2018–19 Reports to the Annual General Meeting

Medical Student, Ines Zuna

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## 2018–19 Reports to the Annual General Meeting

The 114th Annual General Meeting of the Alberta Medical Association will be held at 11 a.m. on Saturday, September 28, 2019, at the JW Marriott Edmonton ICE District, 10344 102 Street, Edmonton in the Wayne Gretzky Ballroom.

Dr. Michelle Bailey

Dr. Patrick Mitchell
AGENDA

O Canada

Call to Order

In Memoriam

President’s Valedictory  Dr. Alison Clarke

Minutes, 2018 Annual General Meeting

Nominating Committee Report  Dr. Neil Cooper

Elections

• Speaker and Deputy Speaker, Representatives to CMA General Council 2020

Report from Representative Forum  Dr. Christine Molnar

• Report from the Board of Directors

Executive Director’s Report

Committee on Bylaws Report  Dr. Daniel Ryan

Committee on Financial Audit Report/Financial Statements  Dr. Lowell J. van Zuiden

Other Business

Next Meeting

• September 26, 2020 – Calgary

Adjournment

2018–19 Reports to the Annual General Meeting

The 114th Annual General Meeting of the Alberta Medical Association will be held at 11 a.m. on Saturday, September 28, 2019 at the JW Marriott Edmonton ICE District, 10344 102 Street, Edmonton in the Wayne Gretzky Ballroom.
AMA Vision, Mission and Values

Our Vision

The AMA is powered individually and collectively by physician leadership and stewardship in a high-performing health system.*

- Our initiatives as leaders, innovators and clinicians drive Patients First® as a cornerstone of the health care system.
- Member wellness and economic wellbeing in their practices and communities are supported by our comprehensive negotiated agreements and programs.
- The voices of members – individually, regionally and within specialties – are heard and reflected within the system through our united voice of openness and accountability.
- Our physicians are valued and respected throughout the system in their professional roles and through their unique relationships with patients and system partners.

Our Mission

The AMA advances patient-centered, quality care by advocating for and supporting physician leadership and wellness.

Our Values

Act with integrity, honesty and openness
Maintain relationships of mutual trust and respect
Treat others – and each other – fairly and equitably
Remain unified through belief in quality care, collective engagement and professionalism

*Alberta’s high-performing health system is stable, compassionate and sustainable, delivering enhanced patient experience and improved population health. Individual and collective physician leadership is essential.

The AMA defines such a system in this way:

- Highest quality care requiring: acceptability; accessibility; appropriateness; effectiveness; efficiency; and safety
- Access based primarily on need, not ability to pay
- Fully integrated community and facility/primary and secondary care
- Management based on timely and accurate data
- Information that follows the patient seamlessly
- Care delivered with the patient, sharing responsibility and working with the physician toward best-possible health

Patients First® Patients First® is a registered trademark of the Alberta Medical Association.
IN MEMORIAM

Members deceased since the last annual meeting are:

Benedictson, Michele S. Calgary
Black, William R. Edmonton
Brooke, Michael Edmonton
Chakravorty, Ashim P. Calgary
Colwell, Murray C. Calgary
Eaton, Gerald D. Canmore
Fedorak, Richard N. Edmonton
Frizzell, John B.H. Calgary
Glasgow, Robert M. Spruce Grove
Harrison, Sidney W. Desert Blume
Higgin, John R. Calgary
Holmes, Edward S. Edmonton
Husain, Zakir Brampton On
Johnson, P. Monica Barrhead
King-Brown, Richard Lethbridge
Letts, Harry W.V. Gatineau QC
Loosmore, William S.B. Drayton Valley
MacCannell, Keith L. Calgary
Maxwell, Gordon A. Calgary
Nahornick, Boris A. Drumheller
Nicas, James A. Edmonton
Okolo, Godwin O. St. Albert
Patel, Shashikant C. Calgary
Sacher, Julian C. A. Calgary
Sawa, Russell J. P. Calgary
Shulman, Desmond Red Deer
Shwaluk, Kenneth S. Calgary
St. Clair, William R. Kelowna BC
Starko, Marvin M. Edmonton
Sutherland, Lloyd R. Calgary
Tang, Andrew R. Calgary
Turnbull, John G. Calgary
Wagner, Elisabeth M. Calgary
Wensel, Ronald Edmonton
Williams, Derek Gibsons BC
1. The 113th Annual General Meeting of the Alberta Medical Association (CMA Alberta Division) was held on September 22, 2018, in the Macleod Hall, Telus Convention Centre, Calgary, Alberta.

2. O Canada was sung.

3. Call to Order
   Dr. Carl Nohr presided as speaker and declared the 113th AGM in session and duly constituted at 11 am.

4. Resolutions Committee
   The Resolutions Committee appointed for the Representative Forum served as the Resolutions Committee for the AGM. Appointees were Dr. Fredrykka Rinaldi, Deputy Speaker, as chair, and RF Planning Group members Dr. Kathryn Andrusky, Dr. Arlie Fawcett and Dr. Sarah Hall.

5. In Memoriam
   Forty-nine members passed away since the last AGM. Dr. Nohr read their names into the record followed by a moment of silence.

   Vanessa Berjat  
   David Binding  
   Roger Bland  
   Alfred Blitz  
   Bireswar Bose  
   Jack Bullard  
   Victor Crapnell  
   Richard Cunningham  
   Leslie De Lima  
   Joseph Desautels  
   Harry Donaldson  
   Josephine Emmett  
   Tom Enta  
   Philip Etches  
   John Fegler  
   Wayne Flanagan  
   Lalji Gohill  
   Srinivas Gottipati  
   Siegfriedt Heydennych  
   Frank Jackson  
   William Johnston  
   Andor Kelemen  
   Robert Kingston  
   Lawrence Kotkas  
   David Lawson

   James Chung-Wan Lee  
   Dominic Leung  
   Lawther Logan  
   Bart Lombard  
   Douglas Longden  
   Sumit Majumdar  
   Henry Medlicott  
   David Muyauchi  
   Doris Nelson  
   Jack Noakes  
   Manu Patel  
   Massoud Rafatt  
   Luigi Rossi  
   Douglas Shedden  
   Patricia Simonds  
   Maurice Simpson  
   Terry Stewart  
   Julius Szekrenyes  
   Carleton Taylor  
   Clementine Tester  
   Guy West  
   Prescilla Wilson  
   Masaru Yukawa  
   Harry Zirk

6. President’s Valedictory
   The outgoing president, Dr. Neil Cooper, reflected on his term as president and on its challenges and accomplishments. He thanked the directorate for its support during his term.

   MOTION: Moved by Dr. Alison M. Clarke and seconded:
   THAT the profession express its sincere appreciation to Dr. Neil Cooper and his family for their service, sacrifice, and dedication to the profession over the past year.
   “CARRIED”

7. Minutes, Meeting of September 16, 2017
   The minutes of the AGM of September 16, 2017, were accepted.

8. Nominating Committee Report
   2018 CMA General Council
   Dr. Padraic Carr, Chair, Nominating Committee, presented the report and the list of nominees.

   MOTION: Moved by Dr. Padraic E. Carr and seconded:
   THAT the following Nominating Committee nominees for representatives to CMA General Council 2019 be approved. (Note: The AMA President attends by virtue of the position):
   - President-Elect
   - Immediate Past President
   - Speaker or Deputy Speaker
   - Ten representatives to be named by the Board
   - Eleven representatives to be named by the Nominating Committee
   - Two physician appointees of the college, at least one of whom must be an elected member of the Council
   - One dean or designate
• Two student representatives
• Two PARA representatives

“CARRIED”

Election of Speaker and Deputy Speaker
• Dr. Carl W. Nohr was elected by acclamation as AMA Speaker, October 1, 2018 to September 30, 2019
• Dr. Fredrykka D. Rinaldi was elected by acclamation as AMA Deputy Speaker, October 1, 2018 to September 30, 2019

Election of Members to the Nominating Committee
Two-year terms (2018–20):
• Dr. Amelia T. Correia
• Dr. Alayne M. Farries
• Dr. Jeffrey C.E. Way

One-year term as alternate (2018–19)
• Dr. Laurie M. Parsons

9. Report from the Representative Forum
Dr. Alison Clarke, President Elect, highlighted the issues addressed in the written report circulated to members.

10. Executive Director’s Report
Delegates were referred to the Reports to the AGM.

11. Committee on Bylaws Report
Dr. Daniel Ryan, Chair, Committee on Bylaws, presented the report from the committee.

MOTION: Moved by Dr. Daniel R. Ryan and seconded:
THAT proposed amendments to the AMA Bylaws outlined in the 2017–18 Annual Reports be authorized as approved.

“CARRIED”

MOTION: Moved by Dr. Daniel R. Ryan and seconded:
THAT the existing bylaws of the association be rescinded in their entirety and the bylaws as amended by resolution passed at this Annual General Meeting held on September 22, 2018, be adopted.

“CARRIED”

12. Report from the Committee on Financial Audit
Dr. Fredrykka Rinaldi, member, Committee on Financial Audit, presented the report from the committee.

MOTION: Moved by Dr. Fredrykka D. Rinaldi and seconded:
THAT the firm of PricewaterhouseCoopers be reappointed as auditors for the Alberta Medical Association for the 2018–19 fiscal year.

“CARRIED”

13. Acknowledgments
MOTION: Moved by Dr. Alison M. Clarke and seconded:
THAT the Annual General Meeting express sincere appreciation to the Senior Management Team and staff for their dedication to the pursuit of the goals of the association.

“CARRIED”

MOTION: Moved by Dr. Alison M. Clarke and seconded:
THAT the association express its sincere appreciation to Dr. Carl W. Nohr and Dr. Fredrykka D. Rinaldi for their conduct of this meeting.

“CARRIED”

14. Adjournment
There being no other business, the Speaker adjourned the formal business session of the 113th Annual General Meeting at noon.

15. Installation of Officers
Dr. Alison M. Clarke was installed as AMA President for 2018–19 by CMA President Dr. Gigi Osler at the CMA President’s Luncheon held following the AGM.
In accordance with the AMA Bylaws, the Nominating Committee nominates candidates for office to be elected by the Annual General Meeting, to be elected by the Representative Forum, and to be appointed by the Board of Directors of the association.

The Nominating Committee submits the following nominations for consideration during the AGM:

1. **Composition of Representatives to CMA General Council 2020**
   As required under the current AMA Bylaws, the Nominating Committee is to provide to this AGM the composition of representatives it proposes for CMA General Council 2020. The president attends General Council by virtue of the position and is not included in the count of Alberta representatives currently allowed to attend (32):
   - President-Elect
   - Immediate Past President
   - Speaker or Deputy Speaker
   - 10 representatives named by the Board
   - 11 representatives named by the Nominating Committee
   - Two physician appointees of the college, at least one of whom must be an elected member of the Council
   - Two deans of medicine (U of A and U of C) or designates
   - Two student representatives
   - Two PARA representatives

2. **Speaker and Deputy Speaker 2019–22**
   **Speaker:** Dr. Carl W. Nohr, General Surgery, Medicine Hat
   **Deputy Speaker:** Dr. Graham M.D. Campbell, Diagnostic Imaging, Calgary
   In accordance with custom, brief profiles for these candidates as contained in AMA records are attached.

3. **Nominating Committee 2019–20**
   The AMA Bylaws require that the AGM elect four (4) members and one (1) alternate member to the Nominating Committee.
   The term for members elected to the Nominating Committee is set at two years; additional terms may be served but cannot be consecutive.
   The AGM shall identify one alternate member to attend meetings of the committee in the event an elected committee member wants to be considered as a Nominating Committee nominee for an elected position. The alternate member will serve a one-year term but cannot serve more than two consecutive one-year terms.
   The current AGM-elected members and their terms follow:
   - Dr. Ann B. Vaidya, GP, Calgary
     Term: 2 years 2017–19
     Eligible for re-election: No
   - Dr. Amelia T. Correia, GP, Medicine Hat
     Term: 2 years 2018–20
     Eligible for re-election: N/A
   - Dr. Alayne M. Farries, ANES, Red Deer
     Term: 2 years 2018–20
     Eligible for re-election: N/A
   - Dr. Jeffrey C.E. Way, GS, Calgary
     Term: 2 years 2018–20
     Eligible for re-election: N/A
   - Dr. Laurie M. Parsons (alternate), DERM, Calgary
     Term: 1 year 2018–19
     Eligible for re-election: Yes
   Drs. Correia, Farries and Way will continue on the Nominating Committee to complete their two-year terms until September 2020.
   Dr. Vaidya’s two-year term ends September 2019 and she is not eligible for re-election.
Having served a one-year term as the alternate, Dr. Parsons is eligible to run for election to the Nominating Committee for a two-year term as a member, or a second one-year term as the alternate member.

Therefore, two members are to be elected to the Nominating Committee at this AGM as follows:

- One member for a two-year term 2019–21.
- One alternate member for a one-year term 2019–20.

The Fall Nominating Committee meeting is Friday, November 1. Two further meetings will be scheduled in February and May of 2020.

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### Profiles

#### Dr. Carl W. Nohr, General Surgery, Medicine Hat

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Dr. Carl W. Nohr, General Surgery, Medicine Hat

2017–present Speaker; CMA Board member; Chair, RF Planning Group
2017–18 Nominating Committee, alternate member
2016–18 Secretary-Treasurer, South Zone Medical Staff Association
2014–17 RF delegate; Member, Board of Directors, Executive Committee, Joint AMA/CPSA Executive
2016–17 Chair, Nominating Committee
2015–16 AMA President
2009–16 Member/Chair, RF Planning Group
2009–13, 2015–16 Member, Provincial Physician Liaison Forum
2009–12, 2015–16 Member, Council of Zonal Leaders
2008–10, 2015–16 Member, Nominating Committee
2014–16 Member, Committee on Constitution and Bylaws
2012–16 Vice-President, South Zone Medical Staff Association
2014–15 Member, Government Affairs Committee
2012–14 Speaker
2010–13 CPSA Councilor
2007–12 RF delegate
2009–10 AMA Co-chair, AHS Medical Staff Bylaws Committee
2008–10 Member, PFSP Advisory Committee

#### Dr. Graham M.D. Campbell, Diagnostic Imaging, Calgary

2019–present Member, CPSA
2018–present Co-chair, Specialty Care Alliance
2018–present, 2013–15 Member, Nominating Committee
2018 Member, AMA/PCA/SCA Executive Group
2017–18 Co-chair, Specialty Care Alliance
2013–17 Member, Government Affairs Committee
2012 CMA General Council
2010–present RF delegate
ELECTIONS

EXECUTIVE DIRECTOR REPORT TO THE
2019 ANNUAL GENERAL MEETING

In accordance with the Alberta Medical Association Bylaws, a Call for Nominations for Speaker, Deputy Speaker and Representatives to Canadian Medical Association General Council 2020 was sent to the membership on July 29, 2019.

In response to the call, one further nomination was received for the Deputy Speaker position and one nomination was received for Representatives to CMA General Council 2020.

Deputy Speaker

In response to the Call for Nominations, Dr. Fredrykka D. Rinaldi has been nominated as Deputy Speaker. Therefore, as a result of the Nominating Committee’s nominee and the Call for Nominations, the following two members will stand for election as Deputy Speaker:

- Dr. Graham M.D. Campbell, Diagnostic Imaging, Calgary
- Dr. Fredrykka D. Rinaldi, General Practice, Medicine Hat

The election will be held at the AMA Annual General Meeting to be held Saturday, September 28, starting at 11 a.m.

The Nominating Committee Report to the Fall 2019 AGM, preceding this report, contains a brief profile of the committee’s nominee. The brief profile for Dr. Rinaldi is provided below.

Dr. Fredrykka D. Rinaldi, General Practice, Medicine Hat

2017–present Deputy Speaker; Member, RF Planning Group
2016–present Secretary-Treasurer, Section of General Practice Secretary-Treasurer, SGP Executive
2012–present President, South Zone Medical Staff Association Council of Zonal Leaders
2012–18 Member, Committee on Financial Audit
2015–17 Speaker; Chair, RF Planning Group
2015–16 Member, Governance Review Group
2004–08, 2014–16 Member, SGP Executive
2012–16 Member-at-Large, Section of General Practice Member, RF Planning Group
2014–15 Deputy Speaker
2003–14 RF delegate
2000–14 AMA rep, AMA/CPSA/LSA Joint Medical-Legal Committee
2006–07, 2010–14 Member, Nominating Committee
2007–13  Member, IM/IT Coordinating Committee and Task Force
2011–12  Joint AMA/CPsA Executive
2009–12  Member, Executive Committee
2006–12  Member, Board of Directors
2003–05  Ad Hoc Committee to Review AMA’s Regional Structure
1999–2004  Member, Health Issues Council
2002–03  Member, Negotiations 2003 Job Action Group
2001–02  Member, AMA/WCB Negotiating Committee
1996–97  RF delegate
2006–2008,
2010–2012,
2016, 2018  AMA delegate, CMA General Council

**Representatives to CMA General Council 2020**

In response to the Call for Nominations, Dr. Dinesh L. Witharana, (General Practice, Stony Plain) has been nominated to attend 2020 CMA General Council as an AMA delegate. A brief profile, based on service as contained in AMA records, is provided below.

**Dr. Dinesh L. Witharana, General Practice, Stony Plain**

Dr. Witharana has not yet had the opportunity to serve on an AMA committee.

The Nominating Committee Report to the Fall 2019 AGM, preceding this report, contains recommendations for AMA representatives to CMA General Council 2020. Direction will be sought regarding AMA representatives to CMA General Council 2020 at the AMA AGM on Saturday, September 28, starting at 11 am.
REPORT FROM THE BOARD OF DIRECTORS

This report represents a retrospective accounting of the challenges, opportunities and accomplishments experienced by the AMA over the course of the 2018–19 fiscal year (October 1, 2018–September 30, 2019).

The Report from the Board of Directors to the Annual General Meeting has two main sections:

- **Performance and the Business Plan**: Highlights and updates related to the AMA's Business Plan performance in the Key Result Areas: Financial Health; Well Being; System Leadership and Partnership.
- **Other Matters and Relationships**: Brief commentary on some relevant topics that are not specifically addressed in the Business Plan.

**Performance and the Business Plan**

The AMA's business plan goals for 2018–19 aimed to deliver value to physicians by remaining true to the AMA Mission (physician leadership and support) and striving to our Vision (a high performing health care system for Albertans).

Under the AMA Mission, the Board established goals for the organization that were categorized into three broad Key Result Areas:

1. **Financial Health for physicians and their practices**;
2. **Well Being (personal, workplace, community)**;
3. **System Leadership and Partnership**.

There are currently nine overarching goals, three under each Key Result Area and several related activities. The activities are linked by both the 2018–19 AMA Business Plan and our agreements.

Achieving the goals under the three Key Result Areas requires a healthy, vibrant and sustainable AMA. "Healthy AMA" underpins the entire business plan and focuses on core organizational capabilities in the areas of governance, workforce, financial, relationships and knowledge. While elements of Healthy AMA activities are covered under the three Key Results Areas and their supporting goals, a summary of Healthy AMA progress during 2018–19 is also provided at the end of this document.

The following content provides a summarized update on the activities under each goal within the Key Result Areas, including highlights, progress and challenges.

**Key Result Area 1 – Financial Health**

The AMA assists and supports members in maintaining their financial health. This includes negotiating with payers to ensure fair compensation, the provision of practice management services and the offering of financial products. Members in training are supported through a number of scholarships and bursaries.

**Goal 1: Physicians are fairly compensated for their skills and training in comparison to other professionals.**

**Representation rights**

The AMA has had a long-term goal to ensure that the AMA remains recognized by payers and that physicians have rights to representation. One of the important provisions of the 2018–20 AMA agreement with government was a commitment to entrench physician recognition and representation rights within legislation.

In December 2018, **Bill 24, An Act to Recognize AMA Representation Rights** achieved Royal Assent and, as such, is now law. This solidifies the AMA's role as the exclusive representative when government negotiates with physicians on compensation and benefits.

**Negotiations**

In 2018–19, negotiations began with several AHS physician groups and WCB. 2018–19 saw increasing numbers of individual physicians asking the AMA for assistance in reviewing/renewing their contracts with AHS.
As the current AMA Agreement will expire on March 31, 2020, preparations are already well underway. The AMA Board has appointed members of the Negotiating Committee and they have been meeting and preparing for upcoming negotiations with government. Delegates at the Spring 2019 Representative Forum participated in a detailed consultation to determine an opening position. An update and further discussion will take place at the Fall 2019 RF.

As we prepare for negotiations, the AMA believes that physicians and our partners need to tackle dual, linked objectives of affordability and value. Experience and the history of public health care tells us that tackling either objective alone is problematic. The AMA believes that we cannot focus exclusively on budget, but we also cannot focus exclusively on quality of care at any cost. Instead, the AMA is proposing a balance between the two, maximizing value and benefits to Albertans. Negotiations may be an opportunity to make this happen.

**Academic Medicine Health Services Program**

Through amendments to the AMA Agreement, the Strategic Agreement and the passing of legislation that enshrines the role of the AMA as the sole and exclusive representative of all physicians, the AMA can now support members within the AMHSP, particularly with respect to future negotiations for a new master services agreement and development of a template to be used for individual service agreements.

At the provincial level, the AMA is on both the Operations and Strategy Committees for the AMHSP. In addition, the AMA made a number of important changes to support academic physicians and increase their voice within the AMA, including establishment of the AMHSP Council.

In addition, AMA representatives were on a Remuneration Subcommittee that developed a process and methodology to determine compensation grids for new AMHSPs. The subcommittee held town-halls for physicians that were considering the new AMHSP arrangements, including Psychiatry and Medical Genetics.

In December 2018, AMHSP physicians elected one physician representative from each arrangement (10). These 10 representatives then elected four (plus one alternate) from within their group to serve as delegates at the AMA’s RF. The council includes arrangement representatives from the North and South Sector – Medical Genetics and South Sector – Psychiatry. As well, one representative amongst physicians considering participation in the AMHSP and representatives from the Provincial Strategy and Operations Committees are members of the council.

Council members have met three times since the spring and are currently working on plans to ensure that AMHSP physicians were well represented and that their issues are addressed going forward.

**Physician Supply**

Made up of Alberta government, Alberta Health Services and the AMA, the Physician Resource Planning Advisory Committee is a ministerial committee that was established as a result of the last AMA agreement.

Over the last year the PRPAC looked at several options to develop a needs-based plan that will effectively and fairly manage that supply and distribution of physicians in Alberta.

Historically, physician supply in our province has grown at a rate 5.5% year over year. The PRPAC recommended that AHS implement restrictions on physicians requiring assessment and these restrictions have slowed the rate growth to approximately 2.5% over the last two years.

**WCB Agreement**

The agreement between the WCB and the AMA was set to expire on March 31, 2019. Prior to the expiration date, both parties chose to invoke the renewal clause and extend the agreement for a one-year period to allow time for the parties to negotiate a new agreement. The AMA has extensively surveyed membership and has used these responses to develop our opening interest paper and proposals. Negotiation meetings are underway.

The AMA provided negotiations support for the Alberta Orthopedic Society with the negotiation of a new orthopedic services agreement with WCB. AOS members and WCB ratified the resulting agreement in early August 2019. At the time of writing, WCB is in the process of implementing the new agreement.
Blended Capitation Model

In our previous agreement, and continuing through our second amending agreement, Alberta Health, AHS and the AMA committed to working on a blended capitation model for family physicians. The BCM was designed to promote comprehensive vs. episodic primary care, founded on a strong relationship between physicians and patients within the Patient’s Medical Home.

Together with the Section of General Practice and our government partners, the AMA undertook a recruitment process in 2018–19 to encourage at least 10 clinics over the next two years to take part in a BCM pilot project. Recruitment activities will continue until end of October 2019.

The Sylvan Family Health Centre has been practicing under BCM since June 2017 with overall positive results. Much has already been learned through this important pilot project. Important lessons will continue to be gleaned through formal evaluation that will aide in understanding how an alternative payment model such as BCM can support Alberta physicians for innovations in care delivery (including use of technology), team-based care, access and continuity, and better patient and system outcomes in Alberta.

Physician Compensation Committee

Made up of representatives from AH, AHS and the AMA, in 2018–19 the PCC continued their mandate to establish rates for physicians’ services, including clinical, Alternative Relationship Plans and alternative funding models.

Under the terms of the AMA Agreement, the AMA and AH have joint responsibility to recruit a chair for the PCC. After the departure of Mr. Chris Sheard, the PCC appointed Dr. David Peachey, as their new chair in the spring of 2019.

Following the appointment of Dr. Peachey, the PCC met to develop a work-plan and discuss a draft set of provincial strategic requirements developed by AH. PCC has also approved a revenue-neutral allocation of Schedule of Medicine Benefits items for October 1, 2019 implementation.

Regarding the joint overhead study conducted by Deloitte, the PCC agreed that they will not implement the results of the study during this financial term of the AMA agreement. PCC acknowledged that the AMA will move forward with the AMA Overhead Working Group and that they will review further information as it becomes available from the group.

Income Equity Initiative

The AMA Board remains committed to the principles and aims of the Income Equity Initiative. Fundamentally, the IEI aims to contribute to the fair distribution of physician payments with due regard to office expenses, hours of work, years of training and the need to ensure that Alberta remains competitive in the market for physician services. The IEI is one part of a much larger picture, fitting within the context of the AMA’s Physician Compensation Strategy, which seeks to drive value and affordability in the system (further details on the AMA’s Physicians Compensation Strategy are included in the KRA 3, Goal 2 section of this document).

The PCC continued to progress work on different components of the IEI throughout 2018–19, including the overhead study, hours of work, market assessment, and training and career length.

In response to concerns from Spring 2019 RF about the overhead model study conducted by Deloitte for the AMA and AH, an Overhead Working Group was formed with representatives identified by the Specialty Care Alliance and both the Sections of General Practice and Rural Medicine.

The working group was asked to:

- Review section concerns and get additional information from the vendor as needed.
- Assess the usability of the study.
- Recommend next steps.

The working group report was shared with members via a President’s Letter in early August.

The report detailed the constraints of the study and its design, participation rates and limitations of the data. The working group recommended to the Board that the results are not usable in their current form and identified some alternative options, which are also described in the paper.
The Board decided to proceed with a process of developing a detailed plan that can be used to determine an acceptable estimate of overhead for the profession, in the form of a model office.

This could include incorporating usable elements of the 2009 Physician Business Costs Model, the Deloitte study and a study out of British Columbia. The AMA has already made many enhancements to the 2009 model in recent years (as recommended by sections), and these enhancements will be included.

The Overhead Working Group will remain in place to provide advice to the Board. While the working group’s recommendations are being implemented, the Board will keep moving forward on other activities that surround the IIE.

**Goal 2: Physicians’ practice management decisions are based on sound management advice and best practice.**

**Peer Review**

In 2018–19, the Peer Review Committee continued to review billing data and consult with sections when billing anomalies presented themselves. Section consultation and general communication (via newsletter, as well as section-specific communications) have proven to be successful and a positive experience for both the sections and the committee.

The AMA discussed with the Management Committee (AH and AHS) its proposal to establish a third-party consultant for direct communication/education pieces with individual physicians. AH has agreed to explore the privacy and confidentiality considerations around this type of structure.

A paper was developed to highlight the alignment of peer review principles/processes with a just culture framework for quality improvement (i.e., having a primary focus on education and addressing systemic barriers to appropriate billing).

Fee Navigator® updates made in 2018–19 incorporated November 1, 2018 and January 21, 2019 SOMB amendments, as well as billing tips arising from peer review activities.

Billing seminar presentations were refreshed and Health Economics staff continue to explore options for remote delivery of billing education.

**Change management programs**

The 2018–20 AMA Agreement brought stability to all AMA programs, including our three former independent change management programs: Practice Management Program, Toward Optimized Practice and the PCN Program Management Office.

On November 1, 2018, these three programs officially merged to become the Accelerating Change Transformation Team (ACTT).

For the past three years, the three programs have been working in earnest to better integrate the support and change services offered to our physician members. This has been an important transition effort and the end result will allow us to provide more effective support and influence the kind of system change that is needed to optimize health care in Alberta.

Portfolios and projects are now aligned and expanded to reflect the wider mandate of the ACTT program. For example, the integration portfolio now has a dedicated director and resources focused on integrating of the health care system. Portfolios have also been created within ACTT to move the PCN zonal governance forward.

**Changes to Laboratory Services**

In June 2019, the government cancelled construction of the Edmonton Medical Lab Hub project, and at time of writing is exploring the needs of the province for laboratory services.

The AMA (and numerous provincial groups) expressed the critical need for appropriate support in this area. The AMA and the Section of Laboratory Physicians met with the Minister of Health, Mr. Tyler Shandro, in August to express the fundamental importance of laboratory medicine in the health care system and for patient care. The AMA encouraged the Minister to consider impacts to patient care and the ability to attract and retain laboratory physicians when considering the future of lab services in the province.

The AMA’s Section of Laboratory Physicians has been actively engaging with members to gather input and further meetings are expected with the Minister to continue the conversation.
Goal 3: Reliable and best-in-class financial products are available to all members.

Insurance

Property and casualty insurance programs were reviewed, resulting in renewed contracts with TD Insurance Meloche Monnex (home and automobile) and Westland Affinity Group Insurance Services Commercial. Members can be confident that our endorsed providers are providing superior protection at competitive rates.

The AMA voluntary group insurance plans for members consist of Disability, Professional Overhead Expense, Term Life, Critical Illness and Accidental Death & Dismemberment. They also include the PARA group Disability and Life Insurance plans. AMA’s ADIUM Insurance Services Inc. administers the plans.

In 2018–19, the AMA partnered with Doctors of BC and the Saskatchewan Medical Association to complete a marketing exercise of our respective group insurance plans. Following the assessment process, the AMA decided to move all plans (except for AD&D) to Manulife Financial effective January 1, 2020. The AD&D plan will move to Chubb effective January 1, 2020. All members currently insured under these plans will have their coverage seamlessly transferred to the new carriers without any loss of coverage or proof of good health.

Members will benefit through immediate reductions in Term Life, Critical Illness and AD&D premium rates. Going forward, the plans will realize significant savings through more competitive administration expenses charged by the insurer on the plans the AMA participates in financially (i.e., Disability, Professional Overhead Expense, Term Life). These savings could result in lower premium rates for members and/or higher premium refunds through the AMA Premium Credit™ in the future.

Key Result Area 2 – Well Being

The AMA supports members in maintaining healthy work-life integration, including being a leader in the development of a comprehensive physician health program. The AMA promotes and supports physicians contributing to the broader community through activities like the AMA Youth Run Club and Emerging Leaders in Health Promotion grant program. The AMA also supports physicians in their efforts to attain safe, healthy and equitable work environments.

Goal 1: Physicians are supported in maintaining their own health and that of their families.

Physician and Family Support Program

PFSP statistics for the period of January to April 2019 showed 713 total callers to the 24-hour assistance line. Of this number, 283 were new callers (up 15% overall from this same period last year) and 430 were existing callers (up 23% overall from this same period from 2018). Total callers for the year was up by 20% overall. There were three new case coordination clients, a slight decrease of 9% from this same time last year.

Unify Consulting Group, the third-party service provider that has replaced Criterion, transitioned smoothly into operation as of April 1. While some small challenges were encountered during the first month of activity, the transition itself was largely uneventful and the clients PFSP serves were not impacted by this change.

Physician burnout

Physician burnout is a genuine problem for physicians, patients and the entire health care system, and this year the AMA shed light on this important issue in a few ways.

In the September-October 2018 issue of Alberta Doctors’ Digest Dr. Jane Lemaire contributed to an article and podcast titled Physician burnout is real: Addressing it is a shared responsibility. At the Spring 2019 RF, Dr. Lemaire presented with Dr. Terrie Brandon on the topic and delegates were provided with information on the systemic drivers of burnout and the resources available to physicians. The AMA’s Healthy Working Environments initiative continues to explore and address this issue on behalf of members (further details on the AMA’s Healthy Working Environments initiative are included in the KRA 2, Goal 3 section of this document).

Well Doc Alberta

In March 2019, Well Doc Alberta became the first initiative to be supported under the AMA-CMA Memorandum of Understanding (further details on the MOU are included in the “Other Matters and Relationships” section of this document). Through this
initiative, Well Doc Alberta received an investment contribution of $1.6 million over three years from Scotiabank, in collaboration with MD Financial Management and the Canadian Medical Association.

Under the leadership of Dr. Jane Lemaire, and with the support of the University of Calgary, Well Doc Alberta expanded its reach and began to generate new resources to address physician burnout and other wellness issues. Well Doc Alberta also hosted its 2019 symposium in March to discuss physician wellness issues and opportunities. The symposium also provided attending physicians with an important opportunity to connect with one another.

**Goal 2: The AMA is a broker in bringing together physicians, patients and families toward healthy communities. Physician and community contributions are supported and celebrated.**

**We All Make a Difference**

Alberta has some of the finest, hardest-working physicians in the country. Our members are committed to helping build a sustainable, successful and innovative health care system, supported by a diverse, inclusive and thriving profession.

In celebration of that hard work and dedication, in 2018–19 the AMA launched a new initiative called “We All Make a Difference” to recognize members who are making a difference, many in ways that they aren’t even aware of, or are too busy to realize.

There are several components of We All Make a Difference.

Initiated by Dr. Alison Clarke during her 2018–19 term as president, Shine A Light recognizes and profiles AMA member physicians who are making a difference through their everyday dedication to their patients. Whether it’s following up on patient test results while travelling within or out of the country; sacrificing personal and family time to work long hours in and out of the office; mentoring younger staff and remaining committed to patients and the craft of medicine through personal health challenges … all of the physicians recognized by Shine A Light exemplify the ‘care’ in health care.

The AMA knows that many of Alberta’s physicians support and participate in projects to help build healthier, stronger communities in Canada and throughout the world. Community Connections (formerly known as Many Hands™) aims to celebrate and tell the stories of AMA members who – often within the context of their practices and not necessarily as volunteers, per se – demonstrate a commitment to advocacy; to improving the lives of their patients, groups of patients or community groups/populations; and who, through strong leadership, go ‘above and beyond’ to make a difference.

**Youth Run Club**

2018–19 was the sixth year the AMA Youth Run Club has been in operation. The YRC aims to increase physical activity in children and youth by providing schools and champions with the needed resources and supports to operate a successful run club.

This year, there were 402 registered schools and approximately 20,100 students participating. These numbers fall below the target of 550 registered schools and 27,500 students. This gap may be due in part to the downturn in the economy (suspected because of lower than usual registration numbers in Calgary). Additionally, all schools that were registered over the first five years of the YRC were contacted to verify if their run club was still active. This review helped to remove inactive schools from the YRC database and contributed to the lower numbers.

Nonetheless, there has been success in the area of increasing participation of students in schools with active YRCs. In the past, there were about 40 students on average participating in each run club. This year, that number increased to about 50 students on average participating in each run club. There have also been successes in increasing participation of Indigenous students and school communities; addressing adaptive physical activity; addressing the gender gap in girls’ participation; and increasing physician involvement in YRCs.

There are ongoing efforts to increase the number of registered schools and participants.

**AMA Awards**

Recognizing and celebrating outstanding accomplishments in health care continued this year with our prestigious award programs. The highest honors of the AMA will be bestowed as follows during the Fall 2019 RF and AGM:
AMA Medal for Distinguished Service – For outstanding personal contributions to the medical profession and to Albertans that have contributed to the art and science of medicine and raised the standards of medical practice:

- Dr. Michael J. Bullard, Edmonton
- Dr. David B. Hogan, Calgary
- Dr. Frances L. Harley, Edmonton

AMA Medal of Honor – For extraordinary contributions by a non-physician to Albertans in medical/health research or education, health care organization or promotion:

- Mr. Harold James, Sherwood Park
- Ms Brenda Reynolds, Edmonton

AMA Award for Compassionate Service: For serving as an inspiration to others with outstanding compassion, dedication and extraordinary contributions to volunteer or philanthropy efforts to improve the state of the community:

- Dr. Vincent I.O. Agyapong, Edmonton
- Dr. Debra L. Isaac, Calgary

Emerging Leaders in Health Care

The following projects were funded through the Emerging Leaders in Health Promotion grant program in 2018–19:

- Dr. Maulik Baxi, University of Alberta, Resident, Public Health and Preventive Medicine “Treatment as health promotion for substance use in Indigenous Albertans” (Mentors: Dr. Lynden Crowshoe, Dr. Rita Henderson)
- Dr. Devin Chetan, U of A, Resident, Pediatrics “Heart Heroes Camp” (Mentor: Dr. Rehana Chatur)
- Dr. Daphne Cheung, U of A, Medical Student “The Re:pro Health Podcast – Discussing pro-health topics regarding women’s sexual and reproductive health” (Mentor: Dr. Jill Konkin)
- Dr. Bridget Hooper, U of A, Resident, Pediatrics “Integrating healthy living among new Canadians” (Mentor: Dr. Doug Klein)
- Dr. Sarah Johnson, U of A, Resident, Pediatrics “Keeping children living with diabetes safe and healthy at school” (Mentor: Dr. Dawn Hartfield)
- Dr. Spencer Krahn, U of C, Medical Student “Youth education on marijuana use” (Mentor: Dr. Blair Ritchie)
- Dr. Chu Yang Lin, U of A, Medical Student “‘Street Sense’: A harm-reduction program promoting informed decision-making regarding drug use” (Mentor: Dr. Joseph Abraham)
- Dr. Michiko Maruyama, U of A, Resident, Cardiac Surgery “Sexual Health Edition - Doctors Against Tragedies” (Mentors: Dr. Daisy Fung, Dr. Cheryl Mack)
- Dr. Reza Ojaghi, U of C, Medical Student “Introduction of Canadian health care system to new immigrants and assisting them in finding a family physician” (Mentor: Dr. Amy Tan)

Goal 3: The AMA is committed to working with and for physicians to address system issues which impede attaining a safe, healthy and equitable working environment.

Healthy Working Environments

In 2018, the Board earnestly considered the convergence of issues related to respect, diversity, inclusion, leadership and wellness, particularly as they relate to our profession and to society. All of these issues are relevant to AMA members and are absolutely necessary if we are to play a leadership role in the system. This discussion manifested in a new business plan goal, committing the AMA to “working with and for physicians to address system issues which impede attaining a safe, healthy and equitable working environment.”

The Board took a comprehensive approach to tackling the Healthy Working Environments challenge, addressing multiple factors and their relationships. Members were engaged to identify ways to create a more diverse, inclusive AMA; create awareness of the importance of HWEs; and determine possible strategies with our partners in the system.
We approached our system partners, who welcomed the opportunity to be involved in a collaborative and system-wide approach. As a result of AMA consultation summits, and an external leaders’ session, a framework was created to advance the co-creation of Healthy Working Environments.

The three main dimensions of the framework are: Psycho-Social Wellness and Safety; Leadership; and Diversity and Inclusion. This framework, along with a preliminary identification of potential strategies, will be advanced through our new Healthy Working Environments Advisory Committee.

In addition to the development of the framework described above, senior leaders from the AMA, AHS, CMA, the Canadian Medical Protective Association, College of Physicians & Surgeons of Alberta, Health Quality Council of Alberta, both the faculties of medicine and Medical Students’ Associations at the U of A and U of C, and the Professional Association of Resident Physicians of Alberta endorsed the following statement:

“We have an interest in co-creating safe, healthy, equitable and inclusive cultures where all health care team members are respected, valued and supported fairly to achieve their full potential while improving patient outcomes/satisfaction and supporting system sustainability.”

Through the PROactive alliance (made up of the AMA, AHS, CPSA, HQCA, the faculties of medicine at the U of A and U of C), an action plan is being refined to launch several demonstration projects focused on supporting cultures of enhanced teamwork and professionalism, as well as a Community of Practice focused on leadership development and capacity building to support those physician leaders involved with managing issues that can lead to disruptive physician behavior.

The Board believes that success will require being flexible and fluid in planning, building on relationships and keeping work aligned across the system. To that end, the AMA has committed to a cycle of external leader meetings through the PROactive alliance and has established an HWE Advisory Committee to provide informed advice and guidance to the Board in developing inclusive policies and innovative practices.

**Bill 21, An Act to Protect Patients**

In April 2019, Bill 21, An Act to Protect Patients officially came into effect. The legislation guards patients against exposure to inappropriate or predatory sexual behavior from their care providers. It applies to all regulated health professions, including physicians. The AMA and other associations were engaged in planning for the implementation of the act in order to properly prepare and inform patients and providers.

The AMA reviewed the bill and identified some consequential issues for the Minister to consider before the act came into effect. While the first draft of the bill would have allowed a convicted provider to reapply for a license after five years, it was subsequently amended to say that a provider convicted of sexual assault would receive a lifetime ban from practicing in this province. The lifetime ban applies to individuals who have been found guilty of criminal offence(s) by the courts – who will also determine the criminal sentence to apply.

The AMA also asked government to be prudent with the limited powers the bill granted the Minister in matters related to sexual misconduct or assault. The Minister was reminded that the public has been well-served by self-regulation because, as professionals, physicians accept responsibilities and accountabilities for their practice.

The AMA stressed that information sharing must balance with the responsibilities of the Minister (and all custodians) to disclose the least amount of information required for the purpose at hand. Only patient and provider information associated with the event that triggered the investigation should be shared. Any expressed wishes of the patient should also be considered.

**Key Result Area 3 – System Leadership and Partnership**

The AMA supports members in their role as leaders within the health care system. This includes supporting physician leadership in developing innovations in care delivery and integration of primary and specialty care. Other activities include the AMA’s key role, with Alberta Health through the AMA Agreement, in developing and implementing the physician payment strategy for the province; several programs aimed at quality improvement; activities
related to eHealth; and supporting the development of physician leadership skills.

**Goal 1: Working with Alberta Health, Alberta Health Services and other partners, lead and influence positive change in the delivery of services.**

**Patient’s Medical Home**

Throughout 2018–19, the AMA continued to support implementation of the Patient’s Medical Home. We supported our members, clinics and their PCNs to progressively implement various elements of the PMH in their practices. In a February 2019 report from the College of Family Physicians of Canada, Alberta was given top rating among the provinces and territories for progress toward the Patient’s Medical Home, scoring a greenlight on seven out of 10 dashboard indicators.


The AMA continues to work with AH and AHS to improve system supports to members, clinics and their PCNs to enable the full delivery of PMH to all Albertans.

**Integration**

In 2018–19, the Primary Care Alliance and Specialty Care Alliance, as well as the AHS Primary Health Care Integration Network (PHCIN), worked together to develop and deliver projects and services that strive to improve the integration of care for Alberta patients:

- Interviews were conducted with primary care physicians sitting on Strategic Clinical Networks and a support framework was developed.
- Based on an Alberta scan and SCA/PCA/PCHIN group consultation, the SCA and PCA identified transitions of care as an area to focus on collectively.
- Specialists and primary care physicians were supported to participate in Institute of Healthcare Improvement conferences, helping to build thought leadership.
- Worked with zones to identify primary care needs to support Hospital to Home.
- Opioid urgent response primary care targets were met

**PCN Framework**

The AMA supported members, clinics and PCNs in realizing new opportunities and delivering on new responsibilities created by the PCN framework. The AMA also provided support to physician leaders to help engage AHS and AH on an equal basis in the planning for new programs and activities created by the PCN framework.

The AMA continued to support the PCN Physician Leads Executive in their regular monthly meetings throughout 2018–19. Support was also provided to allow the Leads Executive to work collaboratively and strategically with SGP and the SCA.

**Goal 2: Key incentives and supports for physicians are aligned with the delivery of care and toward overall system objectives of timely access for patients to quality care.**

**Physician Compensation Strategy**

A multi-year physician compensation strategy was approved by the Board of Directors in December 2018 and is in the process of being implemented.

The strategy seeks to provide value for patients and fairness to physicians and is about more than how physicians are paid. It’s about how compensation can be directly linked to the way care is delivered. Broadly speaking, the strategy links compensation to clinical service delivery, availability to see patients and appropriateness and will consider how other factors (such as informatics, peer review, income equity initiative, etc.) have a role to play.

**Informatics**

2018–19 saw several information management/information technology initiatives progress in Alberta including Connect Care, Community Information Integration/Central Patient Attachment Registry, PrescribeIT and MyHealth Records.

CPAR and CII are two major technologies that have been chosen to integrate community EMR information with two-way data flow. Benefits of this technology include improvements in quality of care, continuity and efficiency and better overall decision-making for health care system supports.
CII/CPAR is gaining traction with 33 clinics participating. The live clinics are both primary care and specialty and use Microquest Healthquest or a Telus EMR (Med Access, PS Suite, Wolf). To date, over 130,000 patient encounters have been submitted to Alberta Netcare contributing to Community Encounter Digests for over 44,000 Albertans. Over 16,000 consult reports have been shared to Alberta Netcare. CII/CPAR facilitation training has been delivered to 150 participants from 27 PCNs building capacity to support participation for PCN member practices.

The AMA continues to work with the AH and AHS in support of the first wave of the Connect Care implementation in November. Work continues on ensuring that impacts to community physicians and their patients are recognized and addressed early in the process. To that end, an advisory group has been established with representation across all stakeholder groups including community physician leaders and specialists.

The AMA, AH and AHS continue to work with EMR vendors through the EMR Vendor Strategy Committee. This committee has been successful in providing a venue for parties to work toward establishing common provincial priorities, resolving issues and sharing ideas.

AH launched MyHealth Records, a secure on-line portal, to all Alberta patients in March 2019. Labs and dispensed medications are currently available; however, in recognition of the value in providing patients access to their health information, plans are in progress to expand MyHealth Records to include further aspects of patients’ medical records.

**Appropriateness and evidence-based practice**

The AMA continued to support the Choosing Wisely Alberta initiative in 2018–19.

The Appropriateness and Evidence Informed Committee is serving as the steering committee for Choosing Wisely, and in 2018–19 the committee hired Jacqueline Rainsbury as the lead for Choosing Wisely Alberta.

Alberta is the only province in Canada where Choosing Wisely has financial support from government (AH), the health authority (AHS), the College (CPSA) and the medical association. Choosing Wisely Alberta is greatly supported by the resources of our Physician Learning Program and AHS Strategic Clinical Networks. The AMA continues to support a project on appropriate ordering of ECGs in acute care and will be selecting one or two other projects to focus on in the fall of 2019.

**Goal 3: Physicians and the AMA, in partnership with patients, play a leadership role in advocating and promoting a system characterized by Patients First®.**

**Albertapatients.ca**

Albertapatients.ca membership continues to grow and 1,300 Albertans have joined since the Spring 2019 RF, bringing the community to just over 9,500 at time of writing. An agenda setting exercise is underway to identify the research that the Board would like to see to inform its efforts in the new business year. At time of writing, 10 sections have responded to an invitation and will be fielding specialty-specific questions to the community in the year ahead.

**Physician leadership**

The AMA has provided eight leadership development courses to the general membership this year. Courses were offered in Edmonton and Calgary and covered four topics:

- Resolving Conflict in the Health Care Workplace
- Power and Influence in the Workplace
- The Spectrum of Behavior in Health Care; Communicating with the High Conflict Personality and Resolving Disruptive Behaviour
- Team Dynamics and Communication for Health Care Professionals

The AMA has also supported leadership development in the AMA Board by supporting five members of the Board to attend the CMA Leadership Conference.

**Indigenous health**

The Indigenous Health Committee welcomed two new members in 2018–19, Pearl Auger, an Elder representing Treaty 8 and Dr. Alika LaFontaine, AMA RF delegate, Lead, CMA Indigenous Community of Interest and 2019 recipient of the CMA Sir Charles Tupper Award for Political Action.

The AMA has continued the process of relationship development with Indigenous leaders and other
health organizations. To date, committee members have met with the Health Co-Management committee, Indigenous Wellness ARP, Indigenous Health SCN, Indigenous Health Program (AHS) etc., to discuss aspects of the AMA Policy Statement on Indigenous Health and determine how best the AMA can contribute to advancing Indigenous health care.

Over the past year, the committee focused on the lack of access to primary care in Indigenous communities. This is a particular concern in the north zone. The committee agreed to strike a sub-committee to better understand the issues affecting care delivery in the north and bring back specific recommendations to the Indigenous Health Committee for review.

The Indigenous health and cultural resources page on the AMA website was greatly enhanced with an array of resources on Indigenous health and culture. Members of the AMA's Indigenous Health Committee thoughtfully curated the page, and the resources are intended to help AMA member physicians, resident physicians and medical students increase their knowledge and understanding of Alberta's Indigenous populations.

The AMA has demonstrated leadership in its support of training for staff and Board members as it works to address the calls to action in the Truth and Reconciliation Commission of Canada’s report. Six sessions were offered – one in Calgary and five in Edmonton. Approximately 79% of employees have received training and the feedback has been overwhelmingly positive.

**Healthy AMA**

**Governance**

As part of the 2018–19 business planning process, the Board reaffirmed the KRAs. One new goal was added under Well Being that supports physicians in attaining a safe, healthy and equitable working environment.

Recommendations from the Governance Review were fully implemented.

The Specialty Care Alliance was active and considered a variety of topics including income equity, integration and transitions of care.

**Workforce**

Efforts continued to establish ACTT as detailed elsewhere in this report.

Through the process made available under the AMA Agreement, the Alternative Relationship Program Management Office evolved to become ARP Physician Support Services in order to provide more direction and support to physicians involved in, or considering, ARPs.

A resource plan for the current fiscal year was advanced and approved in the fall of 2018. Needs will be reviewed on a regular basis to ensure that resources are aligned to the new mandate and coordinated between functional areas.

The AMA conducted an inaugural employee engagement survey to assess the AMA's workplace practices, perceptions of strengths and weaknesses of the association, and suggestions for improvement.

**Financial**

Throughout 2018–19, the AMA remained in good financial health.

AMA Agreement funding was managed in accordance with grant agreements under the financial oversight of the Committee on Financial Audit. The AMA satisfied all grant and reporting requirements related to AMA Agreement funding.

All activities were assessed as part of the annual business planning process to ensure that resources focused on the activities of most value to members.

**Relationships**

AMA/CMA Relationship:

Delegates at the Fall 2018 RF discussed the relationship between the AMA and the CMA; including the question of continuing conjoint membership dues with the CMA. After discussing the AMA's evolving relationship with CMA and hearing from CMA President, Dr. Gigi Osler, as well as Alberta CMA Board members, Dr. Linda Sloomce and Dr. Carl Nohr, the RF concluded that Alberta physicians require a strong provincial and national voice. In February the AMA and CMA established a
new partnership and entered into a principle-based Memorandum of Understanding.

The MOU established a process to align our member-engagement activities and partner on joint initiatives that advance shared priorities. A key feature of the MOU is a commitment to spend a portion of CMA dues collected in Alberta on initiatives of common interest.

At the Spring 2019 RF, delegates considered the specific question of continued joint AMA/CMA membership, bearing in mind the results of the member poll conducted in early March that showed a 50/50 split. In the end, the RF supported choice in the matter. Members can now select or decline CMA membership as they wish. The AMA strongly supports the CMA; we will continue to promote CMA membership and collect dues on behalf of our national association.

Government Relations

The AMA used government affairs programming as part of an overall approach to achieving our mission and vision of a high-performing health care system. Political advisors were retained to advise on building relationships with all parties before and after the provincial election.

Knowledge

In addition to a number of face-to-face engagement opportunities that occurred in 2018–19, a member engagement measurement system was developed and new engagement and analytic tools are being added regularly, including a member app for mobile devices. Artificial intelligence tools to assess member sentiment were piloted and the first module of the AMA’s new information system “Compass” was launched. The new system includes several analytical capability improvements, all intended to improve AMA capability to deliver our mission and serve members.

Other Matters

Canadian Medical Association Updates

The 2019 CMA Health Summit/General Council was held in August in Toronto. This marked the 152nd Annual General Meeting of the CMA. The 2019 AMA delegation consisted of:

- AMA President
- President-Elect
- Immediate Past President
- Deputy Speaker
- 10 representatives named by the Board
- 11 representatives named by the Nominating Committee
- Two physician appointees of the college (at least one to be an elected member of council)
- Two student representatives
- Two PARA representatives

In partnership with the faculties of medicine at the U of A and U of C, the AMA brought an additional 16 medical students to the event.

Discussions and key topics covered at the CMA Health Summit 2019: Building connections for better health included:

- Leveraging best practices;
- Actively engaging on the policy issues that will lead to a better ecosystem of care;
- How to integrate services into a high functioning system of care;
- Fostering effective information exchanges;
- Scaling up virtual care; and
- Identifying which policy issues should be debated during the 2019 federal election.

Immediately following the summit, the CMA held its Annual General Meeting, during which Dr. Sandy Buchman was installed as the CMA President for 2019–20.

Dr. Buchman practised comprehensive family medicine for 22 years with a special interest in primary care cancer care, palliative care, HIV/AIDS, global health and social accountability. He is an associate professor in the Department of Family and
Community Medicine at the University of Toronto and provides home-based palliative and end-of-life care through the Temmy Latner Centre for Palliative Care, Sinai Health System, in Toronto. He also practices palliative care with the Palliative Education and Care for the Homeless (PEACH) program under the auspices of Inner City Health Associates and St. Michael’s Hospital in Toronto. He was recently appointed as the Freeman Family Chair in Palliative Medicine at the North York General Hospital in Toronto.

The CMA Sir Charles Tupper Award for Political Action is presented to a CMA member who has demonstrated recent leadership, commitment and dedication in advancing CMA goals and policies through grassroots advocacy. Dr. Alika Lafontaine from Grande Prairie was this year’s recipient.

Member communications

In terms of member communications, there were 19 President’s Letters to members throughout 2018–19.

In an effort to modernize our approach, and in response to feedback in readership surveys, Alberta Doctors’ Digest transitioned to a fully electronic-only publication in 2018. The interactivity and rich content of the now digital publication is proving successful.

There has been steady uptake since the electronic version of ADD launched. Since its inception on March 27, 2018 to March 27, 2019 we’ve had 50,000 page views from over 15,000 users.

User stats and other metrics will continue to be collected in order to compare readership year over year, and to inform the overall content and design of ADD.

Board of Directors and Executive Committee

During the 2019 AMA AGM, Dr. Christine Molnar will be installed as president for the 2019–20 year. Dr. Paul Boucher was the AMA Nominating Committee’s nominee for president-elect 2019–20. No other nominations were received as a result of a further Call for Nominations to the membership, therefore, Dr. Boucher was acclaimed as president-elect 2019–20.

2018–19 Board of Directors:

Dr. Alison M. Clarke – President
Dr. Christine P. Molnar – President-Elect
Dr. Neil D.J. Cooper – Immediate Past President
Dr. Shelley L. Duggan
Dr. Howard J. Evans
Dr. Tobias N. Gelber
Dr. Sarah A. Hall
Dr. Kimberley P. Kelly
Dr. Robert E. Korbyl
Dr. Lloyd E. Maybaum
Dr. Wendy L. Tink
Dr. Derek R. Townsend
Dr. Jennifer J. Williams

PARA observer-
Dr. Davis Sam (July 1, 2018–June 30, 2019); Dr. Franco Rizzuti (July 1, 2019–September 30, 2019); Dr. Kaylynn Purdy (October 1, 2019–June 30, 2020)

MSA observer-
Zohaib (Anwer) Siddiqi (January 1–December 31, 2018); Moiz Hafeez (January 1–December 31, 2019)

The Board met as follows in 2018–19:

2018
October 25–26 (Calgary)
December 13–14 (Edmonton)

2019
January 22 (teleconference)
February 7–8 (Calgary)
March 18 (teleconference)
April 11–12 (Edmonton)
Board Retreat May 30–June 1 (Kananaskis)
July 18–19 (Edmonton)
September 18 (Calgary)

Executive Committee:

Officers
Dr. Alison M. Clarke – President
Dr. Christine P. Molnar – President-Elect
Dr. Neil D.J. Cooper – Immediate Past President

Board Representatives
Dr. Kimberley P. Kelly
Dr. Derek R. Townsend
The Executive Committee met as follows in 2018–19:

2018
October 5
November 16

2019
January 18
March 25
May 2
June 27
August 28
The Alberta Medical Association is committed to a health care system that delivers value to patients, i.e., timely access to quality care. We advance toward this goal through our mission of supporting and advocating for physician leadership and wellness.

Three key areas of focus have been established regarding vision and mission: Financial Health; Well Being; System Leadership and Partnership. Goals are established under each of these areas that specifically address how the AMA aims to serve physicians.

The goals are long-term in nature and their accomplishment typically extends well beyond a single association year (October to September). The activities the AMA intends to undertake toward each goal are laid out at the start of the year in the Business Plan, with actual progress and work, then described in this Report to the Annual General Meeting. This cycle of reporting to members on what we are trying accomplish, how we are going to attempt to achieve it and what has actually been accomplished is key to the accountability of the AMA back to its members.

The AMA’s success is fundamentally tied to having access to strong physician leadership and a dedicated complement of staff. On both counts, I believe the physicians of Alberta have been very well served. The quality of physician leadership in Alberta is outstanding and is present in our Executive, Board, Representative Forum and committees. AMA staff continue to exceed expectations and I have always been impressed with the energy, competence and loyalty they bring every day.
PROPOSED AMENDMENTS

To the AMA Constitution and Bylaws

Memorandum

Date: July 18, 2019
To: Alberta Medical Association Members
From: Dr. Daniel R. Ryan, Chair, Committee on Bylaws
Subject: Proposed changes – AMA Bylaws

On behalf of the Committee on Bylaws, we respectfully submit the following proposed changes to the AMA Bylaws for approval by the membership at the Annual General Meeting.

Membership

CMA membership will be optional for 2019–20. Therefore it is recommended that membership category definitions be amended to clarify that only AMA members who are also CMA members may be appointed to CMA bodies.

<table>
<thead>
<tr>
<th>Proposed wording</th>
<th>Present wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5 (ii) if also a CMA member may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
<td>7.5 (ii) may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
</tr>
<tr>
<td>7.8 (ii) if also a CMA member, may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
<td>7.8 (ii) may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
</tr>
<tr>
<td>7.11 (ii) if also a CMA member, may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
<td>7.11 (ii) may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
</tr>
<tr>
<td>7.14 (ii) if also a CMA member, may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
<td>7.14 (ii) may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
</tr>
<tr>
<td>7.21 (ii) if also a CMA member, may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
<td>7.21 (ii) may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
</tr>
<tr>
<td>7.25 (ii) if also a CMA member, may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
<td>7.25 (ii) may be appointed or elected, as the case may be, as an Alberta representative to the CMA General Council, the CMA Board of Directors and committees of the CMA</td>
</tr>
</tbody>
</table>
Suspension, Expulsion and Resignation

A legal review of the clause 8.3, which waives a members right to claim damages against the Association if their membership ceases, is likely unenforceable. Therefore it is recommended that the clause be removed from the bylaws.

<table>
<thead>
<tr>
<th>Proposed wording</th>
<th>Present wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.3 Members waive any rights or claims to damages that they may have against the Association if membership ceases in accordance herewith.</td>
<td>8.3 Members waive any rights or claims to damages that they may have against the Association if membership ceases in accordance herewith.</td>
</tr>
</tbody>
</table>

Quorum

A quorum of 50 delegates for the RF no longer represents a majority of Delegates in office as it did when RF was first established (RF currently has 146 voting Delegates). Therefore, it is recommended that RF quorum be amended to ensure a quorum is always a majority of Delegates.

<table>
<thead>
<tr>
<th>Proposed wording</th>
<th>Present wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.10 At any meeting of the Forum, a majority of the Delegates then in office shall constitute a quorum</td>
<td>12.10 At any meeting of the Forum, 50 Delegates shall constitute a quorum.</td>
</tr>
</tbody>
</table>

Harmonization with CMA Bylaws

As a division of the CMA, the Association is required to harmonize its bylaws where necessary with those of the CMA. Therefore, it is recommended that article 25, confirming the AMA as the Alberta division of the CMA be amended to reflect the definition in the current CMA bylaws.

<table>
<thead>
<tr>
<th>Proposed wording</th>
<th>Present wording</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.0 CMA Division The Association shall be the Alberta division of the CMA, representing organized medicine in the Province of Alberta until such time as this relationship is terminated by the proper authority of the CMA or the Association.</td>
<td>25.0 Affiliation The Association shall be the affiliated medical body of the CMA, representing the medical profession of the Province of Alberta until such time as this relationship is terminated by the proper authority of the CMA or the Association. While the Association continues as the affiliated medical body of the CMA, the words “CMA Alberta Division” may be used in its name.</td>
</tr>
</tbody>
</table>

Editorial Amendments

Non-substantive changes were also made to correct page numbering and/or typographical errors.
FINANCIAL STATEMENTS

Alberta Medical Association
(C.M.A. Alberta Division)

Consolidated Financial Statements
September 30, 2018
February 11, 2019

Independent Auditor’s Report

To the Members of Alberta Medical Association (C.M.A. Alberta Division)

We have audited the accompanying consolidated financial statements of Alberta Medical Association (C.M.A. Alberta Division), which comprise the consolidated statement of financial position as at September 30, 2018 and the consolidated statements of changes in net assets, operations and cash flows for the year then ended, and the related notes and schedules, which comprise a summary of significant accounting policies and other explanatory information.

Management’s responsibility for the consolidated financial statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor’s responsibility

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Medical Association (C.M.A. Alberta Division) as at September 30, 2018 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

PricewaterhouseCoopers
Chartered Professional Accountants

PricewaterhouseCoopers LLP
TD Tower, 10088 102 Avenue NW, Suite 1501, Edmonton, Alberta, Canada T5J 3N5
T: +1 780 441 6700, F: +1 780 441 6776

“PwC” refers to PricewaterhouseCoopers LLP, an Ontario limited liability partnership.
Alberta Medical Association (C.M.A. Alberta Division)

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
As at September 30, 2018

<table>
<thead>
<tr>
<th>Assets</th>
<th>General Fund $</th>
<th>Contingency Reserve Fund</th>
<th>Premium Reserve Fund $</th>
<th>Capital Reserve Fund $</th>
<th>Total $</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>6,811,522</td>
<td>-</td>
<td>329,837</td>
<td>-</td>
<td>7,141,359</td>
<td>9,064,792</td>
</tr>
<tr>
<td>Funds held on deposit (note 10)</td>
<td>-</td>
<td>-</td>
<td>1,179,413</td>
<td>-</td>
<td>1,179,413</td>
<td>1,138,878</td>
</tr>
<tr>
<td>Accounts receivable and prepaid expenses</td>
<td>635,648</td>
<td>-</td>
<td>78,014</td>
<td>-</td>
<td>713,662</td>
<td>1,139,845</td>
</tr>
<tr>
<td>Due from administered programs (note 2)</td>
<td>1,075,939</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,075,939</td>
<td>2,039,574</td>
</tr>
<tr>
<td>Due from Alberta Medical Foundation</td>
<td>1,651</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,651</td>
<td>-</td>
</tr>
<tr>
<td>Due from AMA Health Benefits Trust Fund (note 11)</td>
<td>35,213</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>35,213</td>
<td>115,512</td>
</tr>
<tr>
<td></td>
<td>8,559,973</td>
<td>-</td>
<td>1,587,264</td>
<td>-</td>
<td>10,147,237</td>
<td>13,498,601</td>
</tr>
<tr>
<td>Portfolio investments (note 4)</td>
<td>-</td>
<td>15,197,346</td>
<td>9,832,637</td>
<td>-</td>
<td>25,029,983</td>
<td>28,132,384</td>
</tr>
<tr>
<td>Due from (to) other funds</td>
<td>(6,690,166)</td>
<td>7,243,884</td>
<td>(553,718)</td>
<td>-</td>
<td>1,075,939</td>
<td>2,039,574</td>
</tr>
<tr>
<td></td>
<td>2,836,709</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,836,709</td>
<td>2,130,500</td>
</tr>
<tr>
<td>Employee future benefits (note 8)</td>
<td>2,836,709</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,836,709</td>
<td>2,130,500</td>
</tr>
<tr>
<td>Property and equipment (note 5)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8,243,008</td>
<td>-</td>
<td>8,237,009</td>
</tr>
<tr>
<td></td>
<td>4,706,516</td>
<td>22,441,230</td>
<td>8,243,008</td>
<td>8,237,009</td>
<td>11,729,123</td>
<td></td>
</tr>
<tr>
<td>Liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>5,221,248</td>
<td>2,501</td>
<td>1,109,404</td>
<td>-</td>
<td>6,333,153</td>
<td>5,999,308</td>
</tr>
<tr>
<td>Due to Alberta Medical Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,615</td>
</tr>
<tr>
<td>Payable to Canadian Medical Association</td>
<td>101,103</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>101,103</td>
<td>957,023</td>
</tr>
<tr>
<td>Deferred membership revenue (note 6)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,040,579</td>
</tr>
<tr>
<td>Deferred leasehold inducements and other (note 7)</td>
<td>279,874</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>279,874</td>
<td>347,024</td>
</tr>
<tr>
<td></td>
<td>5,602,225</td>
<td>2,501</td>
<td>1,109,404</td>
<td>-</td>
<td>6,714,130</td>
<td>10,348,549</td>
</tr>
<tr>
<td>Deferred leasehold inducements and other (note 7)</td>
<td>1,142,970</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,142,970</td>
<td>1,380,574</td>
</tr>
<tr>
<td></td>
<td>6,745,195</td>
<td>2,501</td>
<td>1,109,404</td>
<td>-</td>
<td>7,857,100</td>
<td>11,729,123</td>
</tr>
<tr>
<td>Net Assets</td>
<td>(2,038,679)</td>
<td>22,438,729</td>
<td>9,756,779</td>
<td>8,243,008</td>
<td>38,399,837</td>
<td>40,269,371</td>
</tr>
<tr>
<td></td>
<td>4,706,516</td>
<td>22,441,230</td>
<td>8,243,008</td>
<td>8,237,009</td>
<td>11,729,123</td>
<td></td>
</tr>
</tbody>
</table>

Commitments (note 16)

Approved by the Board of Directors

The accompanying notes are an integral part of these consolidated financial statements.
Alberta Medical Association (C.M.A. Alberta Division)

CONSOLIDATED STATEMENT
OF CHANGES IN NET ASSETS
For the year ended September 30, 2018

<table>
<thead>
<tr>
<th></th>
<th>General Fund</th>
<th>Contingency Reserve Fund</th>
<th>Premium Reserve Fund</th>
<th>Capital Reserve Fund</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net assets – Beginning of year</strong></td>
<td>(2,033,307)</td>
<td>20,800,015</td>
<td>13,265,654</td>
<td>8,237,009</td>
<td>40,269,371</td>
<td>40,997,147</td>
</tr>
<tr>
<td><strong>Net revenue (expense) for the year</strong></td>
<td>527,671</td>
<td>517,779</td>
<td>(3,254,255)</td>
<td>-</td>
<td>(2,208,805)</td>
<td>391,750</td>
</tr>
<tr>
<td>Remeasurement of employee future benefits</td>
<td>339,271</td>
<td>-</td>
<td>-</td>
<td>339,271</td>
<td>-</td>
<td>(1,119,526)</td>
</tr>
<tr>
<td>Purchase of property and equipment</td>
<td>(1,171,054)</td>
<td>-</td>
<td>-</td>
<td>1,171,054</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Amortization (note 5)</td>
<td>1,165,055</td>
<td>-</td>
<td>-</td>
<td>(1,165,055)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fund transfers (note 15)</td>
<td>(866,315)</td>
<td>1,120,935</td>
<td>(254,620)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net assets – End of year</strong></td>
<td>(2,038,679)</td>
<td>22,438,729</td>
<td>9,756,779</td>
<td>8,243,008</td>
<td>38,399,837</td>
<td>40,269,371</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these consolidated financial statements.
Alberta Medical Association (C.M.A. Alberta Division)

CONSOLIDATED STATEMENT OF OPERATIONS

For the year ended September 30, 2018

<table>
<thead>
<tr>
<th></th>
<th>General Fund $</th>
<th>Contingency Reserve Fund</th>
<th>Premium Reserve Fund $</th>
<th>Capital Reserve Fund $</th>
<th>Total $</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member dues (note 6)</td>
<td>17,034,464</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17,034,464</td>
<td>16,419,091</td>
</tr>
<tr>
<td>Fees and commissions</td>
<td>2,548,295</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,548,295</td>
<td>2,106,725</td>
</tr>
<tr>
<td>Investment income (note 9)</td>
<td>176,648</td>
<td>547,934</td>
<td>427,007</td>
<td>-</td>
<td>1,151,589</td>
<td>1,024,655</td>
</tr>
<tr>
<td>Other</td>
<td>1,313,114</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,313,114</td>
<td>1,010,972</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21,072,521</td>
<td>547,934</td>
<td>427,007</td>
<td>-</td>
<td>22,047,462</td>
<td>20,561,443</td>
</tr>
<tr>
<td><strong>Expenditures (schedule 1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate affairs</td>
<td>6,067,742</td>
<td>30,155</td>
<td>2,521,914</td>
<td>-</td>
<td>8,619,811</td>
<td>8,336,626</td>
</tr>
<tr>
<td>Executive office</td>
<td>2,901,673</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,901,673</td>
<td>2,798,774</td>
</tr>
<tr>
<td>Committees (schedule 2)</td>
<td>2,316,796</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,316,796</td>
<td>2,420,779</td>
</tr>
<tr>
<td>Priority projects</td>
<td>2,833,407</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,833,407</td>
<td>1,655,330</td>
</tr>
<tr>
<td>Public affairs</td>
<td>2,051,050</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,051,050</td>
<td>1,927,947</td>
</tr>
<tr>
<td>Health policy and economics</td>
<td>1,979,674</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,979,674</td>
<td>1,889,375</td>
</tr>
<tr>
<td>Professional affairs</td>
<td>953,356</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>953,356</td>
<td>667,306</td>
</tr>
<tr>
<td>Southern Alberta Office</td>
<td>652,285</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>652,285</td>
<td>594,033</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>19,755,983</td>
<td>30,155</td>
<td>2,521,914</td>
<td>-</td>
<td>22,308,052</td>
<td>20,290,170</td>
</tr>
<tr>
<td><strong>Realization of insurance experience (note 10)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,316,538</td>
<td>517,779</td>
<td>(2,094,907)</td>
<td>-</td>
<td>(260,590)</td>
<td>271,273</td>
</tr>
<tr>
<td><strong>Employee future benefits</strong></td>
<td>-</td>
<td>-</td>
<td>(1,159,348)</td>
<td>-</td>
<td>(1,159,348)</td>
<td>735,787</td>
</tr>
<tr>
<td><strong>Net revenue (expense) for the year</strong></td>
<td>(788,867)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(788,867)</td>
<td>(615,310)</td>
</tr>
<tr>
<td></td>
<td>527,671</td>
<td>517,779</td>
<td>(3,254,255)</td>
<td>-</td>
<td>(2,208,805)</td>
<td>391,750</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these consolidated financial statements.
### CONSOLIDATED STATEMENT OF CASH FLOWS

For the year ended September 30, 2018

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash provided by (used in)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net revenue (expense)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for the year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>527,671</td>
<td>1,305,825</td>
</tr>
<tr>
<td>Contingency Reserve Fund</td>
<td>517,779</td>
<td>437,607</td>
</tr>
<tr>
<td>Premium Reserve Fund</td>
<td>(3,254,255)</td>
<td>(1,351,682)</td>
</tr>
<tr>
<td><strong>(2,208,805)</strong></td>
<td>391,750</td>
<td></td>
</tr>
<tr>
<td>Items not affecting cash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization (note 5)</td>
<td>1,165,055</td>
<td>1,051,695</td>
</tr>
<tr>
<td>Gain on sale of portfolio investments (note 9)</td>
<td>(256,240)</td>
<td>(194,115)</td>
</tr>
<tr>
<td>Gain on pension benefit</td>
<td>(366,938)</td>
<td>(776,058)</td>
</tr>
<tr>
<td>Net change in non-cash working capital items (note 13)</td>
<td>(2,444,092)</td>
<td>1,826,518</td>
</tr>
<tr>
<td><strong>(4,111,020)</strong></td>
<td>2,299,790</td>
<td></td>
</tr>
<tr>
<td><strong>Investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions to property and equipment</td>
<td>(1,171,054)</td>
<td>(1,572,477)</td>
</tr>
<tr>
<td>Purchase of portfolio investments</td>
<td>(6,825,947)</td>
<td>(1,751,863)</td>
</tr>
<tr>
<td>Proceeds from sale of portfolio investments</td>
<td>10,184,588</td>
<td>2,085,511</td>
</tr>
<tr>
<td><strong>2,187,587</strong></td>
<td>(1,238,829)</td>
<td></td>
</tr>
<tr>
<td><strong>Increase (decrease) in cash during the year</strong></td>
<td>(1,923,433)</td>
<td>1,060,961</td>
</tr>
<tr>
<td>Cash – Beginning of year</td>
<td>9,064,792</td>
<td>8,003,831</td>
</tr>
<tr>
<td>Cash – End of year</td>
<td>7,141,359</td>
<td>9,064,792</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these consolidated financial statements.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2018

1. Basis of presentation

Alberta Medical Association (C.M.A. Alberta Division) (the Association or AMA) is a not-for-profit organization incorporated under the Societies Act of the Province of Alberta. As a not-for-profit organization, the Association is not subject to income taxes. Its principal activities include negotiations on behalf of physicians, representation of members, advocacy for a quality health-care system, management of government funded programs, and the provision of products and services for members.

These consolidated financial statements include the general operating accounts of the Association, its Contingency Reserve Fund, and the Insurance Premium Reserve Fund (Premium Reserve Fund). The consolidated financial statements include the accounts of A.M.A. Holdings Inc., a wholly owned subsidiary, which owns and operates a building that has the Association as its sole tenant, and ADIUM Insurance Services Inc., a licensed insurance agency that offers insurance products to members. All inter-entity transactions and balances have been eliminated on consolidation.

2. Administered programs

In addition to its principal activities, by agreement between the Association and Her Majesty the Queen in Right of Alberta (the government), the Association is the administrator of certain programs. These programs are audited separately and are reported to the government. As the Association is an administrator of the programs, the assets, liabilities, revenues and expenses of these programs are not included in these consolidated financial statements. The costs recovered by the Association to administer these programs have been included in these consolidated financial statements and are segregated for greater clarity (note 12). A summary of the programs administered by the Association as at and for the year ended March 31, 2018, which is the most recent fiscal year of the programs, and amounts owing from these programs as at September 30 are as follows:

<table>
<thead>
<tr>
<th>Program</th>
<th>Revenue $</th>
<th>Revenue $</th>
<th>Net change in reserves $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Plans</td>
<td>153,788,961</td>
<td>153,788,961</td>
<td>-</td>
</tr>
<tr>
<td>Physician Locum Services</td>
<td>23,135,818</td>
<td>23,135,818</td>
<td>-</td>
</tr>
<tr>
<td>Electronic Medical Records Completion Project</td>
<td>2,917,011</td>
<td>2,917,406</td>
<td>(395)</td>
</tr>
<tr>
<td>Alternate Relationship Plan Program Management Office</td>
<td>1,672,292</td>
<td>1,672,292</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care Initiative Program Management Office</td>
<td>3,049,580</td>
<td>3,049,580</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>184,563,662</td>
<td>184,564,057</td>
<td>(395)</td>
</tr>
</tbody>
</table>
Due from administered programs

<table>
<thead>
<tr>
<th>Program</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Plans</td>
<td>52,093</td>
<td>982,120</td>
</tr>
<tr>
<td>Alternate Relationship Plan Program Management Office</td>
<td>867,305</td>
<td>501,435</td>
</tr>
<tr>
<td>Primary Care Initiative Program Management Office</td>
<td>94,429</td>
<td>342,468</td>
</tr>
<tr>
<td>Other</td>
<td>62,112</td>
<td>213,551</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,075,939</strong></td>
<td><strong>2,039,574</strong></td>
</tr>
</tbody>
</table>

3. Summary of significant accounting policies

These consolidated financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations (ASNPO). The preparation of consolidated financial statements for a period necessarily includes the use of estimates and approximations, which have been made using careful judgment. Actual results could differ from those estimates. These consolidated financial statements have, in management’s opinion, been properly prepared within reasonable limits of materiality and within the framework of the accounting policies summarized below.

Fund accounting

The Association maintains the following funds in accordance with the principles of the restricted fund method of accounting:

- **General Fund**
  
  This fund includes the ongoing activities of the Association; any restrictions on the fund are internal.

- **Contingency Reserve Fund**
  
  The Contingency Reserve Fund, established by the Board in 1977, is comprised of emergency, capital and strategic initiative components. The emergency component is available for emergency situations, the likelihood of which is relatively small but where the consequence to the Association is significant. The capital component is available for the purchase, replacement and upkeep of property and equipment. The strategic initiative component is available to pursue strategic initiatives or to take advantage of unforeseen opportunities. Funds are internally restricted and may be transferred from the Contingency Reserve Fund to the other funds to cover operating deficits and contingencies.

- **Premium Reserve Fund**
  
  The Premium Reserve Fund was established from past positive experience on the insurance plans offered by the Association. The Fund is internally restricted and is used to stabilize plan premium rates over the long term. Commissions earned on the sale of insurance products are recorded in the General Fund.

- **Capital Reserve Fund**
  
  The Capital Reserve Fund was established to sustain and maintain the property and equipment requirements of the Association. This includes funding the additions and amortization of those assets.

Measurement uncertainty

In preparing these consolidated financial statements, estimates and assumptions are used in circumstances where the actual values are unknown. Uncertainty in the determination of the amount at which an item is recognized in the consolidated financial statements is known as a measurement uncertainty. Such uncertainty exists when there is a variance between the recognized amount and another reasonably possible amount, as there is whenever estimates are used.
Measurement uncertainty exists in the valuation of the pension obligations and arises because actual experience may differ, perhaps significantly, from assumptions used in the calculation of the pension obligation.

While best estimates have been used in the valuation of the pension obligation, management considers that it is possible, based on existing knowledge, that changes in future conditions in the short term could require a material change in the recognized amounts.

Cash

Cash comprises demand, interest bearing bank deposits held with Canadian chartered banks.

Financial instruments

The Association’s financial assets include cash, funds held on deposit, accounts receivable and prepaid expenses, due from administered programs, due from AMA Health Benefits Trust Fund, due from Alberta Medical Foundation and portfolio investments. Cash is recorded at fair value with realized and unrealized gains and losses reported in the consolidated statement of operations for the period in which they arise. Accounts receivable, prepaid expenses, due from administered programs, due from AMA Health Benefits Trust Fund and due from Alberta Medical Foundation are classified as loans and receivables and are accounted for at amortized cost using the effective interest rate method. Loans and receivables are initially recorded at fair value. Portfolio investments are held in pooled index funds comprised of equities, bonds and money market vehicles. No segregated or individual stocks or bonds are held. Portfolio investments are recorded at fair value with gains and losses included in investment income in the consolidated statement of operations for the period in which they arise. Dividends and interest income from portfolio investments are recorded in investment income in the consolidated statement of operations.

The Association’s financial liabilities include accounts payable and accrued liabilities and payable to the Canadian Medical Association. Financial liabilities are classified as other liabilities and are accounted for at amortized cost using the effective interest rate method. Financial liabilities are initially measured at fair value.

The fair value of a financial instrument on initial recognition is normally the transaction price, which is the fair value of the consideration given or received. Subsequent to initial recognition, the fair values of financial instruments that are quoted in active markets are based on bid prices for financial assets. Purchases and sales of financial assets are accounted for at the trade dates. Transaction costs on financial instruments recorded at fair values are expensed when incurred. The fair values of cash, accounts receivable, due from administered programs, due from AMA Health Benefits Trust Fund, due from Alberta Medical Foundation, accounts payable and accrued liabilities and payable to the Canadian Medical Association approximate their carrying amounts due to the short-term maturity of those instruments.

All derivative instruments, including embedded derivatives, are recorded at fair value unless exempt from derivative treatment as a normal purchase and sale. The Association has determined it does not have any derivatives.

Property and equipment

Property and equipment are stated at cost less accumulated amortization. Amortization is provided using the straight-line basis over the following estimated useful lives:

<table>
<thead>
<tr>
<th>Asset</th>
<th>Useful Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
<td>25 years</td>
</tr>
<tr>
<td>Fixtures and improvements</td>
<td>10 years or lease term</td>
</tr>
<tr>
<td>Computers</td>
<td>3 – 5 years</td>
</tr>
<tr>
<td>Office furniture and equipment</td>
<td>5 – 10 years</td>
</tr>
</tbody>
</table>

Land is not subject to amortization.
Employee future benefits

The Association has a defined benefit pension plan for all permanent employees.

The Association recognizes its defined benefit obligation as the employees render services giving them the right to earn the pension benefit. The defined benefit obligation as at the consolidated statement of financial position date is determined using the most recent actuarial valuation report prepared for funding purposes. The measurement date of the plan’s assets and the defined benefit obligation is the Association’s consolidated statement of financial position date. The date of the most recent actuarial valuation prepared for funding purposes is December 31, 2016.

In its year-end consolidated statement of financial position, the Association recognized the defined benefit obligation, less the fair value of the plan’s assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized on the consolidated statement of operations. Past service costs resulting from changes in the plan are recognized immediately in net revenue for the year at the date of the changes.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation in the case of a net defined benefit asset; past service costs; and gains and losses arising from settlements and curtailments. The remeasurement costs are reflected in the consolidated statement of changes in net assets.

Revenue recognition

Annual memberships are valid for the period October 1 to September 30. Member dues received in the current year, which relate to the following fiscal year, are deferred.

Grants, member levy dues and program administration fees are taken into income as related expenditures are incurred. Grants not expended in the current year are recorded as deferred revenue.

Dividends on portfolio investments are recognized as declared. Interest is recognized as earned.

Leases

Leases that transfer substantially all the risks and benefits of ownership of assets to the Association are accounted for as capital leases. Leasehold inducements are considered an inseparable part of the lease agreement and accordingly are accounted for as a reduction of the lease expense over the term of the lease (note 7).

4. Portfolio investments

<table>
<thead>
<tr>
<th>Fund/Pool Fund</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerald Canadian Short-Term Investment Fund</td>
<td>18,143,530</td>
<td>19,909,637</td>
</tr>
<tr>
<td>Emerald U.S. Market Hedged Fund</td>
<td>-</td>
<td>3,108,770</td>
</tr>
<tr>
<td>Emerald Low Volatility Global Equity</td>
<td>2,702,878</td>
<td>-</td>
</tr>
<tr>
<td>Emerald Global Equity Pooled Fund</td>
<td>2,699,319</td>
<td>-</td>
</tr>
<tr>
<td>Emerald International Equity Fund</td>
<td>-</td>
<td>2,856,741</td>
</tr>
<tr>
<td>Emerald Canadian Equity Index Fund</td>
<td>1,484,256</td>
<td>1,698,648</td>
</tr>
<tr>
<td>Emerald Canadian Bond Index Fund</td>
<td>-</td>
<td>558,588</td>
</tr>
<tr>
<td>Total portfolio investments – at quoted fair value</td>
<td>25,029,983</td>
<td>28,132,384</td>
</tr>
<tr>
<td>Total portfolio investments – at cost</td>
<td>25,195,690</td>
<td>27,112,763</td>
</tr>
</tbody>
</table>
The asset mix for the portfolio investments is determined by management, taking into consideration the purposes of the reserves (note 3) as required by Board policy.

### 5. Property and equipment

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
<th>Accumulated amortization</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2018</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>550,000</td>
<td>-</td>
<td>550,000</td>
</tr>
<tr>
<td>Building</td>
<td>5,270,000</td>
<td>1,475,760</td>
<td>3,794,240</td>
</tr>
<tr>
<td>Fixtures and improvements</td>
<td>2,736,013</td>
<td>1,030,682</td>
<td>1,705,331</td>
</tr>
<tr>
<td>Computers</td>
<td>5,009,855</td>
<td>3,139,728</td>
<td>1,870,127</td>
</tr>
<tr>
<td>Office furniture and equipment</td>
<td>1,307,743</td>
<td>984,433</td>
<td>323,310</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14,873,611</td>
<td>6,630,603</td>
<td>8,243,008</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
<th>Accumulated amortization</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2017</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>550,000</td>
<td>-</td>
<td>550,000</td>
</tr>
<tr>
<td>Building</td>
<td>5,270,000</td>
<td>1,264,960</td>
<td>4,005,040</td>
</tr>
<tr>
<td>Fixtures and improvements</td>
<td>2,714,714</td>
<td>783,711</td>
<td>1,931,003</td>
</tr>
<tr>
<td>Computers</td>
<td>3,975,108</td>
<td>2,593,100</td>
<td>1,382,008</td>
</tr>
<tr>
<td>Office furniture and equipment</td>
<td>1,275,964</td>
<td>907,006</td>
<td>368,958</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13,785,786</td>
<td>5,548,777</td>
<td>8,237,009</td>
</tr>
</tbody>
</table>

Amortization for administered programs is recognized in the administered programs. In the current year, amortization was recognized in the Capital Reserve Fund for a total expense of $1,165,055 (2017 – $1,051,695).

### 6. Deferred membership revenue

<table>
<thead>
<tr>
<th></th>
<th>Balance</th>
<th>Net amount</th>
<th>Recognized as revenue</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October 1, 2017</td>
<td>received</td>
<td>as revenue</td>
<td>September 30, 2018</td>
</tr>
<tr>
<td>General Fund</td>
<td>3,040,579</td>
<td>13,993,885</td>
<td>17,034,464</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Balance</th>
<th>Net amount</th>
<th>Recognized as revenue</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October 1, 2016</td>
<td>received</td>
<td>as revenue</td>
<td>September 30, 2017</td>
</tr>
<tr>
<td>General Fund</td>
<td>3,171,147</td>
<td>16,288,523</td>
<td>16,419,091</td>
<td>3,040,579</td>
</tr>
</tbody>
</table>
7. Deferred leasehold inducements and other

<table>
<thead>
<tr>
<th></th>
<th>Balance – October 1, 2017 $</th>
<th>Net amount received $</th>
<th>Recognized in net revenue $</th>
<th>Balance – September 30, 2018 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Medical</td>
<td>79,325</td>
<td>217,805</td>
<td>261,935</td>
<td>35,195</td>
</tr>
<tr>
<td>Foundation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>2,500</td>
<td>-</td>
<td>2,500</td>
</tr>
<tr>
<td>Leasehold inducements</td>
<td>1,648,273</td>
<td>-</td>
<td>263,124</td>
<td>1,385,149</td>
</tr>
<tr>
<td></td>
<td>1,727,598</td>
<td>220,305</td>
<td>525,059</td>
<td>1,422,844</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Balance – October 1, 2016 $</th>
<th>Net amount received $</th>
<th>Recognized in net revenue $</th>
<th>Balance – September 30, 2017 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Medical</td>
<td>112,182</td>
<td>80,766</td>
<td>113,623</td>
<td>79,325</td>
</tr>
<tr>
<td>Foundation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leasehold inducements</td>
<td>342,721</td>
<td>1,459,545</td>
<td>153,993</td>
<td>1,648,273</td>
</tr>
<tr>
<td></td>
<td>454,903</td>
<td>1,540,311</td>
<td>267,616</td>
<td>1,727,598</td>
</tr>
</tbody>
</table>

Leasehold inducements and other to be settled within one year of September 30, 2018 represent $279,874 (2017 – $347,024) of the total balance.

8. Employee future benefits

The Association has a defined benefit pension plan for all permanent employees. The benefits are based on years of service and the employees' final average earnings.

The Association accrues its obligations under the employee defined benefit plans as the employees render the services necessary to earn the pension.

The Association measures its accrued employee future benefit obligation and the fair value of plan assets using the valuation for funding purposes as at December 31 each year (note 3). The most recent actuarial valuation of the pension plan for funding purposes was as at December 31, 2016, and the next required valuation will be as at December 31, 2019.

<table>
<thead>
<tr>
<th></th>
<th>2018 $</th>
<th>2017 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets</td>
<td>31,248,856</td>
<td>28,335,768</td>
</tr>
<tr>
<td>Accrued benefit obligation</td>
<td>28,412,147</td>
<td>26,205,268</td>
</tr>
<tr>
<td>Plan surplus</td>
<td>2,836,709</td>
<td>2,130,500</td>
</tr>
</tbody>
</table>

The net accrued benefit asset is included in the Association's consolidated statement of financial position.

The significant actuarial assumptions adopted in measuring the Association’s employee future benefit determination are as follows:
Discount rate 4.75% 4.75%
Rate of compensation increase 3.00% + SMP 3.00% + SMP
Inflation 2.00% 2.00%

Total cash payments for employee future benefits for 2018, consisting of cash contributed by the Association to the registered pension plan, was $1,445,842 (2017 – $1,559,822). Cash contributions received from administered programs and remitted to the pension plan were $575,724 (2017 – $654,075).

Employee future benefits as reported on the consolidated statement of financial position include the following:

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee future benefit – opening balance</td>
<td>2,130,500</td>
<td>2,473,968</td>
</tr>
<tr>
<td>Net benefit plan expense</td>
<td>(1,190,226)</td>
<td>(1,126,416)</td>
</tr>
<tr>
<td>Remeasurement of employee future benefits</td>
<td>450,593</td>
<td>(776,874)</td>
</tr>
<tr>
<td>Gross employer contributions</td>
<td>1,445,842</td>
<td>1,559,822</td>
</tr>
<tr>
<td>Employee future benefit – ending balance</td>
<td>2,836,709</td>
<td>2,130,500</td>
</tr>
</tbody>
</table>

9. Investment Income

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio interest and dividend income</td>
<td>718,701</td>
<td>728,031</td>
</tr>
<tr>
<td>Gain on sale of portfolio investments</td>
<td>256,240</td>
<td>194,115</td>
</tr>
<tr>
<td>Interest income</td>
<td>176,648</td>
<td>102,509</td>
</tr>
<tr>
<td></td>
<td>1,151,589</td>
<td>1,024,655</td>
</tr>
</tbody>
</table>

10. Insurance experience

The Association maintains a Group Insurance Policy for the benefit of the members and enters into an annual Financial Letter of Understanding. It is the intention of the Association that insurance products operate on a break-even basis over the long term. Over the short term, the Association participates, out of reserves, in experience surpluses and losses calculated as at December 31 of each fiscal year. An experience loss of $1,159,348 (2017 – gain of $735,787) was recognized during the year with $1,179,413 (2017 – $1,138,878) recorded as funds on deposit.

As a result of the historical positive experience in aggregate, the Association has provided premium rate reductions of 15% to 25% for a number of years. The 2018 premium reduction of $2.5 million (2017 – $2.5 million) is funded from the Premium Reserve Fund.
11. Related party transactions

During the year, the Association recognized administration fees totalling $408,224 (2017 – $362,381) from the AMA Health Benefits Trust Fund. Of this amount in the current year, $35,213 (2017 – $115,512) remains due from the AMA Health Benefits Trust Fund at the end of the fiscal year.

These amounts are measured at the exchange amount, which is the amount of consideration established and agreed to by the parties.

The Association is related to AMA Health Benefits Trust Fund by virtue of an Indenture of Trust with Trustees of the AMA Health Benefits Trust Fund on June 1, 2000.

12. Cost recoveries

During the year, the Association recognized cost recoveries for costs incurred on behalf of the programs in the amount of $1,989,156 (2017 – $1,952,350).

13. Net change in non-cash working capital items

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in accounts payable and accrued liabilities</td>
<td>$333,845</td>
<td>$440,099</td>
</tr>
<tr>
<td>(Increase) decrease in due from AMA Health Benefits Trust Fund</td>
<td>$80,299</td>
<td>$(86,388)</td>
</tr>
<tr>
<td>Decrease in deferred membership revenue</td>
<td>$(3,040,579)</td>
<td>$(130,568)</td>
</tr>
<tr>
<td>Decrease in payable to Canadian Medical Association</td>
<td>$(855,920)</td>
<td>$(44,790)</td>
</tr>
<tr>
<td>Decrease in due from administered programs</td>
<td>$963,635</td>
<td>$483,951</td>
</tr>
<tr>
<td>Decrease in accounts receivable and prepaid expenses</td>
<td>$426,183</td>
<td>$621</td>
</tr>
<tr>
<td>Increase (decrease) in deferred leasehold inducements and other</td>
<td>$(304,754)</td>
<td>$1,272,695</td>
</tr>
<tr>
<td>Increase in funds held on deposit</td>
<td>$(40,535)</td>
<td>$(113,717)</td>
</tr>
<tr>
<td>(Increase) decrease in due from Alberta Medical Foundation</td>
<td>$(6,266)</td>
<td>$4,615</td>
</tr>
<tr>
<td></td>
<td>$(2,444,092)</td>
<td>$1,826,518</td>
</tr>
</tbody>
</table>

14. Financial risk management

Liquidity risk

Since inception, the Association has primarily financed its liquidity through member dues, fees and commissions primarily from administered programs and investment income. The Association expects to continue to meet future requirements through all of the above sources.

The Association is not subject to any externally imposed capital requirements. There have been no changes to the Association’s objectives and what it manages as capital since the prior fiscal year.

Credit risk

The Association is subject to credit risk with respect to accounts receivable and related party balances. Accounts receivable relate primarily to members, which comprise a significant number of individuals and hence the Association is not exposed to any significant concentration of credit risk. Management monitors these accounts regularly and as at the consolidated statement of financial position date has identified no heightened risks.
Interest rate risk
The Association is potentially subject to concentrations of interest rate risk principally with its portfolio investments. The Association manages interest rate risk by purchasing units in funds that comprise investments with diverse maturity dates and a variety of issuers.

Currency risk
The Association is subject to currency risk with its portfolio investments. Accordingly, the values of these financial instruments will fluctuate as a result of changes in foreign currency prices. Management does not enter into foreign exchange contracts to limit the exposure to foreign currency exchange risk. This risk is mitigated by diversification of portfolio holdings among different countries.

Market risk
The Association is subject to market risk with its portfolio investments. Accordingly, the value of these financial instruments will fluctuate as a result of changes in market prices, market conditions, or factors affecting the net asset values of the underlying investments. Should the value of the financial instruments decrease significantly, the Association could incur material losses on disposal of the instruments. This risk is mitigated by diversification of portfolio holdings among different asset classes and by holding investments with diverse maturity dates and a variety of issuers.

15. Fund transfers
Any operating excess is transferred from the General Fund to the Contingency Reserve Fund to be held to satisfy Board reserve requirements and to support future strategic initiatives. For the fiscal year ended September 30, 2018, $1,120,935 (2017 – $199,363) was transferred to the Contingency Reserve Fund.

An annual transfer is made from the Premium Reserve Fund to the General Fund to offset the insurance commission lost as a result of any premium discount offered to members (15% discount on life and disability plans for 2018 and 2017 – see note 10). For the fiscal year ended September 30, 2018, $254,620 (2017 – $260,070) was transferred from the Premium Reserve Fund.

16. Commitments
The AMA has lease obligations for the rental of office space for its operations. The estimated minimum annual payments required under the lease agreements are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>$629,810</td>
</tr>
<tr>
<td>2020</td>
<td>$416,772</td>
</tr>
<tr>
<td>2021</td>
<td>$416,772</td>
</tr>
<tr>
<td>2022</td>
<td>$416,772</td>
</tr>
<tr>
<td>2023</td>
<td>$416,772</td>
</tr>
<tr>
<td>Thereafter</td>
<td>$1,400,912</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,697,810</strong></td>
</tr>
</tbody>
</table>

During the year, the Association entered into a lease agreement to obtain office space for its SAO operations with a ten-year term beginning on December 1, 2017. The above table reflects the impact of the estimated minimum annual lease payments required under this lease agreement. A right of the AMA to surrender a portion of the leased premises if the AMA can no longer operate one or more of its administered programs or a program is substantially decreased due to a substantial loss of funding from the Government of Alberta exists within the lease agreement. Estimated annual cost recoveries from the administered programs’ use of the leased premises are expected to offset the aggregate commitment cost.
CONSOLIDATED SCHEDULE OF EXPENDITURES

For the year ended September 30, 2018

Schedule 1

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>6,926,019</td>
<td>6,474,178</td>
</tr>
<tr>
<td>Purchased services</td>
<td>4,001,813</td>
<td>2,998,430</td>
</tr>
<tr>
<td>Insurance discount premium</td>
<td>2,493,883</td>
<td>2,526,104</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>2,286,267</td>
<td>2,335,939</td>
</tr>
<tr>
<td>Committee per diem and travel</td>
<td>2,316,796</td>
<td>2,420,779</td>
</tr>
<tr>
<td>Amortization</td>
<td>1,062,454</td>
<td>947,775</td>
</tr>
<tr>
<td>Zone grants</td>
<td>748,935</td>
<td>268,531</td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td>513,317</td>
<td>372,570</td>
</tr>
<tr>
<td>Travel and accommodation</td>
<td>476,687</td>
<td>342,933</td>
</tr>
<tr>
<td>Facilities</td>
<td>405,022</td>
<td>361,963</td>
</tr>
<tr>
<td>Investment and bank fees</td>
<td>233,441</td>
<td>283,173</td>
</tr>
<tr>
<td>Communications production</td>
<td>162,357</td>
<td>189,355</td>
</tr>
<tr>
<td>Scholarships</td>
<td>147,000</td>
<td>145,500</td>
</tr>
<tr>
<td>Postage and courier</td>
<td>112,245</td>
<td>161,390</td>
</tr>
<tr>
<td>Stationery and office supplies</td>
<td>84,750</td>
<td>115,898</td>
</tr>
<tr>
<td>Sundry</td>
<td>76,867</td>
<td>76,892</td>
</tr>
<tr>
<td>Section support</td>
<td>71,525</td>
<td>70,258</td>
</tr>
<tr>
<td>Insurance</td>
<td>68,131</td>
<td>66,712</td>
</tr>
<tr>
<td>Telephone</td>
<td>58,741</td>
<td>51,115</td>
</tr>
<tr>
<td>Subscriptions and publications</td>
<td>35,692</td>
<td>58,458</td>
</tr>
<tr>
<td>Equipment purchases</td>
<td>26,110</td>
<td>22,217</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,308,052</strong></td>
<td><strong>20,290,170</strong></td>
</tr>
</tbody>
</table>
CONSOLIDATED SCHEDULE
OF COMMITTEE EXPENDITURES

For the year ended September 30, 2018

Schedule 2

<table>
<thead>
<tr>
<th>Governance</th>
<th>2018 $</th>
<th>2017 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative Forum</td>
<td>1,119,011</td>
<td>1,152,715</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>355,001</td>
<td>398,990</td>
</tr>
<tr>
<td>President activities</td>
<td>306,441</td>
<td>243,529</td>
</tr>
<tr>
<td>CMA General Council</td>
<td>196,175</td>
<td>291,557</td>
</tr>
<tr>
<td>Executive Committee</td>
<td>24,129</td>
<td>21,566</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td><strong>2,000,757</strong></td>
<td><strong>2,108,357</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standing committees</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominating Committee</td>
<td>37,950</td>
<td>28,071</td>
</tr>
<tr>
<td>Committee on Financial Audit</td>
<td>27,000</td>
<td>21,832</td>
</tr>
<tr>
<td>Health Issues Council</td>
<td>26,821</td>
<td>26,205</td>
</tr>
<tr>
<td>Committee on Government Affairs</td>
<td>5,266</td>
<td>27,264</td>
</tr>
<tr>
<td>Committee on Student Affairs</td>
<td>2,265</td>
<td>2,981</td>
</tr>
<tr>
<td>Committee on Constitution and Bylaws</td>
<td>850</td>
<td>4,108</td>
</tr>
<tr>
<td><strong>Standing committees</strong></td>
<td><strong>100,152</strong></td>
<td><strong>110,461</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committees</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>115,621</td>
<td>55,940</td>
</tr>
<tr>
<td>Other committees</td>
<td>33,999</td>
<td>53,398</td>
</tr>
<tr>
<td>Property &amp; Casualty Insurance Review</td>
<td>14,918</td>
<td>-</td>
</tr>
<tr>
<td>Indigenous Health</td>
<td>12,636</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care Network Executive Committee</td>
<td>11,288</td>
<td>23,768</td>
</tr>
<tr>
<td>Primary Care Alliance</td>
<td>10,469</td>
<td>16,128</td>
</tr>
<tr>
<td>Council of Presidents</td>
<td>8,648</td>
<td>7,013</td>
</tr>
<tr>
<td>Provincial Physician Liaison Forum</td>
<td>5,501</td>
<td>4,352</td>
</tr>
<tr>
<td>Specialty Care Alliance</td>
<td>2,807</td>
<td>-</td>
</tr>
<tr>
<td>Board task forces</td>
<td>-</td>
<td>35,279</td>
</tr>
<tr>
<td>Physician Learning</td>
<td>-</td>
<td>3,608</td>
</tr>
<tr>
<td>Governance Review</td>
<td>-</td>
<td>2,408</td>
</tr>
<tr>
<td>Information Management Information Technology Coordinating Committee</td>
<td>-</td>
<td>67</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Committees</strong></th>
<th><strong>215,887</strong></th>
<th><strong>201,961</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,316,796</strong></td>
<td><strong>2,420,779</strong></td>
</tr>
</tbody>
</table>