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Section II

Section II of this report is published under a separate cover. It provides the financial statements of the regional health authorities and provincial health boards. To obtain financial statements of individual regional health authorities and provincial health boards, please contact the health authority directly.

PREFACE

Public Accounts 2004/2005

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, released June 29, 2005, contains the Minister of Finance's accountability statement, the consolidated financial statements of the Province and a comparison of the actual performance results to desired results set out in the government's business plan, including the *Measuring Up* report.

This annual report of the Ministry of Alberta 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 provincial agencies for which the minister is responsible, and**
- **other financial information as required by the *Financial Administration Act* and the *Government Accountability Act*, either as separate reports or as a part of the financial statements, to the extent the ministry has anything to report.**

Financial information relating to regional health authorities and provincial health boards is also included in this annual report as supplementary information. Section II of this report provides financial statements of the regional health authorities and provincial health boards, which are accountable to the minister of Alberta Health and Wellness.

Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2005, 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 September 12, 2005 with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[Original Signed]

Iris Evans
Minister of Health and Wellness
September 12, 2005

Message from the Minister

Albertans place great value on their health system. Significant steps have been taken to improve and strengthen the health system in Alberta over the past year. Regional health authorities, health-service providers, community-based partners and the ministry are working together to improve access, streamline services, implement new models of care and respond to the needs of Alberta's rapidly growing population.

In 2004/2005 the Alberta government announced the investment of $700 million in new funding to expand capacity and improve access. This was the largest single funding increase in the history of Alberta's health system. Half of this amount is intended to reduce waitlists and wait times. For example, the number of orthopaedic surgeries will be increased by 1,200 and the average wait time for certain heart surgeries will be reduced from nine to two weeks. In addition, new initiatives for protecting and promoting the health of Albertans are being launched.

In cooperation with Alberta Infrastructure the remaining $350 million was committed to a series of health facility capital projects. These projects include a capital program to develop new supportive living facilities for low- and moderate-income seniors in rural Alberta. These facilities allow seniors to live independently and have access to needed supports and health services in the community.

Our ultimate goal is for every Albertan to achieve and maintain optimum health throughout their life. Each of us needs to know what to do to stay healthy. We must be prepared to take responsibility for our health and make appropriate behavioural and lifestyle choices.

To give Albertans the information they need, we launched a series of public awareness campaigns throughout the year. The Keep Your Body in Check campaign educated Albertans about how to reduce their risk of developing type 2 diabetes. The Fight the Bite campaign reminded Albertans about the serious consequences of West Nile virus and the simple steps that can be taken to protect against this disease.

While many good things have been accomplished, important challenges still lie ahead. The cost of health care continues to rise, especially the cost of drugs and new technologies. In September 2004, the first ministers of federal, provincial and territorial governments agreed on the fundamental principles of a national pharmaceutical strategy. Alberta is proud to provide leadership on issues surrounding drug approvals and strategies to help develop a national framework for expensive drugs for rare diseases.

Alberta's future depends on doing all we can to protect and promote the health of our children and youth. A broad community approach is needed to address their health issues. Addictions affect all Albertans and are a growing problem in our society, particularly in young people. Provincial adolescent treatment services will be enhanced, but dealing with this problem will require the combined efforts of all sectors of society.

The mental health of Albertans is another high priority area. One in five Canadians is affected by mental illness during their lifetime. The overall prevalence of mental illness in Canadian children and adolescents at any given point in time is about 15 per cent. Mental illness can significantly affect individuals, their families, workplaces and the health care system. During this past year, advances were made in integrating mental health services. Plans for further improvements in children's mental health services are anticipated in the months ahead.

Alberta's growing Aboriginal population faces many health challenges particularly as a result of high rates of diabetes and other chronic diseases. Delivery of health services to remote or isolated Aboriginal communities is a challenge as is the provision of culturally appropriate services within the health care system. Strategies to improve Aboriginal health in collaboration with Aboriginal leaders, health authorities, service providers and provincial and federal governments have been initiated.

Looking ahead to next year and beyond, there are a number of areas in which Alberta will continue to demonstrate leadership within Canada. The Alberta Electronic Health Record system will be further extended to include other points of contact within the health system. At the same time, strong safeguards will be in place to protect the privacy of health information. Alberta will continue to allocate resources to the development of primary care initiatives in local communities. The goal is to provide every Albertan with access to well integrated, multi-disciplinary primary care. As a government, we will follow through on our commitment to implement and enforce new standards for continuing care facilities and services.

There is no single solution to the challenges in our health care system. Instead it is important to move ahead with literally hundreds of ideas and improvements – improvements that meet patient needs, and make a positive difference in the health of Albertans.

[Original Signed]

Iris Evans
Minister of Health and Wellness

Management's Responsibility for Reporting

The ministry of Alberta Health and Wellness includes the Department of Health and Wellness and the Alberta Alcohol and Drug Abuse Commission.

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 government's stated accounting policies.

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, Treasury Board, the Minister of Alberta Finance and the Minister of Alberta Health and Wellness any 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.

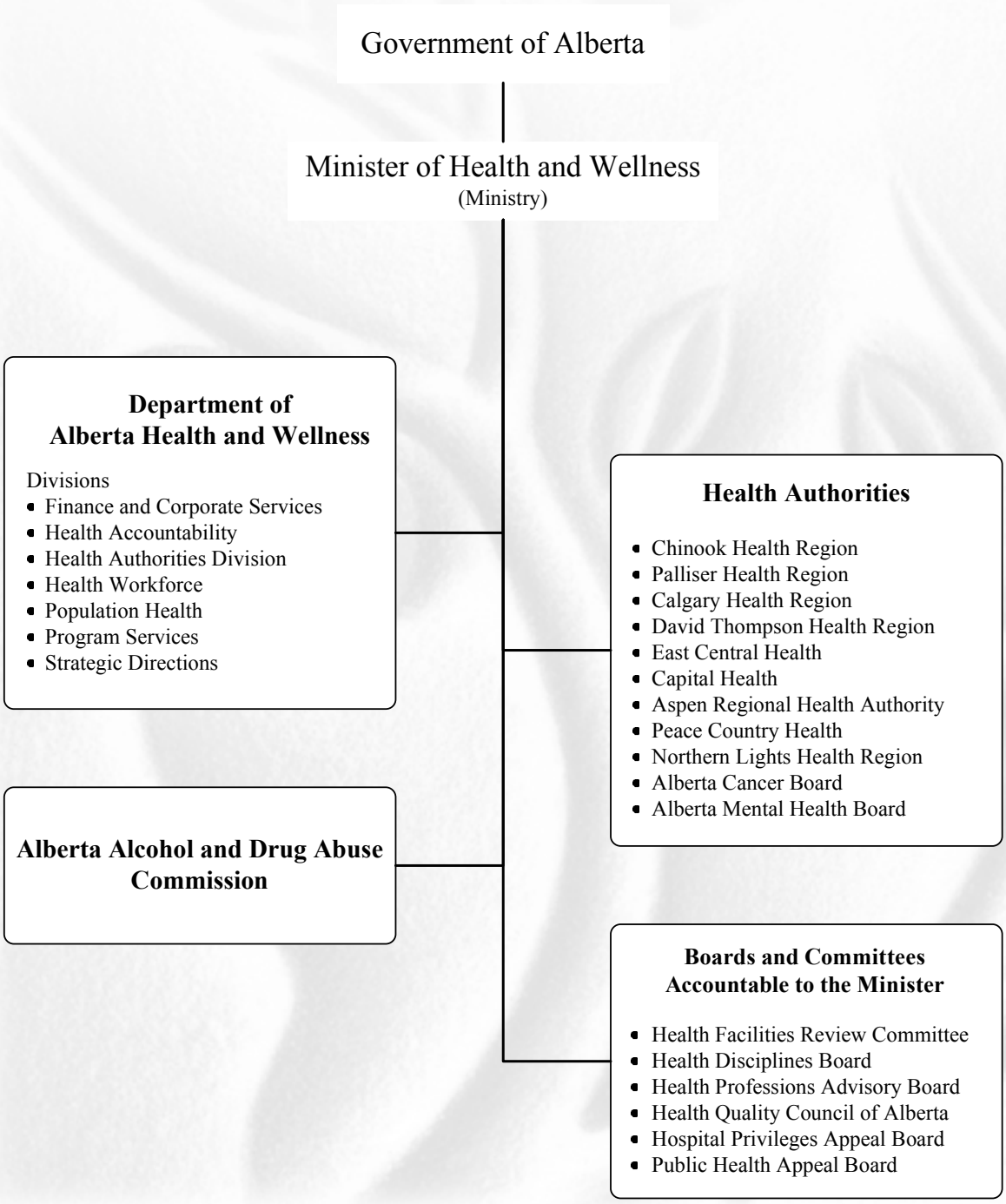
[Original Signed]

Paddy Meade
Deputy Minister
Alberta Health and Wellness
September 12, 2005

OVERVIEW

Ministry of Health and Wellness Organization

(For the year ended March 31, 2005)



Vision, Mission and Core Businesses

Vision

The Government of Alberta's vision for Alberta is:

> *A vibrant and prosperous province where Albertans enjoy a superior quality of life and are confident about the future for themselves and their children.*

That vision is supported by Alberta Health and Wellness' vision:

> *Healthy and well Albertans.*

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 and Core Businesses

The mission of the ministry as set out in the 2004-2007 business plan is:

> *To provide leadership and work collaboratively with partners to assure the delivery of quality, affordable health services and wellness programs to help Albertans be healthy.*

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

Core Business 1: Encourage and support healthy living.

Goal 1 – Albertans choose healthier lifestyles.

Goal 2 – Albertans' health is protected.

Core Business 2: Ensure quality health services.

Goal 3 – Improved access to health services.

Goal 4 – Improved health service outcomes.

Core Business 3: Lead the health system.

Goal 5 – Health system sustainability.

Goal 6 – Ministry organizational excellence.

Highlights for 2004/2005

In 2004/2005 Alberta's health system was strengthened through a number of initiatives and new investments to improve performance and effectiveness. On June 30, 2004, the Alberta government announced that immediate action would be taken to address Alberta's urgent health priorities, while at the same time developing system capacity for the future. System capacity was increased in key service areas, including cardiac and orthopedic surgery, to reduce waitlists and wait times. It was also recognized that Alberta must continue to look for new and innovative ways of resourcing and delivering health services so as to improve quality and long term sustainability. The Alberta government reaffirmed its commitment to learning from the best health systems in the developed world and to explore a Third Way of developing Alberta's health system.

The following are highlights of the ministry's achievements in relation to each core business in its 2004 to 2007 business plan.

Core Business 1: Encourage and support healthy living.

Diabetes Prevention

The prevention, care and management of diabetes in a coordinated and comprehensive manner are the underlying objectives of the 10-year Alberta Diabetes Prevention Strategy which was developed in 2003 in collaboration with an extensive group of stakeholders, including the Canadian Diabetes Association (CDA). Alberta has made significant advances in its efforts to increase awareness of type 2 diabetes and the associated risk factors over the past year. The Mobile Diabetes Screening Initiative (MDSI) provides mobile screening for diabetes and related complications in Aboriginal, off-reserve and remote Alberta communities. MDSI is currently providing this mobile screening service to the eight Métis settlements and four other remote off reserve communities. The Keep Your Body in Check program was launched in cooperation with the Canadian Diabetes Association. The program focuses on type 2 diabetes prevention education in three communities and a province-wide radio and television awareness campaign.

Influenza Pandemic

It is impossible to predict the exact timing of the next influenza pandemic. Influenza experts from the World Health Organization and the Public Health Agency of Canada believe that an influenza pandemic is imminent. Alberta Health and Wellness procured an antiviral stockpile of 1.6 million doses (this total will be increased to 2.6 million in the coming year) and regional health authorities are working to synchronize their emergency plans to the Alberta Pandemic Influenza Contingency Plan (2002). Significant progress was also made on the development of an influenza self-care strategy. Self-care materials will provide information to the public on how to prevent the spread of influenza and to care for themselves and their families if they contract influenza. A province-wide influenza self-care program was identified as a critical health services measure to respond to a pandemic.

Immunization

Alberta's influenza immunization program was expanded to include infants between six and twenty-three months, as well as their caregivers and family members. A province-wide promotion of childhood immunization was carried out using information available on grocery store shelves. The hepatitis A vaccination program was also expanded. High risk groups can now receive the vaccination free of charge. Grade nine students are now provided with the acellular pertussis (whooping cough) vaccination. The expansion of these programs will assist in improved immunization coverage for high risk groups and will result in reduced disease transmission and greater disease protection.

Breast Cancer

In order to detect breast cancer at an early stage and to coordinate breast cancer screening across the province, a new breast cancer screening program operated by the Alberta Cancer Board was announced in October 2004. The new program will encourage women 50 to 69 years old to receive a mammogram every two years. The program will also track women who have been screened and issue reminder letters for follow-up screening appointments.

Core Business 2: Ensure quality health services.

Waitlist Reduction

Alberta continued to improve access to health services. An investment of $700 million in health services and facilities was announced on June 30, 2004. $350 million was provided to Alberta Health and Wellness and $350 million was provided to Alberta Infrastructure and Transportation. Alberta Health and Wellness' portion was aimed at increasing bed capacity, reducing wait times for surgery, improving care for mothers and their babies, and reducing preventable illness. New centralized orthopedic intake clinics were set up in Calgary, Red Deer and Edmonton to reduce waitlists for joint replacement surgery. The clinics will assess patients prior to surgery and assign them to surgeons. This will free up the time of orthopedic surgeons and allow them to provide 1,200 additional joint replacements. Improved co-ordination of care is the first step in developing access standards for orthopedic care. Also, under new access standards for cardiac surgery, some patients scheduled for coronary artery bypass grafting (open heart surgery) received intensive home care. This helps to reduce wait times by allowing patients to wait at home and freeing up hospital beds for additional surgeries. The additional funding was also used to reduce wait times for elective, outpatient MRI scans. An arthroplasty pilot will test a new care path, with the goal of improving access to surgery and patient care.

Comparable Health Indicators

Alberta's 2004 Report on Comparable Health Indicators is the second report released by the Alberta Government since the 2000 agreement by all Canadian health ministries to provide regular reports of health and health care system performance using comparable data. Common health indicators provide a standard way of comparing health status, health outcomes and quality of service. The 2004 report shows health indicator results required by the national accord under four key themes: improving access to health services, improving health care quality, keeping Albertans healthy and primary health care. Results show Albertans have slightly better self-reported health status compared with the Canadian average.

Waiting times for health services are close to the national average. Other report results include:

- Alberta has one of the lowest in-hospital mortality rates and hospital re-admission rates for patients following a heart attack.
- About 90 per cent of Albertans reported receiving service within three months for non-emergency surgery, a specialist visit or diagnostic tests.
- On average, more Albertans are physically active (55.6 per cent) than Canadians (51.7 per cent).
- Alberta households spend a lower percentage of household income on prescription drugs than most Canadians.
- Alberta has a higher rate of hospitalization for certain chronic conditions compared to the national average.
- The self-reported influenza immunization rate for Alberta seniors has increased from 59 per cent in 1996 to 64 per cent in 2003, slightly below the Canadian average.

Mental Health

Improved mental health care for Albertans was the motivation behind innovative funding for two new multi-disciplinary programs in Calgary. The Collaborative Mental Health Care project helps children six and under at risk of mental disorders. It offers early professional assessment, intervention and treatment to children and their families that can significantly alleviate and even eliminate possible long-term consequences of mental disorders. The multidisciplinary staff of two psychiatrists, a family physician and a team of nurses, social workers and psychologists treats approximately 200 children a year. The Prevention through Risk Identification, Management and Education (PRIME) clinic provides early identification and treatment for persons with schizophrenia. It serves adult patients at ultra-high risk for psychosis before their condition becomes serious. The multidisciplinary team, including three psychiatrists, a case manager, a registered nurse, a psychometrician, and a family therapist, handles approximately fifty patients per year and refers another fifty to other facilities.

A province-wide in-service training program for long term care staff who provide care to persons with Alzheimer's and other dementias was established. A total of 3000 frontline workers were trained through this program in 2004/2005. The program will help to improve the quality of care for this group of long term care residents.

Telehealth

Telehealth services are available at 261 sites in Alberta, up from 239 at the end of 2003/2004. Available telehealth services now include psychiatric counseling pediatric care, physiotherapy, clinical discharge planning, case conferencing, and family visitation. Alberta's Telehealth Program Coordination and Scheduling System coordinates the activities of most of those sites. Use of the system has been extended beyond Alberta's borders. It has been adopted for use at 17 sites in Nunavut as well as in areas of Saskatchewan and British Columbia. It is also used by Health Canada.

International Refugees

The Calgary Refugee Health Program was launched to provide a first point of contact for refugees with the health care system. This program will help give refugees a healthy start in their new country. A multidisciplinary team provides initial health assessments, systematic screenings, maternal care, and updated

vaccinations. They also provide education on topics such as the health system, nutrition and reproductive health.

Rural Health

Rural Alberta's shortage of physicians is the focus of two initiatives designed to attract more medical students and family physician residents to rural practice. The first, a joint initiative with Alberta Advanced Education, is a bursary program for ten new students per year under the Rural Physician Action Plan over six years. The plan requires recipients to commit to five years of rural practice once they have graduated. The second initiative is an expanded residency program under the Alberta Rural Family Medicine Network that will allow ten more medical residents to experience rural family practice each year.

Core Business 3: Lead the health system.

The Third Way

The Alberta government announced the start of a major health renewal initiative known as the "Third Way." The Third Way is not based on American style health care nor on adherence to the status quo. Rather, it is about keeping an open mind and learning from the best health systems in the developed world. It is about accepting innovative ideas and working towards a responsive, responsible delivery of health care services.

Alberta Electronic Health Record

Alberta's Electronic Health Record (Alberta EHR) project was further expanded. Key activities included the commencement of a provincial Client Registry project and a province-wide Diagnostic Imaging Information Management/Information Technology Strategy. Technology security standards were defined to allow other systems to integrate with the Alberta EHR. The Regional Shared Health Information Program was adopted by rural health regions. It allows them to link to the Alberta EHR. It also enables physicians, pharmacists, hospitals, home care and other providers across the province to share accurate and timely patient information in a secure environment.

Collaboration with Physicians and Health Regions

Our groundbreaking and collaborative agreement for physician services has led to the most positive government/physician group relationship in any Canadian jurisdiction and created a partnership that also includes the health regions as an equal partner. It supported or established several programs in 2004/2005 that led to better medical care for Albertans. One, the Physician Office System Program (POSP), has now automated the offices of 40 per cent of the physician offices. An important step in fully implementing the Alberta Electronic Health Record, POSP leads to improved patient care.

Albertan's Primary Care Initiave, created in the agreement, also began coming to fruition. This systematic approach to primary care renewal is the Canada's most advanced and comprehensive. Under the intiative, physicians and health regions can form networks that better manage patient care, guarantee their patients access to necessary services, and guarantee access to more Albertans. Three Primary Care Networks are about to become operational, and several others are close behind. Other types of innovative funding for physician services supported by the agreement include academic and non-academic alternate Relationship Plans. These funding plans, one of the country's most competitive fee schedules,

and our relationship have attracted 200 new physicians to the province annually, including many well-known medical specialists.

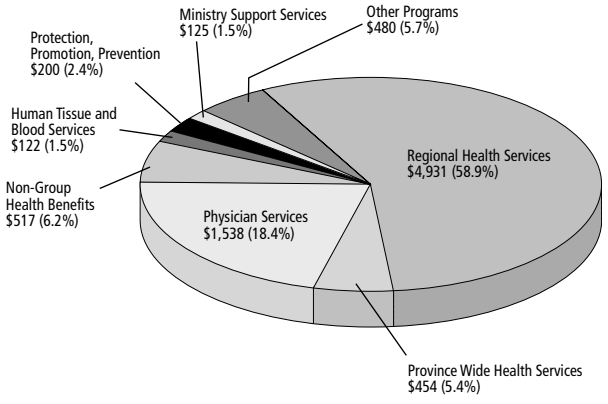
Financial Results

Helping Albertans stay healthy through improved access to quality health services continued to be a focus of the government in 2004/2005. During this period, the Ministry spent $8.4 billion.

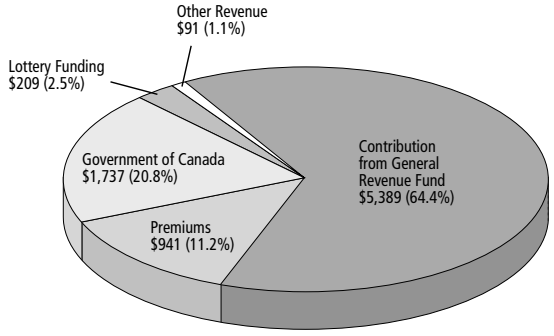
The $8.4 billion expense is an increase of $1 billion (13.6 per cent) over 2003/2004. The increased spending reflects:

- An additional $150 million for medical/ diagnostic equipment, $605 million to reduce wait times and address accumulated deficits of regional health authorities and to support the delivery of acute, continuing care, mental health and cancer services to Albertans as well as continued access to critical health services such as heart surgeries and kidney dialysis.
- Increased demand for physician services – $97 million.
- A reduced funding requirement for the Physician Office System Program ($57 million). This program forms part of the tri-lateral agreement among the Alberta Medical Association, regional health authorities and the department.
- Continued demand for non-group drug benefits, primarily by seniors – $51 million.
- Ongoing support to health renewal projects including electronic health records to allow health care practitioners to see and update health information and the continuing development of information services such as Health Link Alberta – $42 million.
- A continuing focus on Protection, Promotion and Prevention activities such as providing new treatment standards for osteoporosis, improving patient safety during childbirth, immunizing for Hepatitis A and influenza for children under two and programs to reduce barriers for diabetics in making healthy choices – $32 million.
- Increased demand on the health system for services such as air and ground ambulance, out of province health care, services provided by Allied Health practitioners such as chiropractors, optometrists and podiatrists and treatment services for alcohol, other drug and gambling problems – $64 million.
- Increases in Health Care Insurance Premium Revenue Write-Offs – $16 million.

How Funding was Spent ($ in Millions)



Source of Funding ($ in Millions)



Total – $8,367 Million

RESULTS ANALYSIS

The official version of this Report of the Auditor General, and the information the Report covers, is in printed form.

Report of the Auditor General on the Results of Applying Specified Auditing Procedures to Key Performance Measures

To the Members of the Legislative Assembly

In connection with the Ministry of Health and Wellness' key performance measures included in the *2004-2005 Annual Report of the Ministry of Health and Wellness,* I have:

1. Agreed information from an external organization to reports from the organization.

2. Agreed information from reports that originated from organizations included in the consolidated financial statements of the Ministry to source reports. In addition, I tested the procedures used to compile the underlying data into the source reports.

3. Checked that the presentation of results is consistent with the stated methodology.

4. Checked that the results presented are comparable to stated targets, and information presented in prior years.

5. Checked that the key performance measures, as well as targets, agree to and include results for all of the measures presented in Budget 2004.

As a result of applying the above procedures, I found no exceptions. These procedures, however, do not constitute an audit and therefore I express no opinion on the key performance measures included in the *2004-2005 Annual Report of the Ministry of Health and Wellness*.

[Original Signed by Fred J. Dunn, FCA]

FCA
Auditor General

Edmonton, Alberta
August 19, 2005

Ministry Role

The Ministry

In Canada the responsibility for health is primarily that of provincial governments as defined in the Canadian constitution. Provincial governments are responsible for the delivery of medical and hospital services to the majority of Canadians. The federal government is responsible for the provision and funding of health services on behalf of members of the Royal Canadian Mounted Police, the Canadian armed forces, and federal prisoners. The federal government also provides some health services to veterans and persons with status under the *Indian Act*.

Alberta's health care system is defined in provincial legislation and is governed by the Minister of Alberta Health and Wellness. The Ministry of Alberta Health and Wellness provides strategic direction and leadership to the provincial health system. This role includes developing the overall vision for the health system, defining provincial goals, objectives, standards and policies, encouraging innovation, setting priorities, and allocating resources. The ministry's role is to assure accountability and balance health service needs with fiscal responsibility. Alberta Health and Wellness also has the lead role in protecting and promoting public health and facilitates consistency and coordination of service delivery across regions. This role includes: 1) monitoring the health status of the population, 2) identifying and working toward reducing or eliminating risks posed by communicable diseases and food-borne, drug and environmental hazards, 3) providing appropriate information and early intervention services to prevent the onset of disease and injury and 4) promoting healthy choices and developing healthy and supportive environments.

The ministry administers the Alberta Health Care Insurance Plan in accordance with the *Canada Health Act*. The ministry registers eligible Alberta residents for coverage under the plan and compensates practitioners for the insured services they provide. Alberta Health and Wellness also provides funding to regional health authorities and provincial boards. They are responsible to the Minister for providing services in accordance with their legislated mandate. The role of regional health authorities and provincial boards includes assessing needs, setting priorities, allocating resources and monitoring performance for the continuous improvement of health service quality, effectiveness and accessibility.

The following six sections of this annual report are organized according to the six goals of the 2004-2007 ministry business plan. Specific information is provided about actions, key achievements, performance indicators and results, in relation to the planned strategies under each goal. The strategies are highlighted in bold print.

Goal 1 Albertans choose healthier lifestyles.

Early childhood development, education, employment, lifestyle choices, socio-economic environments and genetic make-up are among the many factors that determine the health of an individual and society. Albertans are encouraged to realize their full health potential through informed lifestyle choices. A healthy lifestyle greatly contributes to the quality and length of a person's life. The ministry, health authorities and health service providers play an important role in providing the information to Albertans so that they can make the best choices for their health.

What We Did

Provide health and lifestyle information to help people make healthy choices as encouraged by the Healthy U Campaign and the Framework for a Healthy Alberta.

Healthy U

- Two Healthy U crews of young Albertans toured Alberta sharing the Healthy U Choosewell message at community festivals through lively activities, contests and prizes. The Healthy U crews attended 23 events in 19 communities with 26,000 individual interactions with Albertans.
- The Community Choosewell Challenge, launched in September 2004, had 63 communities register for the challenge, showcasing new and existing programs for physical activity and healthy eating. The Challenge was completed in February 2005. Four overall winners and five high achieving communities were identified and will be planning recognition events. The four winning communities are: Grande Prairie, Fort MacKay, Vermillion and Medicine Hat. The five high achieving communities are: Brooks, Strathcona County, Vegreville, Andrew and Edgerton.
- Ten ministries, seven external organizations, and three other government agencies participated in the Healthy U @ work program. This initiative encouraged Alberta employers to adopt and promote healthy work place practices.
- Information on healthy eating, active living and affordable activity for children was provided for the English Express published by Alberta Advanced Education. Fifty-three thousand copies of English Express have been distributed; free of charge, to 1,500 subscribers including regional health authorities, libraries, English as a Second Language (ESL) programs, adult literacy programs, and daycares. In addition to the regular English Express print run, an additional 20,000 copies were printed for distribution to RHA nutritionists, health promotion professionals, daycares, and Family and Community Support Services (FCSS) offices.

Health Risk Management and Chronic Disease Prevention

- The Keep Your Body in Check program was launched in cooperation with the Canadian Diabetes Association. The program focuses on type 2 diabetes prevention education in three communities and a province-wide radio and television awareness campaign. This program has increased awareness about type 2 diabetes and has increased community capacity for diabetes education.

- Three new projects focusing on health risk management and/or prevention of chronic disease were launched in the fall of 2004.
  - The Alberta Perinatal Health Program (APHP) contracted with the Society of Obstetricians and Gynaecologists of Canada (SOGC) for the Managing Obstetrical Risk Efficiently (MORE) program. Alberta Health and Wellness provided a grant to Capital Health over a five-year period for training 1,500 nurses, physicians and midwives who provide obstetrical care in hospitals, to improve patient safety, promote a multidisciplinary patient safety culture and increase the quality of care. Ten training days were held in 2004/2005 with four health regions. 1,042 individuals were registered for training by March 2005. The program has been enthusiastically received, with participation by regions being much higher than expected; all health regions have made a commitment to participate over the next year. The APHP is also developing rural training strategies and an evaluation plan.
  - The osteoporosis project used a provincial framework to improve the diagnosis and management of osteoporosis. Participants include the Grace Osteoporosis Clinic in Calgary, the Osteoporosis Clinic of the Grey Nuns Hospital in Edmonton, Health Link Alberta and the Osteoporosis Society of Canada, Alberta Branch.
  - The Centre for Health Promotion Studies (CHPS) and the Canadian Diabetes Association collaborated on the Healthy Alberta Communities project. It focuses on the prevention of type 2 diabetes and other chronic disease through community development and community capacity building for chronic disease prevention.

Enable people to make appropriate use of the health system through counseling and information services such as Health Link Alberta.

- The telephone-based information service originally developed by Capital Health was extended province-wide and renamed Health Link Alberta. The total volume of calls from April 1, 2004 to March 31, 2005 was 921,954. In a November 2004 survey by the Health Quality Council of Alberta (HQCA) 64 per cent of Albertans indicated that they are aware of the Health Link Alberta service. Over three quarters (77 per cent) of Albertans who have used the service are satisfied with their experience, including 51 per cent who were very satisfied.

Collaborate with other ministries on initiatives to address the needs of children, youth, seniors, Aboriginal communities and Albertans with disabilities or who are disadvantaged.

- The Aboriginal Wellness initiatives are targeted at those health issues for which Aboriginal people have a higher rate of incidence or the issues that Aboriginals tend to allow to become acute or chronic before seeking medical attention (i.e., diabetes, HIV/AIDS, tuberculosis, tobacco and drug misuse). Many of the initiatives connect Aboriginal people with early interventions that can help them to avoid the unnecessary negative health consequences. A total of 55 new Aboriginal wellness initiatives were implemented. They include the following:
  - *Community-based primary health care:* Thirteen new primary health care initiatives implemented involved promotion of women's and children's health, prenatal nutrition, Aboriginal health career internships, Aboriginal

mental health, Aboriginal spiritual care, and use of an Elders' advisory group in health care delivery.

- *Mobile Diabetes Screening Initiative:* Mobile screening for the early detection of diabetes and related complications was initiated in five Métis settlements in 2003/2004. This year, screening for diabetes and related complications was expanded to seven additional off-reserve Aboriginal and remote communities.
- *Alberta Community HIV Fund:* Nine HIV related projects were directed toward Aboriginal people. These included HIV awareness and prevention, and HIV care and support initiatives.
- *Tobacco Reduction:* The Alberta Alcohol and Drug Abuse Commission (AADAC) supported 19 Aboriginal communities in developing tobacco prevention, reduction and cessation programs focusing on the sacred versus recreational use of tobacco.
- *Substance Abuse Awareness and Prevention:* AADAC supported a number of Aboriginal communities, organizations and service providers to develop and deliver substance abuse awareness and prevention programs, including cultural camps and education campaigns for Aboriginal youth.

• Alberta Health and Wellness contributed to many cross-ministry strategies under the Alberta Children and Youth Initiative (ACYI), including:

- *Aboriginal Youth Suicide Prevention Strategy:* Alberta Health and Wellness is the co-lead for the cross-ministry Aboriginal Youth Suicide Prevention Strategy (AYSPS). The Strategy takes a community development approach to address the issue of suicide prevention by enhancing family and social supports through community action plans focused on education and training. Three community pilot action plans were developed and are currently being implemented.
- *Student Health Initiatives:* Alberta Health and Wellness supported Alberta Education, Alberta Children's Services, Alberta Seniors and Community Development and Alberta Advanced Education in the review of speech-language services for children and youth in Alberta. The review is addressing issues related to the access to speech-language services and developing a strategic approach for action by government, authorities, professions and other stakeholders.
- *Policy Framework for Children and Youth with Special and Complex Needs:* Health regions implemented an integrated case management model, with some shared additional fiscal resources, to more effectively meet the needs of children and youth with complex needs.
- *Alberta Roundtable on Family Violence and Bullying:* Alberta Health and Wellness was a participating ministry in the Roundtable. A Framework for Action that identified key strategies for government and communities to achieve the vision of "an Alberta where children and families are free from family violence and bullying" was developed as a result of the Roundtable.
- *Alberta Fetal Alcohol Spectrum Disorder (FASD):* Alberta Health and Wellness contributed to the development of a provincial FASD strategic plan for government consideration in 2005/2006. Priorities were identified that pertain to Alberta Health and Wellness' focus on awareness and prevention and diagnosis and assessment.

Ensure that addiction information, prevention and treatment are available province-wide.

- *The Prevention of Youth Tobacco Use Amendment Act* received Royal Assent. The amendment expands the definition of public places where youth can be charged with possession or use of tobacco.
- Other achievements in this area are reported in the Alberta Alcohol and Drug Abuse Commission section of this report.

Key Performance Measures and Results

Measure 1.a

Self reported health status

Self-reported health status is a good indicator of the health and well being of Albertans. It is accepted nationally and internationally as a means of reporting on population health. How people rate their own health is affected by a variety of factors, including genetic factors, early childhood development, education, employment status, chronic disease, disability, temporary illness, mental health and the environment.

Self-reported health status was unchanged and slightly below target in 2005 for those 65 years old and over. For the 18 to 64 years category, self reported health status increased slightly in 2005 but was slightly below target. The self-reported health status of Albertans has been at or near the target values for most of the past five years.

Self reported health status "excellent, very good or good health"

	2000	2001	2002	2003	2004	2005	Target 2005
Age 18 – 64 Per cent reporting excellent, very good, or good health	90	89	88	90	88	89	90
Age 65+ Per cent reporting excellent, very good, or good health	79	72	78	80	78	78	80

Source: Public Survey about Health and the Health System in Alberta, for 2001 – 2005, conducted by the Population Research Laboratory, University of Alberta, for the Health Quality Council of Alberta (HQCA)

Data are collected through a telephone survey of 4,000 randomly selected Alberta households. The survey is commissioned by the HQCA (previously by Alberta Health and Wellness) and is conducted by the Population Research Laboratory at the University of Alberta; the response rate for the survey has ranged between 64 and 81 per cent in recent years. Results for the entire sample are accurate within two per cent 19 times out of 20.

Adult Albertans are asked: "In general, compared with other people your age, would you say your health is: excellent, very good, good, fair, or poor?" Sample size for the 18-64 group is about 3,500, and estimates are accurate within about two per cent 19 times out of 20. Sample size for the 65+ group is about 550 and these estimates are accurate within about four per cent 19 times out of 20.

MEASURE 1.B

Per cent of Albertans who smoke

The first decrease in this measure since 1994/1995 was reported in 2002/2003. The per cent of Albertans who smoke decreased from 28 per cent in 2000/2001 to 23 per cent in 2002/2003 this is two per cent below the target for 2004/2005 and is due in large part to the Alberta Tobacco Reduction Strategy (ATRS).

The ATRS aims to reduce disease, disability, and death related to tobacco use by Albertans. The ATRS is comprehensive and includes: increased taxation on tobacco products prevention and education programs, and legislation to prevent youth from smoking.

Tobacco use is one of a few risk factors linked to chronic diseases such as, obstructive lung disease and cancer. Chronic diseases represent the greatest drain on our health care resources. By supporting Albertans in making healthier choices we can move closer to the vision of healthy and well Albertans.

Per cent of Albertans who smoke

	1994/1995	1996/1997	1998/1999	2000/2001	2002/2003	Target 2004/2005
Per cent of Albertans age 12 and older who report being a current smoker (daily or occasional).	28	28	28	28	23	25*

Source: Statistics Canada: Canadian Community Health Survey (CCHS) (2000/2001, 2003), National Population Health Survey (1994/1995, 1996/1997, 1998/1999).
Approximate sample size for Alberta is 14,000 households, which provides a 95 per cent confidence interval of about 1 per cent above or below the reported result. Excluded from CCHS sampling framework were residents of institutions, full-time members of the Canadian armed forces, residents of Indian reserves and of Crown lands, and residents of a few remote areas. Results are adjusted for non-respondents.
* The 2004/2005 target was based on results from CCHS 2000/2001.

MEASURE 1.C

Per cent of Alberta youth (age 12-19) who smoke

Smoking among young people continues to be a serious health concern. Not only is tobacco a highly addictive substance, but its prolonged use can lead to serious health consequences in later life. Smoking rates among young Albertans (12 to 19 years) have fluctuated. The results for 2002/2003, the last full year of reporting are encouraging as the prevalence is below the 2006/2007 target of 15 per cent.

Tobacco prevention programs have been implemented in schools across the province including: Teaming Up For Tobacco Free Kids for children in grades 4 to 6 (implemented in over 175 schools), Building Leadership for Action in Schools Today (BLAST) for youth in grades 7 to 9 (conferences attended by over 200 youth), and the Kick the Nik smoking cessation program for youth aged 15 to 18 (over 200 facilitators trained to deliver the program).

Per cent of Alberta youth (age 12-19) who smoke

	1994/1995	1996/1997	1998/1999	2000/2001	2002/2003	Target 2006/2007
Per cent of Alberta youth (age 12-19) who reported being a current smoker (daily or occasional).	16	21	17	18	14	15*

Source: National Population Health Survey (1994/1995, 1996/1997, 1998/1999) Statistics Canada: Canadian Community Health Survey (CCHS) (2000/2001). Daily and occasional smoking combined for Albertans 12–19 years of age. The CCHS includes a sample of Albertans 12 years and older (n = 14, 456). The response rate at the national level is 84.7 per cent. Statistics Canada: Canadian Community Health Survey (CCHS) (2003). Daily and occasional smoking combined for Albertans 12–19 years of age. The CCHS includes a sample of Albertans 12 years and older (n = 13,871). The response rate at the national level is 80.6 per cent.
Excluded from CCHS sampling framework were residents of institutions, full-time members of the Canadian armed forces, residents of Indian reserves and of Crown lands, and residents of a few remote areas.
*The 2004/2005 target was based on results from CCHS 2000/2001.

MEASURE 1.D

Per cent of Albertans who are "active or moderately active"

The results show that, over the past decade, Albertans have become increasingly active in their leisure-time activities. Albertans who maintain an active lifestyle can improve their quality of life and long-term health outcomes. Physical activity can help protect an individual against heart disease, obesity, high blood pressure, diabetes, osteoporosis, stroke, depression, and certain kinds of cancers. Survey results for 2002/2003 show that 56 per cent of Albertans report being active or moderately active. This exceeds the 2004/2005 target of 55 per cent.

Healthy U is a program designed to encourage Albertans to choose well, that is to make better daily decisions about healthy eating and physical activity. The healthyalberta.com website, Healthy U© work and the Community Choosewell Challenge are working to improve the health of Albertans.

Per cent of Albertans who are "active or moderately active"

	1994/1995	1996/1997	1998/1999	2000/2001	2002/2003	Target 2004/2005
Per cent of Albertans who report that they are "active or moderately active"	47	50	53	52	56	55

Source: Statistics Canada: Canadian Community Health Survey (CCHS) (2000/2001, 2003), National Population Health Survey (1994/1995, 1996/1997, 1998/1999).
Approximate sample size for Alberta is 14,000 households, which provides a 95 per cent confidence interval of about one per cent above or below the reported result. Excluded from CCHS sampling framework were residents of institutions, full-time members of the Canadian armed forces, residents of Indian reserves and of Crown lands, and residents of a few remote areas. Results are adjusted for non-respondents.
Albertans age 12 and older who reported their level of physical activity, based on their responses to questions about the frequency, duration and intensity of their participation in leisure-time physical activity.
Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over the past 3 months. For each leisure time physical activity engaged in by the respondent, average daily energy expenditure is calculated by multiplying the number of times the activity was performed by the average duration of the activity by the energy cost (kilocalories per kilogram of body weight per hour) of the activity. The index is calculated as the sum of the average daily energy expenditures of all activities.
Respondents are classified as follows: 3.0 kcal/kg/day or more = physically active; 1.5 – 2.9 kcal/kg/day = moderately active; less than 1.5 kcal per day = inactive.

MEASURE 1.E

Per cent of Albertans with "acceptable" body mass index

The results show that less than half of Albertans have an "acceptable" body mass index (BMI). There has been no sign of change in recent years due in part to the short time frame since the introduction of the Healthy U initiative in 2003. There are four categories of BMI ranges in the Canadian weight classification system. These are: underweight (BMIs less than 18.5); normal weight (BMIs 18.5 to 24.9); overweight (BMIs 25 to 29.9), and obese (BMI 30 and over). Most adults with a high BMI (overweight or obese) have a high percentage of body fat. Extra body fat is associated with increased risk of health problems such as diabetes, heart disease, high blood pressure, gallbladder disease and some forms of cancer.

Per cent of Albertans with "acceptable" body mass index

	1994/1995	1996/1997	1998/1999	2000/2001	2002/2003	Target 2004/2005
Per cent of Albertans whose body mass index (BMI) is in the range of 18.5-24.9	50	49	46	49	47	50

Source: Satistics Canada: Canadian Community Health Survey (CCHS) (2000/2001, 2003), National Population Health Survey (1994/1995, 1996/1997, 1998/1999).
Approximate sample size for Alberta is 14,000 households, which provides a 95 per cent confidence interval of about 1 per cent above or below the reported result. Excluded from CCHS sampling framework were residents of institutions, full-time members of the Canadian armed forces, residents of Indian reserves and of Crown lands, and residents of a few remote areas. Results are adjusted for non-respondents. The index excludes pregnant women and persons less than 3 feet (0.914 meters) tall or greater than 6 feet 11 inches (2.108 meters). Albertans age 18 and older who reported Body Mass Index (BMI), based on their responses to questions about their height and weight. "Acceptable" BMI includes respondents with a normal weight (BMI 18.5-24.9).
BMI is calculated as follows: weight in kilograms divided by height in meters squared. The index is: under 18.5 (underweight); 18.5-24.9 (normal weight); 25.0-29.9 (overweight); 30.0-34.9 (obese-Class I); 35.0-39.9 (obese-Class II); 40 or greater (obese – Class III).

MEASURE 1.F

Per cent of Alberta women who consumed alcohol during pregnancy

The results show that the number of pregnant women who consume alcohol is declining. Consuming alcohol during pregnancy can result in fetal alcohol spectrum disorder. A baby born with fetal alcohol spectrum disorder can have serious handicaps and therefore could require a lifetime of special care. Alberta's goal is to have zero per cent of women consume alcohol during pregnancy by 2012.

Prevention and awareness campaigns "Your Decision, Baby's Future", about the dangers of drinking alcohol while pregnant, and "Alcohol and Pregnancy Don't Mix", targeted to youth 12 – 17 years old, aim to help Alberta meet the target for limiting alcohol use during pregnancy.

Per cent of Alberta women who consumed alcohol during pregnancy

	1998	1999	2000	2001	2002	Target 2004	Target 2012
Per cent of Alberta women reporting that they consumed alcohol during pregnancy	4.4	4.3	4.0	3.9	4.0	2.5	0

Source: Alberta Vital Statistics, Notice of a live or a stilbirth (n=36, 723)
Includes Albertan women who gave birth and reported they consumed alcohol during pregnancy.
Data excludes non-Albertan residents and is adjusted for non-respondents. There is a delay in obtaining 2003 data due to changes in the collection process.

Goal 2 Albertans' health is protected.

As public health issues such as avian influenza gain attention worldwide, Albertans need to know that their health system is ready and able to protect their health. Alberta Health and Wellness, in collaboration with health authorities and other partners, continues to protect Albertans from disease and injury.

What We Did

Protect Albertans against communicable diseases by strengthening the health system's capacity to respond to public health issues and risks, including immunization and implementation of Alberta's pandemic influenza response plan as necessary.

- Continued implementation of the Alberta pandemic influenza plan including development of a self care strategy, refinement of the command and control processes, and acquisition of 1.6 million doses of antiviral medication. This total will be increased to 2.6 million in the upcoming year.
- Alberta's immunization program for the prevention of communicable diseases was strengthened. The influenza immunization program was expanded to include infants between six and twenty-three months as well as their caregivers and family members. A province-wide promotion of childhood immunization through information available on grocery store shelves that Albertans could take home and read was carried out. The hepatitis A vaccination program was also expanded. High risk groups can now receive the vaccination free of charge. Grade nine students are now provided with the acellular pertussis (whooping cough) vaccination. The expansion of these programs will assist in improved immunization coverage for high risk groups and will result in reduced disease transmission and greater disease protection.
- Alberta updated its response plan to minimize the risk of West Nile virus in the province. Four provincial departments collaborated on a comprehensive bird and mosquito surveillance program. Increased funding was provided for municipal mosquito control programs and the Fight the Bite public information campaign was launched. The campaign provided information about how to avoid mosquito bites and reduce mosquito breeding sites. A baseline survey of the prevalence of infection by West Nile virus in the entire adult population was completed after the 2003 mosquito season. Preliminary results indicate a prevalence rate of 4.6 per cent in rural parts of the Palliser Health Region, 0.8 per cent in Medicine Hat and 0.3 per cent in the province as a whole.
- The Communicable Disease Emergency Response Plan, including a Smallpox Emergency Response Plan, was developed. The Communicable Disease Emergency Response Plan (CDERP) is an overarching emergency action plan to address large infectious disease outbreaks from naturally occurring diseases or from bioterrorism events using viruses such as smallpox. The emergency response plan supports the health system's ability to cope with large numbers of infected people. The goal is to reduce morbidity, mortality and the societal impact of a communicable disease emergency.

Protect Albertans from environmental health risks through education, environmental monitoring, regulatory compliance and enforcement in partnership with other ministries.

- Alberta Health and Wellness participated on an interdepartmental committee with Alberta Environment to review the Environmental Impact Assessments by such development proponents as: 1) BA Energy – Heartland Upgrader, 2) Birch Mountain Resources, 3) Deer Creek Energy, 4) Devon Canada Corporation, 5) Glacier Power, 6) Husky Energy, 7) Suncor Energy South Tailings Pond, and 8) Suncor Voyageur. Alberta Health and Wellness' role in the review process is to provide health expertise to the Government regarding the applications. Regional health authorities provide the ministry team with a local perspective. The reviews, by the interdepartmental committee, identify health risks associated with industrial development. Appropriate risk management initiatives are recommended to minimize the identified risks. The review of these Environmental Impact Assessments provides the Alberta Energy and Utilities Board with the information needed to determine whether public health and safety concerns have been appropriately addressed in each of the development proposals.

Collaborate with other ministries to ensure safe and secure drinking water for Albertans.

- In collaboration with Alberta Environment, Alberta Health and Wellness contributed to key components of the Water for Life strategy. A new 24/7 emergency response protocol has been developed for addressing outbreaks of water borne diseases in public drinking water supplies. A new environmental public health reference manual for use by operators of private, public and communal drinking water systems was completed.

Reduce suicide and the risk of serious injury through education and targeted interventions in collaboration with other agencies.

- Under the leadership of the Alberta Mental Health Board, Alberta Health and Wellness participated in the development of the Alberta Suicide Prevention Strategy aimed at the prevention and reduction of suicide, suicidal behaviour and the effects of suicide in the province.
- Funding was provided to the Alberta Centre for Injury Control and Research (ACICR) to strengthen injury prevention programming across the province.
- In collaboration with the Alberta Occupant Restraint Program, supported initiatives to increase seat belt use in the province. Results from two 2004 rural seat belt surveys (ACICR and Transport Canada) indicate an increase in the rates of seat belt use from five per cent to seven per cent since 2001.
- Participated in the development of the cross-government Traffic Safety Plan and set aggressive targets to reduce serious injury and death on Alberta's roadways (see Measure 2.C).

Develop networks and initiatives that improve access to disease screening and prevention services.

- Funding was provided for 15 community based HIV/AIDS organizations. The HIV/AIDS organizations use the Alberta Community HIV Fund to provide direct service delivery to individuals living with or at-risk of HIV, specifically prevention and support programming. These organizations work collaboratively to present a unified provincial voice on common HIV issues with the goal of eliminating the spread of HIV.
- Regional health authorities have developed three-year Young Family Wellness plans to support families and enhance early childhood development.
- In order to detect breast cancer at an early stage and to coordinate breast cancer screening across the province, a new breast cancer screening program, operated by the Alberta Cancer Board, was announced in October 2004. The role of the Alberta Breast Cancer Screening Program is to provide a coordinated, province-wide approach to the delivery of mammography screening services by ensuring women are screened regularly and appropriately. The program will actively support women who are typically under screened to participate in screening. For example, the program will include education, community and outreach programs for "hard to reach" groups of women – such as ethnic communities for which breast health is an especially sensitive matter. Previously in Alberta, multiple delivery systems for breast cancer screening operated in an uncoordinated fashion.

Key Performance Measures and Results

MEASURE 2.A

Childhood immunization coverage rates for: Diphtheria, tetanus, pertussis, polio, Hib; Measles, mumps, rubella; Meningococcal conjugate and Pneumococcal conjugate

High rates of immunization can help control the incidence of childhood diseases and ensure that outbreaks are controlled. While Alberta has one of the most comprehensive immunization programs in Canada, there is room to improve coverage rates. Strategies are being implemented at the regional level to improve the coverage rates.

Per cent of children 2 years or under who have been immunized

	1998	1999	2000	2001	2002	2003	Target 2005
Diphtheria, tetanus, pertussis, polio, Hib	77	79	79	78	78****	78**	88*
Measles, mumps, rubella	86	89	90	87	90****	90**	98
Meningococcal conjugate	-	-	-	New	-	-***	97
Pneumococcal conjugate	-	-	-	New	-	-***	97

Source: Alberta Health and Wellness, Disease Control and Prevention, CAIT Report 2413, data on childhood immunization are provided by regional health authorities and the First Nations Inuit Health Branch of Health Canada.

The number of doses is produced through the health regions immunization registries based on provincial policies. Population age two years is estimated from mid-year registry population file. Health Canada provides results for immunizations provided to children on First Nations reserves (42 out of 45 communities); these are included only in 2003. Data is based on the calendar year.

* This is the interim target with health regions moving towards 97 per cent as outlined in the Alberta Immunization Manual, 2001 in accordance with national standards.

** Based on preliminary data.

***Data not available for Meningococcal and Pneumococcal conjugates due to complex immunization schedules and challenges in data collection.

**** Data is restated as it is preliminary data in 2003/2004 Annual Report and it now includes children on First Nation reserves.

MEASURE 2.B

Per cent of seniors who have received the recommended annual influenza (flu) vaccine

The annual influenza season can have serious consequences on the health of older people, particularly those with chronic health conditions. Annual vaccination is recommended to reduce the severity of influenza on Albertans and on health system resources.

Vaccine distributed to regions continues to increase annually. Over 750,000 doses were distributed in 2004/2005. This is an increase of 200,000 from the previous year. Results are below target due to the vaccine shortage in the US demand for vaccine increased across Canada and some shortages were experienced. Alberta was able to maintain the provincially funded program; however, supplies for the private market were depleted early in the season.

Per cent of seniors who have received the recommended annual influenza (flu) vaccine

	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005	Target 2004/2005
Per cent of seniors aged 65 and older who have received the recommended annual influenza (flu) vaccine	67	67	66	68	69*	75

Source: Alberta Health and Wellness Disease Control and Prevention, data is collected from regional health authorities.
* Based on preliminary data.

MEASURE 2.C

Mortality rates for injury and suicide (per 100,000)

Injuries and suicide are a major cause of preventable death in Alberta. Alberta's injury and suicide rates are among the highest in Canada. Injury mortality rates in 2003 were similar to those of the past several years. There has been little change since 1998.

The Alberta Mental Health Board led the development of the Alberta Suicide Prevention Strategy, aimed at reducing suicide, suicidal behaviour and the effects of suicide in the provice. Alberta Health and Wellness also provides funding to the Centre for Injury Control and Research (ACICR) whch contributes to the reduction of the overall burden of injury in Alberta.

Mortality rates (per 100,000)

		1998	1999	2000	2001	2002	2003	Target 2004
Mortality rates for injury & suicide	Males	75	67	67	70	69	70	-
	Females	29	29	30	30	28	31	-
	All Albertans	52	48	48	50	49	50	45
Mortality rates for suicide	Males	23	24	20	24	22	21	-
	Females	6	6	7	7	6	7	-
	All Albertans	14	15	14	16	14	14	-

Source: Alberta Health and Wellness: calculated from Vital Statistics Death File and the Alberta Health Registration File (mid-year population estimates).
Results are based on ICD-10 diagnostic coding. Albertans whose deaths were coded as V01-Y98 (injury) and X60-X84, Y87.0 (suicide) within the Alberta Vital Statistics Death file are included in the results. Results are age standardized (per 100,000 population) to the 1996 Canadian Census population and exclude non-Alberta residents. The rates do not include Albertans who died in other provinces.

MEASURE 2.D

Screening rate for breast cancer

Regular mammography screening (every two years) for women age 50 to 69 has been shown to be effective in reducing breast cancer mortality rates. The provincial target is 75 per cent of women in this age group screened regularly. The results for 2002/2003 are very close to this target.

A new breast cancer screening program will actively support women who are typically underscreened to participate in screening. The program will include education, community and outreach programs for "hard to reach" groups of women — such as ethnic communities for which breast health is an especially sensitive matter.

Screening rate for breast cancer

	1996/1997	1998/1999	2000/2001	2002/2003	Target 2004/2005
Per cent of women age 50-69 receiving screening mammogram every two years	63*	69	71	74	75

Source: Statistics Canada: Canadian Community Health Survey (CCHS) (2000/2001, 2002/2003); National Population Health Survey (NPHS) (1996/1997, 1998/1999).
The NPHS and the CCHS are conducted every two years by Statistics Canada, therefore no new data is available for 2004/2005. Approximately 1,200 Albertans are interviewed either by telephone or in person. The measure is the per cent of women aged 50 – 69 years who report having a mammogram for breast cancer screening in the past two years. Estimates for this measure are based on a smaller sub-sample of the NPHS, and may be accurate within eight per cent 19 times out of 20. [Note: The NPHS is a longitudinal survey, interviewing the same persons every two years; trends should be interpreted with caution.] The CCHS includes a much larger sample of Albertans (14,000), and the estimates for this measure from the CCHS are accurate to within four per cent 19 times out of 20.
Includes women aged 50 to 69 who reported when they had their last mammogram for routine screening or other reasons. The values stated include the per cent of women who reported they have "Received a screening mammogram" or "Received a mammogram for other reason" combined. The values have been adjusted for non-response.
*Results are restated for consistency with 2002/2003 methods.

Goal 3 Improved access to health services.

Albertans expect to have timely access to the health services they need. Alberta Health and Wellness sets standards for access to health services in collaboration with health authorities and service providers. Access standards include: wait times and geographic access guidelines for specific services. Alberta's approach to improving accessibility also includes greater opportunities for choice in the mode of health service delivery. Access standards and corresponding targets must reflect the complex interrelationships among different services and providers.

What We Did

Develop and implement access standards for selected services and an electronic booking system for the province.

- Alberta continues to improve access to health services for Albertans. An investment of $350 million in health services was announced on June 30, 2004. This investment was aimed at increasing bed capacity, reducing wait times for surgery, and addressing accumulated deficits of health authorities. Included in this funding was $150 million for health regions to acquire medical and diagnostic imaging equipment. The addition of new machines will provide more Albertans with access to magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans. Regions have also increased the operating hours for MRI and CT machines in an attempt to reduce waiting times.
- Standards for access to hip and knee replacement, coronary artery bypass grafting, breast cancer treatment, MRI and CT scans were developed and are under review.

Expand participation in Alberta's Electronic Health Record.

- The Alberta Electronic Health Record (Alberta EHR) has been deployed to all nine health authorities and to 952 physicians and 715 pharmacists. This brings the total number of individual health providers with access to the Alberta EHR to 10,261.
- Four health professions have been added to the Alberta Provider Directory. The directory is a database of registered health providers who have been granted access to the Alberta EHR. A plan to deploy the directory to both internal and external information custodians to facilitate access to the record has been developed.
- A new regulation was approved under the *Health Professions Act* to authorize the collection, use and disclosure of provider information. This regulation allows for information on individual regulated health professionals to be added to the Alberta Provider Directory for purposes of health service delivery and planning. This enables appropriate management of provider access to the Alberta EHR.

Work tri-laterally with the Alberta Medical Association and health regions to implement changes to improve primary health care.

- Twelve regional physician groups received approval to develop business plans for Local

Primary Care Initiatives (LPCIs). Three of those have been approved to go forward – Edmonton Southside, Edmonton Westview and Bonnyville. These arrangements will provide a comprehensive range of primary care services to patients and will enhance access to family physicians for many Albertans.

- The Primary Care Claims Assessment System Enhancement Project was implemented. This project enables the ministry to provide registration, enrolment, payment and other information management services for Local Primary Care Initiatives. It will also enable the ministry and its partners to develop and support multi-disciplinary teams and physician/regional health authority networks.
- The Calgary Refugee Health Program was launched with the help of Alternate Relationship Plan funding. It provides a first point of contact for refugees with the health care system. A team of specialists provides initial health assessments, systematic screenings, maternal care and vaccinations. They also provide education on nutrition and reproductive health.

Ensure appropriate access to health services in rural and remote areas.

- Rural Alberta's shortage of medical manpower is being addressed through two initiatives aimed at attracting more medical students and family physician residents to rural practice. The first, a joint initiative with Alberta Advanced Education, is a bursary program for ten students per year under the Rural Physician Action Plan over six years. The plan requires recipients to commit to five years of rural practice once they have graduated. The second initiative is an expanded residency program under the Alberta Rural Family Medicine Network. It will allow ten more medical residents per year to experience rural family practice.
- Alberta's Telehealth Program Coordination and Scheduling System has been extended beyond Alberta's borders. It has been adopted at 17 sites in Nunavut as well as in areas of Saskatchewan and British Columbia. It is also used by Health Canada. Telehealth services include psychiatric counseling, pediatric care, physiotherapy, clinical discharge planning, case conferencing, and family visitation. Nunavut's Minister of Health and Social Services commented, "Our partnership with Alberta in this project is an example of working together for the health of Canadians." The system coordinates the telehealth activities of 261 telehealth sites in Alberta.
- The Telehealth Clinical Grant Fund allocated $3.3 million to support 24 new and 16 pre-existing projects over two years. Several of the projects support home telehealth in areas such as wound management, asthma management and cardiology. Funding for these projects enables health authorities and health service providers to provide better primary and specialist care in rural and under-serviced areas.
- Five clinical telehealth projects were extended to provide medical services to several First Nations communities. Funding was provided by the First Nations and Inuit Health branch of Health Canada. Telehealth is enabling health care to be extended to isolated and under-serviced communities in Alberta.
- Provincial access to the benefits of the Alberta Aids to Daily Living program was increased by training an additional 550 health care professionals to serve as authorizers. Approximately 50 per cent

of new authorizers work in rural Alberta regions, increasing access to medical equipment and supplies for rural Albertans.

Develop and implement guidelines for emergency health, trauma services and obstetrical services.

- The Alberta Provincial Trauma Proposal was developed and an implementation plan will be developed in 2005/2006 in collaboration with health regions and the Alberta Centre for Injury Control and Research.
- A revised plan was announced for the transfer of responsibility for ambulance services from local municipalities to the regional health authorities. Two discovery projects were initiated as the first phase of implementing the plan. One project is taking place in the Palliser Health Region and the other in Peace Country Health. The benefits and implications of the discovery projects will be evaluated by the newly established Ambulance Governance Advisory Council. The council will provide advice on how to proceed with the transfer of ambulance services.
- Guidelines for access to emergency health services will be phased into the regional health authority health plans. As part of Phase 1, regional health plans for 2004/2005 identified injury prevention strategies that have already been implemented or that are planned.

Promote options for continuing care that allow Albertans to "age-in-place."

- An increasing number of Alberta seniors were able to have their continuing care needs met in their place of residence rather than in an institution. This trend is evidenced by the decrease in the long-term care resident ratio from 74.1 per thousand in 2002/2003 to 70.5 per thousand in 2003/2004 for Albertans over 75 years of age.
- New investment in supportive living facilities as an alternative to institutional long term care in rural communities was announced by the Premier on June 30, 2004. Alberta Seniors, Alberta Health and Wellness and regional health authorities will be working together to create an estimated 750 new supportive living spaces. Supportive living facilities have lower operating costs and allow seniors to live independently in the community, while having their basic health and personal care needs met.

Complete Healthy Aging: New Directions for Care (Broda) report implementation through strategies focused on quality service, coordinated access, and consolidation and modernization of legislation.

- The Health Care Aide Provincial Curriculum was formally launched in February/March 2005 at workshops for employers of health care aides and for post-secondary educational institutions. Health care aides provide 70 per cent of the care hours in the continuing care sector. Approximately 300 employers and educators attended the workshops. They welcomed the implementation of a consistent, standardized curriculum throughout the province.
- The responsibility for accommodation services in continuing care was transferred from the Ministry of Alberta Health and

Wellness to the Ministry of Alberta Seniors and Community Supports on April 1, 2005. As a result, the full range of provincial services to seniors will be more effectively integrated.

- A special in-service training program for long term care staff who provide care to persons with Alzheimer's and other dementias was established. A total of 3000 frontline workers were trained through this program in 2004/2005. The program will improve the quality of care for this group of long-term care residents.

Protect Albertans from catastrophic drug costs.

- Options were developed to provide universal catastrophic drug coverage to limit the financial hardship for Albertans. This work, and related work on expensive drugs for rare diseases, is now being used in the development and implementation of a National Pharmaceuticals Strategy (NPS) under the leadership of Canada's health ministers.

Key Performance Measures and Results

Measure 3.A

Regional health authority achievement of targets based on clinical urgency for hip replacement, heart surgery, cancer radiation (breast and prostate), and MRI

Wait times for health services are one measure of how well the health system is doing. Patients whose needs are very urgent will receive immediate service, while patients with less urgent needs are placed on waiting lists. The Alberta Waitlist Registry[1] tracks current wait time information for a variety of services, excluding emergent patients. Patients have the opportunity to view wait times by facility and physician prior to scheduling an appointment. This allows them to be more informed on how long they can expect to wait for their procedure.

The ministry is working with health service providers and the regional health authorities to develop and implement specific guidelines for access to selected health services. The work includes wait time standards, guidelines for determining urgency and the development of management processes to ensure Albertans have timely access to these services.

1. http://www.health.gov.ab.ca/waitlist/WaitListPublicHome.jsp

Hip Replacement

The number of persons waiting for hip replacement surgery has slightly increased over the past year, along with the number of surgeries performed. The 90th percentile wait time has also increased over the past year from 45.4 weeks to 59.3 weeks.

With an aging population and people living a more active lifestyle, the demand for hip replacements has increased. At the same time, surgical procedures and artificial joints have greatly improved, making surgery safer and more effective. As a result, demand for these procedures are growing faster than for many other types of surgery.

New centralized orthopedic intake clinics are being prepared in Calgary, Red Deer and Edmonton to reduce waitlists for joint replacement surgery. The clinics will assess patients prior to surgery and assign them to surgeons. This will free up the time of orthopedic surgeons and allow them to provide 1,200 additional joint replacements. An arthroplasty pilot will test a new care path, with the goal of improving access to surgery and patient care.

Hip Replacement

	March 2004	June 2004	September 2004	December 2004	March 2005	Target 2004/2005
Total number waiting	1,664	1,879	1,856	1,924	1,663	-
Waiting time in weeks 50th percentile*	18.3	18.9	18.7	19.9	19.9	TBD
Waiting time in weeks 90th percentile**	45.4	49.9	55.1	57.1	59.3	TBD
Number of surgeries done	205	197	216	170	232	-

Source: Alberta Health and Wellness, Alberta Waitlist Registry.
Total number waiting is the number of people waiting on the last day of the month stated.
*50th percentile means that 50 per cent of patients wait that length of time or less and is calculated using data 90 days prior to the last day of the month.
**90th pecentile means that 90 per cent of patients wait that length of time or less and is calculated using data 90 days prior to the last day of the month.
Total number of surgeries done is the number of surgeries performed in the month stated.

Heart Surgery

The most common open-heart surgery in adults is the coronary artery bypass procedure. This is done to improve blood flow to the heart muscle, and is usually performed on middle-aged or older adults when their arteries have become blocked. It is a specialized service provided by Capital (Edmonton) and Calgary health regions for all Albertans.

Changes in management of care for heart disease, including new methods of treatment, were implemented to reduce the wait list and wait times for heart surgery. Some of these changes mean that some patients who would have received heart surgery in the past are now being treated successfully by other means (e.g., angioplasty). The ministry is working with health service providers and the health authorities to develop and implement specific guidelines for access to heart surgery.

Continuing initiatives to improve wait times include: 1) decreasing surgical postponements by reducing the number of post-surgery patients in the cardiac surgery and cardiology units, 2) working to achieve full staff complements across critical care units through targeted recruitment and retention initiatives, 3) increasing resources to wards and intermediate care beds, and 4) optimizing selection of patients for surgery to ensure efficient throughput from ICUs to wards. The Mazankowski Heart Institute in Edmonton is scheduled to open in 2005/2006 and will provide more resources for cardiac patient care, research, and education.

Heart Surgery (Coronary Artery Bypass Grafting CABG)

	March 2004	June 2004	September 2004	December 2004	March 2005	Target 2004/2005
Total number waiting	155	182	223	252	262	-
Waiting time in weeks 50th percentile*	0.9	0.7	0.7	1.0	1.0	TBD
Waiting time in weeks 90th percentile**	7.0	7.6	6.6	11.3	10.6	TBD
Number of surgeries done	135	118	120	102	119	-

Source: Alberta Health and Wellness, Alberta Waitlist Registry.
Total number waiting is the number of people waiting on the last day of the month stated.
*50th percentile means that 50 per cent of patients wait that length of time or less and is calculated using data 90 days prior to the last day of the month.
**90th pecentile means that 90 per cent of patients wait that length of time or less and is calculated using data 90 days prior to the last day of the month.
Total number of surgeries done is the number of surgeries performed in the month stated.

Cancer Radiation

During the past two years, average wait times for radiation therapy for breast and prostate cancer have remained above, or near the four-week target (reported in the 2003/2004 Ministry Annual Report). The ministry is working with the Alberta Cancer Board to develop and implement specific guidelines for access to these treatments.

A study is underway to examine the major expansion of the Cross Cancer Institute in Edmonton in response to projected increases in the need for cancer services over the next ten years. Under consideration are the expansion of ambulatory care services, additional radiation treatment vaults and a new Comprehensive Breast Centre. Other significant renovations to the facility and expansion of the research facilities are also being considered. Regions are in the process of developing and implementing integrated breast cancer treatment processes in an attempt to reduce the amount of time patients spend waiting for services.

There is ongoing collaboration with health authorities and cancer agencies across Canada to recruit and retain specialized cancer treatment staff. The Alberta Cancer Board is also working with universities to place fellows and oncology specialists within Alberta Cancer Board facilities.

Cancer Radiation: Average waiting time in weeks

		2003/2004				2004/2005				Target
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	2004/2005
Breast cancer	Cross Cancer	15.5	11.0	11.0	8.0	8.0	10.0	9.5	8.0	TBD
	Tom Baker	6.0	5.0	5.5	7.0	9.0	5.5	8.0	4.0	
Prostate cancer	Cross Cancer	9.0	14.0	12.5	20.0	16.0	15.0	14.0	7.5	TBD
	Tom Baker	7.0	7.0	6.0	5.5	6.0	5.0	4.0	2.0	

Source: Alberta Health and Wellness. Data provided by the Alberta Cancer Board, quarterly reporting.

Magnetic Resonance Imaging (MRI)

Over the past year, the number of patients waiting for scheduled MRI scans has decreased. The number of scheduled MRI cases completed has also increased, leading to a reduction in wait times. Emergency patients are seen immediately and inpatient MRI examinations are performed within 24 to 48 hours.

In consultation with regional health authorities and radiologists, a prioritization tool is being developed, which will allow radiologists to consistently categorize patients based on how urgently an MRI scan is needed. The goal is to establish maximum wait times based on priority levels.

Magnetic Resonance Imaging (MRI)

	March 2004	June 2004	September 2004	December 2004	March 2005	Target 2004/2005
Total number waiting	19,409	20,025	19,540	18,871	17,749	-
Waiting time in weeks 50th Percentile*	9.1	10.3	11.0	8.9	7.1	TBD
Waiting time in weeks 90th Percentile**	24.7	29.0	30.0	24.9	20.9	TBD
Number of scans completed	4,912	5,659	6,006	6,056	7,415	-

Source: Alberta Health and Wellness, Alberta Waitlist Registry.
Total number waiting is the number of people waiting on the last day of the month stated.
*50th percentile means that 50 per cent of patients wait that length of time or less and is calculated using data 90 days prior to the last day of the month.
**90th pecentile means that 90 per cent of patients wait that length of time or less and is calculated using data 90 days prior to the last day of the month.
Total number of surgeries done is the number of surgeries performed in the month stated.

MEASURE 3.B

Number waiting for long-term care facility placement: In acute hospital and urgent in community

Continuing a trend since 2002/2003, the number of persons waiting for long-term care facility placement has declined in 2004/2005. The decrease in number of persons waiting was an improvement, as targeted. As Alberta's population ages, the demand for long-term care placements increases. This is reflected in the increase of persons placed for 2004/2005 compared to previous years. These results reflect the success of new continuing care models, such as supportive living, which enable more Albertans to find living arrangements suited to their need for care.

Promotion of options for continuing care that allow Albertans to "age-in-place", and implementation of recommendations of the Healthy Aging: New Directions for Care (Broda) report contributed to the favorable changes in this measure.

Long-Term Care Placement

	2003/2004				2004/2005				Target
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	2004/2005
Number waiting in an acute care hospital	363	412	295	267	273	280	289	268	340
Number of urgent cases waiting in the community	504	442	406	339	395	394	319	272	457
Number of individuals placed*	1466	1564	1661	1593	1496	1478	1647	1674	-

Source: Alberta Health and Wellness. Data provided by regional health authorities, quarterly reporting, data submitted on an annual basis.
*Number of individuals placed was not disclosed in the 2003/2004 annual report.

MEASURE 3.C

Ratings of ease of access to health services: physician services and hospital services

Access to publicly funded health services is a fundamental principle of the health care system. Health services are made available to all Albertans through the public health system. The ministry's goal is to achieve reasonable access for all. Albertans' ratings for ease of access to physician and hospital services were at target levels in 2005. Since 2002, there has been very little variation in the results for either of these measures.

Ratings of ease of access to health services

	2001	2002	2003	2004	2005	Target 2005
Per cent rating that obtaining access to physician services as "very easy" or "easy"	86	84	86	85	86	86 (maintain)
Per cent rating that obtaining access to hospital services as "very easy" or "easy"	71	73	72	73	72	72 (maintain)

Source: Public Survey about Health and the Health System in Alberta, for 2001 – 2005, conducted by the Population Research Laboratory, University of Alberta, for the Health Quality Council of Alberta (HQCA).

Data are collected through a telephone survey of 4,000 randomly selected Alberta households. The survey is commissioned by the HQCA (previously by Alberta Health and Wellness) and is conducted by the Population Research Laboratory at the University of Alberta; the response rate for the survey has ranged between 64 and 81 per cent in recent years. Results for the entire sample are accurate within two per cent 19 times out of 20.

For physician access, the question is asked only of respondents who report having received services from a physician within the past 12 months (approximate sample size of 3,000). The 95 per cent confidence interval for this survey is two per cent above or below the reported results. To assess ease of access to physician services, Albertans 18 and over were asked: "How easy or difficult was it for you to obtain physician services you received most recently from a physician in Alberta? Would you say it was very easy, easy, a bit difficult, or very difficult?"

For hospital access, the question is asked only of respondents who report having received services at a hospital (including inpatient, out-patient, or emergency services) in Alberta within the past 12 months (approximate sample size of 1,200). The 95 per cent confidence interval for this survey is three per cent above or below the reported results. To assess ease of access to hospital services, Albertans 18 and over were asked: "How easy or difficult was it for you to get hospital services you received most recently from a hospital in Alberta? Would you say it was very easy, easy, a bit difficult, or very difficult?"

Goal 4 Improved health service outcomes.

Albertans expect excellent care and positive health outcomes every time they use the health system. The ministry's role is to establish quality standards for safety, accessibility and effectiveness. The ministry not only updates standards, but develops new initiatives in response to technological advances, demographic changes and other factors.

What We Did

Promote quality standards for health services, such as patient safety.

- Priority rating tools were developed to determine urgency for magnetic resonance imaging (MRI) and computer axial topography (CT) procedures. These will enable better prioritization of patients waiting for MRI and CT examinations.
- Alberta's 2004 Report on Comparable Health Indicators was released. It is the second such report published since the 2000 agreement by all Canadian health ministries to provide regular reports of health and health care system performance based on comparable data. Common health indicators give us a standard way to compare health status, health outcomes and quality of service.

Use information from the Health Quality Council of Alberta to improve performance of Alberta's health system.

- The Alberta Health Quality Council was established in 2004 as an extension of the mandate of the former Health Services Utilization and Outcomes Commission. The Health Quality Council of Alberta report Satisfaction with Health Care Services: A Survey of Albertans 2004, conducted by Ipsos-Reid, shows that 81 per cent of Albertans rated the quality of health services as excellent, very good or good as compared to 74 per cent in 2003. The number of Albertans surveyed who reported satisfaction with their family doctor also increased from 81 per cent to 84 per cent. Information on the satisfaction of Albertans with the process for resolving complaints and concerns was included in the Council's 2004 survey. The proportion of Albertans with serious complaints has not decreased since last year (16 per cent). Albertans continue to be quite dissatisfied with the way their complaints are handled. Of the 16 per cent of Albertans with serious complaints, 62 per cent of them were dissatisfied with the way their complaints were addressed. Accessibility to health care represents one-third of the reasons for "serious complaints."
- Alberta Health and Wellness sponsored the Friends of the Emergency Room pilot project which is intended to improve public satisfaction with the emergency room waiting experience. The project is coordinated by St. John Ambulance at the Foothills Medical Centre in Calgary and the Royal Alexandra Hospital in Edmonton. The project began on November 1, 2004 and will conclude on October 30, 2005. The project will be evaluated and a final report will be prepared.

Help Albertans with chronic health conditions maintain optimum health through appropriately managed and coordinated care.

- The need for improved mental health care in Alberta has motivated innovative funding plans, under the tri-lateral master agreement, for two multi-disciplinary programs. The Collaborative Mental Health Care project team helps children six and under at risk of mental disorders by offering early professional assessment and intervention and treatment for them and their families that can significantly alleviate and even eliminate possible long-term consequences of mental disorders. The multidisciplinary team of two psychiatrists, a family physician and a group of nurses, social workers and psychologists, treats approximately 200 children a year. The Prevention through Risk Identification, Management and Education (PRIME) clinic provides early identification and treatment for persons with schizophrenia and serves adult patients at ultra-high risk for psychosis in an attempt to deal with mental disorders before they become serious. The multidisciplinary team, including three psychiatrists, a case manager, a registered nurse, a psychometrician, and a family therapist, handles approximately 50 patients per year and refers another 50 to other facilities.
- The Alberta Monitoring for Health Program, which provides financial assistance to low-income Albertans who require diabetic supplies including insulin and medication was enhanced. Approximately 18,000 Albertans received assistance through this program, twice the total of the previous year.

Ensure Albertans receive health services from the most appropriate facilities or providers.

- A revised capital planning manual was released on January 28, 2005 to all health regions. It sets out the guiding principles and process for identifying, assessing, planning and prioritizing infrastructure needs. The manual provides guidance for preparing multi-year capital plans, programming studies and business cases, sets out the rating criteria that ministries use to evaluate and prioritize proposed major capital projects, articulates the government project approval process and provides an introduction to alternative capital financing (ACF) approaches. The manual also reflects significant changes in accountability mechanisms and funding policies designed to provide health authorities with greater responsibility and autonomy for spending decisions using funds allocated to them for capital projects and programs. In addition to the release to the health regions, the capital planning manual was placed on the Alberta Health and Wellness web site at www.health.gov.ab.ca for ease of updates and access by architects and consultants who support health regions in preparing programming studies and business cases.
- Telehealth provides a two-way videoconference link that allows patients and providers to talk to physicians and specialists in another location. Clinical telehealth activity has increased by 43 per cent in the past year. Approximately 60,000 health care providers took part in educational activities via telehealth, an increase of 17 per cent. As a result, more Albertans were able to receive

health services and more providers were able to access continuing education without the necessity of long distance travel.

- Nurse practitioners have received identification numbers from the Alberta Health Care Insurance Plan that allow them to make referrals directly to medical specialists without the need to request a referral from family physicians. This will reduce the time it takes for patients to be seen by a medical specialist.

Refine mechanisms to deal with health care concerns and complaints.

- The process for responding to patient complaints and concerns will be improved through the regulations developed under the *Regional Health Authorities Act and Cancer Programs Act*. Once the regulations come into force, amendments to the *Ombudsman Act* will be proclaimed. The Ombudsman will then have the authority to review the patient concerns resolution processes of health authorities. The Ombudsman's role is to ensure the processes are fairly administered.

Key Performance Measures and Results

MEASURE 4.A

Ratings of quality of care received: overall and hospital

These key measures reflect Albertan's views about the quality of services they received, based on their experiences with the health system. Results for 2005 indicate that Albertans surveyed report no change from the previous year in their rating of quality of care received overall. There was only a marginal decrease in the rating of quality of hospital care received in 2005. The results are close to target values.

The ministry is working to ensure that adequate levels of health professionals, equipment, medication and supplies are available to provide high quality health care to Albertans. Through such legislation as the *Health Professions Act* and the *Hospitals Act*, the ministry requires health professionals to practice in accordance with appropriate standards and health facilities to be managed appropriately.

Ratings of quality of care received

	2000	2001	2002	2003	2004	2005	Target 2004
Per cent reporting that the quality of the care they received overall was "excellent" or "good"	86	86	86	85	86	86	85 (maintain)
Per cent reporting that the quality of the care they received in hospital was "excellent" or "good"	83	80	81	83	81	80	83 (maintain)

Source: Public Survey about Health and the Health System in Alberta, for 2001 – 2005, conducted by the Population Research Laboratory, University of Alberta, for the Health Quality Council of Alberta (HQCA).
Data are collected through a telephone survey of 4,000 randomly selected Alberta households. The survey is commissioned by the HQCA (previously by Alberta Health and Wellness) and is conducted by the Population Research Laboratory at the University of Alberta; the response rate for the survey has ranged between 64 and 81 per cent in recent years. Results for the entire sample are accurate within two per cent 19 times out of 20.
For quality of care personally received, the question is asked only of respondents who report having obtained health services within the past 12 months (approximate sample size of 3,200). The 95 per cent confidence interval for this survey is two per cent above or below the reported results. To assess quality of care received, Albertans 18 and over were asked "Overall, how would you rate the quality of care you personally have received? Would you say it was excellent, good, fair, or poor?"
For quality of care received in a hospital, the question is asked only of respondents who report having obtained health services in a hospital within the past 12 months (approximate sample size of 1,200). The 95 per cent confidence interval for this survey is two per cent above or below the reported results. To assess quality of care received, Albertans 18 and over were asked "Overall, how would you rate the quality of care you most recently received at the hospital? Would you say it was excellent, good, fair, or poor?"

MEASURE 4.B

Per cent of persons who have received a service who are satisfied with the way the service was provided

Satisfaction in how health services were provided is an important measure of quality. Albertans expect health services to be provided with respect for the dignity of each person. Health service providers should be approachable, friendly, good listeners, and able to answer questions while performing their duties in an efficient and professional manner. High satisfaction rates occur when expectations are met. Survey results show that, generally speaking, Albertans are very satisfied with the way health services are provided. Satisfied patients mentioned that service was "efficient and timely" or that it was "professional and friendly." Less than seven per cent of those surveyed were dissatisfied. These patients frequently noted "the provider did a poor job," "it took too long to get the service" or "the service was rushed."

From 2002 to 2005, the percentage of Albertans satisfied with the way services were provided (percentage responding "very" or "somewhat" satisfied), increased from 86 to 88 per cent, approaching the target of 90 per cent. Strategies for primary care, long-term care, chronic disease management, improved quality of health services and patient safety ensure Albertans' expectations are met each time they use the health system.

Per cent of persons who have received a service who are satisfied with the way the service was provided

	2001	2002	2003	2004	2005	Target 2005
Per cent who were "satisfied" or "somewhat satisfied" with the way the service they received was provided	88	86	87	89	88	90

Source: Public Survey about Health and the Health System in Alberta, for 2001 – 2005, conducted by the Population Research Laboratory, University of Alberta, for the Health Quality Council of Alberta (HQCA).
Data are collected through a telephone survey of 4,000 randomly selected Alberta households. The survey is commissioned by the HQCA (previously by Alberta Health and Wellness) and is conducted by the Population Research Laboratory at the University of Alberta; the response rate for the survey has ranged between 64 and 81 per cent in recent years. Results for the entire sample are accurate within two per cent 19 times out of 20.
Adult Albertans who reported they have obtained health services during the past 12 months (approximate sample size of 3,000) are asked about the service most recently received. The 95 per cent confidence interval for this survey is one per cent above or below the reported results. "How satisfied were you with the way the service was provided to you? Were you: very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, or very dissatisfied?" The measure is the per cent responding "very satisfied" or "somewhat satisfied."

MEASURE 4.C

Success in treating people with chronic conditions in their communities: Ambulatory Care Sensitive Conditions hospitalization rates (per 100,000, age standardized)

Patients are sometimes admitted to hospital for conditions that could have been treated in an ambulatory care setting. A decrease in hospitalization may reflect a change in medical practice, but may also reflect better health service delivery at home and in the community.

The ministry has initiatives to ensure Albertans are receiving health services from the most appropriate facilities or providers with the best technology that responds to demographic changes and other factors. Appropriately managed and coordinated care helps Albertans with chronic health conditions receive the best treatment and care in their communities while maintaining an appropriate lifestyle.

Success in treating people with chronic conditions in their communities

	2003	Target 2004/2005
Hospitalization rate per 100,000, age standardized for Ambulatory Care Sensitive Conditions (ACSC)	434	460

Source: Canadian Institute for Health Information (CIHI), Hospital Morbidity Database
Age-standardized acute care hospitalization rate for conditions where appropriate amulatory care prevents or reduces the need for admission to hospital, per 100,000 population under age 75 years.
This definition of ACSC is based on the work of Billings et al.
Patients who died before discharge are excluded.
A measure of access to appropriate medical care. While not all admissions for ACSC are avoidable, it is assumed that appropriate prior ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disporportionately high rate is presumed to reflect problems in obtaining access to primary care.
Rates are not comparable to those published by Alberta Health and Wellness prior to June 2005 due to a change in the definition made by CIHI for ACSC.

MEASURE 4.D

Heart attack survival rate (30-day survival in hospital) (Three-year average for data)

Alberta's 30-day survival rate following a heart attack has increased slightly over the previous three years. The relatively high survival rates can be attributed to the quality of care provided by professional staff, supported by advanced diagnostic services and quality hospital care.

Heart attack survival rate

	1997 – 1999	1998 – 2000	1999 – 2001	2000 – 2002	Target 2002 – 2005
30-day survival rate in hospital – three-year average data (per cent surviving)	89.6	90.1	90.4	89.8	92

Source: Canadian Institute for Health Information, Hospital Morbidity Database.
30 day Acute Myocardial Infarction (AMI) in-hospital mortality rate: The risk adjusted rate of all causes of in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of AMI. (Primary ICD-9 or ICD-9-CM diagnosis code of 410 or ICD-10 I21, I22).

MEASURE 4.E

Satisfaction with response to complaints about health services

Albertans expect the best possible care and outcomes every time they use the health system. Complaints about health services may be a reflection of how Albertans feel about the health system in general or the outcome they experienced from a particular health service. Rates of satisfaction with the way complaints are responded to is an appropriate measure for gauging the extent to which this expectation was met. The results for this measure declined markedly in 2005 from the previous year and were significantly below target. The ministry has set a fairly ambitious target to reflect the expectation of Albertans when a complaint is made. To respond to this expectation, the ministry has emphasized such strategies as, the promotion of quality standards for health services, including patient safety, and the refinement of mechanisms for responding to concerns and complaints.

Satisfaction with response to complaints about health services

	2002	2004	2005	Target 2007
Per cent who report that they are satisfied with the response to their complaint about health services	33	38	30	50

Source: Public Survey about Health and the Health System in Alberta, for 2002, 2004, 2005 conducted by the Population Research Laboratory, University of Alberta, for the Health Quality Council of Alberta (HQCA).
Data are collected through a telephone survey of 4,000 randomly selected Alberta households. The survey is commissioned by the HQCA (previously by Alberta Health and Wellness) and is conducted by the Population Research Laboratory at the University of Alberta; the response rate for the survey has ranged between 64 and 81 per cent in recent years. Results for the entire sample are accurate within two per cent 19 times out of 20.
Albertans who reported making a complaint about a health service received (by them or someone living in their house) during the past 12 months (approximate sample size of about 200) are asked about satisfaction of the response to the claim. The 95 per cent confidence interval for this survey is about seven per cent above or below the reported results. "How satisfied were you with the response to your complaint?" The measure is the per cent of respondents reporting "Very Satisfied" or "Somewhat Satisfied"

Goal 5 Health system sustainability.

Alberta's health system faces the challenges of continuing population growth, increased public expectations, and rising costs. Alberta's ability to support the rising costs of health care depends on our success in maintaining a healthy, vibrant and diversified economy. All Albertans have a stake in making the provincial health system more sustainable and affordable. A major strategy in this direction is for both providers and patients to use the health system in an appropriate and responsible manner. The most important strategy, however, is for everyone to take positive steps to maintain and improve their own health and address the social and environmental factors that determine health. The determinants of health are also discussed under Goal 1. A multifaceted approach is necessary whereby educators, leaders of industry, political representatives, all levels of government and health service providers work together on long term strategies for health.

What We Did

Lead the Health Sustainability Initiative, which strengthens collaboration, integration and coordination across government ministries to enhance the sustainability of the public health system.

- The Health Sustainability Initiative (HSI) strengthens policy integration and collaboration among ministries so as to enhance the sustainability of the health system. Of the 20 HSI targets, 19 were achieved or exceeded. The target of reducing the prevalence of alcohol use during pregnancy among Alberta women from 3.9 per cent to 2.9 per cent is still in progress. In addition to broad public awareness campaigns, targeted programs for high risk women will continue. Final data for 2004/2005 will not be available until 2005/2006.

Provide leadership in federal / provincial relations to maintain Alberta's ability to meet local health needs.

- In September 2004, the First Ministers signed a ten-year agreement on health that provides a new framework for federal, provincial and territorial cooperation. The agreement focuses on reducing wait times, improving access, addressing human resource issues, and providing first dollar coverage for sub-acute home care. The agreement also supports primary care reform efforts, a national pharmaceuticals strategy and improved Aboriginal health care. The agreement provided Alberta with an additional $213 million in funding for 2004/2005. Additional funding will also be provided by the federal government under the remaining nine years of the agreement.

Collaborate with health authorities and other partners on integrated policy and planning initiatives.

- The Provincial Mental Health Plan was developed under the leadership of the Alberta Mental Health Board in collaboration with Alberta Health and Wellness, regional health authorities and other stakeholders. The plan provides strategic direction and a framework for continuous improvement and effective coordination of mental health services following the transfer of responsibility for the delivery of mental health services from the Alberta Mental Health Board to regional health authorities.
- The landmark Tri-lateral Master Agreement involving the ministry, the Alberta Medical Association and the regional health authorities has resulted in the establishment of several tri-lateral advisory and administrative bodies. The agreement allows the health system to move forward through innovations in service delivery and physician compensation. This, in turn, creates new opportunities for collaboration, integration of services, and improved continuity of care.
- An agreement was reached whereby responsibility for emergency helicopter ambulance service was transferred to the Calgary and Capital health regions in order to improve the coordination of services for critically ill or injured patients.
- As part of a strategy led by Alberta Seniors, Alberta Health and Wellness implemented the elimination of health care premiums for Albertans 65 years and older as part of an overall enhanced benefit package for seniors.
- Approximately $3 million in targeted funding was provided through the Enhancing Clinical Capacity Project Fund. This funding supports 11 projects that increase the capacity of health service organizations to provide students with new clinical learning opportunities. It also supports curriculum redesign and the use of simulation in training where appropriate.

Implement multi-year performance agreements with health authorities that promote innovation and collaboration, and set out performance expectations and deliverables.

- The Alberta Cancer Board and the Alberta Mental Health Board both signed two-year performance agreements. These agreements establish a framework for accountability and the achievement of planned results.
- By mutual agreement, regional health authorities and the Minister of Alberta Health and Wellness established a new accountability framework based on three-year health plans and one-year business plans. Health authorities are required to include in their plans the key expectations of the Minister that were identified in the multi-year performance agreement template.
- The health plans for 2004-2007 submitted by the nine regional health authorities were approved. These plans provide the framework for continued monitoring and reporting of health region performance.

Collaborate to evaluate alternative ways to finance programs not covered by the *Canada Health Act*, including cost-sharing approaches for a wide range of services.

- On June 30, 2004, government announced a broad health renewal plan for Alberta. The plan called for learning from leading health systems in the world as the basis for revitalization and renewal of Alberta's health system.

Work with key stakeholders on plans and initiatives, such as the Rural Physician Action Plan, to educate, recruit and retain the needed health workforce.

- The Alberta International Medical Graduate (AIMG) program was expanded. This program provides residency training to immigrant physicians where appropriate, and enables them to go on to practice in Alberta. Four new family medicine seats were added to the previous eight. For the first time, 16 specialist seats were funded. To date, eight AIMGs have graduated from the program.
- To increase the availability of community medicine specialists in the province, support was provided for two community medicine residency programs; one at the University of Alberta and the other at University of Calgary. These residency programs increase awareness about careers in community medicine. They provide two or three students per year with training rotations in regional health authorities and Alberta Health and Wellness. Training rotations for other medical students and residents are being offered to increase public health awareness by working on related projects.

Increase the flexibility of the health workforce within the provisions of the *Health Professions Act.*

- Regulations were developed under the *Health Professions Act* to include the dental technician profession. This brings the total number of health professions regulated under this Act to 10. In the coming year the remaining 18 health professions will be regulated under the Act. This will ensure that health professions are appropriately regulated and able to work to their full scope of practice.
- The Health Professions Act Employer's Handbook: A Guide for Employers of Regulated Health Professionals was published in June 2004. The handbook clarifies the key concepts of the *Health Professions Act* for the benefit of service managers, training colleges and other stakeholders.

Improve processes to evaluate the effectiveness and cost, and coordinate the implementation of new health care technologies, including drugs.

- Alberta's process for evaluating new technologies was strengthened with the establishment of the Alberta Advisory Committee on Health Technologies. The first technology reviewed using the committee's new process was laparoscopic adjustable gastric banding for the treatment of severely morbid obesity. The experience gained from this review was used to further refine the process. In the coming year, additional new health technologies and services will be reviewed as recommended by the committee.

- The Common Drug Review Process has resulted in greater consistency in public drug plan reviews across Canada. This process reduces the need for involved analysis and a duplication of efforts at the provincial level and facilitates the final review and approval process in Alberta. The improved drug review process results in faster drug plan coverage for beneficial new drugs. As of March 31, 2005, 21 drugs have been reviewed through this process with five being added to the Alberta Health and Wellness Blue Cross drug plans. The Common Drug Review process has enabled Alberta's drug review process to concentrate on other activities including assessing the benefit of new generic drug products as well as new preparations and uses of "old" and existing drugs. Reviews of currently covered drugs in three classes or treatment categories, including antibiotics, have been completed. The goal of the reviews is to ensure best value for dollars spent, consistency in drug coverage and effective program policies. Products that no longer offer treatment benefit were removed, others were added and some were reassigned to different coverage categories.

Implement integrated information systems, including the Alberta Electronic Health Record, that will support research and improve clinical and management decision-making.

- A three-year information management and technology plan for the Alberta Electronic Health Record (Alberta EHR) was agreed to by key stakeholders including health authorities, physicians and pharmacist association representatives.
- Province-wide security standards for the Alberta EHR were implemented.
- Central booking for access to primary care physicians in Calgary and Edmonton was established online through Health Link Alberta.
- The Regional Shared Health Information Program (RSHIP) links these regions to the Alberta EHR and enables physicians, pharmacists, hospitals, home care nurses and other providers across the province to share accurate and timely patient information in a secure environment. RSHIP was implemented in the David Thompson Health Region and the Northern Lights Health Region, and will be implemented in the five remaining rural regional health authorities over the next two years.
- The Physician Office System Program (POSP) puts computer systems in physicians' offices to enable use of the Alberta EHR and support better patient care. In 2004/2005, 442 new physicians joined the program, bringing the total to 40 per cent of the province's physicians.
- Implementation of the Continuing Care Systems Project (CCSP) continues. This includes the implementation of the interRAI assessment and care planning instruments for all long-term care facilities and home care settings. Fourteen facilities have implemented these instruments. Planning for the design of a provincial information system to receive, store and manage the interRAI data is underway. The interRAI instruments serve as the foundation for the new health service standards for continuing care, and will provide Alberta Health and Wellness with standardized data to support quality of care initiatives.

Lead implementation of health information management best practices, including privacy and security.

- A comprehensive privacy framework, including an Alberta EHR Data Stewardship Committee, was established to address issues related to information, communications technology and software applications. The comprehensive framework amalgamates all of the privacy and security requirements and makes them understandable to information custodians and Alberta's citizens. This helps to ensure the safety of health information through consistent practices.

Implement Information Management/ Information Technology Governance Council processes and structures to guide health sector investments in strategic information management and information technology.

- The Information Management/Information Technology Governance Council, a multi-stakeholder committee with public representation was established in 2002/2003 to guide provincial investment in information technology used by the health system.

The council is supported by a series of coordinating committees responsible for data stewardship and standardization of systems. In 2004/2005 the governance council oversaw provincial investment for health information technology initiatives, exclusive of on-going information technology, operational and ministry costs.

Key Performance Measures and Results

MEASURE 5.A

Public rating of health system overall

Albertans' perception of the health system is reflected in survey ratings of the health system. Ratings include perception about the quality of care, service accessibility, the manner in which the service was provided, and the patient-provider relationship.

Over the past few years, Albertans' overall rating of the health system has remained constant. Since 2003 the rating has been at or above the target. The ministry is working on health care strategies, including reform initiatives to ensure steady improvement.

Public rating of health system overall

	2001	2002	2003	2004	2005	Target 2004
Per cent rating the health care system overall as either "excellent" or "good"	68	62	65	65	67	65 (maintain)

Source: Public Survey about Health and the Health System in Alberta, for 2001 – 2005, conducted by the Population Research Laboratory, University of Alberta, for the Health Quality Council of Alberta (HQCA).

Data are collected through a telephone survey of 4,000 randomly selected Alberta households. The survey is commissioned by the HQCA (previously by Alberta Health and Wellness) and is conducted by the Population Research Laboratory at the University of Alberta; the response rate for the survey has ranged between 64 and 81 per cent in recent years. Results for the entire sample are accurate within two per cent 19 times out of 20.

Adult Albertans are asked: "Thinking about the health care system in Alberta, overall, how would you rate it? Would you say it was excellent, good, fair, or poor?"

MEASURE 5.B

Physical condition of health facilities

The physical condition of health facilities is an important factor in ensuring quality care. Results indicate that in 2004/2005, 71 per cent of health facilities were rated as being in good condition, 25 per cent were rated in fair condition and four per cent were rated in *poor* condition. The 96 per cent of facilities in good or fair condition exceeded the original target of 94 per cent. The percentage of health facilities in *good* condition, however, fell from 84 per cent in 2003/2004 to 71 per cent in 2004/2005, while the percentage of facilities rated in *fair* condition increased from 11 per cent in 2003/2004 to 25 per cent in 2004/2005.

As health facilities age, there will be an increased need for major repairs and/or renewal of building components. Major capital preservation projects and maintenance funding will address some of these needs.

Physical condition of health facilities

	2003/2004	2004/2005	Target 2005
Per cent of publicly owned health care facilities in fair or good physical condition	95	96	94

Source: Alberta Infrastructure and Transportation, HFPB Verification Ratings.

MEASURE 5.C

Per cent increase in provincial health expenses in relation to the per cent growth in provincial revenues

This performance indicator is intended to focus on the long term sustainability of Alberta's health system. Growth in health system expenditures should not exceed the province's ability to support those expenditures.

Based on the change from 2003/2004, the growth in both government revenues and Alberta Health and Wellness expenditures was approximately 13 per cent which is a significant increase. While these would indicate that the long-term target ratio of 1.0 has been achieved, it does not necessarily indicate that the health system is sustainable. It may only indicate that the increase in health expenditures is keeping pace with the increase in revenues. These revenues may not be sustainable in the long term and may give rise to expectations that cannot be met.

Per cent increase in provincial health expenses in relation to the per cent growth in provincial revenues

	2004/2005	Target 2005/2006	Target 2011/2012
Ratio of growth in health expenses to growth in provincial revenues	1.0	1.5	1.0

Source: Government of Alberta Annual Report.

MEASURE 5.D

Funding for services provided: Portion of provincial contribution and portion of federal contribution

Canadian provinces have been successful in negotiating additional funding from the federal government for health services. The 2004 First Ministers' Meeting Agreement, a ten-year plan to strengthen health care, provided a general increase for the Canada Health Transfer and short term funding for capital equipment and financial resources to reduce wait times and improve access to services. Increases in the federal contribution will support the development of a sustainable health system that meets the needs of the population while remaining affordable to the taxpayer.

Funding for services provided: A) Portion of provincial and B) Portion of federal contribution

	2003/2004	2004/2005	Target Long Term
Per cent of funding provided by the provincial government	81	79	75
Per cent of funding provided by the federal government	19	21	25

Source: Alberta Health and Wellness Annual Report.

MEASURE 5.E

Developing and maintaining workforce capacity

Alberta continues to recruit and retain health professionals critical to the operation of the health care system. Expanding the supply of health practitioners available in the health sector helps to improve access to health services and builds capacity to better adapt to the changing demands and dynamics of Alberta's population.

Annual per cent growth in Health Workforce Supply

	2004/2005	Target 2004/2005
Specialist Physicians	5	TBD
Non specialist physicians	3	TBD
Registered nurses	4	TBD
Pharmacists	5	TBD

Source: College of Physicians and Surgeons of Alberta (CPSA) Quarterly Reports (January 1 – March 31 2004, 2005); Alberta Association of Registered Nurses (AARN), College of Licensed Practical Nurses of Alberta (CLPNA), and Registered Psychiatric Nurses Association of Alberta (RPNAA) Annual Reporting Statistics (2003, 2004); Alberta College of Pharmacists Annual Reporting Statistics (2004).

Expansion of physician capacity

	2004/2005	Target 2004/2005
Increase in funded post-graduate medical seats	63	TBD

Source: Alberta Advanced Education.

Goal 6 Ministry organizational excellence.

In serving the needs of Albertans, the Ministry of Alberta Health and Wellness must excel in all its areas of responsibility. The ministry must deliver excellent customer service to Albertans, establish and maintain the necessary controls, systems, tools, business relationships and networks, ensure accountability, promote a culture of teamwork and learning and provide a supportive work environment. Achieving excellence means that all ministry organizational units must function harmoniously and support each other in the achievement of optimum performance.

What We Did

Improve the department's leadership and the quality of its contribution to Cross-Ministry Initiatives.

- Alberta Health and Wellness played a strong role in collaboration with other ministries in the achievement of the goals and targets of the following cross-ministry initiatives:
  - **Aboriginal Policy Initiative** – Alberta Health and Wellness, AADAC and the Alberta Solicitor General implemented 56 initiatives aimed at improving health and wellbeing among Aboriginal people. They include community based primary healthcare; mobile diabetes screening implemented in off-reserve and remote communities; Alberta Community HIV Fund; tobacco reduction; substance abuse awareness and prevention; and other wellness initiatives. For more detail see achievements under Goal 1 of this report.
  - **Children and Youth Initiative** – A cross-ministry approach has been developed to address the seven key issues identified by stakeholders related to the availability and accessibility of speech-language services. Pilot sites were established involving eight communities to enhance community capacity to prevent Aboriginal youth suicide: Lethbridge and the surrounding First Nations; High Prairie and the surrounding Métis Settlements; and Eden Valley First Nation.
  - **Economic Development Initiative** – The Alberta Health Survey, conducted annually by the department since 1995, was analyzed in 2003 and 2004 to compare results for urban and rural Albertans. The results will be used as a basis for making positive changes to the access and quality of health care in rural Alberta. The changes are reflected in the Rural Development Strategy, released in February 2005. The strategy consists of four pillars, of which health is one. Areas of emphasis include: 1) access to quality health services in rural Alberta; 2) the role of rural health regions in health renewal; and 3) opportunities for developing the economic potential of rural health care.

Deliver high quality information and client service through ministry direct operated programs.

- The Raise the Bar initiative was implemented in the telephone inquiries area of Alberta Health and Wellness to improve call quality, client satisfaction and increase employee productivity. The results of this initiative have been very positive as demonstrated by performance indicators. An independently

commissioned survey showed that overall Call Centre client satisfaction increased from 88 per cent to 91 per cent (see Measure 6.B).

- Improvements were made to the Alberta Health Care Insurance Plan process for registering Albertans and issuing health cards. A new Registration Validation process was developed and implemented January 1, 2005. This new process requires all new applicants to provide documention to validate their identity, legal entitlement to be in Canada, and residence in Alberta, prior to coverage being granted. A new duplicate/replacement card process was also developed and implemented in November 2004 that adds additional rigor to the card replacement process.
- A business re-engineering project was conducted and the department is in the final stages of determining the optimum delivery model for Alberta Health Care Insurance Plan coverage. This project included an examination of the processes and systems used to register Albertans for health insurance. The enhanced delivery model will be implemented under the Client Connections initiative, which will, over the next few years, result in improved accessibility, more secure identification and better service for eligible health service recipients.
- In 2004/2005 the ministry started a project to determine the process of consolidating the health authorities' financial statements into those of the ministry and of the Government of Alberta. This new reporting requirement resulted from the government's acceptance of the Financial Management Commission's recommendation on Reporting Entity and the update to Section PS 1300 by the Canadian Institute of Chartered Accountants Public Sector Accounting Board. Working groups with representation from the health authorities and other government entities were established to review the issues and assess the impact of the consolidation on fiscal accountability. A dry run of the consolidation, on a modified equity basis, of the health authorities' financial results within the ministry's financial statements was undertaken with completion in July 2005. The initial results of the consolidation of the health authority financial statements are not reflected in the 2004/2005 ministry financial statements reported in this annual report. Government's tentative plans are to repeat the trial consolidation process for the 2005/2006 fiscal year, with full consolidated reporting commencing in the 2008/2009 reporting period.

Cultivate a supportive work environment that encourages teamwork and shared responsibility.

- An annual general meeting, attended by the Minister and Deputy Minister, provided staff with the opportunity to engage in interactive, knowledge building activities and dialogue with the Deputy Minister and the Assistant Deputy Ministers.
- Senior management was provided with the Corporate Employee Survey (CES) results for all divisions and an opportunity to discuss them. Action plans were developed to address the survey results with the involvement of employees. The Human Resource Plan was provided to all employees, and it was posted on the department intranet site.

Foster an organizational culture of learning and continuous improvement.

- A guidebook entitled We Can Be the Best We Can Be was developed and provided to all ministry employees in August 2004. The guidebook describes the roles and behaviours consistent with organizational excellence and a culture of learning. Discussions were held with senior management to reinforce those principles.
- The business resumption plans of branches and divisions were reviewed and updated to incorporate changes resulting from reorganization. An executive-level exercise of the plan provided further "lessons learned" which helped in refining the plans.

Maximize effectiveness of stakeholder networks and relationships.

- A multi-stakeholder steering committee was established to guide provincial initiatives and to maximize stakeholder involvement in information system development.

Enhance ministry performance through appropriate systems and tools.

- In April 2004, an internal and external HealthShare Portal was implemented to foster communication and information sharing in the development of ministry plans. Business areas now have the ability to share documents and participate in online discussions and meetings that are more cost effective and responsive.
- The desktop operating system was upgraded to Windows XP and the office productivity suite was upgraded to Windows Office 2003. The performance and reliability of the Local Area and Wide Area Networks has been improved by a complete overhaul and redesign of the network infrastructure.
- In 2004, Alberta Health and Wellness won three silver Premier's Awards of Excellence. The first was for the province-wide meningococcal immunization campaign. The second was for the province-wide metabolic screening program for newborns. The third was for the contribution of Alberta Health and Wellness as part of a cross-ministry group that carried out a cumulative impact assessment.
- The ministry also won four bronze Premier's Awards of Excellence in 2004. As part of a cross-ministry group Alberta Health and Wellness won bronze for the work done on the *Agricultural Operation Practices Act*. Alberta Health and Wellness also received bronze for the Alberta Electronic Health Record, the Alberta Health and Wellness Healthy U @ work program and for the Provincial Personal Health Identifier project.
- In 2005 Alberta Health and Wellness won two Premier's Awards of Excellence. The Alberta Waitlist Registry team received gold and the Regional Health Authority/Alberta Health and Wellness Physician Services Agreement Negotiations Team received silver.
- The performance of the ministry was strengthened through a series of achievements documented in the report Health Care in Alberta: Strong Today, Stronger Tomorrow. The achievements fall into four categories, primary health care, keeping Albertans healthy, improving health care quality and efficiency, and improving access to health services.
  - Improvements to primary care resulted from Health Link Alberta (a 24 hour information service), the tri-lateral agreement for physician services and new processes for establishing local primary care initiatives.

– Structures and processes for maintaining the health of Albertans included a smoker's helpline, the Framework for a Healthy Alberta and the Healthy U radio and TV campaign.
– Health care quality was improved through the expansion of the Alberta Electronic Health Record system, a major investment in long distance diagnostic and consultation services through telehealth, and a new provincial plan for improving mental health services.
– Access to health services for Albertans was enhanced through the Alberta Waitlist Registry and significant capital investment to increase hospital beds in Edmonton and Calgary.

Key Performance Measures and Results

MEASURE 6.A

Per cent of stakeholders reporting easy access to information

The effectiveness of stakeholder networks depends on the confidence stakeholders have in the quality of data available from Alberta Health and Wellness and their ability to access this data.

A new model for data access was implemented in October 2004, and evaluation will be completed in October, 2005. The ministry has created an external Data Access and Research Advisory Committee that is providing input into the new model and recommending mid-course changes. Anecdotal information as of June 2005 is that the new model is increasing external confidence in data accessibility. The new model will continue to increase trust and maximize the effectiveness of stakeholder networks. This will enhance quality of communication and data access. Data for this measure will be available in October 2005 and the ministry target is to be determined.

MEASURE 6.B

Per cent of Albertans reporting their inquiries to the department were handled satisfactorily

Satisfaction results continue to be strong due to focused efforts to increase productivity and quality in the call centre area. Call centre customer satisfaction ratings for 2004 reached an all time high of 91 per cent. The document processing area customer satisfaction results for the year were 87 per cent. The table below shows an aggregate satisfaction rating for all inquiries to the department.

Per cent of Albertans reporting their inquiries to the department were handled satisfactorily

	2000	2001	2002	2003	2004	Target 2004
Per cent of clients satisfied with department inquiry services.	86	85	82	88	89	85

Source: Alberta Health and Wellness: Customer Service and Registration Branch: Client Satisfaction Survey (CSR), conducted by Criterion Research Corporation; a telephone survey of 1,000 clients (500 for the document processing survey and 500 for the call center survey). Results for the entire sample are accurate within about four per cent 19 times out of 20.

MEASURE 6.C

Number of contacts regarding the Alberta Health Care Insurance Plan

Alberta Health and Wellness has been working towards providing the optimum delivery model for the Alberta Health Care Insurance Plan. The enhanced delivery model will, over the next few years, result in improved accessibility, more secure identification and better service for eligible health service recipients.

New initiatives introduced during the year to increase system security (such as new registration validation and duplicate card processes) created a requirement for telephone and face to face contact. Overall contact levels in these two areas did not show any significant decrease. However, we believe that increased clarity of department correspondence helped lead to a decrease in written contacts received.

Number of contacts regarding the Alberta Health Care Insurance Plan

	Average Number Per Day			
	2003/2004	2004/2005	Per Cent Change	Target 2004/2005
Telephone Calls	3,958	3,942	0%	Decrease in number of contacts as a result of increasing access to timely, quality information. Target TBD.
Walk-in Customers	451	444	-2%	
Documents Received	4,051	3,614	-11%	

Source: Alberta Health and Wellness – Client Services, Weekly and Monthly Statistical Reports

MEASURE 6.D

Satisfaction rating among other ministries with Alberta Health and Wellness' contribution to cross-ministry initiatives

Other government ministries continue to express satisfaction with the contribution of Alberta Health and Wellness to cross-government initiatives.

The Ministry of Alberta Health and Wellness works with other government ministries in order to achieve its goals and the goals of the government in general. Results from 2004 show a very high level of satisfaction among other ministries with the cross-ministry work of Alberta Health and Wellness. The 2004 result is slightly higher than results obtained in 2003 and above the 2004 target. The ministry continues to place a high priority on working with other government ministries, and has strategies in place to demonstrate effectiveness.

Satisfaction rating among other Ministries with Alberta Health and Wellness' contribution to cross-ministry initiatives

	2001	2002	2003	2004	Target 2004
Per cent of other ministry staff satisfied with Alberta Health and Wellness' contribution to cross-ministry initiatives	86	83	90	91	90

Source: Alberta Health and Wellness, survey (annual), "Satisfaction of other Ministries with Alberta Health and Wellness' Contribution to Cross-ministry Initiatives." A total of 56 persons responded to the survey for a response rate of 85 per cent.

MEASURE 6.E

Per cent of Alberta Health and Wellness employees who report that the organization provides the support they need to acquire or develop knowledge and skills in their current jobs

To ensure areas for employee development are identified and addressed, learning plans are promoted and encouraged as part of the performance management process. Learning plans are part of employee performance agreements. Training in performance management is also provided.

Training in supervision and coaching has been provided to staff, building the leadership capacity of the organization.

Per cent of Alberta Health and Wellness employees* who report that the organization provides the support they need to acquire or develop knowledge and skills in their current jobs

	2003	2004	Target 2004
Per cent of Alberta Health and Wellness employees who report that the organization provides the support they need to acquire or develop knowledge and skills in their current jobs	76	75	78

Source: Alberta Health and Wellness, Government of Alberta Corporate Employee Survey conducted by Research Innovations Inc. 452 Alberta Health and Wellness employees were surveyed via the internet or by phone and results for the sample are accurate within about four per cent 19 times out of 20. Adjusted for non-response.

* Refers to department staff only.

Integrated Results Analysis

This section of the report provides a discussion of how all the various results and accomplishments link together for a more complete picture of the health system in 2004/2005. The following is a discussion of what was achieved with the resources consumed. It puts individual financial results, performance measures and achievements into an overall health system context.

On June 30, 2004, the Alberta government announced significant new investments in health care totaling $700 million. Alberta Infrastructure received $350 million in capital funding for health facilities and Alberta Health and Wellness received $350 million for capital equipment and to improve access to services.

The additional $350 million has enabled the expansion of surgical service capacity to respond to increasing pressures and to reduce waitlists.

The following table summarizes the year's expenditures in relation to the budget allocation for each core business. The resultant variances and other factors affecting performance are discussed in relation to each core business area.

Core Business (in thousands)
Unaudited

	Budget	Actuals	Variance
1. Encourage and support healthy living	232,623	267,692	-35,069
2. Ensure quality health services	7,651,356	7,972,946	-321,590
3. Lead the health system	111,862	126,372	-14,510
Total	**$7,995,841**	**$8,367,010**	**-$371,169**

Core Business 1

This core business to encourage and support healthy living includes goals 1 and 2 of the ministry business plan for 2004-2007. The core business focuses on strategies that encourage Albertans to choose healthy lifestyles and protect Albertans from communicable diseases and other health risks. Actual spending for core business 1 was $35 million greater than budgeted. This was due in part to the Public Health and Immunization Trust (PHIT) funding announced by the federal government in March 2004. The PHIT funding supported projects such as the prevention of type 2 diabetes and other chronic diseases, the chronic obstructive pulmonary disease initiative and a campaign to curb risk taking behaviors of young adults. In addition, funding provided to improve patient safety during childbirth also contributed to the variance with the balance attributable to increased costs for the public health laboratories.

A number of diverse health promotion and public awareness initiatives were undertaken. Survey results, for those under the age of 65, show that close to 90 per cent of Albertans feel that their health is excellent, very good, or good. This past year, programs to educate Albertans about how to prevent type 2 diabetes was a major focus of attention. Research into health promotion has shown that tangible improvement in attitudes and behaviours can only be achieved through a sustained investment of time, effort and resources. Because of the close linkage between obesity rates and type 2 diabetes rates the trend of indicators such as body mass index and physical activity levels provides information on overall performance in this area. The performance measure results show little change over the past year; however, it is expected that the targeted improvement in these areas will take several years. Success in adopting healthy behaviors and reducing risk factors will require a concerted effort on the part of government, educators, community organizations, health service providers, advocacy groups and individual Albertans.

Childhood immunization is known to be an effective strategy for preventing communicable childhood diseases such as rubella, pertusis (whooping cough), and meningitis. While Alberta has one of the most comprehensive immunization programs in Canada, there is room to improve coverage rates. Alberta Health and Wellness aspires to immunize all Alberta children and to reach national targets. It is difficult to compare Alberta to other jurisdictions as immunization programs are implemented differently and coverage rates are calculated differently. However, it is estimated that Alberta's rates are similar to other jurisdictions. A broad range of strategies must be adopted to improve these rates. It is important to continue to educate parents about the benefits of protecting the health of their young children through immunization, and to reduce the length of time parents wait for an appointment. Over the next year a specific strategy to encourage parents to have their children receive all immunizations during one visit will be implemented.

Alberta Health and Wellness has a leadership responsibility for ensuring that effective structure, process and strategies are in place to safeguard the health of Albertans. However, the ministry cannot fulfill this responsibility through its efforts alone. Many other organizations such as regional health authorities, schools, voluntary organizations and municipalities play a pivotal role. The key to success lies in combining the unique strengths and capabilities in a common effort to promote health and influence the way people think and behave.

Core Business 2

This core business to ensure quality health services includes goals 3 and 4 of the ministry business plan for 2004-2007. The core business focuses on strategies to improve access to health services and to improve health service outcomes. Actual expenses for core business 2 were $322 million higher than anticipated. This is due primarily to the $350 million announced June 2004 that was provided to health authorities to improve access to services. Delays in starting up Local Primary Care Initiatives and a reduced funding requirement for the Physician Office System Program have helped to offset this additional expense.

To most Albertans the performance of Alberta's health system is determined by accessibility, that is, how easy or difficult it is to gain access to needed health services. The Health Quality Council of Alberta (HQCA) conducted a survey to measure satisfaction with health services. The 2005 survey results show that roughly 20 per cent of Albertans said it was difficult to access health care services. Concerns about access are commonly reflected in waitlists and wait times for major surgery such as hip or knee replacements. Additional funding has resulted in an increase in the number of hip and knee replacement surgeries.

In 2004/2005, 5,627 hip and knee replacements were performed. This represents an increase of 268 procedures over 2003/2004. Despite the increase in the number of procedures performed, the total number of Albertans waiting for hip replacement surgery remained constant and the average length of wait rose from 45 days in March 2004 to 59 days in March 2005. This indicates that recent increases in surgical capacity allowed more Albertans to receive these procedures. However, increases in overall demand have meant that the number waiting has not been reduced.

Future success in reducing waitlists and wait times for surgery will require reorganizing the delivery of service to address factors that affect patient flow, system bottlenecks and process inefficiencies. An arthroplasty pilot will test a new care path, with the goal of improving access to surgery and patient care.

The notion of quality includes appropriate, effective and safe service delivery. According to the 2005 HQCA survey results, 86 per cent of Albertans rate the overall quality of health services they received as good, very good, or excellent. The 30-day survival rates for heart attack victims admitted to hospital remains high at roughly 90 per cent. This is an indicator that acute hospital patients are receiving high quality care. Over the past five years there has been a steady reduction in the number of hospital admissions per 100,000 population for "ambulatory care sensitive conditions." "Ambulatory care sensitive conditions" are diagnostic categories which can be treated on an outpatient basis rather than requiring admission to a hospital bed. This performance measure result indicates the success of strategies aimed at providing the most appropriate care in the most appropriate location.

Appropriate care management strategies have the potential of reducing the cost of care on a case by case basis and reducing the length of time patients spend waiting for services. These strategies also allow patients the option of receiving care in community and non-institutional settings rather than having to rely on traditional hospital care. Rather than requiring patients to navigate through a complex array of services and providers, we must continue our efforts at enhancing multidisciplinary primary care, follow-up and case management services. The Local Primary Care Initiatives created under the tri-lateral

master agreement are one solution the ministry is working on.

An important indicator of health system performance is the satisfaction of patients and their families with the response to their complaints. Survey results show a decline in satisfaction rates from 38 per cent in 2002 to 30 per cent in 2004. These results are well below the target of 50 per cent. The ministry will closely monitor the statistics for public satisfaction with the response to complaints and will look more closely into the underlying factors and processes.

Alberta is a national leader in the development of information technology and advanced systems to improve the quality and timeliness of care. Alberta's approach to the development and implementation of the Alberta Electronic Health Record (Alberta EHR) has led the way in rapid collection and use of data and information critical for quality care. The Alberta EHR has been deployed to all regional health authorities, to 952 physicians and 715 pharmacists. There are currently 10,261 health service providers with access to the Alberta EHR.

Core Business 3

This core business to lead the health system includes goals 5 and 6 of the ministry business plan for 2004-2007. The core business focuses on strategies to promote health system sustainability and ministry organizational excellence. Spending on core business 3 was $15 million higher than budgeted. This is due to higher than anticipated costs to support and maintain departmental information systems.

Achieving the long-term goal of sustainability in Alberta's health system means bringing the growth in health system expenditures in line with the average growth in government revenues. The overall increase in Alberta Health and Wellness expenditures was 13 per cent over the previous year. This matched a 13 per cent growth in total provincial revenues for the same period. Therefore, the resulting ratio of growth in health expenses compared to growth in provincial revenues was 1.0 which is well below the target of 1.5 (see Measure 5.C).

Although the shortage of physician manpower continues to exist in certain specialty areas, Alberta's track record in training, attracting and retaining physicians has been impressive. The total number of specialists has grown by five per cent and the total number of family physicians has grown by three per cent. We cannot be complacent, however, as a large number of physicians are expected to reach retirement age in the next decade while at the same time the population will continue to grow and age.

In September 2004, the First Ministers signed a ten-year agreement on health that provides a new framework for federal, provincial and territorial cooperation. Alberta will be taking the lead in developing a national pharmaceutical strategy, with a focus on high cost drugs for rare diseases and will play a major role in developing strategies to improve access and reduce wait times. Other areas of focus for collaborative work among federal, provincial and territorial jurisdictions are home care, primary care and Aboriginal health. In 2004/2005 the share of Health and Wellness program expense provided by federal contributions increased to 21 per cent compared to 19 per cent in 2003/2004. The new money provided by the federal government was intended to support provinces in reducing wait times and improving access. Beginning in 2005/2006 the Canada Health Transfer for all provinces will be $19 billion and will increase each year by six per cent until 2013.

The health system is a strong economic driver in Alberta's economy. Health system spending is beginning to be recognized for its potential as an economic generator in addition to an investment in improved health outcomes. This is demonstrated by the number of people employed in the sector, annual expenditures for health care supplies and services, health related research initiatives and the construction of health facilities. As of March 31, 2004, the number of health practitioner registrations recorded by the various colleges and associations totaled 83,497 people. Statistics Canada reports that in April 2005, 5.5 per cent of Alberta workers were employed in a health occupation. In 2004, total health care expenditures in Alberta were estimated at $13.687 billion[1]. The Alberta health system helps to attract external revenue and investment to support "made in Alberta" technologies, science, industry and research. It is important for Albertans to recognize and benefit from the many business and economic opportunities associated with the health system.

Looking Ahead

Premier Klein has reaffirmed government's commitment to public health care. As the Ministry of Alberta Health and Wellness proceeds with plans to give Albertans the best and most responsive health care in Canada, it will continue to explore the best practices and innovative ideas of health systems across this country, and around the world. Simply investing more money is not the answer to the challenges we face. Individual health care providers, health regions and other health system leaders must be prepared to look for better ways of delivering services that are innovative and responsive. The adoption of new and flexible approaches to health care will enable Alberta to meet the demands of a growing and aging population. Looking to the future, Alberta will continue to examine the benefits and feasibility of implementing the lessons learned from the world's leading health systems.

Among our top priorities in the coming years will be to help Albertans achieve and maintain optimum health. A special effort will be devoted to improving the health of children, youth and Aboriginal people. Albertans will be encouraged to take more responsibility for their own health and will have greater opportunities for choosing health related goods and services that best suit their needs. Albertans recognize that good health is not simply the absence of disease, but must take into account other health determinants such as economic prosperity, education, and the environment.

Alberta will introduce new models of primary health care that allow Albertans to have ready access to well coordinated, multi-disciplinary care. These include new approaches that fully integrate mental health and addiction services with other health care programs. New and emerging health technologies and information systems present additional opportunities and challenges. Alberta will continue to invest in beneficial new technologies and drugs to improve quality, efficiency and effectiveness. The Alberta Electronic Health Record, telehealth and other advances in communication and information technology are powerful tools in improving the timeliness and accuracy of services. They will shape the health system of the future. Over the next year, discussions will continue on what we heard at Alberta's Symposium on Health (Calgary, May 2005) and how we can apply what was learned to improve health system performance and sustainability.

[1]CIHI National Health Expenditure Trends 1975 – 2004, Table B.1.1p127

Challenges and Opportunities

The future of Alberta depends on the health and wellbeing of Albertans now and in the years to come. Alberta is home to one of Canada's best health care systems, but Albertans continue to look for improvements in the way it serves their needs. Over the last year, innovations in key areas have laid the foundation for improved accessibility, integration and cost-effectiveness. But the goal of maintaining a high quality health system brings with it many issues and challenges.

The first challenge is to meet the needs of a growing and aging population. Alberta's cities continue to expand and are starting to face health problems related to urban sprawl. People living in communities dependent on cars have fewer opportunities for walking to their destinations. This, in turn, leads to a higher incidence of obesity and chronic disease. Alberta Health and Wellness and public health leaders have an opportunity to work with municipalities and urban developers to address these health concerns.

New drugs and technological advances are contributing to increased costs. Drugs represent the fastest growing area of health expenditure in Alberta. For example, high priced "orphan drugs" – pharmaceutical, chemical or biological products for rare diseases or conditions – are becoming a priority.

Maintaining a quality health system depends on having an adequate supply of well trained health care workers. Large numbers of additional health professionals will be needed to staff new facilities and replace those ready for retirement. Shortages of health workers make it difficult to provide the care Albertans need. These shortages affect rural areas the most. The Ministry of Alberta Health and Wellness is working with stakeholders to address these issues through the Rural Physician Action Plan. The plan seeks to train and attract physicians to serve rural Alberta. Measures must also be taken to increase enrolment in educational programs that train health professionals and change how health care is delivered. Initiatives for recognizing the credentials of immigrant health professionals are underway.

In 2005, the ministry enters a new round of negotiations with the AMA and health authorities under the framework of the tri-lateral master agreement. The challenge here will be to maintain the spirit of partnership and innovation created in the last round of negotiations and to continue to move forward with the advancements coming out of the agreement.

Quality improvement and patient safety are a matter of concern to local, regional and provincial health system leaders. Safeguards and mechanisms to anticipate and prevent adverse events such as medication and technical errors must be strengthened. Supportive organizational, professional and legal environments are needed to encourage the reporting of adverse events and the prompt implementation of corrective action. The rapid and accurate transmission of health information is part of the answer. Tools such as the Alberta Electronic Health Record (Alberta EHR) can improve the quality and safety of patient care. The Alberta EHR makes health information readily available at all points of care; this will reduce delays in treatment and support providers in making decisions.

Spending on health care in Alberta and across Canada has been growing at a much faster rate than the economy overall. Federal and provincial governments are striving to control health care spending so as to achieve the best value for every health dollar spent. Financial discipline, sound stewardship and fair allocation processes are needed to sustain health services while remaining within budget. Achieving health system sustainability requires cooperation and compromise on the part of governing authorities, system managers, professional associations, and bargaining units. By leveraging the unique contributions of various partners, by ensuring the best use of Alberta's knowledge and intellectual capital, and by developing innovative ways of delivering services, we will gradually bring health expenditures in line with anticipated revenues.

Albertans expect their health system to provide timely, efficient and safe services. However, there will always be situations that cannot be controlled. For example, we do not know the exact timing of the next influenza pandemic; however, experts from the World Health Organization and the Public Health Agency of Canada predict that a pandemic is imminent. Alberta Health and Wellness will continue to manage stockpiles of medical supplies, antiviral drugs and vaccines. Through surveillance and effective communications the health system is prepared to respond to any public health emergency.

Alberta's growing Aboriginal population faces a variety of health challenges. The delivery of health services to remote or isolated Aboriginal communities is difficult. Over the next year, the ministry will implement and expand strategies to improve Aboriginal health and will do so in collaboration with Aboriginal leaders, health authorities and service providers.

One in five Canadians will be affected by mental illness during their lifetime. The overall prevalence of mental illness in Canadian children and adolescents at any given time is about 15 per cent. Mental illness is having a significant economic impact on individuals, families, workplaces and the health care system. The new Mental Health Innovation Fund will help regional health authorities improve services in keeping with the provincial mental health plan.

Chronic disease leads to high costs for the health system and is a burden on families and society. This leaves less money for education, infrastructure and the environment. Health promotion campaigns take many years to have a significant impact on lifestyle and health. Children who have health issues are more likely to struggle with the same issues as adults. Addressing the health problems of the younger generation constitutes a sound investment for the future. New government programs will address unhealthy body weight, sexually transmitted infections, developmental problems and tobacco use among children. Another priority issue includes finding ways to limit children's access to sexual and violent content on the Internet.

Finally, in a recent report, Alberta's Auditor General focused public attention on the need to improve the quality and monitoring of long-term care for seniors. Alberta Health and Wellness will implement standards for supportive living, assisted living, long-term care facilities and home care. The ministry will also continue to work with regional health authorities and other key stakeholders to increase staffing levels in long-term care.

Alberta Alcohol and Drug Abuse Commission (AADAC)

Mission

Making a difference in people's lives by assisting Albertans to achieve freedom from the harmful effects of alcohol, other drugs and gambling.

Core Businesses, Goals and Performance Measures

AADAC's mission is undertaken through three core businesses: information, prevention and treatment. Programs and services to address the needs of the general population and specific groups are integrated across these core businesses.

AADAC area offices, clinics, institutions and funded services are located in 48 Alberta communities. Individuals and families have access to basic addiction services where they live and work, with more specialized programs available on a regional or provincial basis.

Goal 1

To inform Albertans about alcohol, other drug and gambling issues and AADAC services.

AADAC provides Albertans with current and accurate information on alcohol, other drugs and gambling. Information management and dissemination creates greater awareness of addiction issues and AADAC services, and is required to support the development and delivery of prevention and treatment programming. Information and resource materials are available through AADAC offices and clinics, and are accessible on the AADAC website at **www.aadac.com.**

What We Did

- AADAC worked with the Canadian Centre on Substance Abuse, Health Canada and others to develop a national research agenda in support of Canada's Drug Strategy. As a member of the Canadian Addiction Survey National Advisory Committee, AADAC assisted in the release of the Canadian Addiction Survey (CAS) results during the 2004 National Addiction Awareness Week. Results provide current information on national and provincial prevalence and patterns of alcohol and illicit drug use.
- AADAC developed five new resources to support the Commission's Enhanced Services for Women (ESW). These resources provide information on the effects of substance abuse during pregnancy. In addition, AADAC held 15 ESW Health Kit training events for staff and community stakeholders, and distributed over 500 copies of the ESW Help Kit to allied professionals working with women.
- AADAC implemented a corporate knowledge/information management strategy that focused on records disposition and management, updates to AADAC's corporate website and re-development of AADAC's intranet.

Key Performance Measures and Results

Measure 1.1

Percentage of Albertans who are aware of AADAC services

Albertans who are aware of AADAC services are more informed about where to get information on alcohol, other drugs and problem gambling.

Awareness of AADAC services

	2002/2003	2003/2004	2004/2005	Target 2004/2005
Percentage of Albertans who are aware of AADAC services	89	89	88	90

Source: AADAC Public Opinion Survey (2003); Alberta Survey (2004, 2005).
For 2004/2005, AADAC contracted the Population Research Laboratory, University of Alberta to ask about awareness of AADAC. Data were collected through telephone interviews of 1,208 randomly selected Albertans aged 18 years and older (response rate = 26.3 per cent). The margin of error for these results is ± 2.8 per cent, 19 times out of 20. Respondents were asked: "Prior to me phoning you today, were you aware of the Alberta Alcohol and Drug Abuse Commission, or AADAC?"

MEASURE 1.2

Percentage of women who are aware that alcohol use during pregnancy can lead to lifelong disabilities in a child

Alcohol consumption during pregnancy can have long-term effects on childhood development. Offering a range of prenatal prevention programs can reduce the number of children born with the lifelong disabilities of fetal alcohol spectrum disorder (FASD).

Awareness of effects of alcohol use during pregnancy

	1999/2000	2003/2004	2004/2005	Target 2004/2005
Percentage of women who are aware that alcohol use during pregnancy can lead to lifelong disabilities in a child	89	99	99	90*

Source: Environics Research Group, Health Canada (2000). Awareness of the effects of alcohol use during pregnancy and fetal alcohol syndrome – Results of a national survey. This nation wide survey of 1,205 respondents aged 18 to 40 included 902 women. For the sample of women, the response rate was 29.4 per cent and the margin of error was ± 3.3 per cent, 19 times out of 20.

Alberta Survey (2004, 2005). AADAC contracted the Population Research Laboratory, University of Alberta, to ask about awareness of harms associated with alcohol consumption during pregnancy. For 2003/2004, data were collected through telephone interviews of 1,207 randomly selected Albertans aged 18 years and older (response rate = 38.3 per cent) that included 600 women. The margin of error is ± 2.8 per cent, 19 times out of 20. For 2004/2005, data were collected through telephone interviews of 1208 randomly selected Albertans aged 18 years and older (response rate = 26.3 per cent) that included 605 women. The margin of error is ± 2.8 per cent, 19 times out of 20.

Respondents for the surveys were asked: "True or false – alcohol use during pregnancy can lead to life-long disabilities in a child?"

* The 2004/2005 target was based on results from the survey conducted by Environics Research Group for Health Canada (2000). The target for 2005/2006 has been adjusted based on results from the 2003/2004 Alberta Survey.

DISCUSSION

In 2004/2005, 88 per cent of Albertans surveyed indicated they were aware of AADAC. Results were within two per cent of the 90 per cent target. Ninety-nine per cent of Alberta women surveyed were aware that alcohol use during pregnancy could lead to life long disabilities in a child, exceeding the target of 90 per cent. Results for these two measures indicate Albertans are informed about the services offered by AADAC and the risk of alcohol consumption during pregnancy.

Goal 2 To prevent the development of and reduce the harms associated with alcohol, other drug and gambling problems.

AADAC provides programs and services to prevent alcohol, other drug and gambling problems, and reduce the harms associated with substance use and problem gambling. Prevention strategies are intended to increase protective factors and reduce risk factors for the population as a whole, and within specific groups.

What We Did

- In 2004/2005, AADAC continued to lead and coordinate the Alberta Tobacco Reduction Strategy.
  - To address tobacco use by youth, AADAC expanded local implementation of two provincial programs through schools and sport organizations. The Alberta Spit Tobacco Education Program (ASTEP) focuses on raising awareness of the dangers of spit tobacco use among youth involved in junior hockey, football and rodeo. Sport for Life promotes the benefits of an active, tobacco-free lifestyle and is a partnership between AADAC, Alberta Health and Wellness and the Calgary Olympic Development Association.
  - AADAC launched a public awareness campaign targeting prevention, cessation and protection from second-hand tobacco smoke. The campaign included four television ads along with a print and poster campaign.
- AADAC worked with the Alberta Gaming and Liquor Commission (AGLC) to implement the Enhanced Problem Gambling Strategy that included problem gambling awareness training and the development of new resources for gaming operators and AGLC staff. AADAC continued to deliver problem gambling awareness training for VLT (video lottery terminal) operators throughout the province.
- AADAC supported the re-launch of a multi-media fetal alcohol spectrum disorder (FASD) prevention campaign, Your Decision, Baby's Future, in partnership with Children's Services, the Alberta Medical Association and the Alberta College of Physicians and Surgeons.
- AADAC partnered with the Alberta School Board Trustees to develop and pilot three local school-based prevention strategies. AADAC also participated in Teacher Conventions across the province to profile school-based prevention activities.

Key Performance Measures and Results

Measure 2.1

Prevalence of smoking among Alberta youth

Because most regular smokers start at an early age, activities focusing on youth prevention are key to reducing the number of smokers in Alberta. A decline in the prevalence of smoking by Alberta youth will have positive long-term impacts on the health care system.

Smoking among Alberta youth

	2000/2001	2002/2003	Target 2004/2005
Prevalence of smoking among Alberta youth (in per cent)	18	14	16*

Source: Statistics Canada: Canadian Community Health Survey (CCHS) (2000/2001). Daily and occasional smoking combined for Albertans 12–19 years of age. The CCHS includes a sample of Albertans 12 years and older (n = 14, 456). The response rate at the national level is 84.7 per cent.
Statistics Canada: Canadian Community Health Survey (CCHS) (2003). Daily and occasional smoking combined for Albertans 12–19 years of age. The CCHS includes a sample of Albertans 12 years and older (n = 13,871). The response rate at the national level is 80.6 per cent.
Excluded from CCHS sampling framework were residents of institutions, full-time members of the Canadian armed forces, residents of Indian reserves and of Crown lands, and residents of a few remote areas.
*The 2004/2005 target was based on results from CCHS 2000/2001. The target for 2005/06 has been adjusted based on results from the 2003 CCHS.

MEASURE 2.2

Prevalence of regular, heavy drinking among young Albertans

A pattern of regular, heavy drinking is associated with a higher risk of experiencing alcohol-related harm. Prevention programs targeting young Albertans are intended to reduce acute and chronic problems associated with this pattern of alcohol consumption.

Regular, heavy drinking among young Albertans

	2000/2001	2002/2003	Target 2004/2005
Prevalence of regular or heavy drinking among young Albertans (in per cent)	34	31	33*

Source: Statistics Canada: Canadian Community Health Survey (CCHS) (2000/2001, 2003). Regular, heavy drinking is defined as the consumption of five or more alcoholic drinks per drinking occasion, at least once per month during the previous year for Albertans 15 to 29 years of age.
For 2000/2001, the CCHS included a sample of Albertans 12 years and older (n = 14,456). The overall response rate for Alberta was 85 per cent. For 2003, the CCHS included a sample of Albertans 12 years and older (n = 13,871). The overall response rate for Alberta was 82.7 per cent.
Note: Health Surveillance, Alberta Health and Wellness produced Albertans 15 to 29 years of age custom tabulations. For 2000/2001, the 95 per cent confidence interval for a sample of Albertans 15 to 29 years of age was 31.9 – 36.7. For 2003, the 95 per cent confidence interval for a sample of Albertans 15 to 29 years of age was 28.9 – 32.2.
Excluded from the CCHS sampling framework were residents of institutions, full-time members of the Canadian armed forces, residents of Indian reserves and of Crown lands, and residents of a few remote areas.
* The 2004/2005 target was based on results from CCHS 2000/2001. The target for 2005/2006 has been adjusted based on results from the 2003 CCHS.

DISCUSSION

Prevalence of smoking and rates of regular, heavy drinking among young Albertans have declined since 2001. These declines are better than AADAC's targets. Of Albertans who participated in the Canadian Community Health Survey, 14 per cent of those aged 12 to 19 years were current smokers (target 16 per cent) and 31 per cent aged 15 to 29 years were regular heavy drinkers (target 33 per cent).

Results suggest that prevention activities are having a positive influence on the prevalence of smoking and regular, heavy drinking among young Albertans.

Goal 3 To provide treatment programs and services that assist Albertans to improve or recover from the harmful effects of alcohol, other drug and gambling problems.

AADAC offers a broad continuum of treatment services that assist Albertans to improve or recover from the harmful effects of alcohol, other drug and gambling problems. Treatment is aimed at adults, youth and their families who display significant problems. Services include community-based outpatient counseling, day programs, crisis and detoxification services, short- and long-term residential treatment, and overnight shelter. Specialized programs are available for youth, women, Aboriginal Albertans, business and industry referrals, and persons with opioid dependency or cocaine addiction.

What We Did

- AADAC extended residential gambling treatment services to the Northern Addictions Centre in Grande Prairie, added tobacco cessation programming to Lander Treatment Centre in Claresholm, and introduced a new day treatment program for women through AADAC Counselling and Prevention Services in Edmonton.
- AADAC provided start-up funding to the Safe Harbour Society for the delivery of shelter and detoxification services to the residents of Red Deer and other central Alberta communities.
- AADAC participated in the development of the Bridges program in partnership with Capital Health and the Alberta Solicitor General. This youth residential addiction treatment program targets young male offenders (12 to 17 years) sentenced to open custody, who have been assessed as having co-existing mental health and addictions problems.
- As a member of the Non-Prescription Needle Use Consortium, AADAC co-chaired the Opioid Dependency Treatment (ODT) Provincial Coordinating Committee. This interdisciplinary committee oversees the delivery of ODT services in the province and addresses issues related to service availability, access, acceptability and quality of care.

Key Performance Measures and Results

Measure 3.1

Percentage of clients who are satisfied with AADAC treatment services

To increase the probability of success, it is important that treatment programs meet the needs and expectations of clients receiving these services. AADAC surveys clients to assess their level of satisfaction with treatment services received.

Satisfaction with AADAC treatment services

	2001/2002	2002/2003	2003/2004	2004/2005	Target 2004/2005
Percentage of clients who are satisfied with AADAC treatment services	95	95	96	95	95

Source: AADAC Treatment Follow-up Survey database. Client satisfaction was assessed from two sources. Results from both sources were combined and weighted to provide total client satisfaction (n = 8,878).
An independent private research contractor conducted follow-up telephone interviews with treatment clients. Clients entering treatment services who gave consent for follow-up (excluding detoxification) were eligible for telephone interview selection. Based on annual client admissions, sample quotas were assigned to each treatment type. A random sample of 7,048 clients was telephoned three months after treatment completion. A total of 2,579 clients were interviewed and asked to rate their level of satisfaction with services received (response rate = 36.6 per cent). The margin of error is ± two per cent, 19 times out of 20.
Client satisfaction with detoxification was measured by a self-administered feedback survey given to clients at the end of service. Of the 11,424 client receiving detoxification services, 6,299 surveys were returned (response rate = 55.1 per cent).

MEASURE 3.2

Percentage of clients reporting they were improved following treatment

AADAC offers a continuum of treatment services that address the individual needs of clients. The intended outcome is client abstinence or an improved level of recovery. AADAC measures client improvement following treatment to ensure that programs are effective.

Improvement following AADAC treatment

	2001/2002	2002/2003	2003/2004	2004/2005	Target 2004/2005
Percentage of clients reporting they were improved following treatment	93	94	93	92	95

Source: AADAC Treatment Follow-up Survey database. Client improvement was assessed using the same process as in client satisfaction source (1) above. Number of clients interviewed, response rate and margin of error are as above. Clients were interviewed and asked about their level of substance use and gambling. Improvement was indicated if clients were "abstinent" or "improved" three months after treatment.

DISCUSSION

In 2004/2005, the target for client satisfaction with treatment services was met; 95 per cent of clients surveyed reported they were "somewhat satisfied" or "very satisfied" with the treatment services received. The high level of satisfaction suggests treatment programs are meeting client expectations.

In 2004/2005, the target for clients reporting improvement following treatment was not met. However, results still remain very positive with 92 per cent of clients surveyed reporting improvement three months after treatment. The change since 2002/2003 may be attributed to increasing complexity of addiction issues and client need. Results indicate that the intended outcome of abstinence or improved level of recovery continues to be achieved.

Cross-Ministry Initiatives

AADAC supported the Health Sustainability Initiative (HSI) through continued membership on the Partnering Deputies Committee and activities carried out through the Alberta Tobacco Reduction Strategy, AADAC's Enhanced Services for Women and AADAC's Youth framework.

AADAC contributed to the Aboriginal Policy Initiative (API) through membership on the interdepartmental committee responsible for the API. AADAC also provided funding for 19 community tobacco prevention, education, and cessation initiatives for Aboriginal Albertans living off reserve.

In support of the Alberta Children and Youth Initiative (ACYI) AADAC continued to participate on committees such as the Interdepartmental Committee on Family Violence and Bullying. In addition, AADAC co-chaired the Cross-Ministry Committee on Fetal Alcohol Spectrum Disorder (FASD) that drafted the Provincial FASD Strategic Plan.

AADAC also continued to chair the Provincial Advisory Committee on Illicit Drugs and is leading the development of a comprehensive Alberta Drug Strategy (ADS). The ADS promotes a coordinated approach and community-based response to drug issues in the province.

AADAC participated on the Edmonton Drug Strategy Steering Committee and helped to host the Edmonton Community Drug Strategy Workshop. AADAC also co-hosted (with the Alberta Solicitor General) the Alberta Workshop on Methamphetamine: An Environmental Scan held in Red Deer. The workshops examined the nature and extent of methamphetamine concerns in Alberta and considered broader issues associated with substance use.

AADAC contributed to corporate key administrative initiatives through activities such as the completion of an updated disaster recovery plan and the provision of information and supports to employees to promote healthy choices and a safe work environment. To enhance professional development, AADAC offered 57 courses to support a core-training curriculum for AADAC staff and allied professionals.

Future Challenges

Substance use and gambling problems occur at all levels of society and within communities throughout Alberta. At some point in their lives, many Albertans will experience personal problems related to alcohol, other drugs or gambling. Others will face difficulties because of someone else's addiction.

Demand for AADAC services has increased and is likely to continue. AADAC's priority will be to maintain access to the existing provincial system of addiction services. Continued research and ongoing commitment to partnerships will be required to consolidate and extend service reach. The growing demand for services also requires a deliberate focus on extending services where potential impact will be greatest. Therefore, challenges will include completing the range of services for youth and enhancing specialized services for Aboriginal people, women, seniors and people with opioid dependence.

Individuals, families, communities and governments all contribute in effectively responding to problems related to alcohol, other drugs and gambling. AADAC emphasizes working in partnership and sees the development of an Alberta Drug Strategy designed to support communities, and interdepartmental and cross-sector partnerships, as key ways to increasing overall system co-ordination and capacity.

Changes to Performance Measures Information

New or Changed Key Performance Measures for 2004/2005 Annual Report:

For 2004/2005 several new measures were added to better reflect the new directions and objectives of the Ministry of Alberta Health and Wellness 2004-2007 Business Plan. They focus on healthy lifestyles and the sustainability of the health care system.

- Per cent of Albertans who smoke (new).
- Per cent of Alberta youth (age 12 – 19) who smoke (new).
- Per cent of Albertans who are "active or moderately active" (new).
- Per cent of Albertans with "acceptable" body mass index (BMI) (new).
- Pneumococcal and Meningococcal Immunization coverage rates (new).
- Regional health authority achievement of targets based on clinical urgency (changed). The data collection, analysis and metrics have changed compared to previous years. Data is now collected from the Alberta Waitlist Registry. Data is updated and is no longer gathered quarterly except for cancer data which remains the same.
- Success in treating people with chronic conditions in their communities – Ambulatory Care Sensitive Conditions hospitalization (new).
- Heart attack survival rate (30-day survival in hospital) (new).
- Satisfaction with responses to complaint about services (new).
- Public rating of health system overall (new).
- Physical condition of health facilities (new).
- Per cent increase in provincial health expenses in relation to the per cent growth in provincial revenues (new).
- Funding for service provided – A) portion of provincial contribution and B) portion of federal contribution (new).
- Developing and maintaining workforce capacity (changed). Changed to provide actual numbers, not just the per cent change.
- Number of contacts regarding the Alberta Health Care Insurance Plan (new).
- Per cent of Alberta Health and Wellness employees who report that organization provides the support they need to acquire or develop knowledge and skills in their current jobs (new).

Key Performance Measures to be discontinued after the 2004/2005 Annual Report:

For 2005/2006 several measures will be discontinued. These measures are reported by other organizations or do not reflect the success of the health system overall and therefore belong as part of the Ministry's internal operational planning and reporting process.

- Ratings of ease of access to health services - a. physician services and b. hospital services. This is a subjective measure; wait lists and wait times provide a more accurate picture of access in the health care system.
- Rating of quality of care received - a. overall and b. hospital. The results for this measure are similar to the ratings for the health system overall and do not provide any additional information.

- Per cent of persons who have received a service who are satisfied with the way the service was provided. The results for this measure are similar to the ratings for the health system overall and does not provide any additional information.
- Satisfaction with response to complaints about health services. This measure is reported by regional health authorities.
- Physical condition of health facilities. This measure is reported by Alberta Infrastructure and Transportation.
- Per cent increase in provincial health expenses in relation to the per cent growth in provincial revenues. Extremely high non renewable resource revenue distorts this measure and does not give an accurate picture of the financial sustainability of the health care system.
- Funding for services provided: A) Portion of provincial contribution and B) Portion of federal contribution. Contributions by the federal government for the next six years have been agreed to as a result the First Ministers' Meeting in September 2004. Reporting in this area will be part of that process.
- Per cent of Albertans reporting their inquires to the department were handled satisfactorily. This measure does not reflect the performance of the health system and has been incorporated into the Ministry's operational planning and reporting process.
- Number of contacts regarding the Alberta Health Care Insurance Plan. The focus of Goal 6 will be substantially changed. This measure has been incorporated into the Ministry's operational planning and reporting process.
- Satisfaction rating among other ministries with Alberta Health and Wellness' contribution to Cross-Ministry Initiatives. The focus of Goal 6 will be substantially changed. This measure has been incorporated into the Ministry's operational planning and reporting process.
- Per cent of Alberta Health and Wellness employees who report that the organization provides the support they need to acquire or develop knowledge and skill in their current jobs. The focus of Goal 6 will be substantially changed. This measure has been incorporated into the Ministry's operational planning and reporting process.
- Per cent of Alberta youth (age 12 – 19) who smoke. This is retained in the AADAC section of the ministry annual report. AADAC is responsible for the Alberta Tobacco Reduction Strategy and smoking rates are reported in their portion of the annual report.
- Per cent of Albertans who smoke. AADAC is responsible for the Alberta Tobacco Reduction Strategy.
- Cancer Radiation Therapy: Average waiting time will be replaced by a five-year cancer survival rate.

New Key Performance Measures for 2005/2006 Annual Report:

For 2005/2006 several new measures were added to better reflect the new directions and objectives of the Ministry of Alberta Health and Wellness 2005-2008 Business Plan. The new plan will focus on wellness and prevention of chronic diseases. Greater emphasis will also be placed on maintaining a contemporary health workforce. The new measures reflect healthy lifestyles and ensuring an adequate supply of health workers. These measures are better indicators of the success of target health promotion and disease prevention initiatives or are comparable with other provinces and countries.

- Life expectancy at birth – Source: Statistics Canada.
- Per cent of low birth weight babies – Source: Alberta Vital Statistics Birth File.
- Per cent of Albertans age 12 and over who eat at least five to ten servings of fruit and vegetable each day – Source: Statistics Canada.
- Number of new cases of type 2 diabetes per 1,000 population at risk – Source: Alberta Health and Wellness, Health Surveillance.
- Age adjusted rate of newly reported HIV cases per 100,000 population – Source: Alberta Health and Wellness, Health Surveillance.
- Rates of newly reported sexually transmitted infections (STI) per 100,000 population – Source: Alberta Health and Wellness, Health Surveillance.
- Motor vehicle related mortality rate per 100,000 population – Source: Vital Statistics and the Alberta Health Death Registration Database.
- Screening rate for breast cancer – (will exclude mammograms for diagnostic purposes – source remains the same: Statistics Canada).
- Percentage of households spending over five per cent of household income after taxes on prescription drugs – Source: Statistics Canada.
- Percentage of Albertans who have used Health Link Alberta – Source: HQCA.
- Number of physicians in Alternate Relationship Plans (ARP) – Source: Alberta Health and Wellness ARP Status Update Database.
- Number of postgraduate medical education seats – Source: Alberta Health and Wellness, Workforce Policy and Planning.
- Number of health workforce practitioners – Source: Registration numbers from respective professional colleges; annual publications as well as Alberta Labour Force Statistics.
- Five-year Cancer Survival Rate – Source: Alberta Cancer Board.
- Number of care providers accessing the Alberta Electronic Health Record – Source: Alberta Health and Wellness, Wellnet.

Financial Information

Ministry of Health and Wellness

Consolidated Financial Statements

March 31, 2005

MINISTRY OF HEALTH AND WELLNESS

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2005

Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Cash Flows

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Schedule 3 - Consolidated Expenses Directly Incurred Detailed by Object

Schedule 4 - Consolidated Budget

Schedule 5 – Consolidated Related Party Transactions

Schedule 6 – Consolidated Allocated Costs

The official version of this Report of the Auditor General, and the information the Report covers, is in printed form.

Auditor's Report

To the Members of Legislative Assembly

I have audited the consolidated statement of financial position of the Ministry of Health and Wellness as at March 31, 2005 and the consolidated statements of operations and cash flows for the year then ended. These consolidated financial statements are the responsibility of the Ministry's management. 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 plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these consolidated financial statements present fairly, in all material respects, the financial position of the Ministry as at March 31, 2005 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

As disclosed in Note 2, the recommendations of the Public Sector Accounting Board (PSAB) of the Canadian Institute of Chartered Accountants are the primary source for the disclosed basis of accounting. PSAB has recently revised the definition of the Government reporting entity for implementation for years commencing on or after April 1, 2005. If all organizations referred to in Note 2(a) had been included in the accompanying statements, I estimate that assets and liabilities would increase by approximately $4.9 billion and $1.4 billion respectively as at March 31, 2005.

[Original Signed by Fred J. Dunn, FCA]
FCA
Auditor General

Edmonton, Alberta
May 20, 2005

MINISTRY OF HEALTH AND WELLNESS

CONSOLIDATED STATEMENT OF OPERATIONS

FOR THE YEAR ENDED MARCH 31, 2005

(in thousands)

	2005		2004
	Budget (Schedule 4)	Actual	Actual
Revenues (Schedule 1)			
Internal Government Transfers	$ 209,274	$ 209,274	$ 196,380
Transfer from the Government of Canada	1,625,112	1,736,615	1,412,722
Premiums and Fees	950,999	942,579	963,529
Other Revenue	77,973	89,154	82,278
	2,863,358	2,977,622	2,654,909
Expenses - Directly Incurred (Note 2c (v) and Schedules 3 and 6)			
Program			
Regional Health Services	4,506,899	4,731,009	4,085,950
Diagnostic/Medical Equipment	49,640	199,640	49,600
Province-Wide Services	454,309	454,311	414,962
Physician Services	1,521,600	1,537,438	1,571,272
Non-Group Health Benefits	531,623	516,899	466,051
Allied Health Services	77,500	71,091	67,002
Protection, Promotion and Prevention	176,518	200,037	168,457
Human Tissue and Blood Services	137,000	122,330	122,488
Other Provincial Programs	185,659	181,804	130,348
Alberta Alcohol and Drug Abuse Commission	66,157	67,455	61,001
Health Reform	115,745	88,571	53,482
Ministry Support Services	116,334	125,352	112,931
Systems Development	15,494	6,955	15,533
	7,954,478	8,302,892	7,319,077
Statutory (Schedule 3)			
Valuation Adjustments			
Health Care Insurance Premium Revenue Write-Offs	41,363	63,053	46,723
Other Write-Offs	-	57	39
	41,363	63,110	46,762
Provision for Vacation Pay	-	1,008	532
	41,363	64,118	47,294
	7,995,841	8,367,010	7,366,371
Net Operating Results	$ (5,132,483)	$ (5,389,388)	$ (4,711,462)

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

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2005

(in thousands)

	2005	2004
ASSETS		
Cash (Note 3)	$ 18,780	$ 28,016
Accounts Receivable, Loans and Advances (Note 4)	600,678	161,873
Consumable Inventory	5,974	5,578
Tangible Capital Assets (Note 5)	67,471	57,318
	$ 692,903	$ 252,785
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 6)	$ 490,356	$ 379,582
Unearned Revenue (Note 7)	639,305	291,279
	1,129,661	670,861
NET LIABILITIES		
Net Liabilities at Beginning of Year	(418,076)	(277,306)
Net Operating Results	(5,389,388)	(4,711,462)
Net Transfer from General Revenues	5,370,706	4,570,692
Net Liabilities at End of Year	(436,758)	(418,076)
	$ 692,903	$ 252,785

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

MINISTRY OF HEALTH AND WELLNESS

CONSOLIDATED STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED MARCH 31, 2005

(in thousands)

	2005	2004
Operating Transactions		
Net Operating Results	$ (5,389,388)	$ (4,711,462)
Non-cash items:		
Amortization of Tangible Capital Assets (Schedule 3)	7,340	6,552
Inventory Consumed	28,223	24,206
Health Care Insurance Premium Revenue Write-offs	63,053	46,723
Other Write-Offs	57	39
Provision for Vacation Pay	1,008	532
	(5,289,707)	(4,633,410)
(Increase) in Accounts Receivable and Inventory	(501,611)	(61,968)
Increase (Decrease) in Accounts Payable and Accrued Liabilities	109,766	(33,755)
Increase in Unearned Revenue	348,026	200,250
Cash (applied to) Operating Transactions	(5,333,526)	(4,528,883)
Capital Transactions		
Acquisition of Tangible Capital Assets	(17,493)	(13,243)
Acquisition of Consumable Inventory	(28,920)	(24,003)
Transfer of Tangible Capital Assets	-	100
Cash (applied to) Capital Transactions	(46,413)	(37,146)
Investing Transactions		
Loans and Advances	(3)	-
Repayment of Loans and Advances	-	145
Cash Provided by (applied to) Investing Transactions	(3)	145
Financing Transactions		
Net Transfer from General Revenues	5,370,706	4,570,692
Increase (Decrease) in Cash	(9,236)	4,808
Cash, Beginning of Year	28,016	23,208
Cash, End of Year	$ 18,780	$ 28,016

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

MINISTRY OF HEALTH AND WELLNESS
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2005

Note 1 Authority and Purpose

The Minister of Health and Wellness (Minister) has, by the *Government Organization Act* and its regulations, been designated responsibilities for various Acts. To fulfill these responsibilities, the Minister is responsible for the organizations listed in Note 2(a). The authority under which each organization operates is also listed in Note 2(a). Together these organizations form the Ministry of Health and Wellness (Ministry).

The purpose of the Ministry is to maintain and improve the health of Albertans by leading and working collaboratively with citizens and stakeholders. The Ministry leads and supports a system for the delivery of quality health services and encourages and supports healthy living.

Through a leadership role, the Ministry sets direction, policy and provincial standards that ensure quality services and sets priorities based on health needs, determines the scope of financial, capital and human resources required, and measures and reports on the performance of the system. 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

The recommendations of the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants are the primary source for the disclosed basis of accounting. These financial statements are prepared in accordance with the following accounting policies that have been established by government for all departments.

(a) **Reporting Entity**

The reporting entity is the Ministry of Health and Wellness. The *Government Accountability Act* defines a Ministry as including the Department and any Provincial agency and Crown-controlled organization for which the Minister is responsible.

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

(a) **Reporting Entity (continued)**

These consolidated financial statements include the accounts of the following organizations:

Organization	Authority
Department of Health and Wellness	*Government Organization Act*
Alberta Alcohol and Drug Abuse Commission	*Alcohol and Drug Abuse Act*

The accounts of Regional Health Authorities, the Alberta Cancer Board, and the Alberta Mental Health Board are not included in these consolidated financial statements as these accountable organizations are not considered to be part of the Ministry pursuant to section 1(1)(g) of the *Government Accountability Act*.

Details on balances are disclosed in Notes 4 and 6 and funding to health authorities and provincial boards are included in Schedule 6 to the financial statements under the following programs:

	(in thousands)
Funding to health authorities and provincial boards	
• Regional health services	$ 4,731,009
• Diagnostic and medical equipment	199,640
• Province wide services	454,311
• Physician services - On Call Programs	71,040
• Non-Group Health Benefits	4,611
• Allied Health Services	304
• Health Reform	54,644
• Other Provincial programs	15,593
• Protection, Promotion and Prevention	57,100
	$ 5,588,252

PSAB has released new guidance that controlled entities are to be included and how they are to be included effective April 1, 2005. This may affect how the Ministry reports accountable organizations such as the Regional Health Authorities, the Alberta Cancer Board and the Alberta Mental Health Board depending on whether control exists. The Ministry has agreed in principle to include the financial statements of these entities commencing from fiscal year beginning April 1, 2006, if it is determined that control exists.

(b) **Basis of Consolidation**

Revenue and expense transactions, investing and finance transactions, and related asset and liability accounts between the consolidated organizations were eliminated upon consolidation.

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

(c) **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.

(iii) Transfers from the 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. Established Programs Financing entitlements are recorded based on management's estimate of amounts applicable to the fiscal year. Overpayments relating to Canada Health Transfers and other transfers received before revenue recognition criteria have been met are included in accounts payable.

(iv) Dedicated Revenue

Dedicated revenue initiatives provide a basis for authorizing spending. Dedicated revenues must be shown as credits or recoveries in the details of the Government Estimates for a supply vote.

If actual dedicated revenues are less than budget and total voted expenses are not reduced by an amount sufficient to cover the deficiency in dedicated revenues, the following year's voted expenses are encumbered. If actual dedicated revenues exceed budget, the Ministry may, with the approval of the Treasury Board, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Ministry's dedicated revenue initiatives.

(v) Expenses

Directly Incurred

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

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

- amortization of tangible capital assets.
- inventory consumed.
- pension costs which comprise the cost of employer contributions for current service of employees during the year.

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

(c) **Basis of Financial Reporting (continued)**

(v) Expenses (continued)

Directly Incurred

- 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 disclosed in Schedule 6.

(vi) Assets

Financial assets of the Ministry are limited to financial claims, such as advances to and receivables from other organizations, employees and other individuals as well as cash and consumable inventories. Assets acquired by right are not included. Capital assets of the Ministry are recorded at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. Amortization is only charged if the asset is in use. The threshold for capitalizing new systems development is $100,000 and the threshold for all other capital assets is $5,000 (2004 - $15,000) for the Department and $5,000 for Alberta Alcohol and Drug Abuse Commission.

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

(vii) Liabilities

Liabilities represent all financial claims payable by the Ministry at fiscal year end.

(viii) Net Liabilities

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

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

(c) **Basis of Financial Reporting (continued)**

(ix) Valuation of Financial Assets and Liabilities (continued)

The fair values of cash, accounts receivable, loans and advances, accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments. Fair values of loans are not reported due to there being no organized market for the instruments and it is not practicable within constraints of timeliness or cost to estimate the fair value with sufficient reliability.

(x) Payments under Reciprocal and Other Agreements

The Ministry entered into agreements with other Provincial Governments, the Federal Government 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 consolidated financial statements.

Amounts paid and recovered under these agreements are disclosed in Note 10.

(xi) Measurement Uncertainty
(in thousands)

Measurement uncertainty exists when there is a significant variance between the amount recognized in the financial statements and another reasonably possible amount.

The allowance for doubtful accounts, amounting to $142,592 (2004 - $124,269) is subject to measurement uncertainty.

The allowance for doubtful accounts, in the amount of $142,592 (2004 - $124,269) as reported in Note 4 to these consolidated financial statements, is based on an aging analysis of the accounts receivable balance at March 31, 2005 and past collection patterns. The actual amount collected could vary from that estimated.

The accrual for claims payable to physicians in the amount of $50,321 (2004 - $67,820) is subject to measurement uncertainty. The amount is based on actual payments made subsequent to March 31, 2005 and an estimate for any future payments within the 180 days claim period.

Note 3 Cash
(in thousands)

The cash balance consists of the following:

	2005	2004
Department of Health and Wellness Bank Account	$ 7,898	$ 18,322
Alberta Alcohol and Drug Abuse Commission Consolidated Cash Investment Trust Fund	10,871	9,684
Accountable Advances	11	10
	$ 18,780	$ 28,016

Note 4 Accounts Receivable, Loans and Advances
(in thousands)

	2005			2004
	Gross Amount	Allowance for Doubtful Accounts	Net Realizeable Value	Net Realizeable Value
Accounts receivable	$ 741,477	$ 142,592	$ 598,885	$ 158,115
Amounts due from health authorities and provincial boards	21	-	21	48
Other receivable	1,765	-	1,765	3,706
Loans and advances	7	-	7	4
	$ 743,270	$ 142,592	$ 600,678	$ 161,873

Accounts receivables are unsecured.

Note 5 Tangible Capital Assets
(in thousands)

	2005				2004
	Estimated Useful Life	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Systems development Work in progress					
Wellnet projects		$ 5,023	$ -	$ 5,023	$ 4,258
Others		5,191	-	5,191	3,116
		10,214	-	10,214	7,374
Computer hardware and software	3-10 years	80,577	24,603	55,974	49,783
Equipment	10 years	1,466	183	1,283	161
		82,043	24,786	57,257	49,944
		$ 92,257	$ 24,786	$ 67,471	$ 57,318

Note 6 Accounts Payable and Accrued Liabilities

(in thousands)

	2005	2004
Accounts payable	$ 168,921	$ 113,128
Accrued liabilities	193,752	223,854
Amounts due to Health Authorities and Provincial Boards	118,606	34,509
Accrued vacation pay	9,077	8,091
	$ 490,356	$ 379,582

Note 7 Unearned Revenue

(in thousands)

	2005	2004
Changes in unearned revenues are as follows:		
Cash received / receivable during the year:		
Health Care Insurance Premiums	$ 29,799	$ 30,447
Health Services for Persons with Hepatitis C	5,300	1,013
Third Party Recoveries	71	11
Canada Health Transfer / Canada Health & Social Transfer	100,494	248,298
Wait Times Reduction Transfer	429,974	-
Public Health and Immunization Trust	40,200	-
Institution Fees	37	30
	605,875	279,799
Less amounts recognized as revenue in the year	(257,849)	(79,549)
Increase during the year	348,026	200,250
Balance at beginning of year	291,279	91,029
Balance at end of year	$ 639,305	$ 291,279
Balances at end of year are comprised of:		
Canada Health Transfer / Canada Health & Social Transfer	$ 199,873	$ 248,298
Health Care Insurance Premiums	29,799	30,447
Health Services for Persons with Hepatitis C	15,012	12,493
Third Party Recoveries	41	11
Public Health and Immunization Trust	27,189	-
Wait Times Reduction Transfer	367,354	-
Institution Fees	37	30
	$ 639,305	$ 291,279

Note 8 Contractual Obligations

(in thousands)

As at March 31, 2005, the Ministry has the following contractual obligations:

	2005	2004
Specific programs commitments [a]	$ 2,088,751	$ 3,533,251
Service contracts	66,328	59,475
Equipment leases [b]	234	307
	$ 2,155,313	$ 3,593,033

[a] Included in 2005 specific programs commitments is an amount of $1,458,849 (2004 - $2,787,773) for the provision of insured medical services by physicians under the agreement signed with the Alberta Medical Association.

[b] The Ministry leases certain equipment under operating leases that expire on various dates. The aggregate amounts payable for the unexpired terms of these leases are as follows:

	Specific Programs Commitments	Service Contracts	Equipment Leases	Total 2005
2006	$ 1,756,223	$ 42,901	$ 109	$ 1,799,233
2007	93,029	22,512	70	115,611
2008	75,985	915	39	76,939
2009	55,390	-	16	55,406
2010	57,167	-	-	57,167
Thereafter	50,957	-	-	50,957
	$ 2,088,751	$ 66,328	$ 234	$ 2,155,313

Canadian Blood Services

The Province of Alberta is committed to provide funding to the Canadian Blood Services (CBS). 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.

The Province'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 $122,330 (2004 - $122,488). Budgeted expenditure for the 2006 fiscal year is estimated at $137,000.

Note 9 Contingencies and Equity Agreements with Voluntary Hospital Owners

Hepatitis C

At March 31, 2005, the Ministry was named as defendant in forty specific legal actions (2004- forty-one specific legal actions) relating to the Hepatitis C virus affected through the Canadian blood system. The total claimed in twenty-nine specific legal actions approximates $554 million (2004 – thirty specific legal actions approximates $555 million). For the other eleven claims, no specified amount has yet been claimed (2004 - eleven claims have no specified amount); the amount of these claims will be determined at trial.

Thirty-nine of these claims (2004 – forty claims) are covered by the Alberta Risk Management Fund with twenty-eight claims amounting to $80 million (2004 - twenty-nine claims amounting to $81 million) and eleven claims had no specified amount. Potential liability for these claims is shared by the Canadian Red Cross Society and the federal government. The resulting loss, if any, from these claims cannot be determined.

Federal, provincial and territorial governments have agreed to offer 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 financial package of $1.1 billion is national in scope. Alberta's share of the financial assistance package is estimated at $30 million. The details of assistance will be determined through a negotiation process submitted to the courts for approval. The Ministry made a provision in 1999-2000 for its portion of the Hepatitis C assistance. At March 31, 2005 the unpaid balance of the Ministry's commitment to the financial assistance package was $13,043,265 (2004 - $13,721,265).

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, 2005, the contingent payout liability upon termination is estimated at $14.3 million (2004 - $17.2 million).

Notifications to terminate certain equity agreements have been received by the Ministry. In 2004 - 2005, the Ministry expensed $7.0 million (2004 - $1.7 million) representing the equity of the Voluntary Hospital Owners. In turn, the Voluntary Hospital Owners transferred hospital assets to the Crown, as represented by the Minister of Health and Wellness. The Crown, as represented by the Minister of Infrastructure, then transferred the hospital assets to regional health authorities under lease agreements. The regional health authorities will record the buildings and equipment at their net book value.

Other

At March 31, 2005, the Ministry was named as defendant in twenty-five other legal actions (2004 – twenty legal actions). Twenty-four of these claims have specified amounts totaling $48.0 million (2004 – twenty claims with a specified amount of $25.0 million). Included in the total legal actions are twenty claims amounting to $21.8 million (2004 – eighteen claims amounting to $24.0 million) in which the Ministry has been jointly named with other entities. Fourteen claims amounting to $17.8 million (2004 – sixteen claims amounting to $21.4 million) are covered by the Alberta Risk Management Fund. The resulting loss, if any, from these claims cannot be determined.

Note 10 Payments under Reciprocal and Other Agreements
(in thousands)

The Ministry entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial Governments and the Workers' Compensation Board to provide health services on their behalf. The Ministry pays service providers for services rendered under the agreements and recovers the amount paid from other provinces and the Workers' Compensation Board. Service providers include regional health authorities, Provincial Health Boards and physicians.

The Ministry also entered into agreements with the Western Provinces and Territories for the Western Health Information Collaborative (WHIC) to explore common opportunities that would meet their health information needs and support the strategic directions and initiatives for health infostructure at the national level. In addition, the Ministry entered into agreements with Health Canada, the Workers' Compensation Board and other provincial governments and territories to provide air ambulance services on their behalf. Payments incurred under these agreements are made by the Ministry under authority of the *Financial Administration Act*, Section 25 (1).

Balances receivable from or payable to the Federal Government, other Provincial Governments and the Workers' Compensation Board are reflected in the Statement of Financial Position.

	2005					2004
	Western Health Information Collaborative	Other Provincial Government	Workers' Compensation Board	Air Ambulance	Total	Total
Opening receivable (payable) balance	$ -	$ 23,549	$ (19)	$ 3,707	$ 27,237	$ 30,299
Add: Payments made during the year	266	154,844	-	2,944	158,054	134,239
	266	178,393	(19)	6,651	185,291	$ 164,538
Less: Collections received during the year	266	135,017	-	2,209	137,492	137,301
Less: Adjustments made during the year	-	-	-	2,757	2,757	-
Closing receivable (payable) balance	$ -	$ 43,376	$ (19)	$ 1,685	$ 45,042	$ 27,237

Note 11 Defined Benefit Plans
(in thousands)

The Ministry participates in the multi-employer pension plans, Management Employees Pension Plan and Public Service Pension Plan. The Ministry 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 $6,115 for the year ended March 31, 2005 (2004 – $4,975).

At December 31, 2004, the Management Employees Pension Plan reported a deficiency of $268,101 (2003 – $290,014) and the Public Service Pension Plan reported a deficiency of $450,068 (2003 – $584,213). At December 31, 2004, the Supplementary Retirement Plan for Public Service Managers had a surplus of $9,404 (2003 – $9,312).

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2005, the Bargaining Unit Plan reported an actuarial deficiency of $11,817 (2004 – $9,766) and the Management, Opted Out and Excluded Plan an actuarial surplus of $3,208 (2004 – $1,298). The expense for these two plans is limited to employer's annual contributions for the year.

Note 12 Comparative Figures
(in thousands)

Certain 2004 figures have been reclassified to conform to the 2005 presentation.

Note 13 Subsequent Event

Effective April 1, 2005, responsibility for the Alberta Aids to Daily Living (AADL) program was transferred from the Ministry of Health and Wellness to the Ministry of Seniors and Community Supports. The expenses for this program in 2004-2005 amounted to $82,288.

Note 14 Approval of Financial Statements

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

Schedule 1

MINISTRY OF HEALTH AND WELLNESS

CONSOLIDATED SCHEDULE OF REVENUES

FOR THE YEAR ENDED MARCH 31, 2005

(in thousands)

	2005		2004
	Budget (Schedule 4)	Actual	Actual
Internal Government Transfers:			
Transfer from the Lottery Fund	$ 209,274	$ 209,274	$ 196,380
	209,274	209,274	196,380
Transfers from the Government of Canada:			
Canada Health Transfer/Canada Health & Social Transfer	1,096,791	1,191,435	1,136,440
Health Reform Fund	150,497	150,347	99,676
Wait Times Reduction	-	62,621	-
Diagnostic/Medical Equipment Fund	49,640	99,736	49,585
Other	328,184	232,476	127,021
	1,625,112	1,736,615	1,412,722
Fees:			
Health care insurance:			
Premiums before premium assistance	910,772	1,039,380	1,058,043
Less:			
Premium assistance under legislation	-	(141,700)	(135,820)
	910,772	897,680	922,223
Add:			
Penalties	17,172	20,061	17,398
Interest and miscellaneous	466	181	168
Health care insurance premiums, penalties and interest	928,410	917,922	939,789
Blue Cross:			
Premiums before premium assistance	21,000	25,116	24,174
Less premium assistance	-	(1,973)	(1,978)
Blue Cross premiums	21,000	23,143	22,196
Total premiums	949,410	941,065	961,985
Other	1,589	1,514	1,544
	950,999	942,579	963,529
Other revenue:			
Third party recoveries	62,333	64,787	62,970
Miscellaneous:			
Previous years' refunds of expenditure	1,400	13,457	7,850
Other	14,240	10,910	11,458
	77,973	89,154	82,278
Total revenues	$ 2,863,358	$ 2,977,622	$ 2,654,909

MINISTRY OF HEALTH & WELLNESS
CONSOLIDATED SCHEDULE OF DEDICATED REVENUE INITIATIVES
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005		
	Authorized Dedicated Revenues	Actual Dedicated Revenues[a]	(Shortfall)/ Excess
Health Care Insurance Premiums[b]	$ 928,410	$ 917,922	$ (10,488)
Non-Group Drug Benefits[c]	21,000	23,143	2,143
Primary Health Care Initiative[d]	12,136	11,823	(313)
Health Services for Persons with Hepatitis C[e]	7,300	2,782	(4,518)
Alberta Telehealth Initiative[f]	1,050	1,100	50
Multi-Jurisdictional Health Lines[g]	3,563	1,546	(2,017)
Infoway Pharmaceutical Information Network [h]	9,781	4,500	(5,281)
Statistical Information[i]	200	61	(139)
Government Sponsored Drug Plans[j]	700	2,198	1,498
Chronic Disease Management Infostructure[k]	3,750	2,021	(1,729)
Infoway Provider Registry Project[l]	990	-	(990)
Diabetes Surveillance[m]	60	60	-
	$ 988,940	$ 967,156	$ (21,784)

[a] Revenues from dedicated revenue initiatives are included in the Ministry's revenues in the Statement of Operations.

[b] Albertans contributed to the cost of health programs through Health Care Insurance Premiums. The levels of premiums paid by an individual or family are based on their ability to pay as defined by income. Expenses associated with this initiative are included in the Statement of Operations under the Physician Services expense classification.

[c] Albertans can access public or private supplemental health insurance coverage. The Ministry provides Non-Group Blue Cross coverage on a premium basis for non-seniors. Seniors are provided coverage, but do not pay premiums. Expenses under the Non-Group Drug Benefits initiative represent the expenses incurred to provide Blue Cross services. Expenses associated with this initiative are included in the Statement of Operations under the Non-Group Health Services expense classification.

[d] Health Canada is providing funding to support primary health care initiatives that will be undertaken by the province. Total funding of $54.7 million will be provided for this initiative and will be used in the areas of proposal development, Health Link implementation, capacity-building fund and administration. Expenses associated with this initiative are included in the Statement of Operations under the Other Provincial Programs expense classification.

[e] Health Canada is providing funding to provide health services to individuals who acquired the Hepatitis C (HCV) virus from blood and blood products prior to Jan. 1, 1986 and after July 1, 1990. The funding will be used to treat the HCV infection using antiviral drug therapies, immunization and nursing care. Expenses associated with this initiative are included in the Statement of Operations under the Other Provincial Programs expense classification.

[f] The Alberta Telehealth Initiative commenced in 1999, when a donor pledged $14 million and Alberta Health and Wellness dedicated $7 million to the A.H.A. Hospitalta Funding Foundation to assist the Health Authorities purchase and set-up of tele-video conferencing equipment. The core services that make up this initiative include the following: MCU Bridge Services, Scheduling Services, Standards Development, Evaluation and Business Plan Development. Expenses associated with this initiative are included in the Statement of Operations under the Systems Development and Ministry Support Services expense classification.

Schedule 2

MINISTRY OF HEALTH & WELLNESS
CONSOLIDATED SCHEDULE OF DEDICATED REVENUE INITIATIVES
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

(g) A collaborative effort among the western provinces and territories is being undertaken to develop a long-term vision of strengthened infrastructure to support and further develop Health Lines across Canada. Health Lines are emerging as part of a new model for access to and delivery of high quality health services. Health Lines offer the potential to significantly alter the way consumers access and use health services, as well as the manner in which providers deliver health services. Expenses associated with this initiative are included in the Statement of Operations under the Health Reform expense classification.

(h) The Pharmacy Information Network (PIN) currently focuses on supporting the community drug process. A release of PIN was deployed in a sucessful pilot in 2002. An enhanced release was subsequently implemented into production to a number of sites throughout the province. The next release of PIN supports both browser access and system-to-system messaging access. This release is ready for province-wide implementation. PIN is a critical component of Alberta's Electronic Health Record (EHR) and is being implemented as part of the initial release of the EHR. Expenses associated with this initiative are included as Capital Investment.

(i) The ministry provides statistical information and reports to third party researchers and institutions. The revenue received is used to offset the costs to the department. The expenses associated with this initiative are included in the Statement of Operations under the Ministry Support Services expense classification.

(j) For new drugs to be considered for inclusion on the ministry's Drug Benefit List, they must first receive approval from Health Canada for sale in Canada. Once approved, the drug is reviewed by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics. Discussions between Alberta Health and Wellness and a drug manufacturer are held to ensure the drug is used as intended. An agreement may be entered into with the drug manufacturer to fund specific studies or programs that contribute to the cost-effective use of medications provided through government sponsored drug plans. The funds are used by the ministry to conduct these studies and administer the programs. Expenses associated with this initiative are included in the Statement of Operations under the Non-Group Health Benefits expense classification.

(k) This initiative will include the creation of standards for chronic disease data including minimum data sets, information interchange messages and related data definitions, and the capacity to share this data in support of clinical decision making for the primary health care team. It will also include system solutions that integrate this data with existing clinical decision support tools and within existing care delivery models. It will also include the processes necessary to implement this system and ensure its ongoing use within the primary health care teams. Expenses associated with this initiative are included in the Statement of Operations under the Ministry Support Services expense classification.

(l) The current Provider Registry System was developed under the direction of the Western Health Information Collaborative (WHIC) and has been implemented by the four Western Canadian provincial partners of WHIC. Alberta has chosen to name the product Alberta Provider Registry. The Infoway Provider Registry Project implements an enhanced version of the Provider Registry System in the province of Alberta over three releases and will implement the Provider Registry System usage into two Health Authorities and four Colleges. Work on this project was delayed and no costs were incurred during the 2004/2005 fiscal year. The project is expected to proceed in 2005/2006.

(m) Health Canada is providing funding to support the development of a National Diabetes Surveillance System. The ministry will use this funding to enhance its capacity for public health surveillance in the area of diabetes and its complications. Expenses associated with this initiative are included in the Statement of Operations under the Ministry Support Services expense classification.

Schedule 3

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULE OF
EXPENSES - DIRECTLY INCURRED DETAILED BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005		2004
	Budget (Schedule 4)	Actual	Actual
Voted:			
Grants	$ 7,706,136	$ 8,055,651	$ 7,095,416
Supplies and Services	139,412	118,643	109,457
Salaries, Wages and Employee Benefits	85,579	92,908	83,287
Amortization of Capital Assets	7,286	7,340	6,552
Inventory Consumed	15,909	28,223	24,206
Other	156	127	159
Total Voted Expenses	$ 7,954,478	$ 8,302,892	$ 7,319,077
Statutory:			
Valuation Adjustments			
Health Care Insurance Premium Revenue Write-offs	$ 41,363	$ 63,053	$ 46,723
Other Write-offs	-	57	39
Provision for Vacation Pay	-	1,008	532
	$ 41,363	$ 64,118	$ 47,294

Schedule 4

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2004-2005 Budget	Authorized Supplementary [a]	2004-2005 Authorized Budget
Revenues:			
Internal Government Transfers	$ 209,274	$ -	$ 209,274
Transfer from Government of Canada	1,625,112	-	1,625,112
Premiums and Fees	950,999	-	950,999
Other Revenue	77,973	-	77,973
	2,863,358	-	2,863,358
Expenses - Directly Incurred:			
Program			
Regional Health Services	4,506,899	200,000	4,706,899
Diagnostic/Medical Equipment	49,640	150,000	199,640
Province-Wide Services	454,309	-	454,309
Physician Services	1,521,600	-	1,521,600
Non-Group Health Benefits	531,623	-	531,623
Allied Health Services	77,500	-	77,500
Protection, Promotion and Prevention	176,518	9,454	185,972
Human Tissue and Blood Services	137,000	-	137,000
Other Provincial Programs	185,659	-	185,659
Alberta Alcohol and Drug Abuse Commission	66,157	-	66,157
Health Reform	115,745	-	115,745
Ministry Support Services	116,334	-	116,334
Systems Development	15,494	-	15,494
	7,954,478	359,454	8,313,932
Statutory Expenses			
Valuation Adjustments			
Health Care Insurance Premiums Revenue Write-Offs	41,363	-	41,363
Provision for Vacation Pay	-	-	-
	41,363	-	41,363
Total Expense	7,995,841	359,454	8,355,295
Net Operating Results	$ (5,132,483)	$ (359,454)	$ (5,491,937)
Equipment / Inventory Purchases	$ 41,593	$ 2,896	$ 44,489
Capital Investment	$ 25,025	-	$ 25,025

[a] Supplementary Estimates were approved on March 24, 2005.

Schedule 5

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULE OF RELATED PARTY TRANSACTIONS
FOR THE YEAR ENDED MARCH 31, 2005
(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 Alberta Alcohol and Drug Abuse Commission is an Entity 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 Financial Position at the amount of consideration agreed upon between the related parties.

	2005	2004
Revenue - Internal Government Transfers	$ 209,274	$ 196,830
Expenses - Directly Incurred:		
Other Services	$ 28,452	$ 25,787
Capital Assets Transferred	$ -	$ 100
Payable to	(105)	(624)

The Ministry receives services under contracts managed by the Ministry of Restructuring and Government Efficiency. Any commitments under these contracts are reported by the Ministry of Restructuring and Government Efficiency.

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 6.

	2005	2004
Expenses - Incurred by Others:		
Accommodation	$ 13,086	$ 11,827
Other Services	1,139	1,296
	$ 14,225	$ 13,123

Schedule 6

MINISTRY OF HEALTH AND WELLNESS
CONSOLIDATED SCHEDULE OF ALLOCATED COSTS
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005							2004
		Expenses - Incurred by Others		Valuation Adjustments [4]				
Program	Expenses [1]	Accommodation Costs [2]	Legal Services [3]	Vacation Pay	Health Care Insurance Premiums Revenue Write-Offs	Other Write-Offs	Total	Total
Funding to Health Authorities and Provincial Boards for:								
Regional Health Services	$ 4,731,009	$ 117	$ -	$ -	$ -	$ -	$ 4,731,126	$ 4,135,645
Diagnostic/Medical Equipment	199,640	-	-	-	-	-	199,640	-
Province-Wide Services	454,311	-	-	-	-	-	454,311	414,962
Physician Services	1,537,438	-	-	-	-	-	1,537,438	1,571,272
Non-Group Health Benefits	516,899	-	-	-	-	-	516,899	466,051
Allied Health Services	71,091	-	-	-	-	-	71,091	67,002
Protection, Promotion, and Prevention	200,037	587	-	-	-	-	200,624	169,028
Human Tissue and Blood Services	122,330	-	-	-	-	-	122,330	122,488
Other Provincial Programs	181,804	49	-	-	-	-	181,853	130,399
Alberta Alcohol and Drug Abuse Commission	67,455	7,442	10	398	-	57	75,362	68,361
Health Reform	88,571	-	-	-	-	-	88,571	53,482
Ministry Support Services	125,352	4,603	1,118	610	-	-	131,683	118,255
Systems Development	6,955	288	1	-	-	-	7,244	15,826
Health Care Insurance Premiums Revenue Write-Offs [5]	-	-	-	-	63,053	-	63,053	46,723
	$ 8,302,892	$ 13,086	$ 1,129	$ 1,008	$ 63,053	$ 57	$ 8,381,225	$ 7,379,494

[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 5, allocated by square footage.

[3] Costs shown for Legal Services on Schedule 5, allocated by estimated costs incurred by each program.

[4] Valuation Adjustments as per Statement of Operations, Employee Benefits and Doubtful Accounts provision included in Valuation Adjustments were as follows:
Vacation Pay - allocated to the program by employee,
Doubtful Accounts Provision - estimated.

[5] Health Care Insurance Premium Revenue Write-Offs relate to Premiums and Fees revenue. These costs cannot be reasonably allocated to other programs of the department.

Department of Health and Wellness

Financial Statements

March 31, 2005

DEPARTMENT OF HEALTH AND WELLNESS

FINANCIAL STATEMENTS

MARCH 31, 2005

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Schedule 3 - Expenses Directly Incurred Detailed by Object

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Schedule 6 - Salaries and Benefits

Schedule 7 - Related Party Transactions

Schedule 8 - Allocated Costs

The official version of this Report of the Auditor General, and the information the Report covers, is in printed form.

Auditor's Report

To the Minister of Health and Wellness

I have audited the statement of financial position of the Department of Health and Wellness as at March 31, 2005 and the statements of operations and cash flows for the year then ended. These financial statements are the responsibility of the Department's management. 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 plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the Department as at March 31, 2005 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 Fred J. Dunn, FCA]

FCA
Auditor General

Edmonton, Alberta
May 20, 2005

DEPARTMENT OF HEALTH AND WELLNESS

STATEMENT OF OPERATIONS

FOR THE YEAR ENDED MARCH 31, 2005

(in thousands)

	2005		2004
	Budget (Schedule 4)	Actual	Actual
Revenues (Schedule 1)			
Internal Government Transfers	$ 209,274	$ 209,274	$ 196,380
Transfer from the Government of Canada	1,625,112	1,736,615	1,412,722
Premiums and Fees	949,461	941,122	962,038
Other Revenue	77,503	87,541	80,364
	2,861,350	2,974,552	2,651,504
Expenses - Directly Incurred (Note 2b (v) and Schedule 8)			
Voted (Schedules 3 and 5)			
Ministry Support Services	129,736	140,644	124,932
Health Services	7,758,585	8,096,293	7,133,646
Assistance to Alberta Alcohol and Drug Abuse Commission	64,149	64,149	57,855
	7,952,470	8,301,086	7,316,433
Statutory (Schedules 3 and 5)			
Valuation Adjustments			
Health Care Insurance Premium Revenue Write-Offs	41,363	63,053	46,723
Provision for Vacation Pay	-	610	281
	41,363	63,663	47,004
	7,993,833	8,364,749	7,363,437
Net Operating Results	$ (5,132,483)	$ (5,390,197)	$ (4,711,933)

The accompanying notes and schedules are part of these financial statements

DEPARTMENT OF HEALTH AND WELLNESS

STATEMENT OF FINANCIAL POSITION

AS AT MARCH 31, 2005

(in thousands)

	2005	2004
ASSETS		
Cash	$ 7,900	$ 18,324
Accounts Receivable (Note 3)	600,119	160,948
Loans and Advances (Note 3)	3	1
Tangible Capital Assets (Note 4)	66,922	57,027
Consumable Inventory	5,614	4,917
	$ 680,558	$ 241,217
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 5)	$ 481,267	$ 370,455
Unearned Revenue (Note 6)	639,269	291,249
	1,120,536	661,704
NET LIABILITIES		
Net Liabilities at Beginning of Year	(420,487)	(279,246)
Net Operating Results	(5,390,197)	(4,711,933)
Net Transfer from General Revenues	5,370,706	4,570,692
Net Liabilities at End of Year	(439,978)	(420,487)
	$ 680,558	$ 241,217

The accompanying notes and schedules are part of these financial statements

DEPARTMENT OF HEALTH AND WELLNESS

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED MARCH 31, 2005

(in thousands)

	2005	2004
Operating Transactions		
Net Operating Results	$ (5,390,197)	$ (4,711,933)
Non-cash items:		
Amortization of Tangible Capital Assets (Schedule 3)	7,213	6,447
Inventory Consumed	28,223	24,206
Health Care Insurance Premium Revenue Write-Offs	63,053	46,723
Provision for Vacation Pay	610	281
	(5,291,098)	(4,634,276)
(Increase) in Accounts Receivable	(502,224)	(61,120)
Increase (Decrease) in Accounts Payable and Accrued Liabilities	110,202	(33,819)
Increase in Unearned Revenue	348,020	200,250
Cash (applied to) Operating Transactions	(5,335,100)	(4,528,965)
Capital Transactions		
Acquisition of Tangible Capital Assets	(17,108)	(13,126)
Acquisition of Consumable Inventory	(28,920)	(24,003)
Transfer of Tangible Capital Assets	-	100
Cash (applied to) Capital Transactions	(46,028)	(37,029)
Investing Transactions		
Loans and Advances	(2)	-
Repayment of Loans and Advances	-	143
Cash Provided by (applied to) Investing Transactions	(2)	143
Financing Transactions		
Net Transfer from General Revenues	5,370,706	4,570,692
Increase (decrease) in Cash	(10,424)	4,841
Cash, Beginning of Year	18,324	13,483
Cash, End of Year	$ 7,900	$ 18,324

The accompanying notes and schedules are part of these financial statements

DEPARTMENT OF HEALTH AND WELLNESS
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2005

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 leading and working collaboratively with citizens and stakeholders. The Department leads and supports a system for the delivery of quality health services and encourages and supports healthy living.

Through a leadership role, the Department sets direction, policy and provincial standards that ensure quality services and sets priorities based on health needs, determines the scope of financial, capital and human resources required, and measures and reports on the performance of the system. 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

The recommendations of the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants are the primary source for the disclosed basis of accounting. These financial statements are prepared in accordance with the following accounting policies that have been established by government for all departments.

(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 the Regional Health Authorities, the Alberta Cancer Board, the Alberta Mental Health Board, and the Alberta Alcohol and Drug Abuse Commission. The activities of these organizations are not included in these financial statements.

Details on balances are disclosed in Notes 3 and 5 and funding to health authorities and provincial boards are included in Schedule 5 to the financial statements under the following elements:

	(in thousands)
Sub-program 2.1	$ 71,040
Sub-program 2.2	75,152
Sub-program 2.3	57,100
Sub-program 2.4	5,384,960
	$ 5,588,252

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

(a) Reporting Entity (continued)

The Ministry Annual Report provides a more 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. All cash receipts of departments are deposited into the Fund and all cash disbursements made by departments are paid from the Fund. Net transfer from General Revenues is the difference between all cash receipts and all cash disbursements made.

(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.

(iii) Transfers from the 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. Established Programs Financing entitlements are recorded based on management's estimate of amounts applicable to the fiscal year. Overpayments relating to Canada Health Transfers and other transfers received before revenue recognition criteria have been met are included in accounts payable.

(iv) Dedicated Revenue

Dedicated revenue initiatives provide a basis for authorizing spending. Dedicated revenues must be shown as credits or recoveries in the details of the Government Estimates for a supply vote.

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

(b) Basis of Financial Reporting (continued)

(iv) Dedicated Revenue (continued)

If actual dedicated revenues are less than budget and total voted expenses are not reduced by an amount sufficient to cover the deficiency in dedicated revenues, the following year's voted expenses are encumbered. If actual dedicated revenues exceed budget, the Department may, with the approval of the Treasury Board, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Department's dedicated revenue 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.

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

- amortization of tangible capital assets.
- inventory consumed.
- pension costs which comprise the cost of employer contributions for current service of employees during the year.
- 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 disclosed in Schedule 8.

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

(b) Basis of Financial Reporting (continued)

(vi) Assets

Financial assets of the Department are limited to financial claims, such as advances to and receivables from other organizations, employees and other individuals as well as consumable inventories and bank balances established under the Health Care Insurance Plan.

Assets acquired by right are not included. Tangible capital assets of the Department are recorded at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. Amortization is only charged if the asset is in use. The threshold for capitalizing new systems development is $100,000 and the threshold for all other capital assets is $5,000 (2004 - $15,000).

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

(vii) Liabilities

Liabilities represent all financial claims payable by the Department at fiscal year end.

(viii) Net Liabilities

Net liabilities represents 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, loans and advances, accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short term nature of these instruments. Fair values of loans are not reported due to there being no organized financial market for the instruments and it is not practicable within constraints of timeliness or cost to estimate the fair value with sufficient reliability.

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

(b) Basis of Financial Reporting (continued)

(x) Payments under Reciprocal and Other Agreements

The Department entered into agreements with other Provincial Governments, the Federal Government 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 9.

(xi) Measurement Uncertainty
(in thousands)

Measurement uncertainty exists when there is a significant variance between the amount recognized in the financial statements and another reasonably possible amount.

The allowance for doubtful accounts amounting to $142,506 (2004 - $124,157) is subject to measurement uncertainty.

The allowance for doubtful accounts, in the amount of $142,506 (2004 - $124,157) as reported in Note 3 to these financial statements, is based on an aging analysis of the accounts receivable balance at March 31, 2005 and past collection patterns. The actual amount collected could vary from that estimated.

The accrual for claims payable to physicians in the amount of $50,321 (2004 - $67,820) is subject to measurement uncertainty. The amount is based on payments made subsequent to March 31, 2005 and an estimate for any future payments within the 180 days claim period.

Note 3 Accounts Receivable, Loans and Advances
(in thousands)

	2005			2004
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 740,839	$ 142,506	$ 598,333	$ 157,193
Amounts due from Health Authorities and Provincial Boards	21	-	21	48
Other Receivable	1,765	-	1,765	3,707
Accountable Advance	3	-	3	1
	$ 742,628	$ 142,506	$ 600,122	$ 160,949

Accounts receivable are unsecured.

Note 4 Tangible Capital Assets
(in thousands)

		2005			2004
	Estimated Useful Life	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Systems Development					
Work-in-progress					
Wellnet Projects		$ 5,023	$ -	$ 5,023	$ 4,258
Others		5,191	-	5,191	3,116
		10,214	-	10,214	7,374
Computer Hardware and Software	3-10 years	79,730	24,146	55,584	49,614
Equipment	10 years	1,202	78	1,124	39
		80,932	24,224	56,708	49,653
		$ 91,146	$ 24,224	$ 66,922	$ 57,027

Note 5 Accounts Payable and Accrued Liabilities
(in thousands)

	2005	2004
Accounts payable	$ 167,192	$ 111,659
Accrued liabilities	190,145	219,551
Amounts due to Health Authorities and Provincial Boards	118,606	34,509
Accrued vacation pay	5,324	4,736
	$ 481,267	$ 370,455

Note 6 Unearned Revenue
(in thousands)

	2005	2004
Changes in unearned revenues are as follows:		
Cash received / receivable during the year:		
Health Care Insurance Premiums	$ 29,799	$ 30,447
Health Services for Persons with Hepatitis C	5,300	1,013
Third party recoveries	71	11
Canada Health Transfer / Canada Health & Social Transfer	100,494	248,298
Wait Times Reduction Transfer	429,974	-
Public Health and Immunization Trust	40,200	-
	605,838	279,769
Less amounts recognized as revenue in the year	(257,818)	(79,519)
Increase (Decrease) during the year	348,020	200,250
Balance at beginning of year	291,249	90,999
Balance at end of year	$ 639,269	$ 291,249
Balances at end of year are comprised of:		
Canada Health Transfer / Canada Health & Social Transfer	$ 199,873	$ 248,298
Health Care Insurance Premiums	29,799	30,447
Health Services for Persons with Hepatitis C	15,012	12,493
Third party recoveries	42	11
Wait Times Reduction Transfer	367,354	-
Public Health and Immunization Trust	27,189	-
	$ 639,269	$ 291,249

Note 7 Contractual Obligations

(in thousands)

As at March 31, 2005, the Department has the following contractual obligations:

	2005	2004
Specific programs commitments [(a)]	$ 2,088,751	$ 3,533,251
Service contracts	65,921	58,911
	$ 2,154,672	$ 3,592,162

[(a)] Included in 2005 specific programs commitments is an amount of $1,458,849 (2004 - $2,787,773) for the provision of insured medical services by physicians under the agreement signed with the Alberta Medical Association.

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

	Specific Programs Commitments	Service Contracts	Total 2005
2006	$ 1,756,223	$ 42,503	$ 1,798,726
2007	93,029	22,503	115,532
2008	75,985	915	76,900
2009	55,390	-	55,390
2010	57,167	-	57,167
Thereafter	50,957	-	50,957
	$ 2,088,751	$ 65,921	$ 2,154,672

Canadian Blood Services

The Province of Alberta is committed to provide funding to the Canadian Blood Services (CBS). 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.

The Province'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 $122,330 (2004 - $122,488). Budgeted expenditure for the 2006 fiscal year is estimated at $137,000.

Note 8 Contingencies and Equity Agreements with Voluntary Hospital Owners

Hepatitis C

At March 31, 2005, the Department was named as defendant in forty specific legal actions (2004 – forty-one specific legal actions) relating to the Hepatitis C virus affected through the Canadian blood system. The total claimed in twenty-nine specific legal actions approximates $554 million (2004 - thirty specific legal actions approximates $555 million). For the other 11 claims, no specified amount has yet been claimed (2004 - eleven claims have no specified amount); the amount of these claims will be determined at trial.

Thirty-nine of these claims (2004 – forty claims) are covered by the Alberta Risk Management Fund with twenty-eight claims amounting to $80 million (2004 - twenty-nine claims amounting to $81 million) and eleven claims had no specified amount. Potential liability for these claims is shared by the Canadian Red Cross Society and the federal government. The resulting loss, if any, from these claims cannot be determined.

Federal, provincial and territorial governments have agreed to offer 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 financial package of $1.1 billion is national in scope. Alberta's share of the financial assistance package is estimated at $30 million. The details of assistance will be determined through a negotiation process submitted to the courts for approval. The Department made a provision in 1999-2000 for its portion of the Hepatitis C assistance. At March 31, 2005, the unpaid balance of the Department's commitment to the financial assistance package was $13,043,265 (2004 - $13,721,265).

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, 2005, the contingent payout liability upon termination is estimated at $14.3 million (2004 - $17.2 million).

Notifications to terminate certain equity agreements have been received by the Department. In 2004-2005, the Department expensed $7.0 million (2004 - $1.7 million) representing the equity of the Voluntary Hospital Owners. In turn, the Voluntary Hospital Owners transferred hospital assets to the Crown, as represented by the Minister of Health and Wellness. The Crown, as represented by the Minister of Infrastructure, then transferred the hospital assets to Regional Health Authorities under lease agreements. The Regional Health Authorities will record the buildings and equipment at their net book value.

Note 8 Contingencies and Equity Agreements with Voluntary Hospital Owners (continued)

Other

At March 31, 2005, the Department was named as defendant in twenty-four other legal actions (2004 - twenty legal actions). Twenty-three of these claims have specified amounts totaling $47.7 million (2004 - twenty claims with a specified amount of $25.0 million). Included in the total legal actions are nineteen claims amounting to $21.5 million (2004 - eighteen claims amounting to $24.0 million) in which the Department has been jointly named with other entities. Thirteen claims amounting to $17.6 million (2004 - sixteen claims amounting to $21.4 million) are covered by the Alberta Risk Management Fund. The resulting loss, if any, from these claims cannot be determined.

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

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial Governments and the Workers' Compensation Board 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 and the Workers' Compensation Board. Service providers include Regional Health Authorities, Provincial Health Boards and physicians.

The Department also entered into agreements with the Western Provinces and Territories for the Western Health Information Collaborative (WHIC) to explore common opportunities that would meet their health information needs and support the strategic directions and initiatives for health infrastructure at the national level. In addition, the Department entered into agreements with Health Canada, the Workers' Compensation Board and other provincial governments and territories 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).

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

Balances receivable from or payable to the Federal Government, other Provincial Governments and the Workers' Compensation Board are reflected in the Statement of Financial Position.

	2005					2004
	Western Health Information Collaborative	Other Provincial Government	Workers' Compensation Board	Air Ambulance	Total	Total
Opening receivable (payable) balance	$ -	$ 23,549	$ (19)	$ 3,707	$ 27,237	$ 30,299
Add: Payments made during the year	266	154,844	-	2,944	158,054	134,239
	266	178,393	(19)	6,651	185,291	164,538
Less: Collections received during the year	266	135,017	-	2,209	137,492	137,301
Less: Adjustments made during the year	-	-	-	2,757	2,757	-
Closing receivable (payable) balance	$ -	$ 43,376	$ (19)	$ 1,685	$ 45,042	$ 27,237

Note 10 Defined 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 $3,953 for the year ended March 31, 2005 (2004 – $3,264).

At December 31, 2004, the Management Employees Pension Plan reported a deficiency of $268,101 (2003 – $290,014) and the Public Service Pension Plan reported a deficiency of $450,068 (2003 – $584,213). At December 31, 2004, the Supplementary Retirement Plan for Public Service Managers had a surplus of $9,404 (2003 – $9,312).

Note 10 Defined Benefit Plans (continued)
(in thousands)

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2005, the Bargaining Unit Plan reported an actuarial deficiency of $11,817 (2004 – $9,766) and the Management, Opted Out and Excluded Plan an actuarial surplus of $3,208 (2004 – $1,298). The expense for these two plans is limited to employer's annual contributions for the year.

Note 11 Comparative Figures

Certain 2004 figures have been reclassified to conform to the 2005 presentation.

Note 12 Subsequent Event
(in thousands)

Effective April 1, 2005, responsibility for the Alberta Aids to Daily Living (AADL) program was transferred from the Department of Health and Wellness to the Department of Seniors and Community Supports. The expenses for this program in 2004-2005 amounted to $82,288.

Note 13 Approvals of Financial Statements

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

Schedule 1

DEPARTMENT OF HEALTH & WELLNESS
SCHEDULE OF REVENUES
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005 Budget	2005 Actual	2004 Actual
Internal Government Transfers:			
Transfer from the Lottery Fund	$ 209,274	$ 209,274	$ 196,380
	209,274	209,274	196,380
Transfers from the Government of Canada:			
Canada Health Transfer / Canada Health & Social Transfer	1,096,791	1,191,435	1,136,440
Health Reform Fund	150,497	150,347	99,676
Wait Times Reduction	-	62,621	-
Diagnostic/Medical Equipment Fund	49,640	99,736	49,585
Other	328,184	232,476	127,021
	1,625,112	1,736,615	1,412,722
Fees:			
Health care insurance:			
Premiums before premium assistance	910,772	1,039,380	1,058,043
Less:			
Premium assistance under legislation	-	(141,700)	(135,820)
	910,772	897,680	922,223
Add:			
Penalties	17,172	20,061	17,398
Interest and miscellaneous	466	181	168
Health care insurance premiums, penalties and interest	928,410	917,922	939,789
Blue Cross:			
Premiums before premium assistance	21,000	25,116	24,174
Less premium assistance	-	(1,973)	(1,978)
Blue Cross premiums	21,000	23,143	22,196
Total premiums	949,410	941,065	961,985
Other	51	57	53
	949,461	941,122	962,038
Other revenue:			
Third party recoveries	62,333	64,787	62,971
Miscellaneous:			
Previous years' refunds of expenditure	1,400	13,457	7,850
Other	13,770	9,297	9,543
	77,503	87,541	80,364
Total revenues	$ 2,861,350	$ 2,974,552	$ 2,651,504

Schedule 2

DEPARTMENT OF HEALTH & WELLNESS
SCHEDULE OF DEDICATED REVENUE INITIATIVES
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005		
	Authorized Dedicated Revenues	Actual Dedicated Revenues[a]	(Shortfall) / Excess
Health Care Insurance Premiums[b]	$ 928,410	$ 917,922	$ (10,488)
Non-Group Drug Benefits[c]	21,000	23,143	2,143
Primary Health Care Initiative[d]	12,136	11,823	(313)
Health Services for Persons with Hepatitis C[e]	7,300	2,782	(4,518)
Alberta Telehealth Initiative[f]	1,050	1,100	50
Multi-Jurisdictional Health Lines[g]	3,563	1,546	(2,017)
Infoway Pharmaceutical Information Network [h]	9,781	4,500	(5,281)
Statistical Information[i]	200	61	(139)
Government Sponsored Drug Plans[j]	700	2,198	1,498
Chronic Disease Management Infostructure[k]	3,750	2,021	(1,729)
Infoway Provider Registry Project[l]	990	-	(990)
Diabetes Surveillance[m]	60	60	-
	$ 988,940	$ 967,156	$ (21,784)

[a] Revenues from dedicated revenue initiatives are included in the Department's revenues in the Statement of Operations.

[b] Albertans contributed to the cost of health programs through Health Care Insurance Premiums. The levels of premiums paid by an individual or family are based on their ability to pay as defined by income. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

[c] Albertans can access public or private supplemental health insurance coverage. The Department provides Non-Group Blue Cross coverage on a premium basis for non-seniors. Seniors are provided coverage, but do not pay premiums. Expenses under the Non-Group Drug Benefits initiative represent the expenses incurred to provide Blue Cross services. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

[d] Health Canada is providing funding to support primary health care initiatives that will be undertaken by the province. Total funding of $54.7 million will be provided for this initiative and will be used in the areas of proposal development, Health Link implementation, capacity-building fund and administration. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

[e] Health Canada is providing funding to provide health services to individuals who acquired the Hepatitis C (HCV) virus from blood and blood products prior to Jan. 1, 1986 and after July 1, 1990. The funding will be used to treat the HCV infection using antiviral drug therapies, immunization and nursing care. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

[f] The Alberta Telehealth Initiative commenced in 1999, when a donor pledged $14 million and Alberta Health and Wellness dedicated $7 million to the A.H.A. Hospitalta Funding Foundation to assist the Health Authorities purchase and set-up of tele-video conferencing equipment. The core services that make up this initiative include the following: MCU Bridge Services, Scheduling Services, Standards Development, Evaluation and Business Plan Development. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

Schedule 2

DEPARTMENT OF HEALTH & WELLNESS
SCHEDULE OF DEDICATED REVENUE INITIATIVES
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

(g) A collaborative effort among the western provinces and territories is being undertaken to develop a long-term vision of strengthened infrastructure to support and further develop Health Lines across Canada. Health Lines are emerging as part of a new model for access to and delivery of high quality health services. Health Lines offer the potential to significantly alter the way consumers access and use health services, as well as the manner in which providers deliver health services. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

(h) The Pharmacy Information Network (PIN) currently focuses on supporting the community drug process. A release of PIN was deployed in a sucessful pilot in 2002. An enhanced release was subsequently implemented into production to a number of sites throughout the province. The next release of PIN supports both browser access and system-to-system messaging access. This release is ready for province-wide implementation. PIN is a critical component of Alberta's Electronic Health Record (EHR) and is being implemented as part of the initial release of the EHR. Expenses associated with this initiative are included as Capital Investment on Schedule 5.

(i) The department provides statistical information and reports to third party researchers and institutions. The revenue received is used to offset the costs to the department. The expenses associated with this initiative are included in the Statement of Operations under the Ministry Support Services expense classification.

(j) For new drugs to be considered for inclusion on the department's Drug Benefit List, they must first receive approval from Health Canada for sale in Canada. Once approved, the drug is reviewed by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics. Discussions between Alberta Health and Wellness and the drug manufacturer are held to ensure the drug is used as intended. An agreement may be entered into with the drug manufacturer to fund specific studies or programs that contribute to the cost-effective use of medications provided through government sponsored drug plans. The funds are used by the department to conduct these studies and administer the programs. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

(k) This initiative will include the creation of standards for chronic disease data including minimum data sets, information interchange messages and related data definitions, and the capacity to share this data in support of clinical decision making for the primary health care team. It will also include system solutions that integrate this data with existing clinical decision support tools and within existing care delivery models. It will also include the processes necessary to implement this system and ensure its ongoing use within the primary health care teams. Expenses associated with this initiative are included in the Statement of Operations under the Health Services expense classification.

(l) The current Provider Registry System was developed under the direction of the Western Health Information Collaborative (WHIC) and has been implemented by the four Western Canadian provincial partners of WHIC. Alberta has chosen to name the product Alberta Provider Registry. The Infoway Provider Registry Project implements an enhanced version of the Provider Registry System in the Province of Alberta over three releases and will implement the Provider Registry System usage into two Health Authorities and four Colleges. Work on this project was delayed and no costs were incurred during the 2004/2005 fiscal year. The project is expected to proceed in 2005/2006.

(m) Health Canada is providing funding to support the development of a National Diabetes Surveillance System. The department will use this funding to enhance its capacity for public health surveillance in the area of diabetes and its complications. Expenses associated with this initiative are included in the Statement of Operations under the Ministry Support Services expense classification.

Schedule 3

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE OF EXPENSES - DIRECTLY INCURRED DETAILED BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005		2004
	Budget (Schedule 4)	Actual	Actual
Voted:			
Grants	$ 7,756,002	$ 8,106,768	$ 7,140,614
Supplies and Services	124,723	102,800	95,622
Salaries, Wages and Employee Benefits	48,536	55,970	49,402
Amortization of Tangible Capital Assets	7,159	7,213	6,447
Inventory consumed	15,909	28,223	24,206
Other	141	112	142
Total Voted Expenses	$ 7,952,470	$ 8,301,086	$ 7,316,433
Statutory:			
Valuation adjustments			
Health Care Insurance Premium Revenue Write-offs	$ 41,363	$ 63,053	$ 46,723
Provision for Vacation Pay	-	610	281
	$ 41,363	$ 63,663	$ 47,004

Schedule 4

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2004 - 2005 Budget	Authorized Supplementary [a]	2004 - 2005 Authorized Budget
Revenues:			
Internal Government Transfers	$ 209,274	$ -	$ 209,274
Transfer from Government of Canada	1,625,112	-	1,625,112
Premiums and Fees	949,461	-	949,461
Other Revenue	77,503	-	77,503
	2,861,350	-	2,861,350
Expenses - Directly Incurred:			
Voted Operating Expenses			
Ministry Support Services	129,736	-	129,736
Health Services	7,758,585	359,454	8,118,039
Alberta Alcohol and Drug Abuse Commission	64,149	-	64,149
	7,952,470	359,454	8,311,924
Statutory Expenses			
Valuation Adjustments			
Health Care Insurance Premiums Revenue Write-Offs	41,363	-	41,363
Provision for Vacation Pay	-	-	-
	41,363	-	41,363
Total Expense	7,993,833	359,454	8,353,287
Net Operating Results	$ (5,132,483)	$ (359,454)	$ (5,491,937)
Equipment / Inventory Purchases	$ 41,593	$ 2,896	$ 44,489
Capital Investment	$ 24,895	$ -	$ 24,895

[a] Supplementary Estimates were approved on March 24, 2005.

Schedule 5

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE TO FINANCIAL STATEMENTS
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment by Element to Authorized Budget
For the Year Ended March 31, 2005
(in thousands)

Voted Operating Expenses, Equipment / Inventory Purchases and Capital Investment:	Budget 2005	Authorized Supplementary[a]	Authorized Budget 2005	Actual 2005[b]	Under (Over) Expended
Ministry Support Services					
1.0.1 Minister's Office	$ 494	$ -	$ 494	$ 431	$ 63
1.0.2 Deputy Minister's Office	456	-	456	455	1
1.0.3 Public Communications	1,403	-	1,403	1,635	(232)
1.0.4 Strategic Planning Services	6,648	-	6,648	5,340	1,308
1.0.5 Health Information and Accountability					
- Operating Expense	50,722	-	50,722	63,195	(12,473)
- Equipment / Inventory Purchases	9,050	-	9,050	7,028	2,022
- Capital Investment	2,000	-	2,000	-	2,000
1.0.6 Population Health	11,787	-	11,787	12,297	(510)
1.0.7 Workforce Services	5,949	-	5,949	7,190	(1,241)
1.0.8 Corporate Support Services					
- Operating Expense	23,899	-	23,899	25,270	(1,371)
- Equipment / Inventory Purchases	630	-	630	952	(322)
1.0.9 Program Services					
- Operating Expense	21,822	-	21,822	20,140	1,682
- Equipment / Inventory Purchases	-	-	-	504	(504)
1.0.10 Health Facilities Review Committee	615	-	615	682	(67)
1.0.11 Health Quality Council of Alberta					
- Operating Expense	3,000	-	3,000	1,975	1,025
- Equipment / Inventory Purchases	-	-	-	10	(10)
1.0.12 Health Advisory and Appeal Services	2,840	-	2,840	1,935	905
1.0.13 Standing Policy Committee on Health and Community Living	101	-	101	99	2
Total Ministry Support Services	141,416	-	141,416	149,138	(7,722)
Health Services					
2.1 Physician Services					
2.1.1 Physician Compensation	1,409,700	-	1,409,700	1,459,090	(49,390)
2.1.2 On Call Programs	71,400	-	71,400	71,400	
2.1.3 Physician Office System Project	20,000	-	20,000	-	20,000
2.1.4 Primary Care					
- Operating Expense	20,500	-	20,500	6,948	13,552
- Equipment / Inventory Purchases	-	-	-	705	(705)
Total Physician Services	1,521,600	-	1,521,600	1,538,143	(16,543)
2.2 Provincial Programs					
2.2.1 Non-Group Health Benefits	531,623	-	531,623	516,900	14,723
2.2.2 Allied Health Services	77,500	-	77,500	71,091	6,409
2.2.3 Human Tissue and Blood Services					
- Operating Expense funded by Lotteries	137,000	-	137,000	122,330	14,670
2.2.4 Ambulance Services					
- Operating Expense	66,239	-	66,239	50,543	15,696
2.2.5 Out-of-Province Health Care Services	57,280	-	57,280	52,981	4,299
2.2.6 Alberta Wellnet					
- Operating Expense	15,131	-	15,131	4,767	10,364
- Equipment / Inventory Purchases	2,657	-	2,657	-	2,657
2.2.7 Health Services Research					
- Operating Expense funded by Lotteries	5,325	-	5,325	6,050	(725)
2.2.8 Health Reform					
- Operating Expense	115,745	-	115,745	88,571	27,174
- Equipment / Inventory Purchases	5,256	-	5,256	-	5,256
- Capital Investment	22,895	-	22,895	7,909	14,986
2.2.9 Other Support Programs	56,815	-	56,815	72,230	(15,415)
Total Provincial Programs	1,093,466	-	1,093,466	993,372	100,094

Schedule 5

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE TO FINANCIAL STATEMENTS
Comparison of Expenses - Directly Incurred, Equipment / Inventory Purchases and Capital Investment by Element to Authorized Budget
For the Year Ended March 31, 2005
(thousands of dollars)

Voted Operating Expenses, Equipment / Inventory Purchases and Capital Investment:	Budget 2005	Authorized Supplementary[a]	Authorized Budget 2005	Actual 2005[b]	Under (Over) Expended
2.3 Protection, Promotion, and Prevention					
2.3.1 Vaccines and Sera					
- Operating Expense	24,317	3,104	27,421	35,845	(8,424)
- Equipment / Inventory Purchases	24,000	2,896	26,896	28,920	(2,024)
2.3.2 Public Health Laboratories	17,236	1,100	18,336	26,121	(7,785)
2.3.3 Alberta Aids to Daily Living Benefits	88,225	-	88,225	82,288	5,937
2.3.4 Alberta Wellness Initiative	10,150	-	10,150	9,971	179
2.3.5 Aboriginal Health Strategies					
- Operating Expense funded by Lotteries	2,200	-	2,200	2,200	-
2.3.6 Community-based Health Services					
- Operating Expense	8,351	5,250	13,601	6,789	6,812
- Operating Expense funded by Lotteries	10,000	-	10,000	23,945	(13,945)
2.3.7 West Nile Virus Response	3,000	-	3,000	1,273	1,727
Total Protection, Promotion and Prevention	187,479	12,350	199,829	217,352	(17,523)
2.4 Regional and Provincial-Wide Health Services					
2.4.1 Regional Health Services	4,506,899	200,000	4,706,899	4,731,009	(24,110)
2.4.2 Diagnostic / Medical Equipment	49,640	150,000	199,640	199,640	-
2.4.3 Province-Wide Services	454,309	-	454,309	454,311	(2)
Total Funding to Health Authorities and Provincial Boards for regional and province-wide health services	5,010,848	350,000	5,360,848	5,384,960	(24,112)
Total Health Services	7,813,393	362,350	8,175,743	8,133,826	41,917
Assistance to Alberta Alcohol and Drug Abuse Commission					
3.0.1 Operating Funds for Alberta Alcohol and Drug Abuse					
- Operating Expense funded by Lotteries	54,749	-	54,749	54,749	-
3.0.2 Alberta Tobacco Reduction Strategy	9,400	-	9,400	9,400	-
Total Assistance To Alberta Alcohol and Drug Abuse Commission	64,149	-	64,149	64,149	-
Total Voted	$ 8,018,958	$ 362,350	$ 8,381,308	$ 8,347,114	$ 34,194
Operating Expense	$ 7,743,196	$ 359,454	$ 8,102,650	$ 8,091,812	$ 10,838
Operating Expense funded by lotteries	209,274	-	209,274	209,274	-
Equipment / Inventory Purchases	41,593	2,896	44,489	38,119	6,370
	7,994,063	362,350	8,356,413	8,339,205	17,208
Capital Investment	24,895	-	24,895	7,909	16,986
Total Voted - Operating, Equipment/Inventory Purchases & Capital Investment	$ 8,018,958	$ 362,350	$ 8,381,308	$ 8,347,114	$ 34,194
Statutory Expenses					
Valuation Adjustments					
Health Care Insurance Premium Revenue Write-Offs	$ 41,363	-	$ 41,363	$ 63,053	$ (21,690)
Provision for vacation Pay	-	-	-	610	(610)
Total Statutory Expenses	$ 41,363	$ -	$ 41,363	$ 63,663	$ (22,300)

(a) Supplementary Estimates were approved on March 24, 2005.

(b) Includes achievement bonus of $1,442.

Schedule 6

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2005

	2005				2004
	Base Salary [1]	Other Cash Benefits [2]	Other Non Cash Benefits [3]	Total	Total
Deputy Minister [4] [5] [6]	$ 170,888	$ 32,809	$ 31,079	$ 234,776	$ 232,866
Assistant Deputy Ministers					
Health Accountability	132,216	9,718	20,142	162,076	168,311
Population Health [7]	68,467	24,101	11,833	104,401	164,276
Health Workforce	122,112	14,809	24,707	161,628	151,109
Program Services	122,112	21,545	23,692	167,349	158,486
Strategic Directions	127,248	22,198	25,602	175,048	164,373
Finance and Corporate Services	132,216	19,436	25,865	177,517	175,060
Health Authorities [7] [8]	158,664	17,492	4,813	180,969	173,356

[1] Base Salary includes pensionable base pay.

[2] Other cash benefits include bonuses, vacation payments, overtime and lump sum payments.

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

[4] Automobile provided, no dollar amount is included in benefits and allowances.

[5] This position was occupied by two individuals through the year.

[6] Other cash benefits include achievement bonus for the current incumbent only.

[7] The incumbent retired in Oct 15, 2004. The ADM of Health Authorities occupied this position in an acting capacity as of October 18, 2004.

[8] The current incumbent does not participate in the government pension plan, salary includes a compensating amount for pension.

Schedule 7

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE OF RELATED PARTY TRANSACTIONS
FOR THE YEAR ENDED MARCH 31, 2005
(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. The Alberta Alcohol and Drug Abuse Commission is an Entity in the Ministry.

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 Statements of Operations and Financial Position at the amounts of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2005	2004	2005	2004
Revenues				
Grants	$ -	$ -	$ 209,274	$ 196,830
Expenses - Directly Incurred				
Grants	$ 65,649	$ 58,355	$ -	$ -
Other Services	-	-	27,613	24,966
	$ 65,649	$ 58,355	$ 27,613	$ 24,966
Capital Assets Transferred	$ -	$ -	$ -	$ 100

The Department receives services under contracts managed by the Ministry of Restructuring and Government Efficiency. Any commitments under these contracts are reported by the Ministry of Restructuring and Government Efficiency.

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.

	Entities in the Ministry		Other Entities	
	2005	2004	2005	2004
Expenses - Directly Incurred				
Accommodation	$ -	$ -	$ 4,016	$ 3,424
Legal	-	-	1,119	1,272
Other	-	-	10	-
	$ -	$ -	$ 5,145	$ 4,696

Schedule 8

DEPARTMENT OF HEALTH AND WELLNESS
SCHEDULE OF ALLOCATED COSTS
FOR THE YEAR ENDED MARCH 31, 2005
(in thousands)

	2005						2004
		Expenses - Incurred by Others		Valuation Adjustments [4]			
	Expenses [1]	Accommodation Costs [2]	Legal Services [3]	Vacation Pay	Health Care Insurance Premiums Revenue Write-Offs	Total	Total
Ministry Support Services	$ 140,644	$ 3,899	$ 1,118	$ 610	$ -	$ 146,271	$ 129,777
Health Services	8,096,293	117	1	-	-	8,096,411	7,133,778
Alberta Alcohol and Drug Abuse Commission	64,149	-	-	-	-	64,149	57,855
Health Care Insurance Premiums Revenue Write-Offs [5]	-	-	-	-	63,053	63,053	46,723
	$ 8,301,086	$ 4,016	$ 1,119	$ 610	$ 63,053	$ 8,369,884	$ 7,368,133

[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, allocated by square footage.

[3] Costs shown for Legal Services on Schedule 7, allocated by estimated costs incurred by each program.

[4] Valuation Adjustments as per Statement of Operations, Employee Benefits and Doubtful Accounts provision included in Valuation Adjustments were as follows:

Vacation Pay - allocated to the program by employee,

Doubtful Accounts Provision - estimated.

[5] Health Care Insurance Premium Revenue Write-Offs relate to Premiums and Fees revenue. These costs cannot be reasonably allocated to other programs of the department.

Alberta Alcohol and Drug Abuse Commission

Financial Statements

March 31, 2005

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

FINANCIAL STATEMENTS

FOR THE YEAR ENDED MARCH 31, 2005

Auditor's Report

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The official version of this Report of the Auditor General, and the information the Report covers, is in printed form.

Auditor's Report

To the Members of the Alberta Alcohol and Drug Abuse Commission

I have audited the statement of financial position of the Alberta Alcohol and Drug Abuse Commission as at March 31, 2005 and the statements of operations and cash flows for the year then ended. These financial statements are the responsibility of the Commission's management. 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 plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the Commission as at March 31, 2005 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 Fred J. Dunn, FCA]

Auditor General

Edmonton, Alberta
May 20, 2005

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

STATEMENT OF FINANCIAL POSITION

AS AT MARCH 31, 2005

(In thousands)

	2005	2004
ASSETS		
Current Assets:		
Cash (Note 3)	$ 10,880	$ 9,692
Accounts Receivable	521	925
Inventory	360	661
Prepaid Expenses	36	-
	11,797	11,278
Tangible Capital Assets (Note 4)	549	291
	$ 12,346	$ 11,569
LIABILITIES AND ACCUMULATED SURPLUS		
Current Liabilities:		
Accounts Payable	4,981	5,458
Accrued Vacation Pay	3,753	3,355
Deferred Contributions (Note 7)	355	315
Unearned Revenue	37	30
	9,126	9,158
Accumulated surplus:		
At beginning of year	2,411	1,940
Net operating results	809	471
At end of year	3,220	2,411
	$ 12,346	$ 11,569

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

STATEMENT OF OPERATIONS

FOR THE YEAR ENDED MARCH 31, 2005

(In thousands)

	2005 Budget (Note 9)	2005 Actual	2004 Actual
Revenues (Schedule 1):			
Internal government transfers:			
Department of Health and Wellness	$ 64,149	$ 65,649	$ 58,355
Fees	1,538	1,457	1,492
Investment Income	325	500	568
Other	145	1,113	1,347
	66,157	68,719	61,762
Expenses – Directly Incurred: (Schedule 2 and 3, Note 2 (b))			
Programs:			
Community services	31,042	32,282	27,856
Residential treatment services	13,576	13,552	12,352
Detoxification services	9,273	8,619	7,924
Research, information and monitoring	8,789	9,777	10,553
Administration	3,477	3,282	2,355
Accrued vacation pay adjustment	-	398	251
	66,157	67,910	61,291
Net operating results	$ -	$ 809	$ 471

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED MARCH 31, 2005

(In thousands)

	2005	2004
Operating Activities:		
Net operating results	$ 809	$ 471
Add non-cash charges:		
Amortization of capital assets	126	104
	935	575
Increase in non-cash working capital	637	(493)
Cash provided by operating activities	1,572	82
Investing activities:		
Acquisition of capital assets	(384)	(116)
Net cash provided (used)	1,188	(34)
Cash at beginning of year	9,692	9,726
Cash at end of year	$ 10,880	$ 9,692

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

NOTES TO THE FINANCIAL STATEMENTS

MARCH 31, 2005

Note 1 Authority and Purpose

The Alberta Alcohol and Drug Abuse Commission (Commission) is an agent of the Crown under the authority of the Alcohol and Drug Abuse Act, Chapter A-38, Revised Statutes of Alberta 2000. The Commission is dependent on grants from the Department of Health and Wellness for funding its programs and for meeting its obligations as they become due.

The Commission's purpose is to assist Albertans in achieving a life free from the abuse of alcohol, other drugs and gambling. The Commission does this by providing community-based information, prevention and treatment services.

The Commission is a Government of Alberta agency and is not subject to Canadian taxes.

Note 2 Summaries of Significant Accounting Policies and Reporting Practices

The recommendations of the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants are the primary source for the disclosed basis of accounting. These financial statements are prepared in accordance with the following accounting policies that have been established by government for all departments.

(a) Revenue Recognition

Operating grants from the Department are recognized as revenue when they are receivable.

Unrestricted donations are recognized as revenue when they are received. Donations of materials and services that would otherwise have been purchased are recorded at fair value when it can reasonably be determined.

Externally restricted donations are deferred and are recognized as revenue in the period in which the related expenses are incurred.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(b) Expenses

Directly Incurred

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

Directly incurred expenses are included on Schedules 2 and 3, as well as the Statement of Operations

Incurred by Others
Services contributed by other entities in support of the Commission's operations are disclosed in Schedule 3.

(c) Inventory

Inventory is valued at the lower of cost and replacement cost with cost being determined principally on a first-in, first-out basis.

(d) Tangible Capital Assets

Tangible capital assets are recorded at historical cost net of accumulated amortization. The threshold for capitalizing assets is $5,000. Amortization is provided over the estimated useful lives of the assets as follows:

Furniture and equipment	- 10 years straight-line
Computer equipment and software	- 3 years straight-line

(e) 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 accounts receivable, accounts payable, and accrued liabilities are estimated to approximate their book values. Subsequent actual amounts, which may vary from estimates, will impact future financial results.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(f) Financial Instruments

The Commission's financial instruments consist of cash, accounts receivable, accounts payable, and amounts due to related parties. Unless otherwise noted, it is management's opinion that the Commission is not exposed to significant interest, currency or credit risks arising from these financial instruments.

Note 3 Cash
(In thousands)

Cash consists of deposits in the Consolidated Cash Investment Trust Fund (Fund) of the Province of Alberta. The Fund is managed with the objective of providing competitive interest income to depositors while maintaining appropriate security and liquidity of depositors' capital. The portfolio is comprised of high quality short-term and mid-term fixed income securities with a maximum term to maturity of three years. As at March 31, 2005, securities held by the Fund have an average effective market yield of 2.79% per annum (March 31, 2004: 2.11% per annum).

Interest is earned on the Commission's daily cash balance at the average rate of the Fund's earnings, which vary depending on prevailing market interest rates. The Commission retains the interest earned on all of its bank accounts, and reflects it as income. Interest income of $500 (2004 $568) was earned during the year on this account and is reflected in the financial statements.

Due to the short-term nature of these deposits, the carrying value approximates fair value.

Note 4 Tangible Capital Assets
(In thousands)

Capital assets consist of the following:

	2005			2004
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Computer equipment and software	$ 847	$ 457	$ 390	$ 169
Furniture and equipment	264	105	159	122
	$ 1,111	$ 562	$ 549	$ 291

Note 5 Contractual obligations
(In thousands)

(a) The Commission leases certain vehicles and equipment under operating leases that expire on various dates through to January 31, 2009. The aggregate amounts payable for the unexpired terms of these leases are as follows:

2006	$ 109
2007	$ 70
2008	$ 39
2009	$ 16

(b) The Commission has certain contractual obligations for contracts, which extend into 2006 and 2007. The value of the contractual obligation is $398 in 2006 and $9 in 2007.

Note 6 Contingent Liabilities
(In thousands)

At March 31, 2005, The Commission is a dependent in one legal claim (2004, no claims). The specified amount of the claim is $285.

The resulting loss, if any, from these claims cannot be determined.

Note 7 Deferred Contributions
(In thousands)

Deferred contributions consist of unexpended funds from donations to the Memorial Trust. These are externally restricted contributions to be used to supplement the work of the Commission in the areas of research and education and to acquire capital assets. Changes in deferred contributions are as follows:

	2005	2004
Donations	$ 32	$ 25
Interest Earned	8	9
Transferred to Revenue	-	(2)
Increase during the year	40	32
Balance at beginning of year	315	283
Balance at end of year	$ 355	$ 315

Note 8 Defined Benefit Plans
(In thousands)

The Commission participates in the multi-employer pension plans, Management Employee Pension Plan and Public Service Pension Plan. The Commission 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 $2,162 for the year ended March 31, 2005 (2004 – $1,711) and is reflected in Employer Contributions on Schedule 2.

At December 31, 2004, the Management Employees Pension Plan reported a deficiency of $268,101 (2003 – $290,014) and the Public Service Pension Plan reported a deficiency of $450,068 (2003 – $584,213). At December 31, 2004, the Supplementary Retirement Plan for Public Service Managers had a surplus of $9,404 (2003 – $9,312).

Note 9 Approvals
(In thousands)

(a) Budget

The budget amounts shown on the statement of operations agree with the 2004/05 Government Estimates. The budget amounts shown on Schedules 1 and 2 provide additional revenue information and present expenses by object. The Members of the Commission approved these budgets on April 22, 2004.

(b) Financial Statements

These financial statements and accompanying notes were approved on June 23, 2005 by the Members of the Commission.

Note 10 Related Party Transactions
(In thousands)

Related parties are those entities consolidated in the Province of Alberta's financial statements. Related parties also include management in the Commission.
For purposes of this schedule, the related parties are separated into "Entities in the Ministry" which includes only the Department of Health and Wellness, and "Other Entities".

The Commission and its employees paid and collected certain 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.

	Entities in the Ministry		Other Entities	
	2005	2004	2005	2004
Revenues:				
Grants	$ 65,649	$ 58,355	$ -	$ -
Expenses:				
Other Services	$ -	$ -	$ 839	$ 821
Receivable from	$ -	$ -	$ -	$ -
(Payable to)	$ -	$ -	$ (105)	$ (624)

The Commission also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related parties are estimated based on the costs incurred by the service provider to provide the services. These amounts are not recorded in the financial statements and are disclosed on Schedule 3.

	Entities in the Ministry		Other Entities	
	2005	2004	2005	2004
Expenses:				
Legal Fees	$ -	$ -	$ 10	$ 24
Accommodation	-	-	7,141	7,046
	$ -	$ -	$ 7,151	$ 7,070

Note 11 Federal/Provincial Cost Sharing Agreements
(In thousands)

The Province of Alberta recovers part of its contributions to the Commission from the Government of Canada under the Alcohol and Drug Treatment and Rehabilitation (ADTR) agreement and records this recovery in the financial statements of the Department of Health and Wellness. The ADTR claim relating to the Commission's activities for the year ended March 31, 2005 amounts to approximately $1,415 (2004 $1,340).

Note 12 Salaries, Wages, Benefits and Allowances
(In thousands)

	2005				2004
	Base Salary [a]	Other Cash Benefits [b]	Other Non-cash Benefits [c]	Total	Total
Current Executives					
Chairman of the Board [d]	$ 14	$ -	$ -	$ 14	$ 15
Board Members [e]	25	-	-	25	37
Chief Executive Officer [f]	140	27	29	196	196
Executive Director, Program Services	133	19	27	179	178
Executive Director, Information Services [h]	108	16	22	146	121
Executive Director, Corporate Services [h]	110	16	24	150	127
Director, Provincial Initiatives [i]	99	8	23	130	119
Director, Urban Services [h,i]	104	8	20	132	127
Director, Residential Services	109	16	23	148	136
Director, District and Youth Services [h]	110	16	22	148	108
Director, National Research Coordination [h]	96	7	20	123	117
Director, Corporate Services [g,h]	-	-	-	-	99

(a) Base Salary includes pensionable base pay.

(b) Other cash benefits include bonuses, vacation payments, overtime, and lump sum payments.

(c) Other non-cash benefits include the Commission's share of all employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, group life insurance, short and long-term disability plans, tuition fees, conference fees, and professional memberships.

(d) A new chairperson was appointed during the year.

(e) There were nine Board members in both years.

(f) An amount has not been included in benefits and allowances for the automobile provided to the Chief Executive Officer.

(g) Other cash benefits amounts include vacation payouts totaling $0 (2004 $15).

(h) The Commission reorganized its corporate structure in December 2003. The former Director of Information Services became an Executive Director, and now has responsibility for Research Services. The former Director of Research is now the Director, National Research Coordination. The Director of Community and Youth Services is now the Director of Urban Services. There is a new Director of District and Youth Services. The Director of Corporate Services position was eliminated and replaced with Directors of Information Technology Services and Financial Services. Those positions now report to a new position, the Executive Director of Corporate Services, which also has responsibility for Human Resources and Learning Services. The Directors of Finance,

Note 12 Salaries, Wages, Benefits and Allowances (Continued)

Information Technology Services, and Human Resource and Learning Services are not members of the senior decision making group and their salaries are not disclosed.

(i) The Director, Provincial Initiatives retired on June 30, 2004. The Director, Urban Services assumed this role as of July 1, 2004.

Schedule 1

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

SCHEDULE OF REVENUES

FOR THE YEAR ENDED MARCH 31, 2005

(In thousands)

	2005		2004
	Budget	Actual	Actual
Internal government transfers:			
Department of Health and Wellness	$ 64,149	$ 65,649	$ 58,355
Premiums, Fees and Licenses:			
Fees:			
Clients	1,538	1,438	1,475
Seminars	-	19	17
	1,538	1,457	1,492
Investment Income (Note 3)	325	500	568
Other:			
Donations	-	18	39
Publications	40	33	33
Miscellaneous - Contracted Services	-	929	1,152
- Sundry & Miscellaneous at Residential sites	105	111	99
- General	-	22	24
	145	1,113	1,347
Total revenues	$ 66,157	$ 68,719	$ 61,762

Schedule 2

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION
SCHEDULE OF EXPENSES BY OBJECT and CORE BUSINESS
FOR THE YEAR ENDED MARCH 31, 2005

(In thousands)

	2005		2004
EXPENSES BY OBJECT	**Budget**	**Actual**	**Actual**
Manpower:			
Salaries	$ 29,049	$ 28,918	$ 26,197
Employer Contributions	5,458	5,270	4,721
Wages	2,653	2,873	2,969
Allowances and benefits	304	276	250
	37,464	37,337	34,137
Grants:			
Direct financial assistance to agencies [(a)]	14,446	14,532	13,156
Other:			
Professional, technical, and labor service	8,448	9,335	6,077
Materials and supplies	2,225	3,071	2,685
Travel and relocation	1,161	1,102	973
Advertising	1,018	761	2,571
Rentals	351	362	349
Telephones	368	352	344
Voluntary separation payments	267	59	250
Freight and postage	104	86	101
Board members' fees	15	39	52
Purchased services - other	-	498	324
Repair and maintenance	44	107	42
Insurance	38	38	23
Amortization	151	126	105
Hosting	57	46	49
Bad debts	-	57	39
Other operating expenses	-	2	14
	14,247	16,041	13,998
	$ 66,157	$ 67,910	$ 61,291

Schedule 2(continued)

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

SCHEDULE OF EXPENSES BY OBJECT and CORE BUSINESS

FOR THE YEAR ENDED MARCH 31, 2005

(In thousands)

	2005		2004
EXPENSES BY CORE BUSINESS	**Budget**	**Actual**	**Actual**
Core Business:			
Treatment	$ 45,304	$ 46,268	$ 39,861
Information	14,375	14,791	12,540
Prevention	6,478	6,851	8,890
	$ 66,157	$ 67,910	$ 61,291

(a) For the years ended March 31, 2005 and 2004, direct financial assistance was given to 32 not-for-profit organizations operating at arms-length from the Commission.

ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

SCHEDULE OF ALLOCATED COSTS

FOR THE YEAR ENDED MARCH 31, 2005

(In thousands)

	2005					2004
		Expenses Incurred by Others				
	Expenses [a]	Accrued Vacation Pay Adjustment	Legal Services [b]	Accommodation costs [c]	Total Expenses	Total Expenses
Programs:						
Community services	$ 32,282	$ 224	$ -	$ 2,781	$ 35,287	$ 30,513
Residential treatment services	13,552	64	-	2,256	15,872	14,432
Detoxification services	8,619	38	-	1,621	10,278	10,017
Research information and monitoring	9,777	40	-	345	10,162	10,881
Administration	3,282	32	10	138	3,462	2,518
	$ 67,512	$ 398	$ 10	$ 7,141	$ 75,061	$ 68,361

[a] Expenses – Directly Incurred as per Statement of Operations excluding Accrued Vacation pay.

[b] Cost shown for Legal Services in Note 9, allocated by estimated cost incurred by each program.

[c] Costs shown for Accommodation (includes grants in lieu of taxes) in Note 9, allocated by square footage.

The following information is **Unaudited**

MINISTRY OF HEALTH AND WELLNESS

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2005

(UNAUDITED)
(in thousands)

	2005	2004
Remissions:		
Third Party Recoveries	$ 311	$ 10
		-
Compromises:		
Health Care Insurance Premiums	127	153
Write-offs:		
Health Care Insurance Premiums	43,319	30,374
Medical Claim Recoveries	965	1,150
Penalties, Interest and Miscellaneous Charges	824	892
Third Party Recoveries	-	-
Total Remissions, Compromises and Write-offs	$ 45,546	$ 32,579

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
2004/05 Financial Statement Highlights

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

This section, compiled from the health authorities' audited financial statements, highlights the financial results of the nine regional health authorities, the Alberta Mental Health Board and the Alberta Cancer Board for the fiscal year ended March 31, 2005.

All of the eleven health authorities received an unqualified audit opinion as at March 31, 2005.

Operating Results

- For fiscal year 2004/05, the health authorities reported a total operating surplus of $34 million. This compares to a prior year deficit of $140 million. Of the eleven health authorities, three reported a deficit of $4.3 million and eight reported surpluses of $38.3 million.
- Total 2004/05 expense was $6.3 billion, compared to $5.7 billion in the prior year – a 9.2 per cent increase, of which 3.7 per cent related to salaries. A total of 48,752 Full Time Equivalents were employed by the health authorities in the year.
- Total administration costs in 2004/2005 were $204 million or 3.3 per cent of health authority expenditures of $6.3 billion. This compares to total adminstation costs in 2003/2004 of $189 million, or 3.3 per cent of health authority expenditures of $5.7 billion.

Financial Position

- The health authorities reported total net assets of $279 million as at March 31, 2005, an increase of $44 million from the prior year.
- Total health authority long-term debt at March 31, 2005 was $45 million, up from $27 million at March 31, 2004. No health authorities have exceeded their authorized borrowing limits.
- The health authorities reported total capital assets of $3.1 billion at March 31, 2005, up from $2.9 billion in the prior year.

Additional Information

- Copies of the health authorities' audited financial statements are included in Section II of the Ministry Annual Report.

TABLE I

HEALTH AUTHORITY SUMMARY
ANALYSIS OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	2004/05 BUDGET	2004/05 ACTUAL	% OF TOTAL	2003/04 ACTUAL	% OF TOTAL	CHANGES FROM 2003/04 TO 2004/05 $	CHANGES FROM 2003/04 TO 2004/05 %
REVENUE							
Alberta Health and Wellness contributions	5,283,192	5,299,508	84.4%	4,711,411	84.4%	588,097	12.5%
Other government contributions	88,039	90,807	1.4%	84,898	1.5%	5,909	7.0%
Fees and charges	397,109	422,888	6.7%	373,495	6.7%	49,393	13.2%
Ancillary operations, net	17,542	21,486	0.3%	10,331	0.2%	11,155	108.0%
Donations	14,410	6,483	0.1%	13,502	0.2%	(7,019)	(52.0%)
Investment and other income	207,220	233,817	3.7%	216,060	3.9%	17,757	8.2%
Amortized external capital contributions	186,114	210,645	3.4%	173,421	3.1%	37,224	21.5%
TOTAL REVENUE	6,193,626	6,285,634	100.0%	5,583,118	100.0%	702,516	12.6%
EXPENSE							
Facility-based inpatient acute nursing services	1,638,571	1,621,958	26.0%	1,481,180	25.9%	140,778	9.5%
Facility-based emergency and outpatient services	698,870	690,717	11.0%	610,053	10.7%	80,664	13.2%
Facility-based continuing care services	582,769	577,699	9.2%	545,565	9.5%	32,134	5.9%
Ambulance services	23,323	26,831	0.4%	22,860	0.4%	3,971	17.4%
Community-based care	248,269	237,331	3.8%	214,628	3.8%	22,703	10.6%
Home care	241,356	245,845	3.9%	221,971	3.9%	23,874	10.8%
Diagnostic & therapeutic services	1,167,938	1,173,405	18.8%	1,070,177	18.7%	103,228	9.6%
Promotion, prevention and protection services	175,594	172,636	2.8%	165,966	2.9%	6,670	4.0%
Research and education	145,078	137,655	2.2%	126,351	2.2%	11,304	8.9%
Administration	206,040	204,463	3.3%	189,240	3.3%	15,223	8.0%
Information technology	135,704	149,616	2.4%	128,381	2.2%	21,235	16.5%
Support services	891,692	895,408	14.3%	842,967	14.7%	52,441	6.2%
Amortization of facilities and improvements	103,626	110,696	1.8%	101,927	1.8%	8,769	8.6%
Capital assets write down	-	7,281	0.1%	-	0.0%	7,281	0.0%
TOTAL EXPENSE prior to the following items	6,258,830	6,251,541	100.0%	5,721,266	100.0%	530,275	9.3%
Restructuring / Legal settlement costs AMHE	-	94		2,079		(1,985)	
TOTAL EXPENSE	6,258,830	6,251,635		5,723,345		528,290	
Excess (deficiency) of revenue over expense	(65,204)	33,999		(140,227)		174,226	

HEALTH AUTHORITY
FINANCIAL SUMMARY
STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	CHINOOK REGIONAL HEALTH AUTHORITY			PALLISER HEALTH REGION			CALGARY HEALTH REGION			DAVID THOMPSON REGIONAL HEALTH AUTHORITY		
	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL
REVENUE												
Alberta Health and Wellness contributions	241,571	242,153	216,851	130,847	130,847	121,809	1,757,976	1,778,273	1,570,621	439,401	437,418	381,657
Other government contributions	3,419	4,451	3,661	3,446	3,446	3,550	22,310	19,017	19,133	12,107	11,595	12,759
Fees and charges	19,074	18,223	16,436	13,933	14,936	14,443	133,879	136,276	123,989	30,520	30,605	26,851
Ancillary operations, net	304	243	208	202	275	254	10,130	12,412	10,089	200	262	420
Donations	312	406	391	300	378	264	7,803	976	6,172	751	751	750
Investment and other income	5,164	5,831	5,208	2,647	3,322	3,254	66,467	74,317	65,194	11,508	10,500	10,023
Amortized external capital contributions	10,330	10,301	9,876	5,384	5,684	5,290	57,083	61,986	49,544	19,391	19,391	16,078
TOTAL REVENUE	280,174	281,608	252,631	156,759	158,888	148,864	2,055,648	2,083,257	1,844,742	513,878	510,522	448,538
EXPENSE												
Facility-based inpatient acute nursing services	67,273	67,967	63,560	39,687	40,173	37,869	624,668	598,503	542,553	129,912	132,326	122,850
Facility-based emergency and outpatient services	17,865	17,785	16,302	7,581	7,392	7,291	273,352	265,071	238,976	33,608	33,493	27,743
Facility-based continuing care services	35,832	35,508	34,449	21,215	21,164	19,866	169,300	164,510	154,570	52,068	53,293	52,272
Ambulance services	-	-	-	1,400	1,445	942	6,513	8,280	6,363	118	118	-
Community-based care	14,949	15,617	12,916	6,924	7,352	6,545	84,620	78,237	66,951	13,686	12,924	11,938
Home care	13,564	14,870	13,109	7,253	8,003	7,291	88,471	88,483	76,403	23,020	23,162	20,096
Diagnostic & therapeutic services	47,286	48,157	43,860	28,422	28,799	26,458	405,667	405,483	372,267	83,605	84,003	76,934
Promotion, prevention and protection services	10,279	10,584	10,207	4,659	4,799	4,078	48,975	47,686	46,531	17,089	16,816	15,874
Research and education	-	-	-	-	-	-	27,228	27,234	22,271	388	359	289
Administration	11,266	12,086	10,955	6,440	6,684	5,908	59,187	56,809	54,833	23,157	22,921	20,776
Information technology	5,909	6,120	6,222	2,277	2,728	2,120	40,306	43,618	40,455	9,998	10,766	9,584
Support services	44,736	46,796	44,532	30,159	30,117	28,809	260,667	261,913	247,366	103,393	101,993	96,870
Amortization of facilities and improvements	7,061	6,961	6,940	3,200	3,271	3,239	25,380	30,292	26,059	13,865	13,865	11,389
Capital assets write down	-	-	-	-	-	-	-	6,698	-	-	-	-
TOTAL EXPENSE prior to the following items	276,020	282,451	263,052	159,217	161,927	150,416	2,114,334	2,082,817	1,895,598	503,907	506,039	466,615
Restructuring / Legal settlement costs AMHB												
TOTAL EXPENSE	276,020	282,451	263,052	159,217	161,927	150,416	2,114,334	2,082,817	1,895,598	503,907	506,039	466,615
Excess (deficiency) of revenue over expense	4,154	(843)	(10,421)	(2,458)	(3,039)	(1,552)	(58,686)	440	(50,856)	9,971	4,483	(18,077)

HEALTH AUTHORITY
FINANCIAL SUMMARY
STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	EAST CENTRAL HEALTH			CAPITAL HEALTH			ASPEN REGIONAL HEALTH AUTHORITY			PEACE COUNTRY HEALTH		
	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL
REVENUE												
Alberta Health and Wellness contributions	179,098	180,576	154,810	1,861,807	1,858,329	1,672,222	190,316	190,316	174,585	184,363	183,840	156,670
Other government contributions	4,922	3,927	3,888	36,385	38,496	36,884	2,222	2,357	2,431	768	1,352	818
Fees and charges	18,154	19,530	17,977	137,583	156,216	134,630	19,734	20,556	17,521	16,235	16,309	13,366
Ancillary operations, net	28	38	61	4,763	6,258	(2,206)	196	303	191	992	998	878
Donations	38	220	332	-	-	-	400	368	262	243	380	540
Investment and other income	1,556	3,378	3,312	80,631	96,084	87,698	5,392	6,441	5,954	4,308	5,875	5,519
Amortized external capital contributions	4,472	4,884	4,512	55,000	71,386	56,326	8,018	7,818	7,273	8,418	9,910	8,418
TOTAL REVENUE	208,268	212,553	184,892	2,176,169	2,226,769	1,985,554	226,278	228,159	208,217	215,327	218,664	186,209
EXPENSE												
Facility-based inpatient acute nursing services	32,987	33,792	31,211	621,443	622,982	568,815	32,926	34,038	31,443	46,166	46,832	41,659
Facility-based emergency and outpatient services	8,273	9,017	8,181	243,329	246,624	210,742	20,633	18,935	17,276	15,682	15,502	15,112
Facility-based continuing care services	37,330	37,154	36,525	213,148	213,614	197,476	30,893	29,730	28,265	19,506	18,895	18,739
Ambulance services	2,587	2,789	2,392	9,668	10,269	10,012	-	-	-	3,037	3,818	3,151
Community-based care	8,610	8,792	8,341	65,266	66,940	66,341	11,995	12,028	11,111	6,012	5,737	5,376
Home care	16,104	17,917	14,929	66,247	67,025	66,096	12,546	12,372	11,175	11,527	11,395	10,377
Diagnostic & therapeutic services	28,201	28,700	26,266	419,654	420,654	381,693	41,035	41,144	36,122	36,142	37,291	33,793
Promotion, prevention and protection services	5,682	5,751	5,383	51,256	51,432	49,696	10,034	9,463	8,421	9,784	9,382	8,312
Research and education	66	33	63	87,426	85,565	78,483	-	-	-	-	45	33
Administration	12,521	12,602	11,959	56,323	55,648	51,732	8,946	8,779	8,279	9,613	10,716	10,438
Information technology	3,075	2,803	3,599	56,205	62,788	50,599	2,845	3,864	1,903	3,755	3,595	4,111
Support services	42,601	41,434	41,229	281,811	283,115	262,314	49,706	51,869	49,080	39,412	38,949	37,757
Amortization of facilities and improvements	3,265	3,602	3,264	30,393	31,828	32,634	5,190	5,207	5,239	6,291	6,946	6,308
Capital assets write down	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL EXPENSE prior to the following items	201,302	204,386	193,342	2,202,169	2,218,484	2,026,633	226,749	227,429	208,314	206,927	209,103	195,166
Restructuring / Legal settlement costs AMHB												
TOTAL EXPENSE	201,302	204,386	193,342	2,202,169	2,218,484	2,026,633	226,749	227,429	208,314	206,927	209,103	195,166
Excess (deficiency) of revenue over expense	6,966	8,167	(8,450)	(26,000)	8,285	(41,079)	(471)	730	(97)	8,400	9,561	(8,957)

HEALTH AUTHORITY
FINANCIAL SUMMARY
STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	NORTHERN LIGHTS HEALTH REGION			ALBERTA MENTAL HEALTH BOARD			ALBERTA CANCER BOARD			HEALTH AUTHORITY TOTAL		
	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL
REVENUE												
Alberta Health and Wellness contributions	66,916	67,506	60,355	35,760	35,523	34,918	195,137	194,727	166,913	5,283,192	5,299,508	4,711,411
Other government contributions	708	2,323	723	272	307	390	1,480	3,536	661	88,039	90,807	84,898
Fees and charges	4,297	4,993	3,782	-	-	-	3,700	5,244	4,500	397,109	422,888	373,495
Ancillary operations, net	187	(42)	15	-	-	-	540	739	421	17,542	21,486	10,331
Donations	63	463	224	-	-	50	4,500	2,541	4,517	14,410	6,483	13,502
Investment and other income	861	1,124	1,217	293	479	930	28,393	26,466	27,751	207,220	233,817	216,060
Amortized external capital contributions	4,936	6,019	3,673	306	197	376	12,776	13,069	12,055	186,114	210,645	173,421
TOTAL REVENUE	77,968	82,386	69,989	36,631	36,506	36,664	246,526	246,322	216,818	6,193,626	6,285,634	5,583,118
EXPENSE												
Facility-based inpatient acute nursing services	18,536	19,270	16,880	12,047	12,724	11,513	12,926	13,351	12,827	1,638,571	1,621,958	1,481,180
Facility-based emergency and outpatient services	5,757	5,793	5,050	5,370	4,830	4,621	67,420	66,275	58,759	698,870	690,717	610,053
Facility-based continuing care services	3,477	3,831	3,403	-	-	-	-	-	-	582,769	577,699	545,565
Ambulance services	-	112	-	-	-	-	-	-	-	23,323	26,831	22,860
Community-based care	2,408	2,180	1,554	1,703	1,765	1,634	32,096	25,759	21,921	248,269	237,331	214,628
Home care	2,624	2,618	2,495	-	-	-	-	-	-	241,356	245,845	221,971
Diagnostic & therapeutic services	14,275	15,150	12,374	6,691	6,924	6,161	56,960	57,100	54,249	1,167,938	1,173,405	1,070,177
Promotion, prevention and protection services	5,416	5,507	4,904	2,243	1,289	3,407	10,177	9,927	9,153	175,594	172,636	165,966
Research and education	-	-	-	1,980	795	926	27,990	23,624	24,286	145,078	137,655	126,351
Administration	4,797	5,067	3,859	6,368	5,028	4,689	7,422	8,123	5,812	206,040	204,463	189,240
Information technology	2,635	3,367	1,693	1,193	1,013	962	7,506	8,954	7,133	135,704	149,616	128,381
Support services	13,629	15,309	13,115	916	992	862	24,662	22,921	21,033	891,692	895,408	842,967
Amortization of facilities and improvements	4,414	4,000	2,360	-	-	-	4,567	4,724	4,495	103,626	110,696	101,927
Capital assets write down	-	583	-	-	-	-	-	-	-	-	7,281	-
TOTAL EXPENSE prior to the following items	77,968	82,787	67,687	38,511	35,360	34,775	251,726	240,758	219,668	6,258,830	6,251,541	5,721,266
Restructuring / Legal settlement costs AMHB				-	94	2,079				-	94	2,079
TOTAL EXPENSE	77,968	82,787	67,687	38,511	35,454	36,854	251,726	240,758	219,668	6,258,830	6,251,635	5,723,345
Excess (deficiency) of revenue over expense	-	(401)	2,302	(1,880)	1,052	(190)	(5,200)	5,564	(2,850)	(65,204)	33,999	(140,227)

TABLE III

HEALTH AUTHORITY SUMMARY STATEMENT OF FINANCIAL POSITION AND STATEMENT OF CASH FLOWS FOR THE YEAR ENDED MARCH 31, 2005

(In Thousands)

	CHINOOK REGIONAL HEALTH AUTHORITY		PALLISER HEALTH REGION		CALGARY HEALTH REGION		DAVID THOMPSON REGIONAL HEALTH AUTHORITY	
	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL
ASSETS								
Cash and investments	18,698	7,513	10,233	7,673	45,687	20,485	44,890	59,356
Accounts receivable	4,770	4,498	4,457	3,915	36,013	38,983	6,440	7,327
Contributions receivable from Alberta Health and Wellness	3,421	830	6,454	464	43,454	13,306	6,502	1,400
Inventories	2,314	2,111	982	858	21,089	19,003	5,524	5,247
Prepaid expenses	1,578	1,593	1,021	361	5,812	3,098	2,768	1,413
Current Assets	30,781	16,545	23,147	13,271	152,055	94,875	66,124	74,743
Non-current cash and investments	16,709	19,458	18,812	22,248	390,961	240,298	29,737	25,631
Capital assets	176,950	175,776	71,719	71,188	939,770	802,763	405,415	379,061
Other assets	7,818	7,967	9,999	6,390	11,767	12,017	22,338	21,652
TOTAL ASSETS	232,258	219,746	123,677	113,097	1,494,553	1,149,953	523,614	501,087
LIABILITIES, NET ASSETS AND ENDOWMENTS								
Bank indebtedness	-	-	4,731	2,142	-	-	-	-
Accounts payable and accrued liabilities	24,036	22,615	9,713	9,119	162,326	163,318	39,572	56,782
Accrued vacation pay	10,263	9,559	6,124	5,893	74,114	67,884	19,257	18,020
Deferred contributions	6,635	4,036	13,507	5,569	54,494	29,948	19,450	13,531
Current portion of long term debt	56	71	-	-	218	204	201	52
Current Liabilities	40,990	36,281	34,075	22,723	291,152	261,354	78,480	88,385
Deferred contributions	3,670	3,869	9,999	6,390	30,657	30,336	21,914	22,578
Deferred capital contributions	15,975	10,444	-	-	221,698	60,739	29,737	24,949
Long-term debt	178	233	-	-	16,717	16,927	850	560
Unamortized external capital contributions	164,674	162,904	63,334	64,676	851,470	703,641	372,325	348,790
Other liabilities	367	68	-	-	10,683	10,400	-	-
TOTAL LIABILITIES	225,854	213,799	107,408	93,789	1,422,377	1,083,397	503,306	485,262
NET ASSETS AND ENDOWMENTS								
Accumulated surplus/(deficit)	(5,788)	(6,771)	7,884	12,796	(7,658)	(24,002)	(11,306)	(13,409)
Investment in capital assets from internally funded sources	12,042	12,568	8,385	6,512	79,834	90,558	31,614	29,234
Endowments	150	150	-	-	-	-	-	-
TOTAL NET ASSETS AND ENDOWMENTS	6,404	5,947	16,269	19,308	72,176	66,556	20,308	15,825
TOTAL LIABILITIES, NET ASSETS, ENDOWMENTS	232,258	219,746	123,677	113,097	1,494,553	1,149,953	523,614	501,087
CASH FLOWS								
Cash generated from (used by) operating activities	5,920	(23)	163	1,474	14,153	11,198	(4,254)	(23,045)
Cash used by investing activities	(11,084)	(13,706)	(8,172)	(6,164)	(359,433)	(146,106)	(53,577)	(32,807)
Cash generated from financing activities	16,349	9,128	10,569	4,823	370,482	104,236	43,365	45,314
Increase (decrease) in cash and cash equivalent	11,185	(4,601)	2,560	133	25,202	(30,672)	(14,466)	(10,538)
Cash and cash equivalent, beginning of year	7,513	12,114	7,673	7,540	20,485	51,157	59,356	69,894
Cash and cash equivalent, end of year	18,698	7,513	10,233	7,673	45,687	20,485	44,890	59,356
Non-current cash and investments, end of year	16,709	19,458	18,812	22,248	390,961	240,298	29,737	25,631
Total cash, cash equivalent and non-current investments, end of year	35,407	26,971	29,045	29,921	436,648	260,783	74,627	84,987

HEALTH AUTHORITY SUMMARY
STATEMENT OF FINANCIAL POSITION AND
STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	EAST CENTRAL HEALTH		CAPITAL HEALTH		ASPEN REGIONAL HEALTH AUTHORITY		PEACE COUNTRY HEALTH	
	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL
ASSETS								
Cash and investments	18,334	13,015	176,958	150,500	50,582	23,477	20,620	4,955
Accounts receivable	1,994	3,242	84,787	44,747	4,317	5,853	4,569	4,886
Contributions receivable from Alberta Health and Wellness	1,678	1,196	45,782	14,165	3,774	2,115	8,159	5,861
Inventories	576	521	12,842	10,289	1,452	1,489	1,082	963
Prepaid expenses	-	-	67,809	40,490	1,399	864	1,525	927
Current Assets	22,582	17,974	388,178	260,191	61,524	33,798	35,955	17,592
Non-current cash and investments	19,663	12,057	470,080	202,713	17,774	14,450	5,347	6,076
Capital assets	91,858	82,966	882,028	844,934	128,304	127,971	183,780	189,268
Other assets	-	-	50,314	29,417	2,547	2,629	4,768	1,734
TOTAL ASSETS	134,103	112,997	1,790,600	1,337,255	210,149	178,848	229,850	214,670
LIABILITIES, NET ASSETS AND ENDOWMENTS								
Bank indebtedness	-	-	-	-	-	-	-	-
Accounts payable and accrued liabilities	11,892	16,720	194,600	153,284	19,848	16,912	18,325	18,886
Accrued vacation pay	5,281	5,032	72,322	64,825	9,369	8,463	8,654	7,952
Deferred contributions	5,237	3,227	119,880	84,135	9,274	7,272	7,650	1,606
Current portion of long term debt	-	-	807	378	-	-	34	-
Current Liabilities	22,410	24,979	387,609	302,622	38,491	32,647	34,663	28,444
Deferred contributions	488	872	52,692	53,366	2,547	2,629	-	-
Deferred capital contributions	19,175	11,185	460,629	168,152	28,867	5,599	9,696	6,743
Long-term debt	-	-	25,859	8,054	-	-	102	-
Unamortized external capital contributions	85,771	77,730	768,740	721,458	118,694	117,153	174,480	178,135
Other liabilities	-	-	13,744	14,492	-	-	-	-
TOTAL LIABILITIES	127,844	114,766	1,709,273	1,268,144	188,599	158,028	218,941	213,322
NET ASSETS AND ENDOWMENTS								
Accumulated surplus/(deficit)	172	(7,005)	6,605	(33,035)	11,940	10,002	1,745	(9,785)
Investment in capital assets from internally funded sources	6,087	5,236	74,722	102,146	9,610	10,818	9,164	11,133
Endowments	-	-	-	-	-	-	-	-
TOTAL NET ASSETS AND ENDOWMENTS	6,259	(1,769)	81,327	69,111	21,550	20,820	10,909	1,348
TOTAL LIABILITIES, NET ASSETS, ENDOWMENTS	134,103	112,997	1,790,600	1,337,255	210,149	178,848	229,850	214,670
CASH FLOWS								
Cash generated from (used by) operating activities	6,769	(148)	40,378	31,684	8,534	6,735	14,220	(4,631)
Cash used by investing activities	(21,843)	(5,540)	(436,710)	(126,402)	(12,379)	(9,504)	(4,697)	(9,174)
Cash generated from financing activities	20,393	4,093	422,790	84,178	30,950	9,131	6,142	7,059
Increase (decrease) in cash and cash equivalent	5,319	(1,595)	26,458	(10,540)	27,105	6,362	15,665	(6,746)
Cash and cash equivalent, beginning of year	13,015	14,610	150,500	161,040	23,477	17,115	4,955	11,701
Cash and cash equivalent, end of year	18,334	13,015	176,958	150,500	50,582	23,477	20,620	4,955
Non-current cash and investments, end of year	19,663	12,057	470,080	202,713	17,774	14,450	5,347	6,076
Total cash, cash equivalent and non-current investments, end of year	37,997	25,072	647,038	353,213	68,356	37,927	25,967	11,031

TABLE III

HEALTH AUTHORITY SUMMARY STATEMENT OF FINANCIAL POSITION AND STATEMENT OF CASH FLOWS FOR THE YEAR ENDED MARCH 31, 2005

(In Thousands)

	NORTHERN LIGHTS HEALTH REGION		ALBERTA MENTAL HEALTH BOARD		ALBERTA CANCER BOARD		HEALTH AUTHORITY TOTAL	
	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 ACTUAL	2003/04 ACTUAL
ASSETS								
Cash and investments	9,122	13,112	8,455	7,716	20,427	8,489	424,006	316,291
Accounts receivable	1,875	1,433	115	162	7,191	9,003	156,528	124,049
Contributions receivable from Alberta Health and Wellness	1,544	865	1,460	745	4,075	2,060	126,303	43,007
Inventories	565	555	-	-	6,098	4,508	52,524	45,544
Prepaid expenses	573	636	498	687	861	594	83,844	50,663
Current Assets	13,679	16,601	10,528	9,310	38,652	24,654	843,205	579,554
Non-current cash and investments	1,643	4,201	125	523	39,198	33,301	1,010,049	580,956
Capital assets	81,498	80,266	183	433	135,679	134,761	3,097,184	2,889,387
Other assets	1,788	907	-	-	-	-	111,339	82,713
TOTAL ASSETS	98,608	101,975	10,836	10,266	213,529	192,716	5,061,777	4,132,610
LIABILITIES, NET ASSETS AND ENDOWMENTS								
Bank indebtedness	360	-	-	-	-	-	5,091	2,142
Accounts payable and accrued liabilities	6,109	9,691	725	1,952	25,674	26,042	512,820	495,321
Accrued vacation pay	2,624	2,369	221	175	5,927	4,736	214,156	194,908
Deferred contributions	2,299	1,544	833	464	21,061	14,507	260,320	165,839
Current portion of long term debt	-	480	-	-	-	-	1,316	1,185
Current Liabilities	11,392	14,084	1,779	2,591	52,662	45,285	993,703	859,395
Deferred contributions	5	5	542	-	-	-	122,514	120,045
Deferred capital contributions	3,426	5,103	-	-	12,928	4,212	802,131	297,126
Long-term debt	-	-	-	-	-	-	43,706	25,774
Unamortized external capital contributions	77,832	76,429	115	327	118,884	119,693	2,796,319	2,570,936
Other liabilities	-	-	-	-	-	-	24,794	24,960
TOTAL LIABILITIES	92,655	95,621	2,436	2,918	184,474	169,190	4,783,167	3,898,236
NET ASSETS AND ENDOWMENTS								
Accumulated surplus/(deficit)	2,287	2,517	8,332	7,242	12,260	8,458	26,473	(52,992)
Investment in capital assets from internally funded sources	3,666	3,837	68	106	16,795	15,068	251,987	287,216
Endowments	-	-	-	-	-	-	150	150
TOTAL NET ASSETS AND ENDOWMENTS	5,953	6,354	8,400	7,348	29,055	23,526	278,610	234,374
TOTAL LIABILITIES, NET ASSETS, ENDOWMENTS	98,608	101,975	10,836	10,266	213,529	192,716	5,061,777	4,132,610
CASH FLOWS								
Cash generated from (used by) operating activities	(3,040)	7,323	358	(16,020)	13,995	8,074	97,196	22,621
Cash used by investing activities	(6,694)	(12,064)	381	527	(18,721)	(16,791)	(932,929)	(377,731)
Cash generated from financing activities	5,744	11,774	-	13	16,664	11,101	943,448	290,850
Increase (decrease) in cash and cash equivalent	(3,990)	7,033	739	(15,480)	11,938	2,384	107,715	(64,260)
Cash and cash equivalent, beginning of year	13,112	6,079	7,716	23,196	8,489	6,105	316,291	380,551
Cash and cash equivalent, end of year	9,122	13,112	8,455	7,716	20,427	8,489	424,006	316,291
Non-current cash and investments, end of year	1,643	4,201	125	523	39,198	33,301	1,010,049	580,956
Total cash, cash equivalent and non-current investments, end of year	10,765	17,313	8,580	8,239	59,625	41,790	1,434,055	897,247

HEALTH AUTHORITY FINANCIAL SUMMARY
SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	CHINOOK REGIONAL HEALTH AUTHORITY			PALLISER HEALTH REGION			CALGARY HEALTH REGION			DAVID THOMPSON REGIONAL HEALTH AUTHORITY		
	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL
Salaries and Benefits	158,801	162,696	151,796	91,714	93,123	87,334	1,068,612	1,053,373	990,977	340,143	340,372	317,238
Contracts with health service operators	43,723	46,935	42,860	27,690	27,474	24,583	404,391	395,023	357,745	28,996	29,379	21,881
Contracts under the Health Care Protection Act	-	-	-	-	-	-	11,831	8,706	5,998	-	-	-
Drugs and gases	4,457	4,736	4,589	3,240	3,340	3,244	80,027	80,053	70,643	10,794	10,918	9,810
Medical and surgical supplies	6,485	7,064	6,232	3,960	4,020	3,696	89,793	90,185	84,447	11,173	11,290	10,244
Other contracted services	20,745	18,891	16,167	7,954	8,327	7,694	192,690	200,595	159,132	28,672	28,960	24,156
Interest on long-term debt	20	15	16	-	-	-	-	-	-	31	31	31
Other	30,232	30,863	29,762	18,775	19,129	18,073	204,799	192,311	175,360	66,739	67,853	67,625
Amortization:												
Capital equipment - internally funded	2,734	2,295	3,012	1,500	1,755	1,442	16,135	14,058	14,986	3,623	3,623	3,438
Capital equipment - externally funded	3,371	3,509	3,101	1,900	2,009	1,767	34,245	29,932	26,905	5,629	5,629	4,724
Facilities and Improvements	6,959	7,004	6,984	3,484	3,704	3,552	26,985	31,075	26,911	13,865	13,865	11,627
Capital assets write down - equipment	-	-	-	-	-	-	-	-	-	-	-	-
Capital assets write down - facilities and improvements	-	-	-	-	-	-	-	6,698	-	-	-	-
	277,527	284,008	264,519	160,217	162,881	151,385	2,129,508	2,102,009	1,913,104	509,665	511,920	470,774
Less amounts reported in ancillary operations	(1,507)	(1,557)	(1,467)	(1,000)	(954)	(969)	(15,174)	(19,192)	(17,506)	(5,758)	(5,881)	(4,159)
TOTAL EXPENSES	276,020	282,451	263,052	159,217	161,927	150,416	2,114,334	2,082,817	1,895,598	503,907	506,039	466,615

TABLE IV

HEALTH AUTHORITY FINANCIAL SUMMARY
SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	EAST CENTRAL HEALTH			CAPITAL HEALTH			ASPEN REGIONAL HEALTH AUTHORITY			PEACE COUNTRY HEALTH		
	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL
Salaries and Benefits	78,324	78,638	73,600	1,028,004	1,030,733	974,170	139,079	135,902	125,268	140,580	137,749	128,489
Contracts with health service operators	89,951	91,904	88,614	593,500	595,023	541,487	28,254	29,164	26,681	4,622	5,375	5,527
Contracts under the Health Care Protection Act	-	-	-	3,550	3,332	3,270	-	-	-	-	-	-
Drugs and gases	1,460	1,641	1,572	73,800	74,052	66,155	3,754	3,626	3,413	3,874	3,934	3,943
Medical and surgical supplies	1,114	1,299	1,159	90,200	89,875	84,197	3,460	3,761	3,181	3,942	4,373	3,949
Other contracted services	5,183	4,845	6,103	124,823	125,190	116,974	11,118	11,947	10,174	13,120	14,178	12,422
Interest on long-term debt	-	-	-	682	1,340	497	-	-	-	-	6	-
Other	20,761	21,281	17,785	211,789	213,018	182,377	32,066	34,374	31,375	30,771	32,622	31,014
Amortization:												
Capital equipment - internally funded	700	537	644	26,000	37,988	27,699	1,947	1,787	1,894	1,128	1,212	1,138
Capital equipment - externally funded	1,209	1,315	1,266	38,277	39,171	31,978	2,982	2,690	2,151	2,599	3,074	2,576
Facilities and Improvements	3,265	3,602	3,264	31,723	31,403	34,489	5,257	5,234	5,271	6,291	6,946	6,291
Capital assets write down - equipment	-	-	-	14,000	14,284	5,784	-	-	-	-	(150)	13
Capital assets write down - facilities and improvements	-	-	-	-	-	-	-	-	-	-	-	-
	201,967	205,062	194,007	2,236,348	2,255,409	2,069,077	227,917	228,485	209,408	206,927	209,319	195,362
Less amounts reported in ancillary operations	(665)	(676)	(665)	(34,179)	(36,925)	(42,444)	(1,168)	(1,056)	(1,094)	-	(216)	(196)
TOTAL EXPENSES	201,302	204,386	193,342	2,202,169	2,218,484	2,026,633	226,749	227,429	208,314	206,927	209,103	195,166

HEALTH AUTHORITY FINANCIAL SUMMARY
SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	NORTHERN LIGHTS HEALTH REGION			ALBERTA MENTAL HEALTH BOARD			ALBERTA CANCER BOARD			HEALTH AUTHORITY TOTAL		
	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL	2004/05 BUDGET	2004/05 ACTUAL	2003/04 ACTUAL
Salaries and Benefits	48,269	48,833	43,269	4,073	3,489	3,716	104,359	90,170	84,928	3,201,958	3,175,078	2,980,785
Contracts with health service operators	5,859	5,111	3,627	28,818	28,021	28,454	-	-	-	1,255,804	1,253,409	1,141,459
Contracts under the Health Care Protection Act	-	-	-	-	-	-	-	-	-	15,381	12,038	9,268
Drugs and gases	904	1,193	1,058	-	-	-	58,874	55,572	48,902	241,184	239,065	213,329
Medical and surgical supplies	1,412	1,808	1,192	-	-	-	2,601	2,917	2,627	214,140	216,592	200,924
Other contracted services	148	5,949	2,891	2,103	1,426	1,745	27,286	31,321	27,317	433,842	451,629	384,775
Interest on long-term debt	-	-	-	-	-	-	-	-	-	733	1,392	544
Other	16,586	13,748	12,235	3,188	2,266	2,516	46,140	49,877	45,341	681,846	677,342	613,463
Amortization:												
Capital equipment - internally funded	435	738	471	23	55	47	3,518	3,094	3,067	57,743	67,142	57,838
Capital equipment - externally funded	1,685	1,635	1,353	306	197	376	8,222	8,534	7,574	100,425	97,695	83,771
Facilities and Improvements	3,320	4,161	2,529	-	-	-	4,744	4,724	4,671	105,893	111,718	105,589
Capital assets write down - equipment	-	-	-	-	-	-	-	-	-	14,000	14,134	5,797
Capital assets write down - facilities and improvements	-	583	-	-	-	-	-	-	-	-	7,281	-
	78,618	83,759	68,625	38,511	35,454	36,854	255,744	246,209	224,427	6,322,949	6,324,515	5,797,542
Less amounts reported in ancillary operations	(650)	(972)	(938)	-	-	-	(4,018)	(5,451)	(4,759)	(64,119)	(72,880)	(74,197)
TOTAL EXPENSES	77,968	82,787	67,687	38,511	35,454	36,854	251,726	240,758	219,668	6,258,830	6,251,635	5,723,345

TABLE V

HEALTH AUTHORITY SUMMARY OF OTHER FINANCIAL INFORMATION FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	CHINOOK	PALLISER	CALGARY	DAVID THOMPSON	EAST CENTRAL	CAPITAL HEALTH	ASPEN
I. SURPLUS/(DEFICIT) AS A % OF TOTAL REVENUE	(0.30%)	(1.91%)	0.02%	0.88%	3.84%	0.37%	0.32%
II. ADMINISTRATION COST AS A % OF TOTAL EXPENSES	4.28%	4.13%	2.73%	4.53%	6.17%	2.51%	3.86%
III. WORKING CAPITAL							
Current Assets	30,781	23,147	152,055	66,124	22,582	388,178	61,524
Current Liabilities	40,990	34,075	291,152	78,480	22,410	387,609	38,491
WORKING CAPITAL RATIO	0.75	0.68	0.52	0.84	1.01	1.00	1.60
IV. ALBERTA HEALTH AND WELLNESS FUNDING COVERAGE RATIO *excludes unusual items*	85.73%	80.81%	85.38%	86.44%	88.35%	83.77%	83.68%
V. AVERAGE REMAINING USEFUL LIFE OF CAPITAL EQUIPMENT IN YEARS	3.22	3.83	3.64	4.49	4.73	1.18	3.23
VI. TOTAL FTEs *(excludes Board)*	2,477	1,498	15,763	5,640	1,474	15,326	2,363

HEALTH AUTHORITY SUMMARY OF OTHER FINANCIAL INFORMATION FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	PEACE	NORTHERN LIGHTS	ALBERTA MENTAL HEALTH BOARD	ALBERTA CANCER BOARD	HEALTH AUTHORITY TOTAL 2005	HEALTH AUTHORITY TOTAL 2004
I. SURPLUS/(DEFICIT) AS A % OF TOTAL REVENUE	4.37%	(0.49%)	2.88%	2.26%	0.54%	(2.51%)
II. ADMINISTRATION COST AS A % OF TOTAL EXPENSES	5.12%	6.12%	14.22%	3.37%	3.27%	3.31%
III. WORKING CAPITAL						
Current Assets	35,955	13,679	10,528	38,652	843,205	579,554
Current Liabilities	34,663	11,392	1,779	52,662	993,703	859,395
WORKING CAPITAL RATIO	1.04	1.20	5.92	0.73	0.85	0.67
IV. ALBERTA HEALTH AND WELLNESS FUNDING COVERAGE RATIO *excludes unusual items*	87.92%	81.54%	100.46%	80.88%	84.77%	82.35%
V. AVERAGE REMAINING USEFUL LIFE OF CAPITAL EQUIPMENT IN YEARS	3.91	4.54	0.73	5.25	2.66	2.96
VI. TOTAL FTEs *(excludes Board)*	2,042	771	39	1,359	48,752	47,913

TABLE VI

HEALTH AUTHORITY SUMMARY OF FEDERAL DIAGNOSTIC/MEDICAL EQUIPMENT FUND
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	CHINOOK REGIONAL HEALTH AUTHORITY			PALLISER HEALTH REGION			CALGARY HEALTH REGION			DAVID THOMPSON REGIONAL HEALTH AUTHORITY		
	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE
Diagnostic Imaging	658	539	119	1,064	1,064	-	5,107	2,028	3,079	4,066	367	3,699
Laboratory	352	228	124	-	-	-	140	141	(1)	-	-	-
Medical	250	244	6	-	-	-	8,619	7,710	909	-	-	-
Surgical	750	724	26	181	181	-	2,547	2,219	328	-	-	-
Rehabilitation	233	18	215	-	-	-	-	-	-	-	-	-
Patient Care/Support	-	-	-	-	-	-	391	259	132	-	-	-
Total Expenditures	$ 2,243	$ 1,753	$ 490	$ 1,245	$ 1,245	$ -	$ 16,804	$ 12,357	$ 4,447	$ 4,066	$ 367	$ 3,699

HEALTH AUTHORITY SUMMARY OF
FEDERAL DIAGNOSTIC/MEDICAL
EQUIPMENT FUND
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	EAST CENTRAL HEALTH			CAPITAL HEALTH			ASPEN REGIONAL HEALTH AUTHORITY			PEACE COUNTRY HEALTH		
	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE
Diagnostic Imaging	831	386	445	8,529	11,676	(3,147)	832	832	-	153	5	148
Laboratory	161	-	161	-	-	-	304	304	-	255	223	32
Medical	607	17	590	3,312	2,960	352	119	119	-	670	229	441
Surgical	-	-	-	2,484	2,361	123	517	517	-	358	298	60
Rehabilitation	-	-	-	-	-	-	8	8	-	83	60	23
Patient Care/Support	-	-	-	3,561	889	2,672	-	-	-	80	56	24
Total Expenditures	$ 1,599	$ 403	$ 1,196	$ 17,886	$ 17,886	$ -	$ 1,780	$ 1,780	$ -	$ 1,599	$ 871	$ 728

TABLE VI

HEALTH AUTHORITY SUMMARY OF
FEDERAL DIAGNOSTIC/MEDICAL
EQUIPMENT FUND
FOR THE YEAR ENDED MARCH 31, 2005
(In Thousands)

	NORTHERN LIGHTS HEALTH REGION			ALBERTA CANCER BOARD			HEALTH AUTHORITY TOTAL			
	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	2004/05 PLANNED	2004/05 ACTUAL	UNSPENT BALANCE	UNSPENT %
Diagnostic Imaging	615	615	-	-	-	-	21,855	17,512	4,343	19.87%
Laboratory	-	-	-	-	-	-	1,212	896	316	26.07%
Medical	-	-	-	1,803	-	1,803	15,380	11,279	4,101	26.66%
Surgical	-	-	-	-	-	-	6,837	6,300	537	7.85%
Rehabilitation	-	-	-	-	-	-	324	86	238	73.46%
Patient Care/Support	-	-	-	-	-	-	4,032	1,204	2,828	70.14%
Total Expenditures	$ 615	$ 615	$ -	$ 1,803	$ -	$ 1,803	$ 49,640	$ 37,277	$ 12,363	24.91%

Alphabetical List of Government Entities' Financial Statements in Ministry 2004/2005 Annual Reports

ENTITIES INCLUDED IN THE CONSOLIDATED GOVERNMENT REPORTING ENTITY

Ministry, Department, Fund or Agency	Ministry Annual Report
Agriculture Financial Services Corporation[1]	Agriculture, Food and Rural Development
Alberta Alcohol and Drug Abuse Commission	Health and Wellness
Alberta Capital Finance Authority	Finance
Alberta Energy and Utilities Board	Energy
Alberta Foundation for the Arts	Community Development
Alberta Gaming and Liquor Commission	Gaming
Alberta Government Telephones Commission	Finance
Alberta Heritage Foundation for Medical Research Endowment Fund	Finance
Alberta Heritage Savings Trust Fund	Finance
Alberta Heritage Scholarship Fund	Finance
Alberta Heritage Science and Engineering Research Endowment Fund	Finance
Alberta Historical Resources Foundation	Community Development
Alberta Insurance Council	Finance
Alberta Pensions Administration Corporation	Finance
Alberta Petroleum Marketing Commission	Energy
Alberta Research Council Inc.	Innovation and Science
Alberta Risk Management Fund	Finance
Alberta School Foundation Fund	Education
Alberta Science and Research Authority	Innovation and Science
Alberta Securities Commission	Finance
Alberta Social Housing Corporation	Seniors and Community Supports
Alberta Sport, Recreation, Parks and Wildlife Foundation	Community Development
Alberta Treasury Branches	Finance
ATB Investment Services Inc.	Finance
Child and Family Services Authorities:	
Calgary and Area Child and Family Services Authority	
Central Alberta Child and Family Services Authority	
East Central Alberta Child and Family Services Authority	
Edmonton and Area Child and Family Services Authority	
North Central Alberta Child and Family Services Authority	
Northeast Alberta Child and Family Services Authority	
Northwest Alberta Child and Family Services Authority	
Southeast Alberta Child and Family Services Authority	
Southwest Alberta Child and Family Services Authority	
Metis Settlements Child and Family Services Authority	Children's Services
Credit Union Deposit Guarantee Corporation	Finance

1 The Crop Reinsurance Fund of Alberta was merged into the Agriculture Financial Services Corporation, effective April 1, 2003.

Ministry, Department, Fund or Agency	Ministry Annual Report
Crop Reinsurance Fund of Alberta[1]	Agriculture, Food and Rural Development
Department of Agriculture, Food and Rural Development	Agriculture, Food and Rural Development
Department of Children's Services	Children's Services
Department of Community Development	Community Development
Department of Education	Education
Department of Energy	Energy
Department of Finance	Finance
Department of Gaming	Gaming
Department of Health and Wellness	Health and Wellness
Department of Innovation and Science	Innovation and Science
Department of Seniors and Community Supports	Seniors and Community Supports
Department of Solicitor General	Solicitor General
Department of Sustainable Resource Development	Sustainable Resource Development
Environmental Protection and Enhancement Fund	Sustainable Resource Development
Gainers Inc.	Finance
Government House Foundation	Community Development
Historic Resources Fund	Community Development
Human Rights, Citizenship and Multiculturalism Education Fund	Community Development
iCORE Inc.	Innovation and Science
Lottery Fund	Gaming
Ministry of Advanced Education[2]	Advanced Education
Ministry of Aboriginal Affairs and Northern Development[2]	Aboriginal Affairs and Northern Development
Ministry of Agriculture, Food and Rural Development	Agriculture, Food and Rural Development
Ministry of Children's Services	Children's Services
Ministry of Community Development	Community Development
Ministry of Economic Development[2]	Economic Development
Ministry of Education	Education
Ministry of Energy	Energy
Ministry of Environment[2]	Environment
Ministry of Finance	Finance
Ministry of Executive Council[2]	Executive Council
Ministry of Gaming	Gaming
Ministry of Government Services[2]	Government Services
Ministry of Health and Wellness	Health and Wellness
Ministry of Human Resources and Employment[2]	Human Resources and Employment
Ministry of Infrastructure and Transportation[2]	Infrastructure and Transportation
Ministry of Innovation and Science	Innovation and Science

[1] The Crop Reinsurance Fund of Alberta was merged into the Agriculture Financial Services Corporation, effective April 1, 2003.

[2] Ministry includes only the department so separate department financial statements are not necessary.

Ministry, Department, Fund or Agency	Ministry Annual Report
Ministry of International and Intergovernmental Relations[2]	International and Intergovernmental Relations
Ministry of Justice[2]	Justice
Ministry of Municipal Affairs[2]	Municipal Affairs
Ministry of Restructuring and Government Efficiency[2]	Restructuring and Government Efficiency
Ministry of Seniors and Community Supports	Seniors and Community Supports
Ministry of Solicitor General	Solicitor General
Ministry of Sustainable Resource Development	Sustainable Resource Development
N.A. Properties (1994) Ltd.	Finance
Natural Resources Conservation Board	Sustainable Resource Development
Persons with Developmental Disabilities Boards:	Seniors and Community Supports
Calgary Region Community Board	
Central Region Community Board	
Edmonton Region Community Board	
Northeast Region Community Board	
Northwest Region Community Board	
Provincial Board	
South Region Community Board	
Provincial Judges and Masters in Chambers Reserve Fund	Finance
Supplementary Retirement Plan Reserve Fund	Finance
Victims of Crime Fund	Solicitor General
Wild Rose Foundation	Community Development

[2] Ministry includes only the department so separate department financial statements are not necessary.

ENTITIES NOT INCLUDED IN THE CONSOLIDATED GOVERNMENT REPORTING ENTITY

Fund or Agency	Ministry Annual Report
Alberta Cancer Board	Health and Wellness
Alberta Foundation for Health Research	Innovation and Science
Alberta Heritage Foundation for Medical Research	Innovation and Science
Alberta Heritage Foundation for Science and Engineering Research	Innovation and Science
Alberta Mental Health Board	Health and Wellness
Alberta Teachers' Retirement Fund Board	Education
Improvement Districts' Trust Account	Municipal Affairs
Local Authorities Pension Plan	Finance
Long-Term Disability Income Continuance Plan — Bargaining Unit	Human Resources and Employment
Long-Term Disability Income Continuance Plan — Management, Opted Out and Excluded	Human Resources and Employment
Management Employees Pension Plan	Finance
Provincial Judges and Masters in Chambers Pension Plan	Finance
Provincial Judges and Masters in Chambers (Unregistered) Pension Plan	Finance
Public Post Secondary Institutions	Advance Education
Public Service Management (Closed Membership) Pension Plan	Finance
Public Service Pension Plan	Finance
Regional Health Authorities	Health and Wellness
School Boards	Education
Special Areas Trust Account	Municipal Affairs
Special Forces Pension Plan	Finance
Supplementary Retirement Plan for Public Service Managers	Finance
Workers' Compensation Board	Human Resources and Employment

Ministry Contacts

For further information regarding the contents of this annual report please contact:

Position	Name	Phone Number
Minister of Health and Wellness	Iris Evans	(780) 427-3665 Fax: (780) 415-0961
Deputy Minister of Health and Wellness	Paddy Meade	(780) 422-0747 Fax: (780) 427-1016
Corporate Operations Assistant Deputy Minister	Bruce Perry	(780) 427-0885 Fax: (780) 422-3672
Health Workforce Assistant Deputy Minister	Richard Butler	(780) 427-1310 Fax: (780) 415-8455
Information Strategic Services A/Assistant Deputy Minister and Chief Information Officer	Linda Miller	(780) 415-1501 Fax: (780) 422-5176
Program Services Assistant Deputy Minister	Janet Skinner	(780) 415-1599 Fax: (780) 422-3674
Public Health Assistant Deputy Minister	Wayne McKendrick	(780) 415-8913 Fax: (780) 422-3671
Strategic Directions Assistant Deputy Minister	Annette Trimbee	(780) 427-7038 Fax: (780) 415-0570
Communications Director	Mark Kastner	(780) 427-7164 Fax: (780) 427-1171
Alberta Alcohol and Drug Abuse Commission Chief Executive Officer	Murray Finnerty	(780) 415-0370 Fax: (780) 423-1419