Disposals, including write-downs	-	-	-	(22,311)	(55,784)	-	(78,095)	(67,881)
	108,830	7,783,175	63,986	1,752,073	1,157,788	177,056	11,042,908	10,106,240
Accumulated Amortization								
Beginning of year	-	2,125,328	45,727	1,020,787	578,191	66,096	3,836,129	3,467,259
Amortization expense	-	187,639	2,281	163,094	113,011	15,849	481,874	433,192
Effect of disposals	-	-	-	(21,990)	(52,233)	-	(74,223)	(64,322)
	-	2,312,967	48,008	1,161,891	638,969	81,945	4,243,780	3,836,129
Net Book Value at March 31, 2011	$ 108,830	$ 5,470,208	$ 15,978	$ 590,182	$ 518,819	$ 95,111	$ 6,799,128	
Net Book Value at March 31, 2010	$ 106,330	$ 5,066,969	$ 17,850	$ 550,446	$ 432,417	$ 96,099		$ 6,270,111

[1] Buildings include parking lots.

[2] Historical cost includes work-in-progress at March 31, 2011 totaling $1,683,014 (2010 - $1,844,285)

Note 6 Accounts Payable and Accrued Liabilities

(in thousands)

	2011	2010
Accounts Payable & Accrued Liabilities	$ 1,567,923	$ 1,392,660
Accrued Vacation Pay	393,331	365,269
	$ 1,961,254	$ 1,757,929

The Ministry recognizes the fair value of the asset retirement obligations associated with tangible capital assets as liabilities and adjustments to the carrying values of the relevant tangible capital assets. These adjustments are amortized over the remaining useful life of the assets. The asset retirement obligation is recognized when it is possible to estimate the fair value of the obligation.

Accounts payable and accrued liabilities above include asset retirement obligation of $10,409 (2010 - $10,713). The asset retirement obligation represents the legal obligation associated with the removal of asbestos during planned renovations at certain of the Ministry's health services facilities.

Note 7 Deferred Revenue

(in thousands)

	2011	2010 (Restated- Note 3)
Deferred Contributions	$ 328,099	$ 329,335
Deferred Capital Contributions	327,879	816,109
Unearned Revenue	16,764	26,899
	$ 672,742	$ 1,172,343

Effective June 17, 2010, the Ministry transferred the responsibility for management of capital projects greater than $5,000 and returned unspent deferred capital contributions of $113,000 to the Department of Infrastructure. The Ministry also transferred related contractual obligation of $977,928. The Ministry will record revenue and tangible capital assets as the Department of Infrastructure incurs costs and reports work-in-progress.

Note 8 Notes, Debentures and Mortgages

(in thousands)

	Maturity	Interest Rate	2011 Carrying Value	2011 Fair Value	2010 Carrying Value	2010 Fair Value
Debentures [(a)]	2013 to 2031	4.23-4.93%	$ 180,971	$ 183,217	$ 176,662	$ 180,340
Bank Loan	2011 to 2012	2.24-3.22%	140,000	140,000	83,000	83,000
			320,971	323,217	259,662	263,340
Capital Lease Obligation	January 2028	6.50%	15,328	22,109	16,042	18,902
Total			$ 336,299	$ 345,326	$ 275,704	$ 282,242

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

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

	Debentures and Bank Loan	Capital Lease Obligation	Total
2011-12	$ 152,139	$ 1,660	$ 153,799
2012-13	20,548	1,464	22,012
2013-14	16,732	1,453	18,185
2014-15	6,951	1,453	8,404
2015-16	5,735	1,453	7,188
Thereafter	118,866	18,298	137,164
Less: amount representing interest under leases	-	(10,453)	(10,453)
	$ 320,971	$ 15,328	$ 336,299

Note 9 Contractual Obligations

(in thousands)

Contractual obligations are obligations of the Ministry to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2011, the Ministry has the following contractual obligations:

	2011	2010
Specific programs commitments	$ 102,638	$ 445,582
Capital contracts	317,282	1,639,340
Service contracts and operating leases	280,463	302,004
	$ 700,383	$ 2,386,926

Note 9 Contractual Obligations (continued)
(in thousands)

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

	Specific Programs Commitments	Capital Contracts	Service Contracts and Operating Leases	Total
2012	$ 46,882	$ 257,152	$ 127,757	$ 431,791
2013	37,394	37,125	47,696	122,215
2014	4,971	16,070	28,383	49,424
2015	4,715	6,889	23,461	35,065
2016	4,481	4	16,659	21,144
Thereafter	4,195	42	36,507	40,744
	$ 102,638	$ 317,282	$ 280,463	$ 700,383

Canadian Blood Services

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

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $157,857 (2010 - $156,274). Budgeted expenditure for the 2012 fiscal year is $158,902.

Note 10 Contingent Liabilities and Equity Agreements
(in dollars)

Hepatitis C

In June 1999, the Federal, provincial and territorial governments entered into an agreement to provide financial assistance to Canadians who were affected by the Hepatitis C virus through the Canadian blood system during the period from January 1, 1986 to July 1, 1990. The agreement provided for a total federal, provincial and territorial contribution of $1.1 billion plus interest. Interest is calculated and accrued quarterly on the outstanding balance at a rate equal to the 3 month Government of Canada Treasury Bill rate for the quarter. In the fiscal year 1999/2000, the Ministry accrued $30 million; representing Alberta's estimated proportionate share of the financial assistance, excluding accrued interest. At March 31, 2011, the outstanding unpaid balance, including Alberta's proportionate share of the accrued interest, was $17.9 million (2010-$17.7 million).

Note 10 Contingent Liabilities and Equity Agreements (continued)

(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Ministry has a contingent liability for buy-out of equity under Equity Agreements entered into between the Ministry and Voluntary Hospital Owners. The Ministry's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2011, the contingent payout liability upon termination is estimated at $12.8 million (2010 - $12.8 million).

Other Contingent Liabilities

At March 31, 2011, the Ministry was named as defendant in 375 legal actions; the outcome of which is indeterminable (2010 - 373 legal actions). 322 of these claims have specified amounts totaling $576.9 million and the remaining 53 have no specified amounts (2010 - 322 claims with specified amount of $914.2 million and 51 with no specified amount). Included in the total legal actions are 277 claims amounting to $489.9 million in which the Ministry has been jointly named with other entities and individuals (2010 - 20 claims amounting to $315.4 million). 328 claims amounting to $303.7 million are covered by either the Alberta Risk Management Fund or other insurance carriers (2010 - 333 claims amounting to $469.3 million). 1 claim amounting to $202.2 million is partially covered by Alberta Risk Management Fund (2010 - 2 claims amounting to $205.9 million). The resulting loss, if any, from these claims cannot be determined.

Indemnity

As described in Note 9, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250.0 million with respect to risks associated with the operation of the blood system.

Effective September 28, 2006, CBSE has entered into an agreement whereby the provinces (except Quebec) and territories guarantee and indemnify the risks of operation of the blood system in the amount of $750.0 million in excess of the $250.0 million provided by the insurance coverage from CBSI. Alberta's pro rata share of the $750.0 million is 13.1 per cent or $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2011, no amount has been recognized for this indemnity.

Note 11 Endowment Funds

(in thousands)

Endowment funds are included in net assets and are represented by financial assets amounting to $57,032 (2010 - $50,875). Donors have placed restrictions on their contributions to the endowment funds. The principal restriction is that the original contribution should not be spent.

Note 12 Trust Funds under Administration
(in thousands)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements. As at March, 2011, trust funds under administration were as follows:

	2011	2010
Research and development, education and others	$ 7,263	$ 6,558

Note 13 Benefit Plans
(in thousands)

Except as noted below, the Ministry participates in the multi-employer pension plans, Management Employees Pension Plan (MEPP) and Public Service Pension Plan (PSPP). The Ministry also participates in the multi-employer Supplementary Executive Retirement Plan (SERP) for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions.

Alberta Health Services also participates in the Local Authorities Pension Plan (LAPP), which is a multi-employer defined benefit plan. The pension expense for this plan is equivalent to the annual contributions. In addition, Alberta Health Services also participates in defined contribution plans and Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups.

Alberta Health Services provides defined supplementary executive retirement plan for certain management staff. The cost of these benefits is actuarially determined on an annual basis using the projected benefit method pro-rated on services, a market interest rate, and management's best estimate of expected costs and the period of benefit coverage.

At March 31, 2011, these plans have net accrued benefit asset of $12,516 (2010 - net accrued benefit asset of $6,156). The accrued benefit asset/liability is included in accounts payable and accrued liabilities.

At December 31, 2010, the Management Employees Pension Plan reported a deficiency of $397,087 (2009 - $483,199) and the Public Service Pension Plan reported a deficiency of $2,067,151 (2009 - $1,729,196). At December 31, 2010, the Supplementary Retirement Plan for Public Service Managers had a deficiency of $39,559 (2009 - $39,516).

At December 31, 2010, the Local Authorities Pension Plan reported an actuarial deficiency of $4,635,250 (2009 - $3,998,614).

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

	2011	2010
Registered Benefit Plans	$ 330,139	$ 307,994
SERP	3,357	4,237
Defined Contribution Plans and GRRSPs	13,380	11,326
Expense of transferring PSPP service to LAPP	-	33,000
	$ 346,876	$ 356,557

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2011, the Bargaining Unit Plan reported an actuarial deficiency of $4,141 (2010 - $8,335) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $7,020 (2010 - surplus of $7,431). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 14 Comparative Figures

Certain 2010 figures have been reclassified to conform to the 2011 presentation.

Note 15 Approval of Financial Statements

The financial statements were approved by the Senior Financial Officer and the Deputy Minister.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2011

Schedule 1
Consolidated Revenues
(in thousands)

	2011	2010 (Restated - Note 3)
Internal Government Transfers		
Transfer from Lottery Fund	$ 420,497	$ 392,034
Transfer from Alberta Cancer Prevention Legacy Fund	18,750	21,874
Transfer from Other Government Departments	655,100	802,409
	1,094,347	1,216,317
Transfers from Government of Canada		
Canada Health Transfer	2,175,791	2,260,243
Wait Times Reduction	27,262	27,316
Other Health Transfers	12,061	41,600
	2,215,114	2,329,159
Premiums, Fees and Licences		
Supplementary Health Benefit Premiums	57,910	42,305
Fees and Charges	629,679	598,192
Miscellaneous	125	262
	687,714	640,759
Investment Income	62,761	35,827
Other Revenue		
Third Party Recoveries	94,601	93,187
Previous years' refunds of expenditure	27,253	20,520
Donations	126,346	111,540
Miscellaneous	344,033	355,481
	592,233	580,728
Total Revenues	$ 4,652,169	$ 4,802,790

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2011

Schedule 2
Consolidated Expenses - Directly Incurred Detailed by Object
(in thousands)

	2011	2010 (Restated - Note 3)
Grants	$ 4,435,012	$ 4,004,014
Supplies and Services	4,060,994	3,792,083
Salaries, Wages and Employee Benefits	5,630,872	5,452,564
Amortization of Tangible Capital Assets	481,874	433,192
Inventory Consumed	662,072	726,081
Financial Transactions and Other	8,074	8,976
	15,278,898	14,416,910
Valuation Adjustments		
Health Care Insurance Premium Revenue (Recoveries)	-	(14,851)
Provision for Doubtful Accounts	10,399	24,526
Provision for Vacation Pay	18,289	17,974
Total Expenses	$ 15,307,586	$ 14,444,559

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2011

Schedule 3
Reconciliation of Budget with Actuals
(in thousands)

	Budget	Actual without SUCH sector	Actual SUCH sector	Adjustments	Actual with SUCH sector
REVENUES					
Internal Government Transfers					
Transfer from Lottery Fund	$ 420,497	$ 420,497	$ -	$ -	$ 420,497
Transfer from Alberta Cancer Prevention Legacy Fund	25,000	18,750	-	-	18,750
Transfer from Alberta Health / Other Government Departments	-	-	10,408,012	(9,752,912)	655,100
	445,497	439,247	10,408,012	(9,752,912)	1,094,347
Transfers from Government of Canada					
Canada Health Transfer	2,030,194	2,175,791	-	-	2,175,791
Wait Times Reduction	27,380	27,262	-	-	27,262
Other Health Transfers	14,877	12,061	-	-	12,061
	2,072,451	2,215,114	-	-	2,215,114
Premiums, Fees and Licenses					
Supplementary Health Benefit Premiums	104,100	57,910	-	-	57,910
Fees and Charges	-	-	629,679	-	629,679
Other	190	125	-	-	125
	104,290	58,035	629,679	-	687,714
Investment Income	-	-	62,761	-	62,761
Other Revenue					
Third Party Recoveries	94,500	94,601	-	-	94,601
Previous years' refunds of expenditure	-	49,665	-	(22,412)	27,253
Donations	-	-	95,619	30,727	126,346
Miscellaneous	15,954	22,905	712,704	(391,576)	344,033
	110,454	167,171	808,323	(383,261)	592,233
Total Revenues	$ 2,732,692	$ 2,879,567	$ 11,908,775	$ (10,136,173)	$ 4,652,169
EXPENSES					
Grants	14,708,542	14,503,145	-	(10,080,633)	4,422,512
Supplies and Services	142,729	84,313	4,289,754	(313,073)	4,060,994
Salaries, Wages and Employee Benefits	71,761	71,626	5,656,955	(97,709)	5,630,872
Amortization of Tangible Capital Assets	29,979	13,701	468,173	-	481,874
Inventory Consumed	50,351	42,525	619,547	-	662,072
Financial Transactions and Other	124	120	7,954	-	8,074
	15,003,486	14,715,430	11,042,383	(10,491,415)	15,266,398
Cancer Research and Prevention Investment	25,000	18,750	-	(6,250)	12,500
Valuation Adjustments					
Provision for Doubtful Accounts	2,000	2,202	8,197	-	10,399
Provision for Vacation Pay	-	(49)	18,338	-	18,289
Total Expenses	$ 15,030,486	$ 14,736,333	$ 11,068,918	$ (10,497,665)	$ 15,307,586

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2011

Schedule 4
Consolidated Related Party Transactions
(in thousands)

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

The Ministry and its employees paid or collected certain taxes and fees set by regulation for permits, licenses and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this Schedule.

The Ministry had the following transactions with related parties recorded in the Consolidated Statement of Operations and the Consolidated Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2011	2010
Revenues		(Restated - Note 3)
Grants - Lottery Fund/Cancer Fund	$ 439,247	$ 413,908
- Alberta Infrastructure	623,317	745,173
- Others	41,075	13,777
Other	45,415	31,607
	$ 1,149,054	$ 1,204,465
Expenses - Directly Incurred		
Grants	$ 202,987	$ 94,490
Other	140,481	125,292
Interest (ACFA)	7,954	8,845
	$ 351,422	$ 228,627
Receivables	$ 58,924	$ 6,800
Payables-Alberta Infrastructure	$ 347,609	$ 878,466
-Other Ministries	41,293	42,672
	388,902	921,138
Debt to Related Parties (ACFA)	$ 180,537	$ 176,662
Contractual Obligations	$ 45,571	$ 281,368

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

The Ministry also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the consolidated financial statements and are disclosed in Schedule 5.

	2011	2010
Expenses - Incurred by Others		
Accommodation	$ 44,570	$ 45,988
Legal	2,678	2,555
Other	8,097	7,194
	$ 55,345	$ 55,737

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2011

Schedule 5
Consolidated Allocated Costs
(in thousands)

Program	2011 Expenses [1]	Expenses - Incurred by Others: Accommodation Costs [2]	Expenses - Incurred by Others: Legal Services [3]	Expenses - Incurred by Others: Other	Valuation Adjustments: Provision for Doubtful Accounts	Valuation Adjustments: Vacation Pay	2011 Total	2010 (Restated - Note 3) Total
Physician Compensation and Development	$ 3,176,218	$ -	$ -	$ -	$ -	$ -	$ 3,176,218	$ 2,896,925
Drugs and Supplementary Health Benefits	735,146	-	-	-	-	-	735,146	711,243
Community Programs and Healthy Living	368,175	201	-	-	-	-	368,376	398,635
Support Programs	292,512	-	-	-	-	-	292,512	239,818
Facility Based Patient Care	4,416,359	15,685	-	-	-	18,338	4,450,382	4,277,707
Community Based & Home Care	1,191,825	8,933	-	-	-	-	1,200,758	1,071,535
Diagnostic,Therapeutic & Other Patient Services	2,412,488	2,067	-	-	-	-	2,414,555	2,335,242
Research and Education	150,434	78	-	-	-	-	150,512	146,128
Health Service Delivery Support	1,527,218	5,977	-	-	-	-	1,533,195	1,418,596
Administration & Support Services	809,432	11,629	2,678	8,097	-	(49)	831,787	837,877
Health Care Insurance Premium Revenue (Recoveries)	-	-	-	-	-	-	-	(14,851)
Other	199,091	-	-	-	10,399	-	209,490	181,441
	$ 15,278,898	$ 44,570	$ 2,678	$ 8,097	$ 10,399	$ 18,289	$ 15,362,931	$ 14,500,296

[1] Expenses - Directly Incurred as per Statement of Operations, excluding valuation adjustments.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 4 allocated by square footage.

[3] Costs shown for Legal Services on Schedule 4.

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2011

Schedule 6
Consolidated Portfolio Investments
(in thousands)

	2011		2010	
	Cost	Fair (Market) Value	Cost	Fair (Market) Value
Money Market	$ 640,632	$ 640,765	$ 92,839	$ 92,845
Fixed-income securities:				
Government of Canada, direct and guaranteed	640,015	635,712	59,503	59,783
Provincial - Alberta	-	-	1,197	1,233
Provincial - Other	136,859	135,735	87,997	88,934
Municipal	1,773	1,950	6,384	6,617
Corporate	487,161	483,641	126,093	130,137
Pooled investment funds	19,451	19,753	16,322	16,715
	1,285,259	1,276,791	297,496	303,419
Equities:				
Canadian	29,683	40,510	92,435	112,782
Foreign	18,030	18,621	29,918	28,423
Real estate	4,041	5,452	-	-
Pooled investment funds	36,655	38,039	32,257	30,627
	88,409	102,622	154,610	171,832
Total	$ 2,014,300	$ 2,020,178	$ 544,945	$ 568,096

The majority of Portfolio Investments are held by AHS. In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class, and quality constraints on fixed income securities and equity investments.

a) Interest Rate Risk

The interest rate risk exposure of its fixed income investments is managed by the management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada treasury bills maturing June 2011 and bearing interest at an average effective yield of 0.74% (2010 – 0.22%) per annum.

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2011

Schedule 6 (continued)

Fixed Income securities have an average effective market yield of 2.07% (2010 - 3.70%) per annum and the following maturity structure.

	2011	2010
Under 1 Year	2%	6%
1 to 5 years	85%	39%
6 to 10 years	10%	31%
Over 10 years	3%	24%

b) Currency Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is mitigated by the fact that AHS' investment bylaw limits non - Canadian equities to 25% of total equities.

c) Credit and Market Risks

AHS' investment bylaw restricts the types and proportions of eligible investments. Money market investments are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any other issuer. Investments in corporate bonds are limited to BBB rated bonds or higher and no more than 40% of the total fixed income investments. No more than 10% may be invested in BBB rated bonds. Equities are comprised of publicly traded securities in major stock markets. Investment in debt and equity of any issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

Financial Information

Department of Health and Wellness

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Department of Health and Wellness

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AUDITOR GENERAL
Alberta

Independent Auditor's Report

To the Minister of Health and Wellness

Report on the Financial Statements

I have audited the accompanying financial statements of the Department of Health and Wellness, which comprise the statement of financial position as at March 31, 2011, and the statements of operations and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Department as at March 31, 2011, and the results of its operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher]

Auditor General

June 10, 2011

Edmonton, Alberta

Statement of Operations

Year Ended March 31, 2011
(in thousands)

	2011		2010
	Budget (Schedule 4)	Actual	Actual (Restated - Note 3)
Revenues (Schedule 1)			
Internal Government Transfers	$ 445,497	$ 439,247	$ 413,908
Transfers from Government of Canada	2,072,451	2,215,114	2,329,159
Premiums, Fees and Licences	104,290	58,035	42,567
Other Revenue	110,454	167,171	120,155
	2,732,692	2,879,567	2,905,789
Expenses - Directly Incurred (Note 2b(v) and Schedule 8)			
Voted (Schedules 3 and 5)			
Ministry Support Services	58,952	45,637	41,663
Physician Compensation and Development	3,328,143	3,285,046	3,037,356
Allied Health Services	59,039	55,666	59,872
Human Tissue and Blood Services	162,702	162,979	156,323
Drugs and Supplemental Health Benefits	930,099	914,546	865,743
Community Programs and Healthy Living	166,077	119,550	111,806
Support Programs	321,965	431,423	248,129
Health Authority Services	9,800,216	9,568,170	8,059,880
Information Systems	79,993	61,292	66,441
Infrastructure Support	96,300	71,121	99,662
H1N1 Pandemic Response	-	-	80,156
	15,003,486	14,715,430	12,827,031
Statutory (Schedules 3 and 5)			
Cancer Research and Prevention Investment	25,000	18,750	21,874
Valuation Adjustments			
Health Care Insurance Premium Revenue (Recoveries)	-	-	(14,851)
Provision for Doubtful Accounts	2,000	2,202	3,977
Provision for Vacation Pay	-	(49)	124
	27,000	20,903	11,124
Total Voted and Statutory Expenses	15,030,486	14,736,333	12,838,155
Write-down of Tangible Capital Assets / Inventory	-	(5,535)	(11,321)
Net Operating Results	$ (12,297,794)	$ (11,862,301)	$ (9,943,687)

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

Statement of Financial Position

As at March 31, 2011
(in thousands)

	2011	2010 (Restated - Note 3)
ASSETS		
Cash	$ 4,328	$ 1,511
Accounts Receivable (Note 4)	286,881	79,066
Tangible Capital Assets (Note 5)	91,255	89,604
Consumable Inventory	21,153	18,776
	$ 403,617	$ 188,957
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 6)	$ 549,830	$ 469,881
Unearned Revenue (Note 7)	16,764	26,899
	566,594	496,780
NET LIABILITIES		
Net Liabilities at Beginning of Year	(307,823)	(673,890)
Net Operating Results	(11,862,301)	(9,943,687)
Net Financing provided from General Revenues	12,007,147	10,309,754
Net Liabilities at End of Year	(162,977)	(307,823)
	$ 403,617	$ 188,957

Contractual Obligations and Contingent Liabilities (Notes 8 and 9)

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

Statement of Cash Flows

Year Ended March 31, 2011
(in thousands)

	2011	2010 (Restated - Note 3)
Operating Transactions		
Net Operating Results	$ (11,862,301)	$ (9,943,687)
Non-cash items:		
Amortization of Tangible Capital Assets and Consumption of Inventory	56,226	68,243
Valuation Adjustments and write-downs	7,688	15,422
Other Non-cash items	(751)	-
	(11,799,138)	(9,860,022)
(Increase) in Accounts Receivable	(210,017)	(22,911)
Increase/(Decrease) in Accounts Payable and Accrued Liabilities	79,998	(324,437)
(Decrease) in Unearned Revenue	(10,135)	(34,814)
Cash (applied to) Operating Transactions	(11,939,292)	(10,242,184)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 5)	(16,783)	(22,908)
Purchase of Inventories	(48,255)	(46,646)
Cash (applied to) Capital Transactions	(65,038)	(69,554)
Financing Transactions		
Net Financing provided from General Revenues	12,007,147	10,309,754
Increase/(Decrease) in Cash	2,817	(1,984)
Cash, Beginning of Year	1,511	3,495
Cash, End of Year	$ 4,328	$ 1,511

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

Notes to the Financial Statements
March 31, 2011

Note 1 Authority and Purpose

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

The purpose of the Department is to maintain and improve the health of Albertans by providing increased access to quality health care and improve the efficiency and effectiveness of health care service delivery. The Department is also engaged in inter-ministerial initiatives to effectively address challenges to the health and well-being of the population.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

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

(a) Reporting Entity

The reporting entity is the Department of Health and Wellness, which is part of the Ministry of Health and Wellness and for which the Minister of Health and Wellness is accountable.

Other entities reporting to the Minister are Alberta Health Services (AHS) and its controlled entities, and the Health Quality Council of Alberta (HQCA). The financial results of these organizations are not included in these financial statements.

The Ministry Annual Report provides a comprehensive accounting of the financial position and results of the Ministry's operations for which the Minister is accountable.

All departments of the Government of Alberta operate within the General Revenue Fund (the Fund). The Fund is administered by the Minister of Finance and Enterprise. All cash receipts of departments are deposited into the Fund and all cash disbursements made by departments are paid from the Fund. Net Financing provided from General Revenues is the difference between all cash receipts and all cash disbursements made.

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

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year end is recorded as unearned revenue.

(ii) Internal Government Transfers

Internal government transfers are transfers between entities within the government reporting entity where the entity making the transfer does not receive any goods or services directly in return. Internal government transfers are recognized as revenue when received.

(iii) Transfers from Government of Canada

Transfers from Government of Canada are recognized as revenues when authorized by federal legislation or federal/provincial agreements, eligibility criteria, if any, are met and a reasonable estimate of the amounts can be made. Overpayments relating to Canada Health Transfers entitlements and other transfers received before revenue recognition criteria have been met are included in either accounts payable and accrued liabilities or unearned revenue.

(iv) Credit or Recovery

Credit or recovery initiatives provide a basis for authorizing spending. Credit or recovery is shown in the details of the Government Estimates for a supply vote.

If budgeted revenues are not fully realized, spending is reduced by an equivalent amount. If actual credit or recovery amounts exceed budget, the Department may, with the approval of the Treasury Board Committee, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Department's credit or recovery initiatives.

(v) Expenses

Directly Incurred

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

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

(b) Basis of Financial Reporting (continued)

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

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

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Incurred by Others

Services contributed by other entities in support of the Department's operations are not recognized and are disclosed in Schedule 7 and Schedule 8.

(vi) Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial assets of the Department are limited to cash and financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Assets acquired by right are not included. Tangible capital assets of the Department are recorded at historical cost which includes all amounts directly attributable to the acquisition, construction, development or betterment of the asset. Tangible capital assets are amortized on a straight-line basis over the estimated useful life of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

Consumable inventory is valued at the lower of cost and replacement cost. Cost is determined on a first-in, first-out basis.

(vii) Liabilities

Liabilities are recorded to the extent that they represent present obligations as a result of events and transactions occurring prior to the end of the fiscal year. The settlement of liabilities will result in sacrifice of economic benefits in the future.

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

(b) Basis of Financial Reporting (continued)

(viii) Net Liabilities

Net liabilities represent the difference between the carrying value of assets held by the Department and its liabilities.

(ix) Valuation of Financial Assets and Liabilities

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

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

(x) Payments under Reciprocal and Other Agreements

The Department entered into agreements with other Provincial and Territorial Governments, the Federal Government, the Royal Canadian Mounted Police and the Workers' Compensation Board to provide services on their behalf.

Expenses incurred and revenue earned in the provision of services under these agreements are recorded in the records of the service providers and are not included in these financial statements. Amounts paid and recovered under these agreements are disclosed in Note 10.

(xi) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of Canada Health Transfer. The nature of uncertainty for Canada Health Transfers can arise from changes in the base allocations which are primarily a result of updated personal and corporate tax information or from a new entitlement with little historical experience.

Note 3 Reporting Changes
(in thousands)

As a result of transfers of responsibility for programs between the Department of Health and Wellness, Department of Infrastructure, Department of Service Alberta and the Department of Solicitor General and Public Security, comparatives for 2009/2010 have been restated as if the Department had always been assigned with its current responsibilities.

The following is a summary of the effect of the reporting changes on the 2009/2010 financial statements:

	March 31, 2010				
		Reporting Changes			
	As Previously Reported	Transfers to Infrastructure (1)	Transfers to Service Alberta (2)	Transfer from Solicitor General and Public Security(3)	As Restated
Revenues	$ 2,917,733	$ (11,944)	$ -	$ -	$ 2,905,789
Expenses	12,945,500	(119,534)	(1,946)	14,135	12,838,155
Write-down of Inventory	11,321	-	-	-	11,321
Net Operating Results	(10,039,088)	107,590	1,946	(14,135)	(9,943,687)
Net Transfers From General Revenues	10,405,155	(107,590)	(1,946)	14,135	10,309,754
Net Liabilities at March 31, 2009	(673,890)	-	-	-	(673,890)
Net Liabilities at March 31, 2010	$ (307,823)	$ -	$ -	$ -	$ (307,823)

(1) Responsibility for the Health Facilities Infrastructure capital projects was transferred from the Department of Health and Wellness to the Department of Infrastructure.

(2) Responsibility for the Alberta Health Care Insurance Plan Registration Services was transferred from the Department of Health and Wellness to the Department of Service Alberta.

(3) Responsibility for the delivery of health services in correctional facilities transferred from the Department of Solicitor General and Public Security to the Department of Health and Wellness.

Note 4 Accounts Receivable
(in thousands)

	2011			2010
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 276,211	$ (3,807)	$ 272,404	$ 76,318
Amounts due from AHS	14,425	-	14,425	1,780
Other Receivable	52	-	52	968
	$ 290,688	$ (3,807)	$ 286,881	$ 79,066

Accounts receivable are unsecured and non-interest bearing.

Note 5 Tangible Capital Assets
(in thousands)

	2011			2010
	Equipment	Computer Hardware and Software	Total	Total
Estimated Useful Life	10 years	5 - 10 years		
Historical Cost[1]				
Beginning of year	$ 2,369	$ 172,325	$ 174,694	$ 168,860
Additions	6	16,777	16,783	22,908
Disposals, including Write-downs	-	(1,540)	(1,540)	(17,074)
	2,375	187,562	189,937	174,694
Accumulated Amortization				
Beginning of year	$ 989	$ 84,101	$ 85,090	$ 77,595
Amortization expense	241	13,460	13,701	24,569
Effect of disposals	-	(109)	(109)	(17,074)
	1,230	97,452	98,682	85,090
Net Book Value at March 31, 2011	$ 1,145	$ 90,110	$ 91,255	
Net Book Value at March 31, 2010	$ 1,380	$ 88,224		$ 89,604

[1] Historical cost includes work-in-progress at March 31, 2011 for computer hardware and software totaling $13,800 (2010 - $20,236).

Note 6 Accounts Payable and Accrued Liabilities
(in thousands)

	2011	2010
Accounts payable	$ 115,952	$ 124,193
Accrued liabilities	222,513	255,447
Amounts due to AHS and HQCA	203,837	82,689
Accrued vacation pay	7,528	7,552
	$ 549,830	$ 469,881

Note 7 Unearned Revenue
(in thousands)

Changes in unearned revenues are as follows:

	2011	2010
Cash received/receivable during the year:		
Supplementary Health Benefits Premiums	$ 4,801	$ 3,269
Health Services for Persons with Hepatitis C	-	5,200
	4,801	8,469
Less amounts recognized as revenue in the year	(14,936)	(43,283)
(Decrease) during the year	(10,135)	(34,814)
Balance at beginning of year	26,899	61,713
Balance at end of year	$ 16,764	$ 26,899
Balances at end of year are comprised of:		
Supplementary Health Benefits Premiums	$ 4,802	$ 3,269
Health Services for Persons with Hepatitis C	4,151	6,891
Third Party Recoveries	15	15
Human Papilloma Virus	7,796	16,724
	$ 16,764	$ 26,899

Note 8 Contractual Obligations

(in thousands)

Contractual obligations are obligations of the Department to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2011, the Department has the following contractual obligations:

	2011	2010 (Restated - Note 3)
Specific programs commitments	$ 388,693	$ 554,209
Capital contracts	12,792	10,348
Service contracts	89,401	72,275
	$ 490,886	$ 636,832

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

	Specific Programs Commitments	Capital Contracts	Service Contracts	Total
2012	$ 189,458	$ 12,336	$ 77,625	$ 279,419
2013	182,431	402	10,911	193,744
2014	4,318	4	837	5,159
2015	4,318	4	2	4,324
2016	4,084	4	2	4,090
Thereafter	4,084	42	24	4,150
	$ 388,693	$ 12,792	$ 89,401	$ 490,886

Canadian Blood Services

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

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $157,857 (2010 - $156,274). Budgeted expenditure for the 2012 fiscal year is $158,902.

Note 9 Contingent Liabilities and Equity
(in dollars)

Hepatitis C

In June 1999, the Federal, provincial and territorial governments entered into an agreement to provide financial assistance to Canadians who were affected by the Hepatitis C virus through the Canadian blood system during the period from January 1, 1986 to July 1, 1990. The agreement provided for a total federal, provincial and territorial contribution of $1.1 billion plus interest. Interest is calculated and accrued quarterly on the outstanding balance at a rate equal to the 3 month Government of Canada Treasury Bill rate for the quarter. In the fiscal year 1999/2000, the Department accrued $30 million; representing Alberta's estimated proportionate share of the financial assistance, excluding accrued interest. At March 31, 2011, the outstanding unpaid balance, including Alberta's proportionate share of the accrued interest, was $17.9 million (2010 - $17.7 million).

Equity Agreements with Voluntary Hospital Owners

The Department has a contingent liability for buy-out of equity under Equity Agreements entered into between the Department and Voluntary Hospital Owners. The Department's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2011, the contingent payout liability upon termination is estimated at $12.8 million (2010 - $12.8 million).

Other Contingent Liabilities

At March 31, 2011, the Department was named as defendant in 19 legal actions, the outcome of which is indeterminable (2010 - 22 legal actions). 12 of these claims have specified amounts totaling $254.8 million and the remaining 7 have no specified amounts (2010 - 18 claims with a specified amount of $430.6 million and 4 with no specified amount). Included in the total legal actions are 12 claims amounting to $216.5 million (2010 - 17 claims amounting to $392.4 million) in which the Department has been jointly named with other entities and individuals. 5 claims amounting to $4.7 million (2010 - 9 claims amounting to $6.7 million) are covered by the Alberta Risk Management Fund. 1 claim amounting to $202.2 million (2010 - 2 claims amounting to $205.9 million) is partially covered by Alberta Risk Management Fund. The resulting loss, if any, from these claims cannot be determined.

Indemnity

As described in Note 8, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250.0 million with respect to risks associated with the operation of the blood system.

Effective September 28, 2006, CBSE has entered into an agreement whereby the provinces (except Quebec) and territories guarantee and indemnify the risks of operation of the blood system in the amount of $750.0 million in excess of the $250.0 million provided by the insurance coverage from CBSI. Alberta's pro rata share of the $750.0 million is 13.1% or $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2011, no amount has been recognized for this indemnity.

Note 10 Payments under Reciprocal and Other Agreements

(in thousands)

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments and the Royal Canadian Mounted Police (RCMP) to provide health services on their behalf. The Department pays service providers for services rendered under the agreements and recovers the amount paid from other Provinces, Territories and the RCMP. Service providers include Alberta Health Services and physicians. In addition, the Department entered into agreements with Health Canada, the Workers' Compensation Board and other Provincial and Territorial Governments to provide air ambulance services on their behalf. Payments incurred under these agreements are made by the Department under authority of the *Financial Administration Act*, Section 25 (1).

Balances receivable from or payable to the Federal Government, other Provincial and Territorial Governments and the RCMP are reflected in the Statement of Financial Position.

	2011					2010
	Western Health Information Collaborative	Other Provincial, Territorial Govt & RCMP	Air Ambulance	Collaborative Initiative Fund	Total	Total
Opening receivable (payable) balance	$ 38	$ 33,921	$ 898	$ (409)	$ 34,448	$ 38,519
Add: Payments made during the year	-	215,900	1,032	409	217,341	221,088
	38	249,821	1,930	-	251,789	259,607
Less: Collections received during the year	(38)	(224,632)	(1,825)	-	(226,495)	(225,158)
Less: Adjustments made during the year	-	-	(58)	-	(58)	(1)
Closing receivable balance	$ -	$ 25,189	$ 47	$ -	$ 25,236	$ 34,448

Note 11 Benefit Plans
(in thousands)

The Department participates in the multi-employer pension plans: Management Employees Pension Plan and Public Service Pension Plan. The Department also participates in the multi-employer Supplementary Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions of $7,670 for the year ended March 31, 2011 (2010 - $7,088).

At December 31, 2010, the Management Employees Pension Plan reported a deficiency of $397,087 (2009 - deficiency $483,199) and the Public Service Pension Plan reported a deficiency of $2,067,151 (2009 - deficiency $1,729,196). At December 31, 2010, the Supplementary Retirement Plan for Public Service Managers had a deficiency of $39,559 (2009 - deficiency $39,516).

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2011, the Bargaining Unit Plan reported an actuarial deficiency of $4,141 (2010 - deficiency $8,335) and the Management, Opted Out and Excluded Plan an actuarial surplus of $7,020 (2010 - $7,431). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 12 Comparative Figures

Certain 2010 figures have been reclassified to conform to the 2011 presentation.

Note 13 Approval of Financial Statements

The financial statements were approved by the Senior Financial Officer and the Deputy Minister.

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 1
Revenues
(in thousands)

	2011		2010
	Budget (Schedule 4)	Actual	Actual (Restated - Note 3)
Internal Government Transfers			
Transfer from the Lottery Fund	$ 420,497	$ 420,497	$ 392,034
Transfer from Alberta Cancer Prevention Legacy Fund	25,000	18,750	21,874
	445,497	439,247	413,908
Transfers from Government of Canada			
Canada Health Transfer	2,030,194	2,175,791	2,260,243
Wait Times Reduction	27,380	27,262	27,316
Other Health Transfers	14,877	12,061	41,600
	2,072,451	2,215,114	2,329,159
Premiums, Fees and Licenses			
Supplementary Health Benefit Premiums	104,100	57,910	42,305
Other	190	125	262
	104,290	58,035	42,567
Other Revenue			
Third Party Recoveries	94,500	94,601	93,187
Previous years' refunds of expenditure	-	49,665	20,520
Miscellaneous	15,954	22,905	6,448
	110,454	167,171	120,155
Total Revenue	$ 2,732,692	$ 2,879,567	$ 2,905,789

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 2
Credit or Recovery
(in thousands)

	2011		
	Authorized	Actual [a]	(Shortfall) / Excess
Ministry Support Services			
Policy Development and Support [c]	$ 700	$ -	$ (700)
Human Tissue and Blood Services			
Human Tissue and Blood Services [d]	3,800	2,740	(1,060)
Community Programs and Healthy Living			
Program Support [e]	355	342	(13)
Community-Based Health Services [e]	100	51	(49)
Information Systems			
Program Support [f]	100	54	(46)
Infrastructure Support			
External Information Systems [g]	14,500	10,612	(3,888)
	$ 19,555	$ 13,799	$ (5,756) [b]

[a] Revenues from credit or recovery initiatives are included in the Department's revenues in the Statement of Operations.

[b] Shortfall is deducted from current year's authorized budget, as disclosed in Schedules 4 and 5 to the financial statements.

[c] The Department receives funding from drug companies for specific studies for programs that contribute to cost-effective use of medications.

[d] The Department receives funding from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection.

[e] The Department receives funding from Health Canada to support development of a National Diabetes Surveillance system, Communicable Disease aspects of climate change and Transfusion transmitted injuries surveillance system.

[f] The Department provides statistical information and reports to third party researchers and institutions.

[g] Canada Health Infoway and Alberta Heath and Wellness have jointly invested in a project to digitize diagnostic imaging throughout Alberta.

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 3
Expenses - Directly Incurred Detailed by Object
(in thousands)

	2011		2010
	Budget	Actual	Actual (Restated - Note 3)
Voted:			
Grants	$ 14,708,542	$ 14,503,145	$ 12,585,517
Supplies and Services	142,729	84,313	99,558
Salaries, Wages and Employee Benefits	71,761	71,626	73,583
Amortization of Tangible Capital Assets	29,979	13,701	24,569
Inventory Consumed	50,351	42,525	43,674
Other	124	120	130
Total Voted Expenses	$ 15,003,486	$ 14,715,430	$ 12,827,031
Statutory:			
Cancer Research and Prevention Investment	$ 25,000	$ 18,750	$ 21,874
Valuation Adjustments			
Health Care Insurance Premium Revenue (Recoveries)	-	-	(14,851)
Provision for Doubtful Accounts	2,000	2,202	3,977
Provision for Vacation Pay	-	(49)	124
	$ 27,000	$ 20,903	$ 11,124

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 4
Budget
(in thousands)

	2010 - 2011 Estimates	Adjustments (a)	2010-2011 Budget	Authorized Supplementary	2010 - 2011 Authorized Budget
Revenues:					
Internal Government Transfers	$ 445,497	$ -	$ 445,497	$ -	$ 445,497
Transfers from Government of Canada	2,072,451	-	2,072,451	-	2,072,451
Premiums, Fees and Licences	104,290	-	104,290	-	104,290
Other Revenue	110,454	-	110,454	-	110,454
	2,732,692	-	2,732,692	-	2,732,692
Expenses - Directly Incurred:					
Voted Expenses					
Ministry Support Services	58,952	-	58,952	-	58,952
Physician Compensation and Development	3,328,143	-	3,328,143	-	3,328,143
Allied Health Services	59,039	-	59,039	-	59,039
Human Tissue and Blood Services	162,702	-	162,702	-	162,702
Drugs and Supplemental Health Benefits	930,099	-	930,099	-	930,099
Community Programs and Healthy Living	166,077	-	166,077	-	166,077
Support Programs	321,965	135,000	456,965	-	456,965
Health Authority Services	9,800,216	(135,000)	9,665,216	-	9,665,216
Information Systems	79,993	13,800	93,793	-	93,793
Infrastructure Support	96,300	(13,800)	82,500	-	82,500
Credit or Recovery Shortfall (Schedule 2)	-	(5,756)	(5,756)	-	(5,756)
	15,003,486	(5,756)	14,997,730	-	14,997,730
Statutory Expenses					
Cancer Research and Prevention Investment	25,000	-	25,000	-	25,000
Valuation Adjustments					
Provision for Doubtful Accounts	2,000	-	2,000	-	2,000
Provision for Vacation Pay		-	-	-	-
	27,000	-	27,000	-	27,000
Total Expense	15,030,486	(5,756)	15,024,730	-	15,024,730
Net Operating Results	$ (12,297,794)	$ 5,756	$(12,292,038)	-	$(12,292,038)
Equipment / Inventory Purchases	$ 59,200	$ -	$ 59,200	$ -	$ 59,200
Capital Investment	$ 19,200	$ -	$ 19,200	$ -	$ 19,200

(a) Adjustments include encumbrances and credit or recovery shortfalls. Adjustments reflect Treasury Board approved changes to the authorized budget.

Schedules to Financial Statements

Year Ended March 31, 2011

Schedule 5

Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment, and Statutory Expenses by Element to Authorized Budget
(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2010/2011 Estimates	Adjustments [(a)]	2010/2011 Budget	Authorized Supplementary	2010/2011 Authorized Budget	2010/2011 Actual	Unexpended / (Over Expended)
1 Ministry Support Services							
1.0.1 Minister's Office	$ 551	$ -	$ 551	$ -	$ 551	$ 487	$ 64
1.0.2 Deputy Minister's Office	711	-	711	-	711	736	(25)
1.0.3 Communications	2,027	-	2,027	-	2,027	1,701	326
1.0.4 Strategic Corporate Support	32,531	-	32,531	-	32,531	28,366	4,165
1.0.5 Policy Development and Support	21,375	-	21,375	-	21,375	12,734	8,641
1.0.6 Health Facilities Review Committee	885	-	885	-	885	737	148
1.0.7 Mental Health Patient Advocate Office	872	-	872	-	872	876	(4)
Sub-Total	58,952	-	58,952	-	58,952	45,637	13,315
2 Physician Compensation and Development							
2.0.1 Program Support	8,799	-	8,799	-	8,799	9,531	(732)
2.0.2 Physician Compensation	2,748,272	-	2,748,272	-	2,748,272	2,768,625	(20,353)
2.0.3 On Call Programs	90,795	-	90,795	-	90,795	87,218	3,577
2.0.4 Physician Office System Program	65,500	-	65,500	-	65,500	55,000	10,500
2.0.5 Primary Care	171,505	-	171,505	-	171,505	133,555	37,950
2.0.6 Academic Alternate Relationship Plans	104,641	-	104,641	-	104,641	94,202	10,439
2.0.7 Medical Resident Allowances	108,943		108,943	-	108,943	108,943	-
2.0.8 Clinical Training and Assessment Support	29,688		29,688	-	29,688	27,972	1,716
Sub-Total	3,328,143	-	3,328,143	-	3,328,143	3,285,046	43,097
3 Allied Health Services							
3.0.1 Allied Health Services	59,039	-	59,039	-	59,039	55,666	3,373
Sub-Total	59,039	-	59,039	-	59,039	55,666	3,373

Schedules to Financial Statements

Year Ended March 31, 2011

Schedule 5 (continued)

Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment, and Statutory Expenses by Element to Authorized Budget

(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2010/2011 Estimates	Adjustments [(a)]	2010/2011 Budget	Authorized Supplementary	2010/2011 Authorized Budget	2010/2011 Actual	Unexpended / (Over Expended)
4 Human Tissue and Blood Services							
4.0.1 Human Tissue and Blood Services							
- Operating Expense	$ 37,702	$ -	$ 37,702	$ -	$ 37,702	$ 33,670	$ 4,032
- Operating Expense funded by Lotteries	125,000	-	125,000	-	125,000	129,309	(4,309)
Sub-Total	162,702	-	162,702	-	162,702	162,979	(277)
5 Drugs and Supplemental Health Benefits							
5.0.1 Cancer Therapy Drugs	112,320	-	112,320	-	112,320	110,000	2,320
5.0.2 Specialized High Cost Drugs	70,872	-	70,872	-	70,872	69,400	1,472
5.0.3 Seniors Drug Benefits	550,917	-	550,917	-	550,917	542,760	8,157
5.0.4 Seniors Supplemental Health Benefits	23,395	-	23,395	-	23,395	26,211	(2,816)
5.0.5 Non-Group Drug Benefits	170,980	-	170,980	-	170,980	164,893	6,087
5.0.6 Non-Group Supplemental Health Benefits	1,615	-	1,615	-	1,615	1,282	333
Sub-Total	930,099	-	930,099	-	930,099	914,546	15,553
6 Community Programs and Healthy Living							
6.0.1 Program Support	19,837	-	19,837	-	19,837	13,760	6,077
6.0.2 Immunization Support							
- Operating Expense	62,549	-	62,549	-	62,549	52,592	9,957
- Equipment / Inventory Purchases	48,400	-	48,400	-	48,400	48,255	145
6.0.3 Community-Based Health Services							
- Operating Expense	31,603	-	31,603	-	31,603	29,468	2,135
- Operating Expense funded by Lotteries	10,000	-	10,000	-	10,000	5,691	4,309
6.0.4 Safe Communities	42,088	-	42,088	-	42,088	18,039	24,049
Sub-Total	214,477	-	214,477	-	214,477	167,805	46,672

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 5 (continued)
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment, and Statutory Expenses by Element to Authorized Budget
(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2010/2011 Estimates	Adjustments [(a)]	2010/2011 Budget	Authorized Supplementary	2010/2011 Authorized Budget	2010/2011 Actual	Unexpended / (Over Expended)
7 Support Programs							
7.0.1 Program Support							
- Operating Expense	$ 63,364	$ -	$ 63,364	$ -	$ 63,364	$ 49,732	$ 13,632
- Equipment / Inventory Purchases		-	-	-	-	6	(6)
7.0.2 Air Ambulance Services	32,954	-	32,954	-	32,954	32,604	350
7.0.3 Municipal Ambulance Program	-	-	-	-	-	-	-
7.0.4 Out-of-Province Health Care Services	107,669	-	107,669	-	107,669	107,080	589
7.0.5 Health Research	3,535	-	3,535	-	3,535	4,535	(1,000)
7.0.6 Continuing Care Initiatives	40,700	-	40,700	-	40,700	38,859	1,841
7.0.7 Health Services provided in Correctional Facilities	25,226	-	25,226	-	25,226	26,148	(922)
7.0.8 Other Support Programs	48,517	-	48,517	-	48,517	37,465	11,052
7.0.9 Health Workforce Spaces	-	85,000	85,000	-	85,000	85,000	-
7.0.10 Service Delivery Enhancements	-	50,000	50,000	-	50,000	50,000	-
Sub-Total	321,965	135,000	456,965	-	456,965	431,429	25,536
8 Health Authority Services							
8.0.1 Base Operating funding for Alberta Health Services							
- Operating Expense	8,752,096	-	8,752,096	-	8,752,096	8,751,815	281
- Operating Expense funded by Lotteries	285,497	-	285,497	-	285,497	285,497	-
8.0.2 One-Time Operating funding for Alberta Health Services	759,000	(135,000)	624,000	-	624,000	527,235	96,765
8.0.3 Base Operating funding for Health Quality Council of Alberta	3,623	-	3,623	-	3,623	3,623	-
Sub-Total	9,800,216	(135,000)	9,665,216	-	9,665,216	9,568,170	97,046

Schedules to Financial Statements

Year Ended March 31, 2011

Schedule 5 (continued)

Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment, and Statutory Expenses by Element to Authorized Budget
(in thousands)

Voted Expenses, Equipment/Inventory Purchases and Capital Investment:	2010/2011 Estimates	Adjustments [(a)]	2010/2011 Budget	Authorized Supplementary	2010/2011 Authorized Budget	2010/2011 Actual	Unexpended / (Over Expended)
9 Information Systems							
9.0.1 Program Support	$ 32,179	$ -	$ 32,179	$ -	$ 32,179	$ 20,620	$ 11,559
9.0.2 Internal Information Systems							
- Operating Expense	47,814	13,800	61,614	-	61,614	40,672	20,942
- Equipment / Inventory Purchases	10,800	-	10,800	-	10,800	4,070	6,730
- Capital Investment	19,200	-	19,200	-	19,200	12,707	6,493
Sub-Total	109,993	13,800	123,793	-	123,793	78,069	45,724
10 Infrastructure Support							
10.0.1 Facilities Planning	1,000	-	1,000	-	1,000	1,500	(500)
10.0.2 Cancer Corridor Projects	10,000	-	10,000	-	10,000	-	10,000
10.0.3 External Information Systems	60,300	(13,800)	46,500	-	46,500	42,921	3,579
10.0.4 Diagnostic / Medical Equipment	25,000	-	25,000	-	25,000	26,700	(1,700)
Sub-Total	96,300	(13,800)	82,500	-	82,500	71,121	11,379
Credit or Recovery Shortfall (Schedule 2)	-	(5,756)	(5,756)	-	(5,756)	-	(5,756)
Total Voted	15,081,886	(5,756)	15,076,130	-	15,076,130	14,780,468	295,662
Operating Expense	14,582,989	(5,756)	14,577,233	-	14,577,233	14,294,933	282,300
Operating Expense funded by lotteries	420,497	-	420,497	-	420,497	420,497	-
	15,003,486	(5,756)	14,997,730	-	14,997,730	14,715,430	282,300
Equipment/Inventory Purchases	59,200	-	59,200	-	59,200	52,331	6,869
	15,062,686	(5,756)	15,056,930	-	15,056,930	14,767,761	289,169
Capital Investment	19,200	-	19,200	-	19,200	12,707	6,493
Total Voted - Expenses, Equipment/Inventory Purchases & Capital Investment	$ 15,081,886	$ (5,756)	$ 15,076,130	$ -	$ 15,076,130	$ 14,780,468	$ 295,662

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 5 (continued)
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment, and Statutory Expenses by Element to Authorized Budget
(in thousands)

Voted Expenses, Equipment / Inventory Purchases and Capital Investment:	2010/2011 Estimates	Adjustments [(a)]	2010/2011 Budget	Authorized Supplementary	2010/2011 Authorized Budget	2010/2011 Actual	Unexpended / (Over Expended)
Statutory Expenses:							
Cancer Research and Prevention Investment	$ 25,000	$ -	$ 25,000	$ -	$ 25,000	$ 18,750	$ 6,250
Valuation Adjustments							
Provision for Doubtful Accounts	2,000	-	2,000	-	2,000	2,202	(202)
Provision for Vacation Pay	-	-	-	-	-	(49)	49
Total Statutory Expenses and Valuation Adjustments	$ 27,000	$ -	$ 27,000	$ -	$ 27,000	$ 20,903	$ 6,097

(a) Adjustments include encumbrances and credit or recovery shortfalls. Adjustments reflect Treasury Board approved changes to the authorized budget.

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 6
Salary and Benefits Disclosure
(in dollars)

	2011				2010
	Base Salary [1]	Other Cash Benefits [2]	Other Non-cash Benefits [3]	Total	Total
Deputy Minister [4]	$ 264,576	$ 32,161	$ 64,056	$ 360,793	$ 716,939
Executives - Assistant Deputy Ministers					
Information Strategic Services [5]	-	-	-	-	85,783
Health Information Technology & Systems [6]	157,908	1,750	38,034	197,692	114,543
Community and Population Health	170,856	1,750	41,144	213,750	212,093
Health Workforce	185,472	1,750	44,581	231,803	230,504
Health Policy and Service Standards	185,472	8,856	44,077	238,405	229,887
Health System Development [7]	-	-	-	-	171,666
Corporate Operations [8]	-	-	-	-	70,628
Financial Accountability [8][9]	213,293	1,750	51,267	266,310	101,941
Corporate Support [8][10]	185,472	1,750	45,861	233,083	153,941
Executives - Other					
Executive Director, Human Resources	151,836	1,750	37,522	191,108	189,244

Prepared in accordance with Treasury Board Directive 12/98 as amended

[1] Base salary includes pensionable base pay.

[2] Other cash benefits include vacation payouts and lump sum payments. There were no bonuses paid in 2011.

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

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

[5] This division was abolished effective July 1, 2009 as a result of restructuring.

[6] This division was established effective July 1, 2009 as a result of restructuring. The current incumbent is in an acting capacity.

[7] This division was abolished effective July 1, 2009. The incumbent continued as the ADM until November 30, 2009 to help with the reorganization transition.

[8] This division was split into Financial Accountability and Corporate Support on restructuring effective July 1, 2009.

[9] The current incumbent became the ADM of Financial Accountability effective November 16, 2009. The previous incumbent was ADM of Corporate Support but continued to be responsible for this division until November 15, 2009.

[10] The incumbent was in an acting capacity during July 2009 and became ADM effective August 1, 2009.

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 7
Related Party Transactions
(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's financial statements. Related parties also include management in the department. Entities in the Ministry include Alberta Health Services and its controlled entities and the Health Quality Council of Alberta.

The Department and its employees paid or collected certain taxes and fees set by regulation for permits, licences and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The Department had the following transactions with related parties recorded on the Statement of Operations and the Statement of Financial Position at the amounts of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2011	2010 (Restated - Note 3)	2011	2010
Revenues				
Grants	$ -	$ -	$ 439,247	$ 413,908
Other	22,412	-	2,664	-
	$ 22,412	$ -	$ 441,911	$ 413,908
Expenses - Directly Incurred				
Grants	$ 10,252,646	$ 8,700,153	$ 183,291	$ 75,679
Other Services	-	-	7,732	8,024
	$ 10,252,646	$ 8,700,153	$ 191,023	$ 83,703
Receivable from	$ 14,425	$ 1,780	$ 1,000	$ -
Payable to	$ 203,837	$ 82,689	$ 6,074	$ 3,738

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

	Entities in the Ministry		Other Entities	
	2011	2010	2011	2010
Expenses - Incurred by Others				
Accommodation	$ -	$ -	$ 9,834	$ 9,900
Legal	-	-	2,678	2,555
Other	-	-	8,097	7,194
	$ -	$ -	$ 20,609	$ 19,649

Schedules to Financial Statements
Year Ended March 31, 2011

Schedule 8
Allocated Costs
(in thousands)

	2011								2010
		Expenses - Incurred by Others			Statutory	Valuation Adjustments			(Restated - Note 3)
	Expenses [1]	Accomm-odation Costs [2]	Legal Services [3]	Other	Cancer Research & Prevention Investment	Provision for Doubtful Accounts	Vacation Pay	Total	Total
Ministry Support Services	$ 45,637	$ 9,834	$ 2,678	$ 8,097	$ -	$ -	$ (49)	$ 66,197	$ 61,436
Physician Compensation and Development	3,285,046	-	-	-	-	-	-	3,285,046	3,037,356
Allied Health Services	55,666	-	-	-	-	-	-	55,666	59,872
Human Tissue and Blood Services	162,979	-	-	-	-	-	-	162,979	156,323
Drugs and Supplemental Health Benefits	914,546	-	-	-	-	-	-	914,546	865,743
Community Programs and Healthy Living	119,550	-	-	-	-	-	-	119,550	111,806
Support Programs	431,423	-	-	-	-	-	-	431,423	248,129
Health Authority Services	9,568,170	-	-	-	-	-	-	9,568,170	8,059,880
Information Systems	61,292	-	-	-	-	-	-	61,292	66,441
Infrastructure Support	71,121	-	-	-	-	-	-	71,121	99,662
H1N1 Pandemic Response	-	-	-	-	-	-	-	-	80,156
Cancer Research and Prevention Investment	-	-	-	-	18,750	-	-	18,750	21,874
Health Care Insurance Premium Revenue (Recoveries)	-	-	-	-	-	-	-	-	(14,851)
Provision for Doubtful Accounts	-	-	-	-	-	2,202	-	2,202	3,977
	$14,715,430	$ 9,834	$ 2,678	$ 8,097	$ 18,750	$ 2,202	$ (49)	$14,756,942	$12,857,804

[1] Expenses - Directly Incurred as per Statement of Operations, excluding valuation adjustments.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 7.

[3] Costs shown for Legal Services on Schedule 7.

Unaudited Information

Ministry of Health and Wellness

Unaudited Information

MINISTRY OF HEALTH AND WELLNESS

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2011

(UNAUDITED)
(in thousands)

		2011	2010
Compromises			
	Health Care Insurance Premiums	$ 52	$ 122
Write-offs			
	Health Care Insurance Premiums	8,187	39,175
	Medical Claim Recoveries	2,051	2,240
	Penalties, Interest and Miscellaneous Charges	429	481
Total Remissions, Compromises and Write-offs		$ 10,719	$ 42,018

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.

Health Authority Financial Statement Highlights

This section highlights the financial results of Alberta Health Services (AHS) and the Health Quality Council of Alberta (HQCA) for the fiscal year ended March 31, 2011.

The financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles (GAAP) and Alberta Health and Wellness' Financial Directives.

ALBERTA HEALTH SERVICES

Operating Results

- For fiscal 2010/2011 AHS reported an $856 million operating surplus, compared to a prior year deficit of $238 million. The improved surplus is aided by one-time funding of $527 million to eliminate AHS' prior year accumulated deficit, delays in implementing new initiatives and filling vacancies, lower utilities expenses, and cost containment strategies implemented during the year.
- 2010/2011 expenditures were $11.0 billion, compared to $10.5 billion in the prior year — a 4.8 per cent increase overall, of which 1.8 per cent or $184 million related to salaries and benefits. AHS employed 64,418 Full-Time-Equivalents as of March 31, 2011.
- Administration costs in 2010/2011 were $307 million, or 2.8 per cent of total expenditures. This compares to administration costs in 2009/2010 of $382 million, or 3.6 per cent of total expenditures.

Financial Position

- At March 31, 2011, AHS reported an accumulated surplus of $116 million after internally restricting $50 million to fund start up costs at Calgary's South Health Campus Hospital and $17 million to establish a parking infrastructure reserve for future maintenance, upgrades and construction.
- AHS reported net assets and endowments of $961 million at March 31, 2011, an $832 million increase from the prior year. The increase is due in part to one-time funding of $527 million to eliminate AHS' 2009/2010 accumulated deficit.
- At March 31, 2011, AHS reported long-term debt of $336 million, an increase of $61 million from the prior year, the majority of which relates to parkades. AHS is compliant with its authorized borrowing limits.
- AHS reported capital assets of $6.7 billion at March 31, 2011, up from $6.2 billion in the prior year.

HEALTH QUALITY COUNCIL OF ALBERTA

Operating Results

- For fiscal 2010/2011 HQCA reported an operating surplus of $239 thousand, compared to a prior year surplus of $130 thousand. The improved surplus is due to hiring delays, unfilled positions and delayed project starts.
- 2010/2011 expenditures were $4.44 million, compared to $4.07 million in the prior year — a 9.1 per cent increase overall, including a 4.5 per cent increase related to salaries and benefits. HQCA employed 17 Full-Time-Equivalents as of March 31, 2011.

Financial Position

- At March 31, 2011, HQCA reported an accumulated surplus of $824 thousand and a prior year accumulated surplus of $613 thousand.
- HQCA reported net assets of $885 thousand at March 31, 2011, an increase of $239 thousand from the prior year. The increase is due in part to the retention of surplus funds from previously restricted grants.
- HQCA reported capital assets of $61 thousand at March 31, 2011, compared to $33 thousand in the prior year.
- HQCA has no long-term debt.

HEALTH AUTHORITY
SUMMARY OF OTHER FINANCIAL INFORMATION
FOR THE YEAR ENDED MARCH 31, 2011
(In Thousands)

	ALBERTA HEALTH SERVICES		HEALTH QUALITY COUNCIL OF ALBERTA	
	2010/2011 ACTUAL	2009/2010 ACTUAL	2010/2011 ACTUAL	2009/2010 ACTUAL
I. OPERATING SURPLUS/(DEFICIT) AS A % OF TOTAL REVENUE	7.2%	-2.3%	5.1%	3.1%
II. ADMINISTRATION COST AS A % OF TOTAL EXPENSES	2.8%	3.6%	97.7%	96.4%
III. WORKING CAPITAL				
Current Assets	2,283,814	1,386,498	2,506	1,755
Current Liabilities	2,271,553	1,901,214	1,682	1,142
WORKING CAPITAL RATIO	1.01	0.73	1.49	1.54
IV. ALBERTA HEALTH AND WELLNESS FUNDING COVERAGE *(excludes unusual items)*	94.0%	84.5%	104.5%	99.0%
V. AVERAGE REMAINING USEFUL LIFE OF CAPITAL EQUIPMENT IN YEARS *(includes information systems)*	3.0	3.2	1.7	0.5
VI. CAPITAL INVESTMENTS DURING THE YEAR				
Funded from Internal Resources				
Equipment	107,612	36,097	63	25
Information Systems	137,082	-	-	-
Facilities and Improvements	-	7,103	-	-
	244,694	43,200	63	25
Funded by External Parties				
Equipment	94,365	139,317	-	-
Information Systems	43,331	42,256	-	-
Facilities and Improvements	467,154	708,985	-	-
	604,850	890,558	-	-
Total capital investments during the year *(excludes debt-funded and donated assets)*	849,544	933,758	63	25
VII. TOTAL FTEs *(excludes Board)*	64,418	64,533	17	17

Financial Information

Alberta Health Services

Financial Statements

March 31, 201**1**

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2011

Alberta Health Services

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2011

The accompanying consolidated financial statements for the year ended March 31, 2011 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, 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 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.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This 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 Audit and Finance 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. Chris Eagle
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Chris Mazurkewich
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 10, 2011

Independent Auditor's Report

AUDITOR GENERAL *Alberta*

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

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2011, and the consolidated statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2011, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]

Auditor General

June 10, 2011

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2011

	2011		2010
	Budget	Actual	Actual
	(Schedule 3)		(Note 21)
Revenue:			
Alberta Health and Wellness contributions			
Unrestricted ongoing	$ 9,037,311	$ 9,037,311	$ 7,712,855
Unrestricted deficit funding (Note 4)	527,235	527,235	343,000
Restricted	735,680	747,830	795,747
Other government contributions	97,972	100,893	102,529
Fees and charges	611,980	621,481	577,644
Ancillary operations	112,404	112,367	120,330
Donations	29,646	28,574	20,383
Investment and other income (Note 5)	288,730	292,119	261,331
Amortized external capital contributions (Note 14)	370,329	364,181	305,054
TOTAL REVENUE	11,811,287	11,831,991	10,238,873
Expenses:			
Inpatient acute nursing services	2,664,563	2,584,209	2,523,169
Emergency and outpatient services	1,265,973	1,220,870	1,150,680
Facility-based continuing care services	852,608	844,753	806,303
Ambulance services	364,395	343,034	326,319
Community-based care	768,382	800,256	706,667
Home care	404,054	402,375	381,523
Diagnostic and therapeutic services	1,909,167	1,861,589	1,796,378
Promotion, prevention and protection services	296,125	289,508	303,728
Research and education	214,659	214,253	215,859
Administration (Note 6)	374,726	307,342	381,663
Information technology	385,315	387,655	293,490
Support services	1,478,968	1,521,754	1,427,440
Amortization of facilities and improvements	202,352	198,238	147,338
Write down of capital assets (Note 9(d))	-	-	2,682
Funded transition costs	-	-	13,804
TOTAL EXPENSES (Schedule 1)	11,181,287	10,975,836	10,477,043
Operating surplus (deficiency) of revenue over expenses	$ 630,000	$ 856,155	$ (238,170)

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2011

	2011 Actual	2010 Actual (Note 21)
ASSETS		
Current:		
Cash and cash equivalents (Note 8)	$ 1,721,465	$ 977,216
Accounts receivable	201,293	166,807
Contributions receivable from Alberta Health and Wellness	200,313	79,233
Inventories	99,097	108,339
Prepaid expenses	61,646	54,903
	2,283,814	1,386,498
Non-current cash and investments (Note 8)	599,335	999,614
Capital contributions receivable from Alberta Health and Wellness	11,476	4,372
Capital assets (Note 9)	6,707,464	6,151,112
Other assets (Note 10)	214,546	233,188
TOTAL ASSETS	$ 9,816,635	$ 8,774,784
LIABILITIES AND NET ASSETS		
Current:		
Accounts payable and accrued liabilities	$ 1,136,937	$ 953,357
Accrued vacation pay	385,525	367,187
Deferred contributions (Note 11)	595,292	567,732
Current portion of long-term debt (Note 13)	153,799	12,938
	2,271,553	1,901,214
Deferred contributions (Note 11)	163,725	163,250
Deferred capital contributions (Note 12)	541,856	1,046,140
Long-term debt (Note 13)	182,500	262,766
Unamortized external capital contributions (Note 14)	5,598,973	5,254,711
Other liabilities (Note 15)	97,454	18,431
	8,856,061	8,646,512
Net assets:		
Accumulated surplus (deficit)	115,741	(527,235)
Accumulated net unrealized gains (losses) on investments	(9,110)	17,243
Other internally restricted net assets (Note 16)	66,722	-
Internally restricted net assets invested in capital assets	777,071	628,114
Operating net assets	950,424	118,122
Endowments (Note 17)	10,150	10,150
	960,574	128,272
TOTAL LIABILITIES AND NET ASSETS	$ 9,816,635	$ 8,774,784

Commitments and contingencies (Note 18)

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

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS
FOR THE YEAR ENDED MARCH 31, 2011

	2011							2010
	Accumulated surplus (deficit)	Accumulated net unrealized gains/ (losses) on investments	Other internally restricted net assets (Note 16)	Internally restricted net assets invested in capital assets	Sub-total operating net assets	Endowments (Note 17)	Total	Total
Balance at beginning of year	$ (527,235)	$ 17,243	$ -	$ 628,114	$ 118,122	$ 10,150	$ 128,272	$ 320,790
Operating surplus (deficiency) of revenue over expenses	856,155	-	-	-	856,155	-	856,155	(238,170)
Capital assets purchased with internal funds	(244,694)	-	-	244,694	-	-	-	-
Amortization of internally funded capital assets	105,905	-	-	(105,905)	-	-	-	-
Repayment of long-term debt used to fund capital assets	(7,880)	-	-	7,880	-	-	-	-
Net repayment of life lease deposits	212	-	-	(212)	-	-	-	-
Purchase of land	-	-	-	2,500	2,500	-	2,500	5,723
Transfer of other internally restricted net assets	(66,722)	-	66,722	-	-	-	-	-
Net unrealized gain (losses) arising during the period on investments	-	(5,074)	-	-	(5,074)	-	(5,074)	39,382
Transfer of net realized losses (gains) on investments to revenue	-	(21,279)	-	-	(21,279)	-	(21,279)	(4,402)
Reclassification adjustments	-	-	-	-	-	-	-	4,949
Balance at end of year	$ 115,741	$ (9,110)	$ 66,722	$ 777,071	$ 950,424	$ 10,150	$ 960,574	$ 128,272

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

CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2011

	2011		2010
	Budget (Note 3)	Actual	Actual (Note 21)
Operating activities:			
Operating surplus (deficiency) of revenue over expenses	$ 630,000	$ 856,155	$ (238,170)
Non-cash transactions:			
Amortization expense, loss on disposal and write down (Schedule 1)	479,000	470,511	411,585
Amortized external capital contributions	(371,000)	(364,606)	(305,357)
Other	31,000	(2,503)	(147,554)
Changes in non-cash working capital	155,000	(2,169)	107,095
Cash generated from (used by) operating activities	924,000	957,388	(172,401)
Investing activities:			
Purchase of capital assets:			
Internally funded equipment	(65,000)	(107,612)	(36,097)
Internally funded information systems	(135,000)	(137,082)	-
Internally funded facilities and improvements	-	-	(7,103)
Externally funded equipment	(25,000)	(94,365)	(139,317)
Externally funded information systems	(70,000)	(43,331)	(42,256)
Externally funded facilities and improvements	(1,210,000)	(467,154)	(708,985)
Debt funded facilities and improvements	(96,000)	(71,353)	(89,107)
Purchase of investments	(775,000)	(7,343,537)	(341,196)
Proceeds on sale of investments	787,000	5,995,607	412,688
Allocations from non-current cash and investments	925,000	1,774,562	775,595
Changes in non-cash working capital	(287,000)	76,458	(53,911)
Other	-	-	(329)
Cash used by investing activities	(951,000)	(417,807)	(230,018)
Financing activities:			
Capital contributions received	300,000	202,923	160,992
Capital contributions returned	-	(58,850)	-
Proceeds from long-term debt	96,000	73,160	88,830
Principal payments on long-term debt	(12,000)	(12,565)	(14,410)
Cash generated from financing activities	384,000	204,668	235,412
Net increase (decrease) in current cash and cash equivalents	357,000	744,249	(167,007)
Current cash and cash equivalents, beginning of year	977,000	977,216	1,144,223
Current cash and cash equivalents, end of year	$ 1,334,000	$ 1,721,465	$ 977,216

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2011

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta). Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services (AHS). All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and amalgamated with AHS. All assets, liabilities, rights and obligations of the disestablished entities were assumed by AHS.

Effective July 15, 2010, the operations and administration of Correctional Health Services in Provincial Correctional Institutions within the province of Alberta were transitioned from the Solicitor General and Minister of Public Security to AHS. The Consolidated Statement of Operations includes $11,435 related to health services in provincial correctional institutions.

Effective October 1, 2010, the operations and administration of fixed wing and other rotary air ambulance services within the province of Alberta were transitioned to AHS. The Consolidated Statement of Operations includes $22,168 related to fixed wing and other rotary air ambulance services.

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 reasonable access to quality health services; 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.

AHS's operations include the facilities and sites listed in the AHS annual report. AHS is a registered charity under the *Income Tax Act* (Canada) and is exempt from the payment of income tax.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of Alberta Health and Wellness (AHW) Financial Directive 4.

(i) These financial statements have been prepared on a consolidated basis. Included in these consolidated financial statements are the following wholly owned subsidiaries:

Note 2 Significant Accounting Policies and Reporting Practices (continued)

- Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and southern Alberta.

- Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.

- Carewest, who manages continuing care programs and facilities in the Calgary area.

The transactions between AHS and these subsidiaries have been eliminated on consolidation. These entities of AHS are exempt from the payment of income tax.

(ii) AHS uses the proportionate consolidation method to account for its 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta (Note 19(a)(i)), and its 50% interest in the Primary Care Networks disclosed in Note 19 (b).

(iii) AHS consolidates its interest in the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP). AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber. LPIP is exempt from the payment of income tax but is subject to the Alberta provincial premium tax.

(iv) These consolidated financial statements do not include the assets, liabilities and operations of controlled foundations (Note 19 (c)), voluntary or private facilities providing health services in the Province (Note 19(d)), or the Health Benefits Trust of Alberta (Note 19(e)). These consolidated financial statements do not include trust funds administered on behalf of others (Note 20).

(b) Revenue Recognition

These consolidated financial statements have been prepared using the deferral method of accounting for contributions; the key elements of AHS's revenue recognition policies are:

(i) Unrestricted contributions are recognized as revenue in the year receivable.

(ii) Externally restricted non-capital contributions are deferred and recognized as revenue in the year the related expenses are incurred.

(iii) Externally restricted capital contributions are recorded as deferred capital contributions until invested in capital assets. Amounts expended, representing externally funded capital assets, are then transferred to unamortized external capital contributions. Unamortized external capital contributions are recognized as revenue in the year the related amortization expense of the funded capital asset is recorded.

(iv) Contributions receivable from AHW and capital contributions receivable from Alberta Health and Wellness are recorded as receivable when confirmed with AHW.

(v) Pledges receivable from foundations are recorded as receivable when amounts to be received can be reasonably estimated and ultimate collection is reasonably assured.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(vi) Externally restricted contributions to purchase capital assets that will not be amortized and endowments are treated as direct increases to net assets.

(vii) Investment income includes dividend and interest income, and realized gains or losses on the sale of investments. Unrealized gains and losses on available for sale investments are included directly in net assets or deferred contributions as appropriate, until the related investments are sold. Unrealized gains and losses on held for trading investments are included in the Consolidated Statement of Operations. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Other unrestricted investment income is recognized as revenue when earned.

(viii) Donations and contributions in kind are recorded at fair value when such value can reasonably be determined.

(ix) Revenue from sales of goods and services is recorded in the period that goods are delivered or services are provided.

(c) Full Cost

AHS accounts for all costs of services for which it is responsible. Full cost transactions comprise the following:

(i) Revenue earned by contracted health service providers from AHW designated fees and charges are recorded as AHS's fees and charges. An equivalent amount is recorded as program expenses as this revenue funds part of the cost of AHS's programs.

(ii) AHW payments directly to contracted health service providers are recorded as revenue and an equivalent amount is recorded as program expenses as these payments represent part of the cost of AHS's programs.

(iii) The estimated cost for use of acute care facilities not owned by AHS is recorded as other government contributions and as program expenses, since AHS's contract payments do not include an amount for the use of these facilities.

(iv) The estimated cost for use of non-acute care facilities not owned by AHS and provided to AHS at zero or nominal rent is recorded as other government contributions and as program expenses.

(v) Other assets, supplies and service contributions that would otherwise have been purchased are recorded as revenue and expenses, at fair value at the date of contribution, when a fair value can be reasonably determined. Volunteers contribute a significant amount of time each year to assist AHS in carrying out its programs and services. However, contributed services of volunteers are not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(d) Cash, Cash Equivalents and Investments

Cash and cash equivalents consist of cash on hand, balances with banks and investments in money market securities with original maturities of less than three months.

Current cash and cash equivalents are comprised of both unrestricted and restricted funds. Unrestricted funds are used for general operating purposes or internally funded capital projects.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Restricted funds comprise received but unspent deferred contributions, as well as amounts restricted to fund long-term insurance obligations (Note 8(d)).

Non-current cash and investments consist of cash on hand, balances with banks and investments in fixed income and equities. All non-current cash and investments are restricted and are comprised of received but not spent non-current deferred contributions and deferred capital contributions.

Investments are accounted for in accordance with the accounting policies described in Note 2(f). Transaction costs associated with the acquisition and disposal of investments are capitalized and are included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade-date accounting.

(e) Inventories

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value. All other inventories are valued at lower of cost (defined as moving average cost) and net realizable value.

(f) Financial Instruments

AHS has classified its financial assets and financial liabilities as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in those fair values recognized in the Consolidated Statement of Operations.
Investments	Available for sale	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Changes in Net Assets or deferred contributions until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
	Held for trading	Measured at fair value with changes in those fair values recognized in the Consolidated Statement of Operations.
Accounts receivable, contributions and capital contributions receivable from AHW	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable and accrued liabilities, long-term debt, provision for unpaid claims and life lease deposits	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS does not use hedge accounting and is not impacted by the requirements of Canadian Institute of Chartered Accountants (CICA) accounting standard Section 3865 - Hedges. AHS as a not-for-profit organization elected to not apply the standards for embedded derivatives in non-financial contracts. In addition, AHS has elected not to adopt Section 3862 Financial Instruments - Disclosures and Section 3863 Financial Instruments - Presentation, and instead has continued to disclose financial instruments under Section 3861 – Financial Instruments Disclosure and Presentation.

When it is determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions is removed and recognized in the Consolidated Statement of Operations even though the financial asset has not been derecognized. Impairment losses recognized in the Consolidated Statement of Operations for a financial instrument classified as available for sale are not reversed.

The carrying value of current cash and cash equivalents, accounts receivable, contributions and capital contributions receivable from AHW, accounts payable and accrued liabilities approximate their fair value because of the short term nature of these items. Unless otherwise noted, it is management's opinion that AHS is not exposed to significant interest, currency or credit risks arising from its financial instruments.

Further disclosure on financial instruments is provided in Note 2(d) Cash, Cash Equivalents and Investments, Note 13 Long-term Debt and Note 15 Other Liabilities.

(g) Capital Assets

Capital assets and work in progress are recorded at cost. Capital assets and work in progress acquired from other government organizations are recorded at the carrying value of that government organization. Costs incurred by Alberta Infrastructure (AI) to build capital assets on behalf of AHS are recorded by AHS as work in progress and unamortized external capital contributions as AI incurs costs. The threshold for capitalizing new systems development is $250 and major enhancements is $100. The threshold for all other capital assets of $5. All land is capitalized.

Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Leased facilities and improvements	term of lease
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete. Leases transferring substantially all benefits and risks of capital asset ownership are reported as capital asset acquisitions financed by long-term obligations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(h) Asset Retirement Obligations

AHS recognizes the fair value of a future asset retirement obligation as a liability in the period in which it incurs a legal obligation associated with the retirement of tangible long-lived assets that results from the acquisition, construction, development, and/or normal use of the assets. AHS concurrently recognizes a corresponding increase in the carrying amount of the related long-lived asset that is amortized over the life of the asset. The fair value of the asset retirement obligation is estimated using the expected cash flow approach that reflects a range of possible outcomes discounted at a credit-adjusted risk-free interest rate.

Subsequent to the initial measurement, the asset retirement obligation is adjusted at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes in the obligation due to the passage of time are recognized as an operating expense using the effective interest method. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset that is amortized over the remaining life of the asset.

An asset retirement obligation related to the removal of hazardous material that would be required as part of a capital project is only recognized when there is approval from the Minister of Health and Wellness to proceed with the project.

(i) Employee Future Benefits

Registered Benefit Pension Plan

AHS participates in the following registered benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP). These multi-employer public sector final average plans provide pensions for participants, based on years of service and earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). As these plans are multi-employer plans and sufficient information is not available, these plans are accounted for on a defined contribution basis.

Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings. In addition, AHS administers a supplemental defined contribution pension plan for a certain employee group. AHS contributes a specified percentage of an employee's earnings in excess of the limits of the *Income Tax Act* (Canada). These plans provide participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Supplemental Executive Retirement Plans (SERPs)

AHS sponsors three defined benefit SERPs which are funded. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. A majority of the SERPs are final average plans, however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits. The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service and management's best estimate assumptions, including a market-related discount rate.

Due to *Income Tax Act* (Canada) requirements, the SERPs are subject to the Retirement Compensation Arrangement (RCA) rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a fixed income portfolio. The net benefit cost of SERPs reported in these financial statements include the current service cost, interest cost on the current service cost and obligations, as well as the amortization of past service cost, initial obligations and net actuarial gains and losses. These amounts are offset by the expected return on the plans' assets.

Past service costs, including the initial obligations of the plans, are amortized on a straight-line basis over the average remaining service lifetime of the relevant employee group. Cumulative net actuarial gains or losses over 10 percent of the greater of the benefit obligation and fair value of the plans' assets, are amortized on a straight-line basis over the average remaining service lifetime of the employee group. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net benefit cost in the following year.

Supplemental Pension Plan (SPP)

The AHS Board has approved a defined contribution SPP for staff not participating in SERP that supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, excluding pay at risk, in excess of the limits of the *Income Tax Act* (Canada). This plan will provide 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.

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's contributions are expensed to the extent that they do not relate to discretionary reserves. AHS fully accrues its obligations for employee non-pension future benefits.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Internally Restricted Net Assets Invested in Capital Assets

AHS discloses internally restricted net assets invested in capital assets separately on the Consolidated Statement of Financial Position and Consolidated Statement of Changes in Net Assets. The AHS Board has approved the restriction of net assets equal to the net book value of internally funded capital assets that will be amortized.

(k) Grants for Research and Other Initiatives

AHS awards grants to other organizations for research and other initiatives. The term of the grants range from less than one year to more than one year. AHS records the committed value of the grant awarded as an expense when it has been approved and when the agreement between AHS and the principal investigator has been executed.

(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 significant variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of capital assets and amortization of external capital contributions are based on the estimated useful life of the related assets. The amounts recorded for asset retirement and employee future benefits obligations are based on estimated future cash flows. As disclosed in Note 15, the provision for unpaid claims is subject to significant management estimates and assumptions. These estimates and assumptions are reviewed periodically. Actual results could differ from the estimates determined by management in these financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(m) Capital Disclosure

For operating purposes, AHS defines capital as including working capital and unrestricted net assets. For capital purposes, AHS defines capital as including deferred capital contributions, long term debt, unamortized external capital contributions, and internally restricted net assets invested in capital assets.

AHS's objectives for managing capital are:

- In the short term, to safeguard its financial ability to continue to deliver health services; and
- In the long term, to plan and build sufficient physical capacity to meet future needs for health services.

The majority of AHS's operating funds are from AHW. AHW provides the operating funds on the first of each month. AHS monitors and forecasts its working capital and cash flow as part of its ongoing cash management activities.

AHW approves health care facilities based on long-term capital plans and Alberta Infrastructure (AI) provides the majority of the funding through one-time capital grants. AHS funds the required equipment and systems by a combination of allocating a portion of operating funds and obtaining external funding from charitable donations and capital grants. AHS borrows to finance capital investments related to ancillary operations, which includes parking and rental operations, non-patient food services and the sale of goods and services, since AHW and AI do not fund ancillary operations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS complied with all debt covenants during the year. In the event of default, the entire outstanding indebtedness secured by and payable to Alberta Capital Financing Authority (ACFA), at their option, becomes due and payable forthwith and without notice to AHS. ACFA may also elect to retain all or any part of the collateral in satisfaction of the indebtedness of AHS. AHS monitors and forecasts all debt covenants as part of its ongoing debt management activities.

Where AHS has incurred an accumulated deficit, legislation requires submission of a deficit elimination plan.

(n) Changes to Accounting Framework

The Public Sector Accounting Board of the CICA (PSAB) has issued a framework for financial reporting by government not-for-profit organizations. The framework includes the 4400 series of standards from the CICA Handbook – Accounting, which have been incorporated into the Public Sector Accounting (PSA) Handbook as PS 4200 series of standards. This framework will be effective for fiscal periods beginning on or after January 1, 2012. Government not-for-profit organizations have been given the choice to apply either PS 4200 series of standards plus the PSA Handbook, or PSA Handbook without the PS 4200 series of standards. AHS will adopt a framework effective April 1, 2012. However, AHS has not yet decided which option it will adopt and therefore the impact of this framework cannot be determined. AHS will identify the differences in the standards that will impact the financial statements and quantify the differences. AHS will also determine whether any of the specific exemptions and exceptions applicable to the first time adoption of PSA standards by government organizations will be applicable to AHS.

Note 3 Budget

A preliminary business plan with a budgeted surplus of $630,000 was approved by the Board on June 29, 2010 and the full financial plan was submitted to the Minister of Health and Wellness. The reported budget reflects the original $630,000 surplus and additional reclassifications required for more consistent presentation with current and prior year results (Schedule 3).

Note 4 Unrestricted Deficit Funding

AHS started on April 1, 2009 with an opening accumulated deficit of $343,219 from the former health entities. In February 2010 the five-year funding commitment for health was announced including funding the accumulated deficit of AHS after the first year of operations in two phases: $343,000 in 2009-2010 and $527,235 in 2010-2011.

The Consolidated Statement of Operations reports the operating surplus (deficit) including the deficit funding. The operating surplus (deficit) excluding the deficit funding is as follows:

	2011	2010
Operating surplus (deficiency)	$ 856,155	$ (238,170)
Less: Deficit funding	(527,235)	(343,000)
Operating surplus (deficit) excluding deficit funding	$ 328,920	$ (581,170)

Note 5 Investment and Other Income

	2011	2010
Investment income	$ 55,936	$ 25,480
Other income	236,183	235,851
	$ 292,119	$ 261,331

Note 6 Administration Expense

	2011	2010
General administration	$ 90,627	$ 134,397
Human resources	90,119	120,813
Finance	62,598	66,577
Administration- contracts with health service providers	63,998	59,876
	$ 307,342	$ 381,663

Note 7 Pension Expense

	2011	2010
Registered benefit pension plans [(a)]	$ 322,009	$ 300,513
Costs to transfer employees to LAPP	-	33,000
Defined contribution pension plans and Group RRSPs	12,922	10,850
Supplemental Executive Retirement Plans	3,351	4,233
Supplemental Pension Plan	458	476
	$ 338,740	$ 349,072

(a) Registered Benefit Pension Plans

AHS participates in the Local Authorities Pension Plan (LAPP) and the Management Employee Pension Plan (MEPP), which are multi-employer defined benefit plans. The pension expense recorded in these consolidated financial statements is equivalent to AHS's contributions to the plan during the year as determined by LAPP and MEPP. At December 31, 2010 LAPP reported a deficiency of $4,635,250 (2009 - deficiency of $3,998,614), and MEPP reported a deficiency of $397,087 (2009 – deficiency of $483,199).

Note 8 Cash, Cash Equivalents and Investments

	2011		2010	
	Fair Market Value	Cost	Fair Market Value	Cost
Cash	$ 457,951	$ 457,951	$ 1,552,995	$ 1,552,995
Money market securities	614,132	614,132	65,101	65,095
Fixed income securities	1,220,750	1,230,108	251,528	247,374
Equities	27,967	25,678	107,206	94,123
	$ 2,320,800	$ 2,327,869	$ 1,976,830	$ 1,959,587
Classified as:				
Current				
Unrestricted	$ 1,170,910		$ 313,663	
Restricted	550,555		663,553	
	1,721,465		977,216	
Non-current				
Restricted[(d)]	599,335		999,614	
	$ 2,320,800		$ 1,976,830	

In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class, and quality constraints on fixed income securities and equity investments.

(a) Interest Rate Risk

AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada treasury bills maturing June 2011 and bearing interest at an average effective yield of 0.74% (2010 – 0.22%) per annum.

Fixed income securities, such as bonds, have an average effective yield of 2.07% (2010 – 3.70%) per year, maturing between 2011 and 2044. The securities have the following maturity structure:

	2011	2010
1 – 5 years	88%	42%
6 – 10 years	9%	30%
Over 10 years	3%	28%

(b) Currency Rate Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is managed by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of the total investment portfolio. As at March 31, 2011, investments in non-Canadian equities represented 0.57% (2010 – 4.55%) of total investments.

Note 8 Cash, Cash Equivalents and Investments (continued)

(c) Credit and Market Risks

AHS is exposed to credit risk from the potential non-payment of accounts receivable. However, the majority of the value of AHS's receivables are from AHW; therefore credit risk is considered to be minimal.

AHS's investment bylaw restricts the types and proportions of eligible investments, thus mitigating AHS's exposure to market risk. 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. 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. Short selling is not permitted.

(d) Restricted Funds for Long Term Insurance Obligations

Included in restricted cash are cash and investments held by AHS to meet long term liability and property insurance obligations. Amounts totaling $85,386 are restricted as provision for unpaid claims and include an amount to satisfy the reserve and guarantee funds under the *Insurance Act* (Alberta).

Note 9 Capital Assets

	2011			2010
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Facilities and improvements	$ 6,001,129	$ 2,118,659	$ 3,882,470	$ 3,135,415
Work in progress	1,669,214	-	1,669,214	1,824,049
Equipment	1,740,142	1,160,474	579,668	542,220
Information systems	757,329	541,302	216,027	266,082
Building service equipment	349,066	194,307	154,759	168,688
Land	108,830	-	108,830	106,330
Leased facilities and improvements	162,892	81,900	80,992	90,576
Land improvements	63,512	48,008	15,504	17,752
	$ 10,852,114	$ 4,144,650	$ 6,707,464	$ 6,151,112

(a) Leased Land

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

Site	Leased from	Lease expiry
Alberta Children's Hospital	University of Calgary	2101
Banff Health Unit	Mineral Springs Hospital	2028
Cross Cancer Institute parkade	University of Alberta	2019
Foothills Medical Centre parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2035
Northeast Community Health Centre	City of Edmonton	2048

Note 9 Capital Assets (continued)

(b) Work in Progress

During the year, the responsibility for building the following capital assets was transferred to Alberta Infrastructure (AI) (Note 19(a)(ii)):

- Edson Regional Hospital
- Grande Prairie Regional Health Complex
- High Prairie Health Complex
- Medicine Hat Regional Hospital Redevelopment
- Lethbridge Chinook Regional Hospital
- Sherwood Park Strathcona Hospital – Phase 1
- Fort Saskatchewan Health Centre
- Edmonton Clinic South
- Alberta Hospital Edmonton Food Service Depot
- South Calgary Health Campus
- Bow Island Health Centre (Capital for Emergent Projects)
- Central Alberta Cancer Centre (Red Deer)
- Grande Prairie QEII Emergency Department Redevelopment and Endoscopy Suite
- Lloydminster Dr. Cooke Extended Care Centre
- Fort McMurray Community Health Centres (Thickwood and Timberlea)
- Stollery Childrens Hospital Emergency Department Expansion
- Stollery Childrens Hospital Paediatric Surgical Suite and Inter-operative Magnetic Resonance Imaging Renovations
- Foothills Medical Centre-McCaig Tower Renovations
- Sturgeon Community Hospital Expansion (St. Albert)
- Northern Lights Health Centre Emergency Room Renovations and Ambulatory Care Upgrade (Capital for Emergent Projects) (Fort McMurray)

AHS recorded the costs incurred by AI for these capital assets of $105,966 for the year ended March 31, 2011 as additions to work in progress and capital contributions received in kind (Note 12).

(c) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $12,250 (2010 - $11,283) with accumulated amortization of $10,938 (2010 - $10,415).

(d) Write-Down of Capital Assets

During the prior year AHS discontinued operations of the Raymond Care Centre and Picture Butte Municipal Hospital, and recorded a write-down of $2,682 to reduce the facilities' carrying value to their fair market value.

Note 10 Other Assets

	2011	2010
Long-term care partnerships – loans (Note 11 (a))	$ 122,739	$ 93,904
Capital contributions receivable	77,600	126,089
Other non-current assets	14,207	13,195
	$ 214,546	$ 233,188

Note 11 Deferred Contributions

Deferred contributions represent unspent externally restricted resources. Changes in the deferred contributions balance are as follows:

	2011			2010
	AHW	Others	Total	Total
Balance beginning of the year	$ 373,262	$ 357,720	$ 730,982	$ 811,971
Received during the year	801,985	145,969	947,954	892,186
Restricted investment income	1,703	4,387	6,090	3,164
Transferred from (to) deferred capital contributions	(20,924)	23,047	2,123	(4,475)
Recognized as revenue	(747,829)	(180,303)	(928,132)	(971,864)
Balance end of the year	$ 408,197	$ 350,820	$ 759,017	$ 730,982

Note 11 Deferred Contributions (continued)

The balance at the end of the year is restricted for the following purposes:

	2011			2010
	AHW	Others	Total	Total
Current				
Mental Health and Safe Communities	$ 107,364	$ 1,225	$ 108,589	$ 129,901
Research and education	2,926	73,792	76,718	73,279
Physician revenue and Alternate Relationship Plans	53,618	857	54,475	39,184
Continuing care and seniors health	49,128	2,461	51,589	22,609
Virtual site training for Calgary South Health Campus	49,630	-	49,630	-
Cancer prevention and research	30,780	15,567	46,347	51,680
Primary Care Networks (Note 19(b))	41,940	-	41,940	41,826
Promotion, prevention and community	27,159	13,470	40,629	34,800
Infrastructure maintenance	-	37,305	37,305	46,548
Emergency and outpatient services	5,306	7,357	12,663	13,849
Inpatient acute nursing services	3,497	9,061	12,558	10,089
Diagnostic and therapeutic services	6,992	5,131	12,123	15,617
Pandemic	8,619	-	8,619	8,613
Healthy Workforce Action Plan	-	7,595	7,595	11,128
Information technology	7,028	232	7,260	11,086
Telehealth	5,791	79	5,870	7,422
EMS transition	5,655	-	5,655	18,318
Support services	284	3,805	4,089	5,402
Wait times	-	-	-	9,898
Regional Shared Health Information Program	-	-	-	8,090
Others less than $5,000	2,480	9,158	11,638	8,393
	408,197	187,095	595,292	567,732
Non-current:				
Long term care partnerships [(a)]	-	159,691	159,691	157,435
Other	-	4,034	4,034	5,815
	-	163,725	163,725	163,250
	$ 408,197	$ 350,820	$ 759,017	$ 730,982

Note 11 Deferred Contributions (continued)

(a) Long-term care partnership agreements

AHS has entered into partnership with voluntary and private health service providers to build and operate long-term care facilities within Alberta. The Government of Alberta has supported these partnerships through providing one-time, up-front capital funding to enable AHS and the voluntary and private partners to develop the approved infrastructure. Two partnership models have been used for the payment of the grant from AHS to the partnership organizations; the Supplementary Payment Model and the Forgivable Mortgage Model.

Under the Supplementary Payment Model, AHS makes annual payments to the partner over the term of the partnership contract, which is usually the expected useful life of the infrastructure. Amounts invested under the terms of long-term care partnership agreements will be utilized to fund future payments to providers over the next 22 years. These payments have a net present value of $20,695 at March 31, 2011 (2010 - $26,067) discounted at 3.7% (2010 – 3.0%). The amounts invested under the terms of the long-term care partnership agreements have a market value at March 31, 2011 of $29,654 (2010 - $37,020). AHS is subject to risk to meet the payment obligations as they become due.

AHS recognizes the supplementary payment expenses in facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions from deferred contributions long-term care partnership projects. Investment income earned, net of management fees, is recorded as an increase to both the investment base and the deferred contribution.

Under the Forgivable Mortgage Model, AHS provides a loan to the partner who uses the funds to construct the infrastructure. AHS does not accrue interest on the loan as AHS intends to forgive the balance of the loan in accordance with the agreement. The loan is repayable on demand in the event of default and is secured by the facility. The loan is considered an asset as it is recoverable from services rendered by the owner over the life of the agreement.

AHS amortizes the long-term care partnership project asset (Note 10) on a straight line basis over the useful life of the infrastructure to facility-based continuing care services on the Consolidated Statement of Operations and recognizes an equal amount of revenue as other government contributions from deferred contributions long-term care partnership projects.

Note 12 Deferred Capital Contributions

Deferred capital contributions represent unspent externally restricted resources related to capital assets. Changes in the deferred capital contributions balance are as follows:

	2011				2010
	AHW	AI	Others	Total	Total
Balance beginning of the year	$230,031	$763,983	$ 52,126	$1,046,140	$1,696,776
Received or receivable during the year	74,365	39,227	43,165	156,757	236,457
Received in kind	-	105,966	86	106,052	-
Restricted investment income	965	-	-	965	272
Capital contributions returned	(5,469)	(53,000)	(381)	(58,850)	-
Transferred to unamortized external capital contributions	(93,504)	(582,305)	(35,006)	(710,815)	(891,148)
Transferred from (to) deferred contributions	20,924	(23,025)	(22)	(2,123)	4,475
Other	(12,705)	16,435	-	3,730	(692)
Balance end of the year	$ 214,607	$ 267,281	$ 59,968	$ 541,856	$1,046,140

Note 12 Deferred Capital Contributions (continued)

The balance at the end of the year is restricted for the following purposes

	2011				2010
	AHW	AI	Others	Total	Total
Facilities and improvements:					
Infrastructure maintenance projects	$ -	$ 143,009	$ -	$ 143,009	$ 158,031
Capital escalation	-	-	-	-	63,658
North Treatment Centre	-	-	5,674	5,674	33,708
Stollery Pediatric Emergency Expansion	-	-	5,000	5,000	-
The Edmonton Clinic					102,731
South Calgary Hospital	-	-	-	-	93,548
Rockyview General Hospital	-	-	-	-	35,909
Peter Lougheed Centre	-	-	-	-	22,045
Foothills Medical Clinic	-	-	-	-	18,702
Other initiatives		124,272	18,139	142,411	271,850
	-	267,281	28,813	296,094	800,182
Information systems:					
Regional Shared Health Information Program	44,979	-	-	44,979	36,851
Diagnostic Imaging Project Year 3	29,004	-	-	29,004	33,201
Diagnostic Imaging Project Year 4	26,219	-	-	26,219	-
Provincial Health Information Exchange	10,909	-	-	10,909	14,477
Others less than $10,000	75,971	-	-	75,971	82,179
Equipment	27,525	-	31,155	58,680	79,250
	$ 214,607	$ 267,281	$ 59,968	$ 541,856	$ 1,046,140

Note 13 Long-term Debt

	2011	2010
Debentures payable: [a]		
Parkade loan #1	$ 46,683	$ 48,747
Parkade loan #2	42,303	44,020
Parkade loan #3	51,582	53,332
Parkade loan #4	15,000	5,000
Parkade loan #5	5,000	-
Calgary Laboratory Services purchase	16,583	22,697
Term loan-Parkade #4 [b]	138,000	83,000
Term loan-Parkade #5 [c]	2,000	-
Obligation under capital lease [d]	15,328	16,042
Other	3,820	2,866
	$ 336,299	$ 275,704
Current	$ 153,799	$ 12,938
Non-current	182,500	262,766
	$ 336,299	$ 275,704
Fair value of total long-term debt [e]	$ 345,325	$ 282,242

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenues derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

As at March 31, 2011, $15,000 (2010 - $5,000) of $181,000 has been advanced to AHS relating to the Parkade loan #4 debenture with the remaining to be drawn by September 1, 2011. Semi-annual principal and interest payments of $7,165 will commence March 1, 2012.

As at March 31, 2011, $5,000 (2010 - $NIL) of $42,300 has been advanced to AHS relating to the Parkade loan #5 debenture with the remaining to be drawn by June 1, 2012. Semi-annual principal payments of $1,577 will commence December 1, 2012.

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

	Maturity Date	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%
Calgary Laboratory Services purchase	May 2013	4.6810%

(b) AHS obtained a term loan facility of $181,000 during 2010, of which $138,000 (2010 - $83,000) has been drawn at March 31, 2011. The facility has been secured by the issuance of the Parkade #4 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at an average rate of 2.241%, with the full principal repayment due upon maturity on September 1, 2011. Management does not believe that the demand features of the callable debt will be exercised in the current period.

Note 13 Long-term Debt (continued)

(c) AHS obtained a term loan facility of $42,300 during 2011, of which $2,000 has been drawn at March 31, 2011. The facility has been secured by the issuance of the Parkade #5 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at 3.22%, with the full principal repayment due upon maturity on June 1, 2012. Management does not believe that the demand features of the callable debt will be exercised in the current period.

(d) The capital lease with the University of Calgary expires January 2028. The implicit interest rate payable on this lease is 6.5%.

(e) The fair value of long-term debt is estimated based on market interest rates from ACFA for debentures of similar maturity.

(f) As at March 31, 2011 AHS held a $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 0.5% per annum. As at March 31, 2011, AHS has no draws against this facility.

AHS also holds a $33,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects. As at March 31, 2011, AHS had $6,024 (2010 - $4,305) in letters of credit outstanding against this facility.

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Capital Lease Minimum lease payments
2012	$ 153,113	$ 1,660
2013	21,286	1,464
2014	17,347	1,453
2015	14,533	1,453
2016	15,221	1,453
Thereafter	301,611	18,298
	$ 523,111	25,781
Less: interest		10,453
		$ 15,328

During the year, the amount of interest expensed was $7,954 (2010 - $8,845).

Note 14 Unamortized External Capital Contributions

Unamortized external capital contributions at year-end represent the external capital contribution to be recognized as revenue in future years. Changes in the unamortized external capital contributions balance are as follows:

	2011	2010
Balance beginning of year	$ 5,254,711	$ 4,675,230
Transferred from deferred capital contributions	710,815	891,148
Transfer of land to investment in capital assets	(2,500)	(5,723)
Less amounts recognized as revenue:		
Amortized external capital contributions- Equipment	(129,551)	(118,341)
Amortized external capital contributions- Information systems	(52,326)	(52,117)
Amortized external capital contributions- Facilities and improvements	(182,304)	(134,596)
Amortization – Ancillary operations	(425)	(259)
Other	553	(631)
Balance end of year	$ 5,598,973	$ 5,254,711

Note 15 Other Liabilities

	2011	2010
Provision for unpaid claims [(a)]	$ 76,802	$ -
Life lease deposits [(b)]	12,815	12,603
Asset retirement obligations [(c)]	10,409	10,713
Accrued benefit (asset) liability of SERPs [(d)]	(12,511)	(6,180)
Other	9,939	1,295
	$ 97,454	$ 18,431

(a) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals, on historical precedent and trends, on prevailing legal, economic, and social and regulatory trends, and on expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materiality from the best estimates made.

The fair value of unpaid claims is not practicable to determine with sufficient reliability. Under accepted actuarial practice, the appropriate value of the claims liabilities is the discounted value of such liabilities plus the provision for adverse deviation. The provision for unpaid claims has been estimated using the discounted value of claim liabilities using a discount rate of 3.25%.

Note 15 Other Liabilities (continued)

(b) Life Lease Deposits

Funding for the Laurier House facilities, a project for long-term care residents in Edmonton, is provided by the tenants with a non-interest bearing repayment deposit, for the right to occupy the unit they are leasing. When the life lease agreement is terminated, which may be by death of the tenant or the tenant moving out, the life lease deposit is returned to the tenant without interest and in accordance with the terms of the Life Lease Agreement. The liability for life lease deposits is based on a discharge rate of 25% (2010 – 25%) and a discount rate of 2.2% (2010 - 2.0%), representing the bank secured lending rate. The reported liability is based on estimates and assumptions with respect to events extending over a 4 year period using the best information available to management. The carrying value of the reported liability approximates the fair value.

(c) Asset Retirement Obligation

The asset retirement obligation (ARO) represents the legal obligation associated with the removal of asbestos during planned renovations of AHS facilities. The total undiscounted amount of the estimated cash flows required to settle the recorded obligation is $11,151 (2010 - $11,474), which has been discounted using a weighted average credit-adjusted risk free rate of 2.2% (2010 - 2.1%). Payments to settle the ARO are expected to occur by 2014. AHS has identified the existence of asbestos in other buildings which is not required to be remediated at this time and therefore is not recorded as an obligation.

Note 15 Other Liabilities (continued)

(d) Supplemental Executive Retirement Plans

During the year there were three SERPs sponsored by AHS. Under the terms of the three SERPs, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SERPs are described in Note 2 (i).

	2011	2010
Change in accrued benefit obligation		
Accrued benefit obligation, beginning of year	$ 31,809	$ 28,715
Current service cost	1,668	1,701
Interest cost	1,754	2,000
Benefit payments	(2,159)	(3,224)
Actuarial losses	1,071	2,617
Accrued benefit obligation, end of year	$ 34,143	$ 31,809
Change in plan assets		
Fair value of plan assets, beginning of year	$ 32,367	$ 10,178
Adjustment to opening value	(984)	-
Actual return on plan assets	1,189	510
Actual employer contributions	9,682	24,903
Benefit payments	(2,159)	(3,224)
Fair value of plan assets, end of year	$ 40,095	$ 32,367
Reconciliation of funded status to accrued benefit asset/liability		
Funded status of the plan	$ 5,952	$ 558
Unrecognized net actuarial losses	5,921	4,334
Unrecognized initial obligations	342	512
Unrecognized past service cost	296	776
Accrued benefit asset (liability), end of year	$ 12,511	$ 6,180

Note 15 Other Liabilities (continued)

	2011	2010
Determination of net benefit cost		
Current service cost	$ 1,668	$ 1,701
Interest cost	1,754	2,000
Actual return on assets	(1,189)	(510)
Actuarial losses (gains) in year	87	2,617
Amortization of initial obligations	392	264
Difference between expected and actual return on assets	302	224
Difference between recognized and actual actuarial gains/losses	79	(2,468)
Difference between recognized and actual past service Costs	258	405
Net benefit cost	$ 3,351	$ 4,233
Members		
Active	60	64
Retired and terminated	48	55
Total members	108	119
Assumptions		
Weighted average discount rate to determine year end obligations	4.90%	5.40%
Weighted average discount rate to determine net benefit costs	5.40%	6.38%
Expected return on assets	2.70%	2.70%
Expected average remaining service life time	5	5
Rate of compensation increase per year	2011-2012	2010-2011
	1.5%	1.5%
	2012-2013	2012-2014
	2.5%	3.2%
	Thereafter	Thereafter
	3.5%	3.5%

Note 16 Other Internally Restricted Net Assets

	2011	2010
South Health Campus [(a)]	$ 50,000	$ -
Parkade infrastructure reserve [(b)]	16,722	-
	$ 66,722	$ -

(a) The AHS Board has approved the restriction of $50,000 (2010 - $NIL) to assist with funding start up costs for South Health Campus in Calgary.

(b) The AHS Board has approved the restriction of $16,722 (2010 - $NIL) from parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades and construction.

Note 17 Endowments

	2011	2010
Cancer Research Institute of Alberta Director Research Chair [(a)]	$ 10,000	$ 10,000
J.K. Bigelow Education Fund [(b)]	150	150
	$ 10,150	$ 10,150

(a) The Cancer Research Institute of Alberta (CRIA) Director Research Chair endowment is internally restricted and is designated for use as a Research Chair for the Director of CRIA. The principal amount of $10,000 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for the salary, infrastructure and operating grant support for the CRIA Director Research Chair.

(b) The J.K. Bigelow Education Fund endowment is internally restricted and is designated for funding of health related courses undertaken by employees of AHS in the Lethbridge area. The principal amount of $150 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for education.

Note 18 Commitments and Contingencies

(a) Leases

AHS is contractually committed to future operating lease payments for premises and vehicles until 2029 and 2017 respectively as follows:

	Premises	Vehicles	Total
2012	$ 47,673	$ 2,877	$ 50,550
2013	34,927	1,858	36,785
2014	26,366	1,180	27,546
2015	22,811	648	23,459
2016	16,521	136	16,657
Thereafter	36,468	15	36,483
	$ 184,766	$ 6,714	$ 191,480

(b) Capital Assets

AHS has the following outstanding contractual commitments for capital assets as of March 31:

	2011
Facilities and improvements	$ 114,758
Information systems	79,500
Equipment	110,232
	$ 304,490

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 19 (d). AHS has contracted for services in the year ending March 31, 2012 similar to those provided by these providers in 2011.

Note 18 Commitments and Contingencies (continued)

(d) Contingencies

As at March 31, 2011 AHS is named as a defendant in 361 legal claims (2010 – 368 legal claims). 314 of these claims have specified amounts totalling $325,490 and the remaining 47 have no specified amounts. (2010 – 321 claims with specified amounts of $678,474 and 47 with no specified amounts). Included in the total legal claims are 30 claims amounting to $215,253 (2010 – 7 claims amounting to $93,965) in which AHS has been jointly named with other government entities.

AHS has been named as a defendant in a legal action in respect of increased long-term care accommodation charges levied effective August 1, 2003. The claim has been filed against the Government of Alberta and the former Regional Health Authorities (now AHS). The amount of the claim has not been specified but has been estimated to be between $100 million and $175 million per year based on the amount of the increase in accommodation charges levied, which came into effect August 1, 2003. The outcome of the claim is not determinable and no liability is recorded at this time.

AHS has a contingent liability in respect of claims relating to the failure of St. Joseph's Hospital to provide adequate infection control and safety measures to prevent contamination of medical equipment. The total amount of these claims is in excess of $25 million. The outcome of the claims is not determinable, and no liability is recorded at this time.

Included in Other Liabilities (Note 15(a)) is $19,488 representing claims identified and likely to be paid and $57,314 representing claims to be paid but not yet identified.

The restricted cash and investments described in Note 8(d), are available to fund future payments of certain losses. AHS can access these funds subject to a maximum limit of $5 million per occurrence with an additional $5 million limit per occurrence. The additional limit is subject to an absolute limit of $15 million in aggregate for all occurrences for each policy year. Claims in excess of these limits are to be funded by AHS's unrestricted funds. AHS does not purchase any reinsurance.

Note 19 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

(a) Government of Alberta

The Minister of Health and Wellness appoints the AHS Board members. AHS is economically dependent on AHW since the viability of its operations depend on contributions from AHW. Transactions between AHS and AHW are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements.

Note 19 Related Parties (continued)

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the Province of Alberta's financial statements. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenue		Expenses	
	2011	2010	2011	2010
Ministry of Advanced Education [(i)]	$ 24,298	$ 24,098	$ 121,472	$ 115,045
Ministry of Infrastructure [(ii)]	4,614	87	539	391
Other ministries	28,579	24,821	19,630	22,029
Total for the year	$ 57,491	$ 49,006	$ 141,641	$ 137,465

	Receivable from		Payable to	
	2011	2010	2011	2010
Ministry of Advanced Education [(i)]	$ 5,396	$ 2,662	8,891	$ 14,887
Ministry of Infrastructure [(ii)]	39,227	-	12,951	3
Other ministries	9,630	7,462	180,572	177,445
Balance at end of the year	$ 54,253	$ 10,124	$ 202,414	$ 192,335

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

(ii) During the year, AHS signed an agreement effective June 17, 2010 transferring to AI responsibility for management of major capital projects greater than $5,000. As a result, AHS transferred to AI $113,000 of unspent funds from deferred capital contributions and responsibility for twenty projects currently in progress. AHS also transferred future obligations on the twenty projects related to contractual commitments of $977,928. AHS retained title to work in progress and recorded costs incurred by AI as non-cash capital contributions and additions to work in progress (Note 9(b)).

Note 19 Related Parties (continued)

(b) Primary Care Networks

AHS has joint control with various physician groups over Primary Care Networks (PCNs). AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services. Both parties have equal share ownership and equal Board representation. The Primary Care Initiative Committee (PCIC) was established under the tri-lateral agreement between AHS, AHW and Alberta Medical Association (the "parties") to provide strategic direction as well as facilitate the achievement of key objectives of PCNs. The parties have equal representation on PCIC. As a requirement of the PCIC, PCNs can only use accumulated surpluses based on an approved surplus reduction plan, and as such, AHS's proportionate share of these surpluses has been recorded by AHS as restricted deferred contributions. The following PCNs are included in these consolidated financial statements under the proportionate consolidation method:

Alberta Heartland Primary Care Network
Athabasca Primary Care Network
Big Country Primary Care Network
Bonnyville / Aspen 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
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
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 River Primary Care Network
Provost/Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park-Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
St. Paul / Aspen Primary Care Network
Vegreville Primary Care Network
Vermilion Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

Note 19 Related Parties (continued)

AHS's proportionate share of assets, liabilities, revenues and expenses, and cash flows of the PCNs is as follows:

	March 31, 2011	March 31, 2010
Assets:		
Current	$ 43,110	$ 42,872
Non-current	4,029	4,484
Total assets	$ 47,139	$ 47,356
Liabilities:		
Current [(i)]	$ 47,139	$ 47,356
Total liabilities	47,139	47,356
Total revenue	$ 67,531	$ 56,785
Total expenses	67,531	56,785
	$ -	$ -

(i) Included in current liabilities are deferred contributions of $41,940 (2010 - $41,826) (Note 11).

(c) Foundations

A large number of foundations provide donations of money and services to AHS to enhance health care in various communities throughout Alberta. This financial support to AHS is reflected in donations revenue and capital contributions. These foundations are registered charities under the *Income Tax Act* (Canada) and accordingly, are exempt from income taxes, provided certain requirements of the Income Tax Act are met.

(i) Controlled foundations

A number of foundations are considered to be controlled entities as AHS appoints all trustees for such foundations. Controlled foundations are not consolidated in these financial statements.

Note 19 Related Parties (continued)

The Alberta Cancer Foundation (ACF) and the Calgary Health Trust (CHT) are the most significant controlled foundations. The following aggregated financial results of ACF and CHT is presented using the same accounting policies as AHS:

	2011		2010	
	ACF	CHT	ACF	CHT
Revenue	$ 43,872	$ 40,634	$ 27,263	$ 59,456
Expenses	43,276	39,670	29,420	58,146
Operating surplus (deficiency) of revenue over expenses	$ 596	$ 964	$ (2,157)	$ 1,310
Total assets	$ 118,248	$ 87,572	$ 95,634	$ 88,448
Total liabilities[1] [2]	43,227	64,406	28,835	68,670
Net assets[1] [2]	$ 75,021	$ 23,166	$ 66,799	$ 19,778

(1) In accordance with donor imposed restrictions ACF must maintain permanently $72,577 (2010 - $65,502) with the investment revenue earned to be used for purposes in accordance with the various purposes established by the donors or the Trustees. A further $40,780 (2010 - $27,380) included in liabilities are deferred contributions that must be used for the purpose of cancer research, prevention and screening initiatives, as well as patient care and support, education and equipment.

(2) In accordance with donor imposed restrictions CHT must maintain permanently $19,880 (2010 - $16,441) with the investment revenue earned to be used in accordance with the various purposes established by the donors or the Board. A further $53,371 (2010 - $59,989) included in liabilities are deferred contributions that must be used for the purpose of capital projects and medical equipment, patient care and program support and medical research.

Financial information for the remaining controlled foundations is not disclosed because AHS does not receive financial information from all these foundations on a timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. These foundations' financial statement balances are immaterial individually and in aggregate relative to AHS. The following are the remaining foundations controlled by AHS as at March 31, 2011:

Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District 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 Region Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Windy Slopes Health Foundation

Note 19 Related Parties (continued)

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Lakeland Regional Health Authority Foundation
Peace Health Region Foundation
Peace River Community Health Centre Foundation
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Vermilion and Region Health and Wellness Foundation

(ii) Other foundations

AHS has an economic interest in a number of foundations as they raise and hold resources to support AHS. AHS appoints one board trustee for such foundations. Financial information for these foundations is not disclosed because AHS does not receive financial information from all these foundations on a consistent and timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. The following are the foundations that AHS has an economic interest in as of March 31, 2011:

Alberta Children's Hospital Foundation
Beaverlodge Hospital Foundation
Black Gold Health Foundation
Capital Care Foundation
Chinook Regional Hospital Foundation
Consort Hospital Foundation
Coronation Heath Centre Foundation
Daysland Hospital Foundation
Devon General Hospital Foundation
Drayton Valley Health Services Foundation
Drumheller Area Health Foundation
Fairview Health Complex Foundation
Glenrose Rehabilitation Hospital Foundation
High River District Health Care Foundation
Hinton Healthcare Foundation
Hythe Nursing Home Foundation
Northern Lights Regional Health Foundation
Northwest Health Foundation
Queen Elizabeth II Hospital Foundation
Red Deer Regional Health Foundation
Regional EMS Foundation
Rosebud Health Foundation
Royal Alexandra Hospital Foundation
Sheep River Health Trust
St. Paul and District Hospital Foundation
Stollery Children's Hospital Foundation
Strathmore District Health Services Foundation
Sturgeon Community Hospital Foundation
Taber and District Health Foundation
Tri-Community Health and Wellness Foundation
University Hospital Foundation
Valleyview Health Complex Foundation
Wainwright and District Community Foundation
Wetaskiwin Health Foundation

The following foundations are in the start-up process and are expected to be operating within the first quarter of fiscal 2012:

Lacombe Hospital and Care Centre Foundation
Ponoka Health Centre Foundation
Vulcan County Health and Wellness Foundation

Note 19 Related Parties (continued)

(d) Contracts with Health Service Providers

AHS is responsible for the delivery of health services in the Province. To this end, AHS contracts with various voluntary and private health service providers to continue to provide health services throughout Alberta. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $617,083 (2010 - $551,098). As of March 31, 2011, the net book value of capital assets owned by AHS but operated by a voluntary or private health service provider was $138,036 (2010 - $141,506).

AHS has an economic interest through its contracts with certain voluntary and private health service providers as AHS transfers significant resources as follows:

	2011			2010		
	Voluntary Health Service Providers	Private Health Service Providers	Total	Voluntary Health Service Providers	Private Health Service Providers	Total
Direct AHS funding	$893,259	$857,597	$1,750,856	$816,197	$778,183	$1,594,380
Fees and charges	97,643	96,009	193,652	95,490	94,284	189,774
Full cost adjustments	13,035	83	13,118	14,387	83	14,470
Direct AHW funding	-	643	643	-	986	986
	$1,003,937	$954,332	$1,958,269	$926,074	$873,536	$1,799,610

Included in the Statement of Operations as follows:

Inpatient acute nursing services	$ 265,105	$ 227,760
Emergency and outpatient services	80,183	68,631
Facility-based continuing care services	510,772	493,082
Ambulance services	13,352	-
Community-based care	291,287	241,514
Home care	150,893	145,403
Diagnostic and therapeutic services	296,011	279,466
Promotion, prevention and protection services	7,775	10,269
Research and education	3,902	2,928
Administration	64,005	59,876
Information Technology	497	324
Support services	274,487	270,357
	$ 1,958,269	$ 1,799,610

Note 19 Related Parties (continued)

(e) Health Benefit Trust of Alberta

Effective July 1, 2010, the Health Organization Benefit Plan (HOBP) changed its name to the Health Benefit Trust of Alberta (HBTA) following an amendment to the Trust Agreement. AHS is one of more than thirty participants in HBTA and has a majority of representation on HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement. HBTA uses various carriers for the different benefits. HBTA is exempt from the payment of income taxes.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $79,576 as at December 31, 2010 ($29,594 as at December 31, 2009). For the period January 1 to December 31, 2010 AHS paid premiums of $132,121 (2010 - $38,159). Included in prepaid expenses is $44,118 (2010 - $15,824) representing AHS's proportionate share of the HBTA's surpluses at December 31, 2010.

Note 20 Trust Funds

AHS receives funds in trust from AHW that are to be paid to operators of non-owned facilities for capital purposes or facility repairs, and for specific projects. In addition, AHS receives funds in trust for research and development, education and other programs. AHS received funds in trust from AHW for some PCNs; AHS uses these funds to cover the Primary Care Networks' expenditures until they make their own banking arrangements. These amounts are held on behalf of others with no power of appropriation and therefore are not reported in these consolidated financial statements. As at March 31, 2011, the balance of funds held by AHS is as follows:

	2011	2010
AHW	$ -	$ 694
Research and development, education and other programs	7,263	6,558
Primary Care Networks	-	3,943
	$ 7,263	$ 11,195

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not reflected in these consolidated financial statements.

Note 21 Corresponding Amounts

Certain 2010 amounts have been reclassified to conform to the 2011 presentation.

Note 22 Approval of Consolidated Financial Statements

The consolidated financial statements have been approved by the Alberta Health Services Board.

SCHEDULE 1 - CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2011

	2011		2010
	Budget (Schedule 3)	Actual	Actual (Note 21)
Salaries and benefits (Schedule 2)	$ 5,803,536	$ 5,667,428	$ 5,483,260
Contracts with health service providers (Note 19 (d))	1,950,034	1,958,269	1,799,610
Contracts under the Health Care Protection Act	20,657	19,308	23,866
Drugs and gases	383,726	361,468	332,600
Medical and surgical supplies	314,113	330,132	320,135
Other contracted services	1,165,268	1,112,310	1,101,908
Other *	1,064,953	1,056,410	1,004,079
Amortization:			
Internally funded equipment	33,000	33,501	45,147
Internally funded information systems	49,000	48,656	36,838
Internally funded facilities and improvements	26,000	24,341	24,474
Externally funded equipment	135,000	129,379	117,792
Externally funded information systems	50,000	50,773	52,117
Externally funded facilities and improvements	185,000	181,420	132,171
Loss on disposal of assets	1,000	2,441	364
Write down of capital assets (Note 9 (d))	-	-	2,682
	$ 11,181,287	$ 10,975,836	$ 10,477,043
* Significant amounts included in Other are:			
Equipment expense	$ 154,172	$ 155,690	$ 127,839
Building and ground expenses	126,717	139,787	138,933
Other clinical supplies	116,455	117,928	119,717
Utilities	115,055	100,614	94,622
Minor equipment purchases	50,562	93,903	73,139
Food and dietary supplies	64,654	67,928	69,733
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	66,319	64,249	64,103
Office supplies	62,110	60,668	79,353
Travel	57,062	48,758	51,379
Building rent	22,194	28,852	26,095
Insurance	17,490	20,646	17,549
Licenses, fees and membership	14,808	17,564	19,124
Education	44,460	13,549	12,026
Other	152,895	126,274	110,467
	$ 1,064,953	$ 1,056,410	$ 1,004,079

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011

	2011								2010	
						Severance [e]				
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board	13.37	$ -	$ 706	$ -	$ 706	-	$ -	$ 706	15.00	$ 898
Total Executive	10.98	3,946	1,083	613	5,642	1	661	6,303	11.24	6,230
Management Reporting to CEO Reports	51.29	10,601	2,183	2,922	15,706	4	1,143	16,849	42.78	11,186
Other Management	3,454.45	351,533	13,499	72,957	437,989	74	4,395	442,384	3,472.32	455,079
Medical Doctors not included above	143.68	38,447	1,901	4,309	44,657	-	-	44,657	172.44	42,945
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	16,819.47	1,387,709	164,991	274,950	1,827,650	-	(2,810)	1,824,840	16,764.59	1,825,494
LPNs	3,349.88	196,819	19,826	38,098	254,743	6	221	254,964	3,307.90	236,626
Other Health Technical & Professionals	13,130.73	1,005,958	64,576	204,382	1,274,916	96	4,632	1,279,548	12,580.79	1,168,773
Unregulated Health Service Providers	6,302.33	271,865	20,748	53,812	346,425	56	769	347,194	6,047.78	321,272
Other Staff	21,155.09	1,144,180	51,824	249,642	1,445,646	224	4,337	1,449,983	22,132.96	1,381,757
Costs to transfer employees to LAPP	-	-	-	-	-	-	-	-	-	33,000
Total	**64,431.27**	**$ 4,411,058**	**$ 341,337**	**$ 901,685**	**$ 5,654,080**	**461**	**$ 13,348**	**$ 5,667,428**	**64,547.80**	**$ 5,483,260**

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

	Term	2011 Committees	2011 Honoraria	2010 Honoraria
Board Chair				
Ken Hughes[1]	Since May 15, 2008	AF, GOV, HA, HR, QS	$ 91	$ 104
Board Members				
Catherine Roozen[2]	Since Jul 29, 2008	AF, GOV, HA, HR, QS	55	53
Jack Ady	May 15, 2008 to Aug 31, 2010	HR, QS (former Chair)	23	62
Lori Andreachuk	Nov 20, 2008 to Aug 31, 2010	GOV, HA	28	61
Dr. Ray Block[5]	Since Feb 18, 2011	HR	-	-
Gord Bontje	Nov 20, 2008 to Nov 26, 2010	AF, GOV	35	60
Teri Lynn Bougie	Since Nov 20, 2008	HA, QS	52	61
Jim Clifford	Nov 20, 2008 to Aug 31, 2010	AF, HR	23	61
Dr. Ruth Collins-Nakai	Since Feb 18, 2011	HR, QS	6	-
Strater Crowfoot	Nov 20, 2008 to Mar 31, 2011	HA, HR	46	59
Tony Franceschini	Nov 20, 2008 to Nov 24, 2010	AF, GOV	35	58
Dr. Kamalesh Gangopadhyay	Since Oct 13, 2010	GOV, HA, QS	23	-
Linda Hohol	May 15, 2008 to Nov 26, 2010	GOV (former Chair)	34	59
Don Johnson	Since Feb 18, 2011	AF, HA	6	-
Dr. Andreas Laupacis	Nov 20, 2008 to Nov 27, 2010	QS (former Chair)	28	60
John Lehners	Since May 15, 2008	HA (Chair)	52	65
Irene Lewis	Since May 15, 2008	HR (Chair)	49	60
Stephen Lockwood	Since Oct 13, 2010	AF, GOV (Chair), HR	24	-
Don Sieben[3]	Since May 15, 2008	AF(Chair)	64	75
Dr. Eldon Smith	Since Feb 18, 2011	AF, GOV	5	-
Sheila Weatherill[5]	Since Feb 18, 2011	AF, GOV	-	-
Gord Winkel[4]	Since Nov 20, 2008	AF, QS(Chair)	27	-
Total Board			$ 706	$ 898

Board members are compensated with monthly honoraria and honoraria for attendance at board and committee meetings in accordance with Ministerial Order #50. Although M.O. #50 was repealed by M.O. #93, original rates from M.O. #50 were adopted again as of January 1, 2010.

(1) Ken Hughes is Board Chair and Ex-Officio Member on all Committees.
(2) Catherine Roozen is Board Vice Chair and Ex-Officio Member on all Committees.
(3) Don Sieben also received honoraria for serving on the Alberta Hospital Edmonton Implementation Committee from October 20, 2009 to March 31, 2010.
(4) Gord Winkel started to claim honoraria August 2010 following his retirement from Syncrude Canada Ltd.
(5) Ray Block and Sheila Weatherill do not claim honoraria.

Committee legend: AF = Audit and Finance, GOV = Governance, HA = Health Advisory, HR = Human Resources, QS = Quality and Safety

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

For the Current Fiscal Year	2011									
	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer (f)(k)	0.65	$ 383	$ -	$ 54	$ 29	$ 48	$ 3	$ 517	$ 661	$ 1,178
Acting President and Chief Executive Officer (f)(i)(l)(q)	0.35	167	-	25	43	4	43	282	-	282
Chief Audit Executive (m)(r)	0.76	151	21	-	-	-	18	190	-	190
Interim VP Internal Audit and Enterprise Risk Management - Contracted Services (n)	0.24	113	-	-	-	-	-	113	-	113
Ethics and Compliance Officer (s)	1.00	209	-	-	-	-	35	244	-	244
CEO Direct Reports										
Executive VP and Chief Financial Officer (f)(t)	1.00	370	55	-	-	33	65	523	-	523
Executive VP, Corporate Services (f)(t)	1.00	370	60	-	-	27	60	517	-	517
Executive VP, Quality and Service Improvement (f)(i)(l)(q)	0.65	307	-	49	190	7	79	632	-	632
Executive VP and Acting Executive Lead for Quality and Service Improvement (j)(o)(u)	0.33	159	-	27	-	-	19	205	-	205
Executive VP, Rural, Public and Community Health (h)(v)	1.00	370	-	62	-	1	106	539	-	539
Executive VP, Strategy and Performance (f)(t)	1.00	370	59	-	-	27	59	515	-	515
Executive VP, Clinical Support Services (g)(w)	1.00	365	-	65	16	2	60	508	-	508
Executive VP and Chief Medical Officer (j)(o)(u)	0.67	323	-	52	92	-	40	507	-	507
Acting Executive VP and Chief Medical Officer (p)(s)	0.33	137	16	-	-	-	-	153	-	153
Chief of Staff, Board Office and VP Community Engagement (s)	1.00	152	-	19	-	-	26	197	-	197
Total Executive	10.98	$ 3,946	$ 211	$ 353	$ 370	$ 149	$ 613	$ 5,642	$ 661	$ 6,303

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

For the Prior Fiscal Year (Note 21)	2010									
	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer	1.00	$ 575	$ -	$ 77	$ -	$ 62	$ 30	$ 744	$ -	$ 744
Interim VP Internal Audit and Enterprise Risk Management - Contracted Services	0.09	42	-	-	-	-	-	42	-	42
VP Internal Audit and Enterprise Risk Management	0.52	120	-	-	31	-	53	204	362	566
VP Internal Audit and Enterprise Risk Management	0.42	82	-	-	3	3	16	104	-	104
Ethics and Compliance Officer	0.98	205	-	-	-	2	42	249	-	249
CEO Direct Reports										
Executive VP and Chief Financial Officer	0.97	359	57	-	-	32	44	492	-	492
Executive VP, Corporate Services	0.74	274	44	-	-	37	38	393	-	393
Acting Executive VP, Corporate Services	0.33	62	-	-	-	-	19	81	-	81
Executive VP, Quality and Service Improvement	1.00	472	-	82	-	29	229	812	-	812
Executive VP, Rural, Public and Community Health	1.00	370	-	60	-	-	91	521	-	521
Executive VP, Strategy and Performance	0.41	152	26	-	-	41	27	246	-	246
Acting Executive VP, Strategy and Performance	0.75	257	-	-	42	60	62	421	61	482
Senior VP, Clinical Support Services	1.00	330	-	47	-	-	49	426	-	426
Senior Physician Executive	1.00	480	-	80	-	6	160	726	-	726
VP Community Engagement and Chief of Board Office	0.37	53	-	6	-	6	13	78	-	78
Chief of Staff, Board Office	0.58	111	-	-	27	6	35	179	-	179
Interim Chief Operating Officer, Health Research and Design	0.08	24	-	-	13	1	51	89	-	89
Total Executive	11.24	$ 3,968	$ 127	$ 352	$ 116	$ 285	$ 959	$ 5,807	$ 423	$ 6,230

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

Supplemental Pension Plan (SPP) and Supplemental Executive Retirement Plan (SERP)

	2011					2010			
	SPP		SERP						
	Current Service Costs	Prior Service Costs	Current Service Cost	Other SPP Costs	Total	Total	Account Balance or Accrued Benefit Obligation March 31, 2010	Change During the Year	Account Balance or Accrued Benefit Obligation March 31, 2011
President and Chief Executive Officer	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Acting President and Chief Executive Officer/Executive VP, Quality and Service Improvement [(l)]	-	-	107	65	172	179	1,140	237	1,377
Chief Audit Executive	5	-	-	-	5	-	-	5	5
Interim VP Internal Audit & Enterprise Risk Management - Contracted Services	-	-	-	-	-	-	-	-	-
Ethics and Compliance Officer	7	7	-	-	14	-	-	14	14
Executive VP and Chief Financial Officer	23	23	-	-	46	-	-	46	46
Executive VP, Corporate Services	23	17	-	-	40	-	-	40	40
Executive VP and Acting Executive Lead for Quality and Service Improvement/ Executive VP and Chief Medical Officer [(o)]	-	-	74	14	88	109	391	208	599
Executive VP, Rural, Public and Community Health	-	-	35	18	53	62	638	87	725
Executive VP, Strategy and Performance	23	9	-	-	32	-	-	32	32
Executive VP, Clinical Support Services	-	-	27	3	30	27	80	214	294
Acting Executive VP and Chief Medical Officer	-	-	-	-	-	-	-	-	-
Chief of Staff, Board Office and VP Community Engagement	1	1	-	-	2	-	-	2	2

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991. The SPP is a defined contribution plan and the SERP is a defined benefit plan. The SPP costs are AHS contributions in the period. Changes in the account balance include current and prior service costs and investment income. The SERP costs are not cash payments in the period but are the cost for the period for rights to these future retirement benefits. Current service cost is the actuarial present value of the benefits earned in the fiscal year. Other SERP costs include interest cost on the obligations and current service cost, the amortization of past service cost, initial obligations and net actuarial gains and losses, offset by the expected return on the plans' assets. Changes in the accrued benefit obligation include current service cost, interest accruing on the obligations and the current service cost as well as the full amount of any actuarial gains or losses in the period. The SERP is disclosed in Notes 2(i) and 15(d).

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

Definitions

a. For this schedule, Full time equivalents (FTE) are determined by actual hours paid divided by 2,022.75 annual base hours. If applicable, FTE for Board Members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year or the beginning of the year and the termination date. Total actual discrete number of individuals employed during the fiscal year was 99,386 (2010 – 94,715).

b. There are two compensation models for senior leaders. Some receive a base salary with a component that is at risk if they do not meet performance objectives. Others receive a base salary plus other variable pay if they meet performance objectives.

Pay at risk: As new staff is hired or existing contracts end, senior leaders are required to participate in 'pay-at-risk'. Under this model, a component of remuneration is withheld during the year and released (in full or in part) based on achievement of performance objectives.

Other variable pay: The President and Chief Executive Officer and senior leaders with contracts existing prior to formation of AHS may have variable pay provisions in their contracts. Variable pay is in addition to, and calculated as a percentage of, base salary. Variable pay is paid based on achievement of performance objectives.

Vacation payouts, which are a cash benefit, are shown separately for direct reports of the Board or President and Chief Executive Officer. Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer where it is included in other non-cash benefits.

c. Other cash benefits may include as applicable honoraria, overtime, automobile allowance, and lump sum payments. For anyone other than direct reports of the Board or the President and Chief Executive Officer, other cash benefits may also include pay at risk or other variable pay if applicable.

d. Other non-cash benefits include:

- Employer's current and prior service cost of supplemental pension plan and supplemental executive retirement plans.
- Share of employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

e. Severance includes direct or indirect payments to individuals upon termination or voluntary exit which are not included in other cash benefits or non-cash benefits. Severance also includes under or over accruals from the prior year. For example, the current year severance amount for RNs, Reg. Psych. Nurses, and Grad Nurses includes the effect of an over accrual in the prior year for a voluntary exit program. The prior year accrual was based on 488 individuals but during the current year only 362 individuals received a severance payment.

f. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits.

g. Incumbents are provided with an automobile. Dollar amounts are not included in other non-cash benefits.

h. Incumbent had been provided an automobile for which dollar amounts were not included in other non-cash benefits. Effective March 11, 2011, incumbent is provided an automobile allowance. Dollar amounts are included in other cash benefits.

i. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary, honorarium and market supplements; all amounts have been included in base salary.

j. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

Appointments and Departures

k. Position held by incumbent until November 24, 2010. The incumbent received the salary and other accrued entitlements to the date of departure of December 2, 2010 and other variable pay to November 24, 2010. The reported severance includes 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of all other benefits, both in accordance with the incumbent's contract. In addition to the reported severance, the incumbent's contract also allows a relocation expense to be paid not to exceed $20,000. The severance will be paid when the incumbent signs the release. Incumbent's share of other cash benefits included an amount for the maximum contribution to a registered retirement savings plan. The incumbent did not complete five full years of employment and therefore is not entitled to any paid sabbatical leave.

l. Incumbent held the position of Executive Vice President, Quality and Service Improvement until November 24, 2010 at which time the incumbent was appointed to Acting President and Chief Executive Officer. There was no additional compensation for the Acting President and Chief Executive Officer position. Compensation has been allocated to each position based on the time held in each position during the year except that other variable pay has been allocated to each position based on the performance review relating to each position.

m. Incumbent appointed to position effective June 28, 2010.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

n. Position held by incumbent until June 28, 2010.

o. Incumbent held the position of Executive Vice President and Chief Medical Officer until December 2, 2010 at which time the incumbent was appointed to Executive Vice President and Acting Executive Lead for Quality and Service Improvement. There was no additional compensation for the Executive Vice President and Acting Executive Lead for Quality and Service Improvement position. Compensation has been allocated to each position based on the time held in each position during the year except that other variable pay has been allocated to each position based on the performance review relating to each position.

p. Incumbent appointed to position effective December 2, 2010.

Termination Liabilities

q. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay for a maximum 18 months base salary[(i)] and premium payments at the rate in effect at the date of termination. The incumbent will also receive the incentive bonus for the prior two years divided by 24 months multiplied by a maximum of 18 months, and up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

r. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. This severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

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 the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. Such severance will be paid in 12 equal monthly installments. The incumbent will also be paid 15% of the severance in lieu of all other benefits. Upon obtaining alternate employment, the incumbent is only entitled to receive one-half of the unpaid severance at that time.

u. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary[(j)] and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

v. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 24 months base salary at the rate in effect at the date of termination. The incumbent will also be paid an amount equal to 24 months of AHS's cost of benefits.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

w. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a severance package equivalent to 12 months salary and benefits plus one additional month per year of service provided to a maximum of 24 months.

x. SPP and SERP

For those who departed within the 2010-2011 fiscal period that are direct reports of the Board or the President and Chief Executive Officer, there were no benefits to be received based on the provisions of the SPP or SERP.

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2011

	Original Financial Plan (Note 3)	Additional Reclassifications	Reported Budget
Revenue			
Alberta Health and Wellness contributions			
Unrestricted ongoing	$ 9,038,000	$ (689)	$ 9,037,311
Unrestricted deficit funding	527,000	235	527,235
Restricted	745,000	(9,320)	735,680
Other government contributions	81,000	16,972	97,972
Fees and charges	598,000	13,980	611,980
Ancillary operations	123,000	(10,596)	112,404
Donations	20,000	9,646	29,646
Investment and other income	257,000	31,730	288,730
Amortization of external capital contributions	371,000	(671)	370,329
TOTAL REVENUE	11,760,000	51,287	11,811,287
Expenses			
Inpatient acute nursing services	2,681,000	(16,437)	2,664,563
Emergency and outpatient services	1,231,000	34,973	1,265,973
Facility-based continuing care services	871,000	(18,392)	852,608
Ambulance services	353,000	11,395	364,395
Community-based care	747,000	21,382	768,382
Home care	411,000	(6,946)	404,054
Diagnostic and therapeutic services	1,907,000	2,167	1,909,167
Promotion, prevention and protection services	353,000	(56,875)	296,125
Research and education	219,000	(4,341)	214,659
Administration	397,000	(22,274)	374,726
Information technology	344,000	41,315	385,315
Support services	1,414,000	64,968	1,478,968
Amortization of facilities and improvements	202,000	352	202,352
TOTAL EXPENSES	11,130,000	51,287	11,181,287
Operating surplus of revenue over expenses	$ 630,000	$ -	$ 630,000

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2011 (CONTINUED)

	Original Financial Plan (Note 3)	Additional Reclassifications	Reported Budget
Expenses by object			
Salaries and benefits	$ 5,721,000	$ 82,536	$ 5,803,536
Contracts with health service providers	2,027,000	(76,966)	1,950,034
Contracts under the Heath Care Protective Act	24,000	(3,343)	20,657
Drugs and gases	349,000	34,726	383,726
Medical and surgical supplies	340,000	(25,887)	314,113
Other contracted services	1,187,000	(21,732)	1,165,268
Other	1,003,000	61,953	1,064,953
Amortization			
Internally funded equipment	33,000	-	33,000
Internally funded information systems	49,000	-	49,000
Internally funded facilities and improvements	26,000	-	26,000
Externally funded equipment	135,000	-	135,000
Externally funded information systems	50,000	-	50,000
Externally funded facilities and improvements	185,000	-	185,000
Loss on disposal of capital assets	1,000	-	1,000
Write down of capital assets	-	-	-
TOTAL EXPENSES BY OBJECT	$ 11,130,000	$ 51,287	$ 11,181,287

Financial Information

Health Quality Council of Alberta

Financial Statements

March 31, 201**1**

HEALTH QUALITY COUNCIL OF ALBERTA

FINANCIAL STATEMENTS

MARCH 31, 2011

HEALTH QUALITY COUNCIL OF ALBERTA

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2011

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 Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts that are based on estimates and judgment.

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 members carry out their responsibility for the financial statements through the Audit and Finance Committee. This 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 for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance 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]

Chief Executive Officer
Dr. John Cowell
June 8, 2011

[Original signed by]

Executive Director
Charlene McBrien-Morrison
June 8, 2011

AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Members of the Health Quality Council of Alberta and the Minister of Health and Wellness

Report on the Financial Statements

I have audited the accompanying financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2011, and the statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2011, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher]

Auditor General

June 8, 2011

Edmonton, Alberta

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF FINANCIAL POSITION
As at March 31, 2011
(in thousands)

	2011 Actual	2010 Actual
ASSETS		
Cash and cash equivalents	$ 1,463	$ 1,703
Accounts receivable	38	48
Contributions receivable from Alberta Health and Wellness	1,000	-
Prepaid expenses	5	4
Capital assets	61	33
TOTAL ASSETS	$ 2,567	$ 1,788
LIABILITIES AND NET ASSETS		
Liabilities		
Accounts payable and accrued liabilities (Note 5)	$ 575	$ 228
Accrued vacation pay	107	106
Deferred contributions (Note 3)	1,000	808
	1,682	1,142
Net assets		
Accumulated surplus	824	613
Investment in capital assets	61	33
TOTAL NET ASSETS	885	646
TOTAL LIABILITIES AND NET ASSETS	$ 2,567	$ 1,788

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF OPERATIONS
Year ended March 31, 2011
(in thousands)

	2011 Budget	2011 Actual	2010 Actual
REVENUE			
Alberta Health and Wellness - global funding	$ 3,623	$ 4,431	$ 4,026
Alberta Health and Wellness -restricted funding	-	207	-
Investment and other income	6	39	172
TOTAL REVENUE	3,629	4,677	4,198
EXPENSES (Schedule 1)			
Administration	$ 3,969	$ 4,338	$ 3,920
Information technology	136	100	148
TOTAL EXPENSES	4,105	4,438	4,068
Excess (deficiency) of revenue over expenses	$ (476)	$ 239	$ 130

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CHANGES IN NET ASSETS
Year ended March 31, 2011
(in thousands)

	2011			2010
	Accumulated surplus/(deficit) (Note 8)	Investment in capital assets	Total	Total
Balance at beginning of year	$ 613	$ 33	$ 646	$ 516
Excess (deficiency) of revenue over expense	239	-	239	130
Capital assets purchased with internal funds	(63)	63	-	-
Amortization of internally funded capital assets	35	(35)	-	-
Balance at end of year	$ 824	$ 61	$ 885	$ 646

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CASH FLOWS
Year ended March 31, 2011
(in thousands)

	2011		2010
	Budget	Actual	Actual
Cash generated from (used by):			
Operating Activities:			
Excess (deficiency) of revenue over expenses	$ (476)	$ 239	$ 130
Non-cash transactions:			
Amortization	35	35	68
Changes in non-cash working capital account	(217)	(451)	(119)
Cash generated from (used by) operating activities:	(658)	(177)	$79
Cash used by investing activities	(35)	(63)	(25)
Cash generated from financing activities	-	-	-
Increase (decrease) in cash and cash equivalents	(693)	(240)	54
Cash and cash equivalents, beginning of year	1,957	1,703	1,649
Total cash and cash equivalents, end of year	$ 1,264	$ 1,463	$ 1,703

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
March 31, 2011
(in thousands)

Note 1 Authority, Purpose and Operations

The Health Quality Council of Alberta (HQCA) was established July 1, 2006 under the Alberta Regional Health Authorities Act. HQCA is considered not-for-profit under the Income Tax Act and exempt from payment of income tax.

HQCA is engaged in promoting and improving patient safety and health service quality across Alberta.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

(1) The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of Alberta Health and Wellness' Financial Directive HQCA 1.

(2) These financial statements use the deferral method of revenue recognition.

(b) Financial Instruments

HQCA has classified its financial assets and financial liabilities as held-for-trading. Financial assets and liabilities classified as held-for-trading are measured at fair value with changes in their value (unrealized gains or losses) recorded in "net income" in the Statement of Operations. Unrealized gains or losses from changes in fair value or realized gains or losses on disposal are accounted for as investment income. Any interest earned (or incurred) is recognized on an accrual basis as interest income (or expense).

(c) Employee Future Benefits

HQCA participates in the Local Authorities Pension Plan. This multi-employer defined benefit pension plan provides pensions for participating employees based on years of service and earnings. Defined contribution plan accounting is applied where HQCA has insufficient information to apply defined benefit plan accounting.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Pension costs comprise the employer's contributions during the year, based on rates expected to provide benefits payable under the pension plans. The HQCA does not record its portion of the plan's deficit or surplus.

(d) Capital Assets

Capital assets are recorded at cost. Capital assets with unit costs less than five thousand dollars are expensed. Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Computer Equipment	2 years
Office Equipment	3 years

Leasehold improvements are amortized over the life of the lease.

(e) Measurement Uncertainty

The financial statements, by their nature, contain estimates and are subject to measurement uncertainty. The amounts recorded for amortization of capital assets are based on estimates of the useful life of the related assets. Actual results could differ from estimates.

Note 3 Deferred Contributions

The balance at the end of the year is restricted for the following purposes:

	2011	2010
Current		
Ministerial Review	$ 1,000	$ -
	1,000	-
Non-current		
Research on Quality and Safety	$ -	$ 283
Medication Management	-	525
Total	$ 1,000	$ 808

Note 4 Pension Expense

Pension expense recorded in the financial statements is equivalent to HQCA's annual contribution payable of $132 for the year ended March 31, 2011 (2010: $131.)

At December 31, 2010, the Local Authorities Pension Plan reported a deficit of $4,635,250 (2009 deficit of $3,998,614).

Note 5 Accounts payable and Accrued Liabilities

The HQCA has accrued a potential liability of $52 in relation to operating and realty tax expense for the lease of the Calgary office. This liability is dependent on the landlord providing audited statements of operating costs. The HQCA is currently waiting to receive the 2010 audited statement for verification.

Note 6 Commitments and Contingencies

The HQCA is committed to contract payments in future years as follows:

2011/2012	$ 783
2012/2013	782
2013/2014	513
2014/2015	257
2015/2016	257
2016/2017	65
	$2,657

An "Assignment of Partial Leasehold Interest" agreement was put into place for April 1, 2007 to June 30, 2011 for office space in Calgary. This commits the HQCA to annual rent in the amount of $132 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease, of approximately $118 annually.

A lease agreement is in place for July 1, 2011 to June 30, 2016 for office space in Calgary. This commits the HQCA to annual rent in the amount of $137 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease, of approximately $120 annually.

The HQCA signed a 5 year lease for office space in Edmonton with annual rent in the amount of $47 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease of approximately $27 annually.

The HQCA has a commitment with Dr. John W. Cowell Consulting Ltd. to receive executive oversight. The value of the commitment as at March 31, 2011 is $38 per month and extends until September 2013.

Note 7 Budget

The budget was approved by the HQCA on March 26, 2010, and submitted to the Minister of Health and Wellness.

Note 8 Accumulated Surplus

The accumulated surplus is comprised of amounts relating to the release to general operations of a previously restricted grant, hiring delays, unfilled positions, projects that were under budget, in addition to delayed project starts.

Note 9 Related Parties

(a) Province of Alberta and Alberta Health Services

The Minister of Health and Wellness appoints the members of the HQCA. The Council is economically dependent on the Ministry of Health and Wellness since the viability of its operations depends on contributions from the Ministry.

HQCA had the following transactions with Alberta Health Services recorded on the Statements of Operations and Financial Position:

	2011				2010			
	Revenue	Expense	Receivable	Payable	Revenue	Expense	Receivable	Payable
	11	12	1	12	164	-	38	-
Total	$ 11	$ 12	$ 1	$ 12	$ 164	$ -	$ 38	$ -

Note 10 Corresponding Figures

Certain corresponding 2010 figures have been reclassified to match their 2011 presentation.

Note 11 Approval of Financial Statements

These financial statements were approved by the HQCA Council.

Schedule 1

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE OF EXPENSES BY OBJECT
Year ended March 31, 2011
(in thousands)

	2011 Budget	2011 Actual	2010 Actual
Salaries and Benefits (Schedule 2)	$ 2,199	$ 2,337	$ 2,237
Other *	1,871	2,066	1,763
Amortization:			
Capital equipment - internally funded	35	35	68
	$ 4,105	$ 4,438	$ 4,068
*Other:			
Office, General supplies, miscellaneous	$ 596	$ 454	$ 460
Referred Out Services	758	1,092	696
Lease, Fees and Minor Equipment	366	317	386
Information Technology	136	100	148
Grants	15	103	73
	$ 1,871	$ 2,066	$ 1,763

Schedule 2

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE OF SALARIES AND BENEFITS
Year ended March 31, 2011
(in thousands)

	2011								2010	
	Number of FTEs [1]	Base Salary [2]	Other Cash Benefits [3]	Other Non-Cash Benefits [4]	Sub Total	Number of FTEs	Severance [5]	Total	Number of FTEs [1]	Total
Chair										
L.Tyrrell	-	-	$ 20	-	$ 20	-	-	$ 20	-	$ 20
Members										
B. Laing	-	-	2	-	2	-	-	2	-	6
M.Lee	-	-	2	-	2	-	-	2	-	5
A. Fuchs	-	-	1	-	1	-	-	1	-	-
L.Steinmann	-	-	4	-	4	-	-	4	-	7
D.Tupper	-	-	14	-	14	-	-	14	-	13
A. Lam	-	-	2	-	2	-	-	2	-	-
P.Pelton	-	-	14	-	14	-	-	14	-	6
D.Schopflocher	-	-	2	-	2	-	-	2	-	2
C.Skappak	-	-	3	-	3	-	-	3	-	4
J.Birdsell	-	-	3	-	3	-	-	3	-	3
Sub-total	-	-	67	-	67	-	-	67	-	66
Staff										
Chief Executive Officer [6]	1.0	450	35	-	485	-	-	485	1.0	482
CEO Direct Reports (by position)										
Management reporting to CEO										
Executive Director	1.0	138	14	26	178	-	-	178	1.0	174
Patient Safety Lead	0.7	111	8	3	122	-	-	122	1.0	149
Controller	-	-	-	-	-	-	-	-	0.3	62
Other management	7.6	824	36	146	1006	1.0	30	1,036	6.2	816
Other staff	6.0	356	22	71	449	-	-	449	7.0	488
Sub Total	16.3	1,879	115	246	2,240	1.0	30	2,270	16.5	2,171
Grand Total	16.3	$ 1,879	$ 182	$ 246	$ 2,307	1.0	$ 30	$ 2,337	16.5	$ 2,237

HEALTH QUALITY COUNCIL OF ALBERTA
SCHEDULE OF SALARIES AND BENEFITS
Year ended March 31, 2011

(1) Full Time Equivalent (FTE) is determined at the rate of 2,022.75 annual hours for each full-time employee. Total actual discrete number of individuals employed: 20 (2010: 21). "Discrete" number of individuals refers to all employees who were in the system during the fiscal year.

(2) Base salary includes pensionable base pay.

(3) Other cash benefits include bonuses, overtime, lump sum payments and honoraria.

(4) Other non-cash benefits include:

a. Share of all employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans, professional membership and tuition and:

b. Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay, financial planning services, retirement planning services, concessionary loans, travel allowances, car allowances and club memberships.

(5) Severance includes direct or indirect payments to individuals upon termination, which are not included in other benefits.

(6) HQCA's CEO is retained through a 7 year executive oversight contract, which holds HQCA harmless of any related overtime, benefits or supplementary retirement.

Ministry Contacts

For further information regarding the contents of this annual report, please contact:

Position	Name	Phone Number
Minister of Health and Wellness	Gene Zwozdesky	780.427.3665 Fax: 780.415.0961
Deputy Minister of Health and Wellness	Jay Ramotar	780.422.0747 Fax: 780.427.1016
Community and Population Health Assistant Deputy Minister	Margaret King	780.415.2783 Fax: 780.422.3671
Corporate Support Assistant Deputy Minister	Martin Chamberlain	780.422.1045 Fax: 780.422.3674
Financial Accountability Assistant Deputy Minister	David Breakwell	780.415.1599 Fax: 780.422.3672
Health Policy and Service Standards Assistant Deputy Minister	Susan Williams	780.644.3086 Fax: 780.415-0570
Health Information Technology and Systems Assistant Deputy Minister and Chief Information Officer	Mark Brisson	780.427.1572 Fax: 780.422.5176
Health Workforce Assistant Deputy Minister	Glenn Monteith	780.415.2745 Fax: 780.415.8455
Chief Medical Officer of Health	Dr. André Corriveau	780.415.2809 Fax: 780.427.7683
Communications Director	Andy Weiler	780.427.5344 Fax: 780.427.1171
Human Resources Executive Director	Rick Brick	780.427.1060 Fax: 780.422.1700