The 115th AGM of the Alberta Medical Association will be held at 7 p.m. on Monday, October 5, via Zoom.
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## Order of Business

### AMA Annual General Meeting Agenda
**Monday, October 5, 2020 from 7 - 9 p.m.**
*Via Zoom*

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<td>• Committee on Bylaws</td>
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<td>Board Report to the AGM and Q&amp;A with President, Past President and CEO</td>
<td>Dr. Paul Boucher, President Dr. Christine Molnar, Immediate Past President Michael Gormley, CEO</td>
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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.

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.

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
In Memoriam

Members deceased since the last annual general meeting are:

Bester, Daniel
Blahey, Walter, Brian
Brown, Josephine Mary
Choupannejad, Shekoufeh
Chychota, Norman Ned
Collins, Lorne Burritt
Cummins, Phillip W.
Dartana, Sioe Hiang
Dickson, Ruth Ann
Empey, John H.S.
Fairfield, Finlay Munroe
Feroz, Mohammad
Hamidi, Bijan
Hedges, Bruce Martyn
Hucul, Michelle Leigh
Hulyk, Raymond Michael
Jampolsky, Noel Arran
Kosakoski, Laura
Kumar, Roopee O.
Lee, Bernard
Lipinski, John Joseph
Mathur, Parshottam Sahai
Mccaffery, James Thomas
Mccrank, Ernest William Thomas
Mcgowan, David George
Miller, David D.
Mitchell, Marvin

Vancouver, BC
Calgary
Athabasca
Edmonton
Taber
Lethbridge
Grande Prairie
Edmonton
Calgary
Chemainus, BC
Sidney, BC
Sherwood Park
Calgary
Calgary
Calgary
Red Deer
Vancouver, BC
Canmore
Vancouver
Edmonton
Edmonton
Calgary
Edmonton
Calgary
Edmonton
Drumheller
Edmonton

Myburgh, Johannes Lambertus
Owen, Michael L.S.
Papadopoulos, Dionysios Fotios
Paton, Thomas John
Prakash, Anil
Pratt, Michael
Qureshi, A. Quddus
Reynolds, Walter John French
Rogan, Ernest
Sayeed, Wajid
Selman, William Gary
Shragge, David Lawrence
Shuster, Michael
Siwak, Theodore Henry
Somani, Parviz N.
Spence, David C.
Takacs, Ernest Stephen
Taylor, Geoffrey David
Taylor, Margaret I.
Te, Luis D.
Van Zyl, Stephanus Andreas
Warneke, Lorne
Williams, Christopher Noel
Wray, David Leslie
Wray, Marvin Brent
Yar Khan, Saulat

Jarvis Bay
Lethbridge
Brooks
Edmonton
St. Albert
Lethbridge
Carstairs
Red Deer
St. Albert
Edmonton
Calgary
Edmonton
Banff
Sherwood Park
Edmonton
Edmonton
Edmonton
Canmore
Calgary
Edmonton
Okotoks
Edmonton
Edmonton
Peace River
St. Albert
Edmonton
Minutes

114th Annual General Meeting of the Alberta Medical Association (CMA Alberta Division)

September 28, 2019

1. The 114th Annual General Meeting of the Alberta Medical Association (CMA Alberta Division) was held on September 28, 2019, in the Wayne Gretzky Ballroom B/C, JW Marriott, ICE District, Edmonton, Alberta.

2. O Canada was sung.

3. Call to Order

Dr. Carl W. Nohr presided as Speaker and declared the 114th AGM in session and duly constituted at 11 a.m.

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. Harold Chyczij and Dr. Ann Vaidya.

5. In Memoriam

Thirty-five members passed away since the last AGM. Dr. Nohr read their names into the record followed by a moment of silence.

Michele Benedictson  Zakir Husain  Russell Sawa
William Black       Monica Johnson  Desmond Shulman
Michael Brooke      Richard King-Brown  Kenneth Shwaluk
Ashim Chakravorty   Harry Letts  William St. Clair
Murray Colwell      William Loosemore  Marvin Starko
Gerald Eaton        Keith MacCannell  Lloyd Sutherland
Richard Fedorak     Gordon Maxwell  Andrew Tang
John Frizzell       Boris Nahornick  John Turnbull
Robert Glasgow      James Nicas  Elisabeth Wagner
Sidney Harrison     Godwin Okolo  Ronald Wensel
John Higgin         Shashikant Patel  Derek Williams
Edward Holmes       Julian Sacher

6. President’s Valedictory

The outgoing president, Dr. Alison Clarke, reflected on her term as president and on its challenges and accomplishments. She thanked the directorate for its support during her term.
MOTION: Moved by Dr. Christine Molnar and seconded:

THAT the profession express its sincere appreciation to Dr. Alison Clarke and her husband Josip Nizetic and her family for her service, sacrifice and dedication to the profession over the past year.

CARRIED

7. Minutes, Meeting of September 22, 2018

The minutes of the AGM of September 22, 2018, were accepted.

8. Nominating Committee Report

2019 CMA General Council

Dr. Neil Cooper, Chair, Nominating Committee, presented the report and the list of nominees.

MOTION: Moved by Dr. Neil Cooper 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
- 10 representatives to be named by the Board
- 11 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, 2019 to September 30, 2022
- There were two candidates for Deputy Speaker for one 3-year term:
  - Dr. Graham M.D. Campbell
  - Dr. Fredrykka D. Rinaldi

Each candidate presented a two-minute platform to the meeting.

Dr. Fredrykka D. Rinaldi was elected as AMA Deputy Speaker, October 1, 2019 to September 30, 2022.

Election of Members to the Nominating Committee

There were three nominees for one 2-year term and one 1-year term as alternate

- Dr. Arun K. Abbi
• Dr. Craig D. Hodgson
• Dr. Laurie M. Parsons

Each candidate presented a two-minute platform to the meeting. The following members were elected.

Two-year term (2019-21):
• Dr. Craig D. Hodgson

One-year term as alternate (2019-20)
• Dr. Arun K. Abbi

9. Report from the Representative Forum

Dr. Christine Molnar, 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 R. 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 2018-19 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 28, 2019, be adopted.

CARRIED

12. Report from the Committee on Financial Audit

Dr. Ogonda Bennett, member, Committee on Financial Audit, presented the report from the committee.

MOTION: Moved by Dr. Ogonda Bennett and seconded:

THAT the firm of PricewaterhouseCoopers be reappointed as auditors for the Alberta Medical Association for the 2019-20 fiscal year.

CARRIED
13. **Acknowledgments**

**MOTION: Moved by Dr. Christine Molnar 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. Christine Molnar 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

**MOTION: Moved by Dr. Christine Molnar and seconded:**

THAT the Annual General Meeting express sincere appreciation to the staff, administrative staff and events team for their dedication and support to ensure the successful operation of this meeting.

CARRIED

14. **Adjournment**

There being no other business, the Speaker adjourned the formal business session of the 114th Annual General Meeting at noon.

15. **Installation of Officers**

Dr. Christine Molnar was installed as AMA President for 2019-20 by CMA President Dr. Sandy Buchman at the CMA President’s Luncheon held following the AGM.
Nominating Committee

Report to the Fall 2020 Annual General Meeting

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 2021**

   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 2021. The president attends General Council by virtue of the position and is not included in the count of Alberta representatives currently allowed to attend (34):

   - President-Elect
   - Immediate Past President
   - Speaker or Deputy Speaker
   - Ten representatives named by the Board
   - Thirteen 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**

   AMA Bylaws section 16.9 “The Speaker and Deputy Speaker shall be elected by the AGM for a term of three years and shall remain in office from the close of the AGM when elected until the close of the third subsequent AGM.” Elections were conducted in August 2019 therefore; there is no requirement by the committee members to submit nominees for Speaker and Deputy Speaker until 2022.

   **Speaker:** Dr. Carl W. Nohr, General Surgery, Medicine Hat  
   **Deputy Speaker:** Dr. Fredrykka Rinaldi, Family Medicine, Medicine Hat
3. Nominating Committee 2020-21

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 two alternate members 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 number of alternates is being increased from one to two, effective September 2020 in order to facilitate a sufficient pool for scheduling purposes.

The current AGM-elected members and their terms follow:

<table>
<thead>
<tr>
<th>AGM (4 members, 1 alternate)</th>
<th>Term</th>
<th>Eligible for re-election</th>
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</thead>
<tbody>
<tr>
<td>Dr. Amelia Correia</td>
<td>Member elected by AGM</td>
<td>FM, Medicine Hat</td>
</tr>
<tr>
<td>Dr. Alayne Farries</td>
<td>Member elected by AGM</td>
<td>ANES, Red Deer</td>
</tr>
<tr>
<td>Dr. Craig Hodgson</td>
<td>Member elected by AGM</td>
<td>FM, Whitecourt</td>
</tr>
<tr>
<td>Dr. Jeffrey Way</td>
<td>Member elected by AGM</td>
<td>GS, Calgary</td>
</tr>
<tr>
<td>Dr. Arun Abbi</td>
<td>Alternate elected by AGM</td>
<td>EMER, Calgary</td>
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Dr. Craig Hodgson will continue on the Nominating Committee to complete his two-year term ending September 2021.

Drs. Amelia Correia, Alayne Farries and Jeffrey Way’s two-year terms end September 2020 and they are not eligible for re-election.

Having served a one-year term as the alternate, Dr. Arun Abbi 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, five members are to be elected to the Nominating Committee at this AGM as follows:

- **Three members each for a two-year term 2020-22.**
- **Two alternate members for a one-year term 2020-21.**

<table>
<thead>
<tr>
<th>AGM-elected</th>
<th>TERM</th>
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<tr>
<td>1. TBD</td>
<td>Member elected by AGM</td>
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<td>2. TBD</td>
<td>Member elected by AGM</td>
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<td>3. TBD</td>
<td>Member elected by AGM</td>
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<td>4. TBD</td>
<td>Alternate elected by AGM</td>
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<tr>
<td>5. TBD</td>
<td>Alternate elected by AGM</td>
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The Fall Nominating Committee meeting is Monday, November 2. Two further meetings will be scheduled in February and May of 2021.
**Elections**

**EXECUTIVE DIRECTOR REPORT TO THE 2020 ANNUAL GENERAL MEETING**

In accordance with the Alberta Medical Association Bylaws, a Call for Nominations for Representatives to Canadian Medical Association (CMA) General Council 2021 was sent to the membership on August 6, 2020.

**Representatives to CMA General Council 2021**

Three nominations were received in response to the Call for Nominations for representatives to attend 2021 CMA General Council as an AMA delegate. Brief profiles, based on service as contained in AMA records, are provided below.

<table>
<thead>
<tr>
<th>Dr. Robert Ferrari, Internal Medicine, Edmonton</th>
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<tr>
<td>2017-present</td>
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<table>
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<tr>
<th>Dr. Kimberley Kelly, Addiction Medicine, Edmonton</th>
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<tbody>
<tr>
<td>2019-present</td>
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<td>2015-19</td>
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<td>2010-11</td>
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<tr>
<td>2018-19, 2016-17, 2015-16</td>
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<td>2013-16</td>
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<td>2011-16</td>
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<tr>
<td>2009-11</td>
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<table>
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<tr>
<th>Dr. Marcus Shaw, General Surgery, Grande Prairie</th>
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<tr>
<td>2020-present</td>
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</table>
Elections - continued

The Nominating Committee Report to the Fall 2020 AGM, preceding this report, contains recommendations for AMA representatives to CMA General Council 2021. Direction will be sought regarding AMA representatives to CMA General Council 2021 at the AMA AGM on Monday, October 5 at 7 p.m.
Report from the Board of Directors to the Annual General Meeting

This report represents a retrospective accounting of the challenges, opportunities and accomplishments experienced by the AMA over the course of the 2019-20 fiscal year (October 1, 2019–September 30, 2020).

The Report from the Board of Directors to the Annual General Meeting has four main sections.

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Highlights and updates related to the AMA’s Business Plan performance in the Key Result Areas: Financial Health; Well Being; System Leadership and Partnership.
  
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Brief commentary on some relevant topics that are not specifically addressed in the Business Plan.
The Big Picture

As the report will amply demonstrate, 2019-20 was a year of unprecedented turmoil in our relationship with government. Added to that, was the impact of the COVID-19 pandemic. In supporting members through both of these challenges, the AMA also continued to pursue important activities under our Business Plan that are key to our mission and vision.

The commentary details many events and activities that can easily be viewed as individual events but taking only that perspective would be short-sighted. By looking at the larger picture, we can see that the fundamental relationship between physicians and the public health care system was challenged this year from every direction, including:

1. **The relationship between the profession and government**: Termination of the AMA Agreement; Bill 21 allowing government to terminate any future agreement between physicians and the Crown; loss of rights to arbitration.

2. **Self-regulation**: New legislation making 50% the regulatory councils of all health professions ministerial appointees; discussion paper contemplating government taking over of licensing, registration and complaints/discipline from all health professions.

3. **Foundation of the Canada Health Act**: New legislation that (i) shifts away from the linkage to physician services (or dentist services) as the defining criteria for “medically necessary” care; and (ii) establishes new entities that may contract with government. Moving care into the community and seeking new partnerships to improve system performance are worthwhile goals. For physicians, however, a number of important principles will need to be upheld.

4. **Physician supply and mobility**: Bill 21 provides for implementation of PRAC ID restrictions in 2022; the Minister has called for a review of provincial medical staff bylaws, fundamentally involving privileging.

Between all these forces, never have the connections between physicians and the public system been challenged so completely and with such great potential for a tectonic shift that would result in massive changes to patient care.

In this report, you will see this context and perspective reflected in the AMA’s response to events, in our approach to negotiations and in our work with others in the system.

The Board of Directors particularly wishes to record our sincere appreciation and gratitude for the unwavering support of the Canadian Medical Association, who have been at our side under our Memorandum of Understanding with added advocacy and significant financial support for many of the activities we undertook this year on behalf of members.
Year in Review

In 2019-20, many major government decisions and actions directly and negatively impacted the profession. When looking back, it is important to consider the interconnected nature of government’s actions. None of these actions existed in isolation and each one – both on its own and in combination with others – has had, or will have, a far-reaching impact on physicians, patients and our health care system. At the heart of the complex issues we faced were a number of questions: Who makes the decisions about what happens in the health care system? On whose behalf and to what end are they made?

Throughout the year, the Minister of Health demonstrated a desire to exercise control over decision-making within the system. Additionally, from the earliest days of the administration, there has been a continuous narrative that Alberta physicians are overpaid for mediocre performance and collaboration with the AMA was kept to a minimum.

Key events of the past year appear in the condensed timeline below.

*Note: Links to supplementary information and related President’s Letters have been provided within each topic.*

AMA Negotiations and Government Relations Timeline

**September 3, 2019: MacKinnon Blue Ribbon Panel Report released**

*President’s Letters: Initial thoughts on Blue Ribbon Panel report – September 4, 2019, Value for Patients, Fairness for Physicians - September 25, 2019*

In early September 2019, the government released the *Report and Recommendations of the Blue Ribbon Panel on Alberta’s Finances*. This was the beginning of the government’s public narrative suggesting that Alberta doctors are overpaid.

The AMA published an economics paper, *The Economic Realities of Physician Compensation in Alberta*, that captured key aspects associated with physician compensation in Alberta that were missed by the MacKinnon report.

An independent analysis, commissioned by the AMA and conducted by a firm that government has used numerous times in the past, provided confirmation that Alberta’s rates are in line with those of our counterparts when proper comparators are used.
October 28, 2019: Bill 21 tabled  
President’s Letter: [New Legislation – AMA Agreement and Physician Supply – October 30, 2019](#)

Bill 21, *Ensuring Fiscal Sustainability Act*, was an omnibus bill that amended a number of statutes, and included important provisions relating to the *Alberta Health Care Insurance Act*.

Bill 21 gave Cabinet the ability to terminate any agreement for physician compensation “between the Crown in right of Alberta and the Alberta Medical Association, or any other person.” This was not only for the existing AMA Agreement, the bill also clearly outlined that government is not required to live up to terms of future contracts. The AMA immediately requested a meeting with the Minister to discuss our concerns and began to explore legal options.

Bill 21 also enabled the Minister of Health to restrict physician billing numbers (PRAC IDs) as of April 2022. All physicians with PRAC IDs on that date will be grand-fathered; all others will have to apply. At time of writing, regulations are still being developed with respect to implementation of this new process.

Draft regulations for implementation of PRAC IDs were to be developed in the summer of 2020, but COVID-19 appeared to delay this (expected now in fall 2020). The AMA advised government that consultation with all stakeholders on these regulations would be essential, particularly with the AMA, resident physicians (through the Professional Association of Resident Physicians of Alberta) and medical students. The AMA met with these groups to share concerns while awaiting the regulations.

November 14, 2019: Consultation proposals tabled, formal negotiations commence  
President’s Letter: [Deep Concerns re Government Consultation – November 29, 2019](#)

Prior to formal commencement of negotiations, government provided an approach to our discussions in the form of 16 consultation proposals. This included items that the AMA insisted must be addressed at the negotiating table and a number of items that the AMA recognized were within the Minister’s purview. AH provided a timeline for the consultation process to occur, beginning November 14 and ending on December 20, 2019.

These proposals, far reaching and destructive – particularly for rural medicine – set the stage for a year of conflict with government.

December 20, 2019: Response to government proposals  
President’s Letter: [AMA response to government consultation proposals - December 20, 2019](#)

From November 14 to December 20, the AMA undertook a far-reaching internal consultation process to assess the government’s consultation proposals. This included holding a special Representative Forum meeting on December 7.
At the December 7 meeting, the Representative Forum passed a number of motions that supported the unity of the profession behind the AMA and conveyed a strong message to government that their approach was inappropriate. The RF agreed that the consultation proposals were an end-run around the negotiations process and that most of the proposal items should remain at the negotiating table.

RF delegates expressed deep anxiety for what these proposals would mean to members’ ability to maintain practices and serve the patient communities that they have invested their careers in. This was particularly apparent in rural family medicine, who faced the heaviest blow from what government tabled.

The AMA provided a formal response to Alberta Health’s Insured Services Consultation on December 20.

January 2020: Mediation began

After being at the negotiating table since November 2019, both sides agreed that discussions would benefit from mediation. A mutually agreed upon mediator was appointed and meetings were scheduled to the end of February.

January 2020: Elimination of various AHS stipends
President’s Letter: Update on AHS stipends – January 24, 2020

The consultation proposals tabled by government included a proposal to eliminate some stipends that were being paid to physicians practicing in AHS programs.

There were many unknowns with respect to this proposal, including uncertainty and questions around exactly which programs or physicians would be affected.

February 15, 2020: Voluntary mediation not successful
President’s Letter: Negotiations update – mediation unsuccessful - February 15, 2020

Members were informed that mediation had failed, but that outreach to the Minister would pursue options for moving forward.

February 20, 2020: Unilateral termination of AMA Agreement
President’s Letter: Response to government announcement - February 20, 2020

Even though the parties agreed to extend the period of time for “good faith” negotiations until February 29, on February 20 the government terminated our Master Agreement.

This termination, prior to the official end of good faith negotiations, was an outrageous action that put physicians and patients at risk. It should be noted that the AMA had no advance notice and learned of the termination only when contacted by the media for comment. The Board immediately responded by exploring legal options, planning to engage the public and taking next steps needed to get the government’s attention and find a resolution.
March 16, 2020: COVID-19 lockdown initiated

The AMA closed all office locations. Before this, we also made the unprecedented decision to cancel the Spring RF. If not already marked as such, meetings associated with events reported below can be assumed to have been held virtually.

Through effective collaboration across the organization, staff responded quickly to the challenges of working from home and were able to successfully deliver services and support to members with little disruption. In some ways, we engaged more with members in this space than ever before, e.g., webinars attended by thousands of physicians.

At time of writing, return to office plans were still being finalized.

March 31, 2020: Unilateral imposition of Physician Funding Framework

President’s Letters: Government rejects call for delayed implementation of framework - March 30, 2020, Supporting each other through the storm - April 3, 2020

The AMA had conducted an Assessment of Government Proposed Initiatives on Physician Compensation and this information was used to inform a broader response to government.

Unfortunately, despite the AMA continually stressing strong objections to the imposition of the new Physician Funding Framework, the Minister of Health notified the AMA of government’s intent to proceed on March 31 with the remaining elements of the framework. The changes were implemented in a disorderly and disorganized fashion, with little to no information provided. It was difficult to get clarity on the changes and how they were being implemented. The limited information government did share was confusing and often contradictory to information that had been previously communicated.

April 9, 2020: AMA files constitutional challenge

President’s Letter: Our charter challenge for due process and fair negotiations - April 9, 2020

The AMA had few alternatives but to defend the interests of physicians and their patients in court. As such, on April 9 the AMA served the Minister of Health with a Statement of Claim for a constitutional challenge.

The AMA’s position was that by terminating our agreement in February, the Minister of Health violated the charter rights of all Alberta physicians by removing our access to independent third-party arbitration. The lawsuit seeks two things:

- fair and reasonable negotiations toward an agreement; and
- the right to third-party arbitration, which is something that is available to every other essential service provider in the province.
April 15 – 21, 2020: Virtual Representative Forum
President’s Letters: Embattled - April 17, 2020, Your representation matters - April 30, 2020

From April 15-21, we held our first ever virtual Representative Forum (RF), which included an initial meeting among all available delegates, followed by small group break-out sessions. Topics discussed included: the Minister’s Physician Funding Framework; involving the public in our efforts; the profession’s role in managing the Physician Services Budget; support for physicians during COVID-19; and physician payment reform.

The Board discussed the direction provided by RF and committed to working with sections, Zone Medical Staff Associations, the Family Medicine Task Force, the Specialty Care Task Force and others to implement a sustained advertising and government relations campaign and to move forward on conducting a Confidence Vote Referendum on the Minister of Health.

April 24, 2020: AMA Response to Provincial Announcement on Support for Rural Health Care
President’s Letters: AMA Response to Provincial Announcement on Support for Rural Health Care - April 24, 2020, Complex modifier change paused; other proposals remain to be implemented - March 17, 2020

After weeks of public advocacy by rural physicians and the AMA and increasing public outcry, the Health Minister made a major announcement regarding support for rural medicine. The great majority of the “support” was actually a roll-back of most of the provisions of the Physician Funding Framework that affected rural care. Following discussions with the AMA through an ad hoc working group, the Minister had already rolled back (March 17) the most contentious proposal to change Complex (Time) Modifiers.

Many of the impositions were not definitively removed. Several items remain, such as capping, loss of ability to submit good faith claims, loss of Continuing Medical Education benefits, increased Medical Liability Reimbursement deductibles for many specialties and the over-taking of the MLR program. AMA President, Dr. Christine Molnar, expressed concern publicly that if these ideas were imposed again, history would repeat itself “with government having to put out fires they started themselves.”

While the AMA appreciated that the announcement was a positive step, there were still major concerns with respect to the lack of certainty, clarity and collaboration in government’s approach with physicians.

April 27, 2020: Medical Liability Reimbursement
President’s Letter: MLR: Setting the Record Straight - April 27, 2020

Since the onset of negotiations, Alberta Health took the unwavering position that funding for the MLR would be reduced to approximately 50% of the total cost of Canadian Medical Protective Association dues. The AMA had repeatedly warned the Minister about the consequences of reducing the reimbursement for liability premiums.

The MLR was an evergreen program through the AMA Agreement and, as such, was to continue to be fully funded this year during negotiations, unless otherwise agreed to by both parties. When the Minister tore up our agreement, programs such as MLR were thrown into limbo.
On April 24, the Minister accused the AMA of not being truthful with members regarding proposed changes to Medical Liability Reimbursement. Dr. Molnar, wrote to members on April 27 to set the record straight.

As months passed without government signing off the grant agreement governing MLR and other programs, the AMA approached the Canadian Medical Protective Association and obtained a delay in premium withdrawals to allow time for resolution.

**May 1, 2020: Telling the UCP to get back to the bargaining table**  
*President’s Letter: Tell the UCP to get back to the bargaining table - May 1, 2020*

The AMA launched a campaign designed to encourage the government to get back to the bargaining table with the AMA. The campaign website, [patientsfirst.ca](http://patientsfirst.ca), informed Albertans about the situation and provided an option for physicians and other Albertans to send a direct email to their MLA and Health Minister Tyler Shandro.

Further information about the specifics of the campaign appear in the “AMA Advocacy” section below.

**May 5, 2020: Declaring the AMA as the official representative of physicians**  
*President’s Letter: In this together – May 5, 2020*

Dr. Molnar sent a [letter](http://patientsfirst.ca), co-signed by physician leaders, to the Minister declaring the AMA as the exclusive representative body for all of Alberta’s physicians.

This was a clear message of unity and a reminder to the Minister that the AMA is more than an organization. It is the collective voice of our 14,000 members.

**May 15, 2020: Physician representation in Alternative Relationship Plans**  
*President’s Letter: Exercise your right of representation - May 15, 2020*

Physician representation in ARPs is a critical issue facing the profession. Government made the expansion of ARPs a priority, and while the AMA strongly supports alternative relationship plans as an important component of our Physician Compensation Strategy, the AMA expressed the importance of developing ARPs in Alberta through a collaborative approach.

**June 24 –Member survey conducted**  
*President’s Letter: Your Practice, Your Plans: Your Results - July 9, 2020*

To represent members effectively, it was important to take stock of how members were doing amid the challenges of COVID-19 and the added stress and anxiety caused by the unilateral implementation of the Physician Funding Framework.

A member survey, conducted from June 24 to July 3, asked members about impacts to their practice, whether their plans had changed as a result of the compounding circumstances, what they thought of ARPs and how the AMA could best represent them. We had an excellent response rate and the information gleaned from the survey results was used to directly inform planning.
On July 6, Bill 30, the Health Statutes Amendment Act, was introduced in the legislature. The AMA was not consulted about Bill 30 and, much like Bill 21, this bill introduced elements of health care reform with no transparency or consultation with important stakeholders.

Bill 30 was an omnibus bill covering several matters:

- increased public representation on health profession regulatory bodies;
- revised reporting and mandate for the Health Quality Council of Alberta;
- an amendment to the process for chartered surgical facilities;
- change processes around Alternative Relationship Plans;
- and the ability for the Minister to contract with a range of organizations to handle the administrative work of operating medical clinics.

From the AMA’s perspective, the idea of private contracting for publicly funded services is not an issue. As Dr. Molnar wrote to members, our concerns, including ensuring that physicians maintain their ownership of the practice of medicine, were that physicians would be represented in contractual arrangements and fairly remunerated, and that participation in such ventures would remain an option.

In July, as the Minister continued to tell Albertans that the AMA had never tabled any proposals in our negotiations, the AMA took the opportunity to set the record straight. We publicly released an overview of our July offer to government, which was, at that time, the latest of four proposals for savings that the AMA had submitted.

The AMA held a virtual press conference to explain that, no matter what the Minister claimed, we had indeed brought forward multiple proposals with significant potential for savings. Our most recent proposal was posted on the AMA website, along with a recording of the press conference, and ads detailing the proposal were published in both the Edmonton Journal and Calgary Herald, as well as in smaller newspapers throughout the province.

In June, the Minister sent a letter to the College of Physicians & Surgeons of Alberta regarding what steps physicians may take in adjusting their practices and what he characterizes as “job action”.

While the AMA respects the work that the College does in its mandate to protect the public, many physicians were being forced to make difficult decisions due to steps taken by the Minister and the AMA had great concerns with the Minister’s approach.
**July 21, 2020: Alberta's physician leadership call for confidence vote on the Minister of Health**

*President’s Letter: Members: Do you have confidence in the Minister? - July 21, 2020*

At a special virtual meeting on Saturday, July 18, the Representative Forum voted to seek the opinion of members through a Confidence Vote Referendum, designed to gauge the confidence of physicians in the performance of the Minister of Health.

Electronic voting opened on July 21 and closed on July 28. The vote provided all Alberta physicians the opportunity to have their say and give the AMA direction on next steps. If the vote results expressed confidence in the Minister of Health, the AMA would continue to try to work with him, and to engage him in a meaningful way. If the results expressed non-confidence, then the AMA would attempt to elevate our impasse to a higher authority; namely Premier Jason Kenney, and ask that he give his personal attention to this pressing issue.

**July 24, 2020: News about changes to AMA grant programs**

*President’s Letter: News on programs and other matters - July 24, 2020*

Since the announcement of the Physician Funding Framework in February, the AMA worked to put a grant agreement in place for the benefits and grant programs. Despite various discussions, budget iterations, grant schedule development and indications that the grant was forthcoming, the AMA did not receive a signed grant agreement.

In early July, we met with Alberta Health and indicated that by the end of July we would need either a grant in place or a commitment on wind down costs.

In mid-July, Alberta Health made the following changes to the benefits and grant programs:

- **Physician Locum Program:** Grant will be provided to AMA April 1, 2020 - August 30, 2020 for expenses incurred during this time. The program was to have been moved to AHS effective September 1, 2020 but an extension was granted to September 30.
- **ARP Physician Support Services:** Originally was to be funded until August 30, 2020 but extended to September 30. Reasonable wind down costs were to be funded by AH.
- **Physician Learning Program** - Grant funding to AMA April 1, 2020 - August 30, 2020. After August 30, 2020 AH funds the universities directly. Since no funding has yet been provided to the AMA or the Universities for this fiscal year, the grant may be provided to the universities in its entirety.
- **Accelerating Change Transformation Team:** Grant funding April 1, 2020 - March 31, 2021. During this year AH will issue an RFP for the services that are currently provided by ACCT. The AMA can apply through this process. The grant agreement will also include a provision for reasonable wind down costs after March.
- **Physician and Family Support Program, Compassionate Assistance and Parental Leave:** Grant funding to be maintained, but a review will be undertaken to determine if this should continue to be AMA-administered.

While the AMA could work with some aspects of the above changes, others diminished the AMA’s role and/or would have very significant implications for physicians and patients. In a subsequent return to
negotiations, the AMA’s position is that these changes, along with earlier decisions relating to MLR and CME, would be reopened.

**July 29, 2020: Bill 30 comes into force**
*President’s Letter: Bill 30 – July 27, 2020*

Bill 30 officially passed in the legislature on July 29. The Bill is complicated and the AMA submitted a formal response to government that outlined our main concerns. Our response commented on a number of aspects, but one of the most significant was the issue of adding a third category to the list of those entitled to bill the Alberta Health Care Insurance Plan for the provision of insured services pursuant to an “arrangement” with the Minister. Bill 30 refers to this third category as a “person” (as opposed to a medical practitioner or dental surgeon), clearly intended to be either a corporation, a partnership, a society or another recognized legal corporate entity.

The AMA is not opposed to moving forward with more efficient models of care, but our message to government asked for clear, agreed upon rules of the game, along with the full engagement of physicians at the outset.

**July 29/30, 2020: Members declare non-confidence in Minister, AMA reached out to the Premier**
*President’s Letters: An unprecedented and overwhelming vote - July 29, 2020, Reaching out to the Premier - July 30, 2020*

On July 29, the results of our referendum vote were in: 98% of physicians, residents and medical students across Alberta who voted indicated they did NOT have confidence in the Minister. There were 8,934 votes cast, representing a voter turn-out of 67%.

As promised, the AMA reached out to Premier Jason Kenney and sought his leadership and support in restoring a meaningful dialogue between physicians and the Minister. At time of writing, no response had been received from the Premier.

**August 6, 2020: Possible changes to Health Professions Act: Self-regulation concerns**
*President’s Letter: Possible changes to Health Professions Act: Self-regulation concerns - August 6, 2020*

The AMA received a consultation document from government regarding proposed changes to the Health Professions Act. Some of the options presented in the discussion paper suggest a wholly new, government-led approach to licensing and complaints registration. This approach was unprecedented in Canada.

The AMA stressed that self-regulation is essential to physicians’ ability to meet their professional responsibilities to patients. Members were invited to submit their own feedback.

**August 21, 2020: Correspondence with government**
*President’s Letter: Correspondence with government - August 21, 2020*

The AMA received a communication from the Minister of Health that included a request for a written response to what effectively was government’s first proposal, provided back in November 2019.
There have been numerous AMA proposals since then, both before and after termination of the AMA Agreement. The AMA provided another document addressing all relevant issues in detail, so that government could reply in writing. The AMA hoped that this could lead to greater understanding between the parties.

**September 9, 2020: Release of Sunshine List regulations**

President’s Letter: [Release of Sunshine List regulations – September 11, 2020](#)

On September 9, government released [regulations on physician payment disclosure](#). The regulations are brief and lay out a 60-day disclosure date, meaning the information can be released as of Sunday, November 8, or anytime before.

Greater transparency for the public through the Sunshine List, in our view ([August 10 President’s Letter](#)), does not require the release of individual names. However, government decided to proceed with the release of physician names with and their gross billing data.

Two issues of prime importance remain: that the public is fully informed about the context of the information and that a fair and reasonable process for exemption is implemented. The AMA will continue to advocate for members on this issue and will take the Minister up on his offer to continue discussions with us.

**AMA Advocacy**

The AMA undertook extensive government relations and advocacy activities as part of an overall approach to the breakdown in negotiations. Political advisors and a polling firm were retained to advise on how to overcome the impasse with government and advocacy campaigns were designed and executed to help inform Albertans and mobilize their support for Alberta’s physicians.

While the Board sets direction for the organization in terms of public messaging and strategies, the input of members is always essential to making the best decisions. In fall 2019, the Physician Advocacy Group was reactivated. PAG is a small working and focus group for the Board, comprised primarily of RF delegates. PAG met several times and provided valuable advice for member communication and engagement in the early months of negotiations.

With the tearing up of the AMA Agreement in February, members across the province were speaking up against government decisions and in support of the AMA. Observing the scale of need and the many differing advocacy opportunities through these loyal members, the AMA spun up a staff team (communications, logistics, media support, etc.) for two groups that eventually were able to streamline their efforts into a single entity. The Family Medicine Task Force (Sections of Family Medicine, Rural Medicine, primary care networks, local physician leaders) and the Specialty Care Task Force (Specialty Care Alliance) eventually were merged into the Joint Task Force. The AMA is also working with the Zone Medical Staff Associations through the JTF. The self-formed Facebook group, [ABDocs4Patients](#), has been active and effective and, through the JTF, the AMA shares messaging and content to promote alignment of our activities.
With the guidance of the JTF, the AMA has developed a wide range of advocacy tools and support such as MLA talking points, townhall toolkits, office posters, social media content and media training sessions.

Meanwhile, since the spring, the AMA launched three public relations campaigns to support our objectives.

- Share the Care
- Patients First®
- Stand Up for Health Care, Together

This year the AMA radically changed its approach to social media. The Twitter environment has been the frontline through which the Minister, Premier, MLAs and government “issues managers” communicated to and about the AMA and Alberta’s physicians. The AMA has actively engaged in such conversations through our corporate account.

THANK YOU to the hundreds of self-initiated individual members and groups such as ABDocs4Patients, who were also active in social media, poking holes in government arguments, keeping issues alive and expressing support for the AMA and unity of the profession. Their tireless contributions, passion and advocacy were as encouraging as they were effective.

**Equity, Diversity and Inclusion**

The Healthy Working Environments initiative continued this year, in three dimensions of: Leadership; Psycho-Social Wellness and Safety; Diversity and Inclusion. The AMA also ‘walked the talk’, establishing a Board Working Group on Nominating Committee Processes. This group will continue its efforts this fall, due to a hiatus due to the COVID-19 pandemic.

The AMA also took the opportunity speak out against systemic racism in response to a 2016 racist incident in Grande Prairie that gained public attention, especially in the context of the rising Black Lives Matter movement. On June 3, the AMA released the following statement on social media:

> Each of us has a role to play in opposing systemic racism. As physicians dedicated to serving patients, we believe a healthy environment strives for equity and embraces, respects and values our differences. Inclusive cultures strengthen our country, and our health. This supports a sustainable system in which all Albertans share the benefits - patients and their families, physicians and all health care team members. With system partners, we have a commitment to co-creating safe, healthy, equitable and inclusive cultures where all are respected, valued and supported fairly to achieve their full potential.
AMA & the COVID-19 Pandemic

Like businesses and organizations across the world, the AMA was hugely impacted by the arrival of the pandemic, which influenced much of the AMA’s work and focus in the second half of the 2019-20 fiscal year. At time of writing, Alberta was in the second stage of government’s relaunch strategy. This second stage began on June 12 and allowed additional businesses and services to reopen and resume operations with physical distancing requirements and other public health guidelines in place.

The AMA remained committed to supporting physicians as they cared for their patients, their families and themselves during the pandemic. In an April survey, members told the AMA that they wanted the Association to support their needs related to the pandemic, while also continuing to advocate for them in negotiations with government.

Community Supports Working Group
This collaborative stakeholder group, chaired by Alberta Health, was established during the pandemic at the request of the AMA to maximize community physician contribution in addressing patient and physician safety, providing access to care and ensuring pertinent information was communicated. The group included representation from the AMA, AHS, the College of Physicians & Surgeons of Alberta, Alberta College of Family Physicians and the Office of the Information and Privacy Commissioner. Originally meeting once a week, at time of writing the working group was meeting monthly to discuss and facilitate resolution of issues related to Personal Protective Equipment, COVID-19 testing, relaunch guidance, etc.

COVID-19 Virtual Care Codes
Following advocacy by the AMA, government introduced a set of virtual care codes, initially available only for the duration of the pandemic. On June 8, with the urging of the AMA, the Minister of Health announced that the new pandemic virtual codes would be made permanent. The accompanying Med Bulletin 231 provided little detail on how the codes would be integrated into the SOMB.

In general, Alberta Health took a relatively rigid stance on the new COVID-19 virtual codes, modeling Alberta's fees after Ontario's virtual schedule that contains only a few basic fees without modifiers. AMA believed that complex modifiers should be paid on these services (along with the Business Cost Program and the Rural Remote Northern Program payments). Government was firmly opposed to paying for any modifiers associated with non-face-to-face time. In a June 22 discussion with a Fort McMurray physician group, the Minister of Health suggested that the government might be willing to discuss modifiers for these codes, and on June 30 the AMA provided a formal request to reinstate the use of modifiers for virtual codes, citing the Fort McMurray discussion.

The AMA continues to advocate for a more comprehensive set of virtual codes at multiple levels:

1. The AMA’s has brought together a Virtual Care Working Group and developed a strategy for integrating virtual care into clinical practice (focusing initially on the patient care aspects, but also on barriers and enablers including technology and physician payments). An initial strategy was presented to Alberta Health in July, and it was positively received. The Working Group is now further developing its proposal by seeking input from AMA sections.
2. Recent discussions with Alberta Health regarding the Schedule of Medical Benefits, via an economics group, AMA has proposed various improvements, most notably:
   - To allow complex modifiers to be billed with virtual care codes
   - To include prolonged visit and consultation codes in the virtual care codes
   - To allow for virtual team conferences
   - To remove the restriction limiting to virtual care to in-person time only
   - To review restrictive rules which may be a barrier to virtual care
   - To align with strategy being undertaken by Virtual Care Working Group

3. Through provincial negotiations for an AMA Agreement.
4. Through the Physician Compensation Advisory Committee.

**Business Continuity Support for Physicians**

In April, the AMA submitted a proposal to government for a program similar to those in place in Nova Scotia and Newfoundland, whereby physicians would receive 80% of their typical earnings during the pandemic, provided they are willing to be redeployed, as necessary, to meet any COVID-19 needs. In a June 12 letter, the Minister declined the AMA’s request, pointing to significant job and business losses across the entire economy.

**Webinars and Other Supports**

As a profession, physicians endured rapid and unprecedented changes in 2020. The pandemic presented extraordinary challenges to members and the operation of the AMA itself, but the AMA remained focused on maintaining value for members. Very early on, the AMA committed to delivering relevant information to members and developed an ongoing series of webinars titled *Maintaining and Optimizing Your Practice During Times of Rapid Change*. These webinars offered an effective method to deliver tools, resources and advice to members in a safe, virtual manner.

**Personal Protective Equipment**

The pandemic Community Supports Working Group extensively discussed the critical issue of Personal Protective Equipment and on May 26, Alberta Health Services moved to providing PPE for community-based physicians on a cost-recovery basis. Their procurement assistance and their ability to buy in bulk helped to ensure the best pricing, especially given a rapidly fluctuating market. Physicians also have had the option to source their own PPE. Government has been unwilling to provide PPE for physicians (or other health professionals) practicing in community settings. The AMA continues to point out this inequity and to seek solutions as the ongoing nature of the pandemic becomes better understood.

**COVID-19 Webpage**

In addition to offering webinars, the AMA created a [COVID-19 (2019 novel coronavirus) page](https://www.ama-alberta.com/covid-19) on its website that served as a resource centre, providing physicians with easy access to information and resource links to help them as they worked to care for patients and themselves during the pandemic. The page included re-launch information, links to Alberta Health Services and information about various business and financial supports for physicians. AMA staff continuously updated the page as new information became available.
Performance and the Business Plan

The AMA’s business plan goals for 2019-20 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 Partnership and Leadership.

There are currently nine overarching goals, three under each Key Result Area, and several related activities. The activities are linked by both the 2020 -21 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 2019-20 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**

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

The first priority for the year was to negotiate a new AMA Agreement and financial reopener. The “Year In Review” section of this report provides a timeline covering the attempts to negotiate a new AMA Agreement and all of the related surrounding events.

With respect to compensation issues specifically, the **Physician Funding Framework** was government’s alternative to an Agreement and the Physician Compensation Advisory Committee (PCAC) was government’s alternative to the long standing Physician Compensation Committee. The AMA warned that the framework – mostly a reiteration of government’s 16 consultation proposals – was not only short-sighted, but an ill-conceived scheme that would diminish the medical care of Albertans. It also threatens the viability of community medical practices across the province that form the backbone of health care for patients. Despite the AMA continually stressing our strong objections to the imposition of the new framework, government unilaterally implemented it on March 31.
With pressure from physicians, communities and general public, the government has either reversed or postponed many of the Physician Funding Framework cuts that were implemented, including changes to complex modifiers, to overhead charges for hospital-based services (withdrawn for rural, postponed for urban), and to the Medical Liability Reimbursement (also especially in rural practices). Several items remain such as capping, loss of ability to submit good faith claims, loss of Continuing Medical Education benefits, increased MLR deductibles for many specialties, and over-taking administration of the MLR program. The government’s imposition of the Physician Funding Framework remains in place, along with the lack of certainty, clarity and collaboration in government’s approach. The AMA continues to call on government to repeal the remainder of this framework.

As a part of the Physician Funding Framework, the Physician Compensation Advisory Committee was created by the government (with the intent of replacing the PCC) to conduct reviews of rates for services under the SOMB and make recommendations to the Minister.

The AMA recommended three physicians to sit on the Physician Compensation Advisory Committee. Two of the physician recommendations (Dr. Melanie Currie and Dr. Jeff Way) were accepted by the Minister of Health. At time of writing, only two meetings had taken place. AMA staff have been excluded from the meetings, but we are in close contact with our representatives and are able to provide support.

Represent interests of Academic Medicine Health Services Program

The AMA represented the interests of the AMHSP Council’s Negotiating Committee in the development of the new Academic Medicine Health Services Plan (AMHSP) Master Agreement to take effect April 2021.

940 physicians in 14 AMHSP arrangements were supported by the AMA this year.

We have established the AMA AMHSP Council. The Council’s Negotiating Committee met with Alberta Health and Alberta Health Services May 27, 2020 and August 31, 2020. The Committee advanced a negotiating proposal that has objectives as follows:

- Strengthen AMA and participating physician engagement with respect to improvement of AMHSP contractual arrangements and governance structures
- Advance transparent policy development processes
- Advance a Just Culture by promoting physician wellness and procedural fairness
- Encourage innovation and entrepreneurship

The Faculties of Medicine are engaged in discussions with government and AHS regarding the new AMHSP Master Agreement through existing governance structures, including the North and South Sector Committees and Provincial AMHSP Operations and Strategy Committees. The interests brought forth by the AMA are being discussed in these venues as well.

- It remains to be seen which issues are addressed through contractual changes in the Master Agreement, the ISA Template or through operational policies that support the two agreements. At time of writing, Alberta Health had expressed the view that the AMHSP Master Agreement is simply a grant agreement that covers the flow of funds from AH to AHS and the
Universities. Further AMA input will therefore emphasize content within the Individual Services Agreement which is between AHS, the University and the Participating Physician.

- At this point, the intent is for there to be one Master Agreement, covering North and South Sectors in place for April 2021.

The AMHSP Council met June 25, 2020 and discussed the above, as well as the results of the AMHSP Review, completed by Nichols Applied Management Inc. There were 22 recommendations grouped around the following program components:

- Legal framework
- Purpose and goals
- Strategic and funding framework
- Governance and program support
- Performance monitoring, accountability and continuous improvement

This report serves as a further input into the development of the next AMHSP Master Agreement.

**Negotiations and support for ARP physicians**

Government cancelled meetings of the Physician Compensation Committee in January and, as a result, there was little progress regarding decision-making around ARP rates and methodologies. Cancelling the PCC halted further progress on clinical ARP rates and methodology, which seems counterproductive given government’s obvious interest to advance ARP uptake in the province. Furthermore, in August government provided verbal notice that it would be cancelling funding for the ARP Physician Support Services office. Loss of this unique program, along with its highly talented staff, will create a vacuum in physician awareness, advocacy and support for any new or existing clinical ARPs. AMA is working to fill the gap as a priority in our business planning process.

In mid-February, AH announced a new expedited 6-week process for approving ARPs, but this has not yet shortened the significant timeframes needed for approval processes.

The AMA and AHS met regarding plans to create a provincial hospitalist program, but AHS was non-committal regarding a possible implementation date.

The AMA continued its active involvement in the development and refinement of the Blended Capitation Model. Key areas of focus in 2019-20 included negation rules, development of a draft rural model and development of an evaluation framework. The AMA also remains prepared to support physician groups interested in implementing new capitation-based models and continues to advocate for improvements to the model.

**Physician Contracted Groups within AHS**

The AMA was increasingly occupied with advocating for the needs of colleagues working within AHS, both in groups and per individual contracts. The Strategic Agreement, by which groups of physicians
could choose to be represented by the AMA within AHS, expired March 31. The AMA worked with several groups under contract with AHS and subject to stipend arrangements. Many of these contracts are in the process of renegotiation and the applicability of the Strategic Agreement is being considered. AHS agreed to extend all stipends until March 31, 2021 to allow the parties time to negotiate in good faith.

**List of groups affected**

Prior to March 31, 2020, notices to advance to arbitration were sent to AHS for all of the groups (except Pediatric Plastic Surgery ACH, and CancerControl). Other groups are inquiring and collecting opt-in forms for AMA representation. Increasing numbers of individual physicians continue to receive AMA assistance in reviewing/renewing their contracts.

**WCB**

AMA representatives completed negotiations with WCB this year. The new agreement was ratified by AMA membership, and is in effect as of April 1, 2020 to December 31, 2024. This was a great accomplishment and a refreshing reminder of the value of collaborative and interest-based negotiations.

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

The AMA supported well-functioning practices in Alberta from many different angles this year.

One element was helping physicians to bill appropriately and efficiently for their services. Support through our Billing Services unit and Fee Navigator® were popular choices with individual members. Fee Navigator is now being linked to Connect Care and being used by the Locum Program for the launch of e-reporting.

At a system level of audit and peer review, the Peer Review Committee worked hard to review billing data and consult with sections concerning anomalies. The PRC strongly recommended to AH that a third-party be retained for direct communication with individuals who remained unaffected by education and awareness. This request was tabled as part of our negotiations proposals. To further support this work, the AMA has been seeking to obtain access to billing profiles, beginning with a pilot profile of the Section of Family Medicine, based on desired elements for monitoring provided by the section itself.

The Physician Compensation Committee had nearly completed a methodology to review and implement new rates for clinical ARPs in Alberta. With the government cancellation of the AMA Master Agreement, the PCC was discontinued in February. An AMA Clinical ARP Working Group composed of ARP representatives from across Alberta was appointed to develop a common understanding of the needs and concerns of cARP physicians and to advocate for changes to address those needs and concerns. This group met with AH representatives at the end of June 2020. Discussion included AH’s perspective on cARPs and an open dialogue on ARP successes and barriers.
Goal 3 Reliable and best-in-class financial products are available to all members

As part of keeping physician finances healthy, the AMA’s insurance agency, ADIUM, completed a thorough competitiveness review of its products and successfully transitioned to a new carrier, Manulife Financial. This involves group Disability, Professional Overhead Expense, Term Life, Critical Illness, Accidental Death & Dismemberment and PARA Group Disability & Life Insurance Plans. The carrier change provides greater plan stability and better pricing for members. A strong marketing and awareness campaign for our group insurance plans resulted in increased in member uptake and market share. Greater participation improves plan stability and helps to maintain low rates for members.

The links below provide access to information for members to further augment their understanding and use of beneficial financial products:

Insurance

Retiree health & dental benefits are now available to AMA members
Calgary hailstorm affects AMA members
ADIUM’s paramedical provider now open for home visits
Commercial Office Insurance not responding to COVID-19 office closures

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
On July 22, the AMA was informed that the grant funding the AMA receives for PFSP will continue for the period of April 1, 2020 - March 31, 2021. During the timeframe, Alberta Health will review options for future delivery of this program. This is obviously a significant concern. Ongoing work will be done to express the criticality of this program residing within the AMA on the basis of best practice and past effectiveness.

PFSP statistics and other important updates

WellDoc Alberta
PFSP continued to work with Well Doc Alberta throughout 2019-20 to develop a collaborative and synergistic approach for delivering physician wellness related education.
In 2018-19, Well Doc Alberta became the first program supported under the Memorandum of Understanding between the AMA and the Canadian Medical Association. Working with and in parallel to PFSP, the program continued to evolve, in particular supporting wellness and self care for physicians during COVID-19.

**2019-20 Well Doc updates**

**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. Even in the face of incredible adversity and challenge over most of the past year, our members remained committed to serving their patients and helping build a sustainable, successful and innovative health care system.

In celebration of that hard work and dedication, as part of “We All Make a Difference”, the AMA introduced the *Shine A Light* and *Community Connections* physician recognition programs.

**Youth Run Club**
2019-20 was a strange and wonderful year for the AMA Youth Run Club. We were fortunate to enjoy the continued financial support of Alberta Blue Cross as a Gold Level Sponsor and MD Financial Management as a Silver Level Sponsor. Like so many activities and programs, the Youth Run Club had to rejig, re-position and in some ways re-invent itself because of COVID-19.

**2019-20 YRC updates**

**Emerging Leaders in Health Care**
The Emerging Leaders in Health Promotion grant committee received 21 applications and approved seven projects from medical students and residents for funding in 2019-20. This program encourages medical student and resident physician members to collaborate with physician mentors to develop public health promotion activities in the community.

**2019-20 Emerging Leaders in Health Care projects**

**AMA Awards**
In recognition of the extraordinary circumstances caused by the pandemic, the AMA’s regular annual awards program was paused for the 2019-20 year. Instead of presenting our annual awards for Distinguished Service, Compassionate Service and the Medal of Honor, we took the opportunity to recognize the exceptional contributions of our public health physician members during the pandemic.

During the Fall 2020 RF and AGM we recognized and celebrated our Long-Service and Member Emeritus Award recipients.

AMA Long-Service Awards recognize physicians with 10 years of AMA service who contribute their knowledge, skill and time to the advancement of the profession. Their work, whether on the Board of Directors, its committees or service within their sections of medicine, supports and encourages the Association’s development.
AMA Member Emeritus Awards recognize significant contributions to the goals and aims of the AMA, seniority, long-term membership and distinguished service (20 years) based on criteria determined by the Board of Directors.

The AMA placed ads celebrating these outstanding physicians in Avenue Magazine (Calgary) and Edify Magazine (Edmonton). The ads will appear in early October.

The ad also celebrates Alberta physicians who were recognized by the CMA through their own awards program, including:

- Honorary Membership
- CMA John McCrae Memorial Medal
- CMA Award for Young Leaders, Resident Physician category

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
There are three main dimensions of the AMA’s Healthy Working Environments framework: Psycho-Social Wellness and Safety; Leadership; and Diversity and Inclusion. This framework, along with a preliminary identification of potential strategies, was advanced through our new Healthy Working Environments Advisory Committee. The Committee continued to meet and progress their work in 2019-20.

Healthy Working Environments update

Physician leadership
As a result of the COVID-19 pandemic, the AMA was only able to provide four of the eight leadership development courses to the general membership this year. Courses were offered in Edmonton and Calgary. This year’s topics included:

- Team Dynamics and Communication for Health Care Professionals
- Walk Your Talk: The Three Levels of Diversity & Inclusion
- The Spectrum of Behavior in Health Care; Communicating with the High Conflict Personality and Resolving Disruptive Behaviour
- Errors in Decision Making; why we make the wrong decisions with the “right” facts

To continue its support of leadership development in the AMA Board, six members of the Board were scheduled to attend the CMA Leadership Conference in Vancouver. The conference was cancelled due to the ongoing pandemic.
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 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
The AMA continued work to strengthen the Patient’s Medical Home for all Albertans in 2019-20.

The Accelerating Change Transformation Team continued training and network support for practice facilitators and physician champions, with workshops and follow up support in the field. ACTT program staff worked with PCN boards and physician leaders to accelerate understanding the value of the health transformation workforce and the transformational support they provide to primary health care and Patient’s Medical Home advancement.

ACTT also supported CII/CPAR implementation through project leadership with stakeholders, removing barriers for clinics, supporting implementation by training improvement facilitators and setting up PCNs to support their member clinics to implement.

The AMA continues to work toward improving system supports to members, clinics and their PCNs to enable the full delivery of the PMH model to all Albertans.

Integration
ACTT continued to support the Primary Care Alliance in their leadership consultations and recommendations and the Specialty Care Alliance with a synthesis of evidence for better transitions of care.

In 2019-20, ACTT provided guidance to AHS Primary Health Care Integration Network on appropriate consultation approaches and partnership role development for Home to Hospital to Home guidelines and implementation. ACTT supported PCNs with their planning and implementation of current primary care changes to support Home to Hospital to Home processes and behavior changes, as well as new provincial level primary care supports.

PCN Framework
ACTT supported PCN physician leaders provincially and within zones to understand the environment around shared services, as well as the benefits and risks of implementing the various opportunities for standard shared services.

As a member of the PCN zone support team, ACTT supported the PCN zonal committees, specifically the PCN physician leaders. ACTT also continued to work with NPC boards and their partnership with AHS as the joint venture of PCNs.
ACTT also supported PCN leads executive in renewing the Provincial PCN committee ministerial order to be extended with new and ongoing provincial priorities.

ACTT uncertainty
Unfortunately, since the spring and end of negotiations, the grant agreement remained unsigned, which meant all involved programs were left in limbo. Given the importance of these programs to physicians and the health care system, the AMA ceaselessly pushed for clarity on their future and underscored the value of retaining them within the AMA.

On July 22, the AMA was informed that the Accelerating Change Transformation Team grant to the AMA would continue to be funded for the period of April 1, 2020 - March 31, 2021. During that timeframe, Alberta Health will issue a Request for Proposal for the services that are currently provided by ACTT. The AMA will have the ability to submit a proposal to the RFP.

The grant to the AMA will include a wind down provision if ACTT does end or delivery is moved to other organizations after March 31, 2021.

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.

Income Equity Initiative
The Income Equity Initiative fits within the context of the AMA’s Physician Compensation Strategy. The Compensation Strategy emphasizes value for patients and fairness to physicians while identifying physician compensation objectives of equity, quality, access and productivity. The strategy also considers how other factors (such as informatics, peer review, etc.) have a role to play.

The AMA Board remained committed to the principles and aims of the Income Equity Initiative throughout 2019-20 in accordance with the components and milestones endorsed by the RF and Board. IEI studies continue to proceed with the Overhead Study and Market Assessment progressing, while the launch date for the Hours of Work study was delayed until the pandemic crisis and the resulting demands on physician time have passed. While it was anticipated that all IEI information would be gathered by the end of 2020, these timelines will need to be adjusted due to the impacts of the COVID-19.

The Overhead Working Group continues to engage members through a section representative panel to discuss and approve the Overhead Approach methodology. A similar approach will be used for the Hours of Work Study when it resumes. Section presidents and fees representatives, along with AMA Board members, have participated in the second Hours of Work Pilot.

Despite achieving ethics approval, AH expressed privacy concerns with the requested data for the empirical phase of the Market Assessment study. The Institute of Health Economics and AMA staff have developed a sampling strategy to address AH concerns. IHE is currently waiting for data from AH in order to proceed with the analysis.

Informatics
2019-20 recognized the advancement of key information management/information technology
initiatives supporting continuity of care through improvements in data sharing. These initiatives included: Connect Care, Community Information Integration/Central Patient Attachment Registry, Virtual Care, PrescribeIT and MyHealth Records.

Informatics update
The AMA business plan for 2019-20 included working to support initiatives that connect Albertans with enhanced service in areas such as e-care, virtual care, schedule modernization, and appropriateness management.

Virtual care has become a fixture of care in the community and this report has spoken to their presence as a result of AMA advocacy. Patients are being encouraged to partner in their own care and expansion of the patient portal via MyHealth Records is a sign of this trend. With facilitation by the AMA, community electronic medical record vendors have expedited development of patient portals to those systems, providing more ways for patients to communicate with physicians.

This single instance of multiple systems for similar purposes speaks to the need for increased integration in e-health systems. The AMA has backed strategic and tactical initiatives that improve informational continuity and enhance information integration in the system. There are many ways in which these objectives can be pursued and the AMA will focus its activities by monitoring and tracking where our input has made a difference as discussion leads to decision making by government and AHS. The year-end update explains what we have been doing:

- Working with CPSA, AH and other key health system stakeholders toward a Virtual Care Strategy for Alberta.
- Successfully advocating for community physician needs in the continuation of eDelivery results and clinical reports arising from Connect Care implementation.
- Working with government to advance Central Patient Attachment Registry and Community Information Integration: the chosen vehicle to integrate community EMRs with two-way data flow.

Obtaining a one-time grant from government to develop privacy-related support for community practices

Physician Supply
The AMA firmly believes that a needs-based plan is a lever that can be used to manage the budget.

The Physician Resource Planning Advisory Committee was a ministerial committee made up of Alberta government, Alberta Health Services and the AMA. Part of that committee’s mandate was to develop a needs-based plan that would effectively and fairly manage that supply and distribution of physicians in Alberta. Government dissolved the PRPC and regulations around implementing PRAC IDs are expected in the fall. To date, the AMA has not seen a draft of these regulations.

All of our negotiations proposals called for a budget management model. At time of writing, our latest proposal committed the AMA to managing the budget and covering utilization from existing physicians.
As of 2022, government’s legislation to control physician billing numbers will mean that they will have direct control over the number (and location) of new doctors. Since Bill 21 gave the Minister exclusive control over new physicians entering Alberta, the AMA proposed that government be responsible for paying for any “net new” physicians.

Both parties recognize that there are always challenges with getting physicians to all the places where they are needed. Managing physician supply is a complex matter, and that’s why our AMA proposal included a provision for the AMA to work with government on their physician supply strategy. We offered to continue to help develop a needs-based plan to identify the optimal number and distribution of physicians across the province.

The move to PRAC ID restrictions is obviously of critical importance to learners and early career physicians who must make decisions about where to study, match, train and transition to practice. While the COVID-19 situation distracted from work that might have been done in anticipation of the regulations, the AMA is planning work with PARA and the medical students associations as we move into fall.

Appropriateness and evidence-based practice
With the dissolution of the Appropriateness committee, the parties involved in supporting Choosing Wisely Alberta (AMA, Alberta Health, AHS and CPSA) met with representatives from U of C Physician Learning Program in the summer. The four organizations agreed to form a new Steering Committee to meet the needs of Choosing Wisely Canada. A terms of reference for the committee was developed and an inaugural meeting was held in September.

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
At time of writing, Albertapatients.ca had 12,739 members and was on target to exceed 13,000 patients by year-end. These numbers represent healthy growth of the community over the past year. The community continues to gather tracking of patient feedback on their primary care experiences (conducted roughly twice a year) and has now completed benchmarking of patient experiences with specialists as well. Over the past year, topics have ranged from childhood vaccination to diagnostic imaging experiences, as well providing unique insights from patients about their health and health needs during the COVID-19 pandemic, including their thoughts related to virtual care and in-office visits during the pandemic.

Albertapatients has also been helpful in our ongoing issues with the provincial government. While not directly advocating the AMA’s position through the platform, it did provide a very solid base of initial public participation for the patientsfirst.ca initiative by notifying members of the community. The platform also captured some timely and valuable information from patients relating to the early elements of the government’s Physician Funding Framework (most notably comparing patient views on the Minister’s approach vs. AMA’s approach in relation to complex modifiers). The community provided us with a thorough assessment of our Share the Care/#stayhealthyab campaign (which performed very well) and helped to leverage research efforts of other important stakeholders like AHS (Vaping/Smoking cessation study) and HQCA (COVID-19 study).
Indigenous Health
The Indigenous Health Committee approved work on a series of videos and articles that will focus on Indigenous approaches to health and wellness. The videos and articles will highlight some of the experiences, opportunities and challenges of providing health care in Indigenous communities. These videos/articles will be showcased in upcoming issues of Alberta Doctors’ Digest and other AMA platforms.

The IHC continues to collaborate with AHS to offer feedback and support in devising ways to increase the uptake of AHS’ Indigenous training course. The IHC also supports the idea of the AMA offering its own Indigenous course as part of its Health Care Leadership series to give greater access to physicians to complete this important training.

The following areas were identified as crucial to the work of the committee in 2020 and beyond:

- Increasing awareness of the positive side of Indigenous health care by showcasing positive stories and experiences via various AMA media
- Identifying gaps in health outcomes between Indigenous and non-Indigenous populations
- Continuing the work of the North Zone sub-committee to address the lack of access to primary care in Indigenous communities, particularly in the north
- Better understanding Jordan’s Principle to determine how the AMA can support Indigenous populations in this area.

HEALTHY AMA

Governance
As part of the 2019-20 business planning process, the Board reaffirmed the KRAs.

The AMA’s Healthy Working Environments Advisory Committee, with the support of experts from the Colbourne Institute for Inclusive Leadership, is developing a tool kit for Sections, Zones and others.

A broad range of leadership skill development support was offered early in the year, including direct leadership course offerings by Justice Heather Lamoureux and Elaine Seifert. Many planned development events and conferences in the second half of the year were put on hold because of COVID-19.

Workforce
A review of the AMA’s job evaluation process was also completed in 2019-20. A market evaluation was to be undertaken as a second phase, but given the financial challenges faced by members and the Association, a 5% staff salary reduction will be implemented effective November 1, 2020 and the market evaluation will be put on hold. We will also be conducting a position by position review of duties with an eye to shifting duties to cover gaps due to attrition, increasing workload and new priorities in the most cost effective manner.

A staff engagement survey was completed and organizational and branch results shared with staff. Organizational and branch priorities for improvement were identified, but much of the work was put in
abeyance as internal capacity shifted to respond to COVID-19 and the urgent need to shift all staff to a remote work environment to satisfy public health requirements.

Due to the COVID-19 pandemic, the AMA made the decision to shut our offices and on March 16, AMA staff began working remotely. Like many businesses and organizations across the world, the AMA quickly responded to the challenges of working remotely and used virtual solutions, such as Zoom, to maintain connections between leadership and staff during this challenging time.

Financial
Development of an enterprise risk management framework was put on hold with finance capacity pivoting to respond to the unilateral program changes implemented by government, including the transfer of MLR administration to government and the wind up of the CME program.

The AMA is in good financial health with fully funded Board reserves. As part of the business planning process this year, a number of direct savings and efficiencies were identified and incorporated into the upcoming budget, including a 5% reduction in staff salaries, committee honoraria rates and personal service contract rates, as well as a wide range of operational savings including travel and facility costs savings.

All accountability and reporting requirements related to external agreement funding are being satisfied.

Relationships
AMA/CMA Relationship
The strength of the AMA’s relationship with the CMA was critical during the challenging 2019-20 year. The AMA is very appreciative of the support and assistance the CMA demonstrated in many tangible ways.

The CMA came out publicly on several occasions to denounce the actions of the Alberta government and support our call for a fair negotiations process. CMA President, Dr. Sandy Buchman, personally raised concerns about the breakdown in negotiations with federal Health Minister, Patty Hajdu, both one-on-one and as part of a joint meeting with the presidents of the provincial and territorial medical associations. Dr. Buchman also attended the AMA’s Special Representative Forum meeting on July 18, 2020.

In addition to its public advocacy and support, the CMA doubled its initial financial commitment to help support the AMA's legal, research and advocacy efforts. An open letter of support to Alberta physicians was published on August 20. The letter asked all CMA members, and members of the public, to send an email to the Alberta government as part of a new letter writing campaign. The CMA continues to work with all the provincial/territorial medical associations on other ways to lend support to Alberta. Alberta’s physicians are extremely grateful for this strong support at the national level.

Working closely with the CMA, AMA members were given a choice with respect to continuing CMA membership in 2019/20. The AMA was pleased to see that roughly 90% of members maintained their CMA membership.
In addition to the Well Doc initiative already funded under the auspices of the AMA/CMA MOU, other opportunities were pursued, including a project supporting the AMA’s diversity and inclusiveness initiative and an initiative to support increased capacity in health policy.

**AMA/Alberta Health Services Relationship**

**AHS Review:**

In February, government released a long awaited Ernst & Young summary report of the *Alberta Health Services Performance Review*. The report highlights the need for an approach to health care that is based on continuous quality improvement. The report has 57 recommendations and a potential savings of $1.9 billion.

The AMA’s response was around several themes, as detailed in Dr. Molnar’s February 3 *President’s Letter*. The need to involve patients in decisions about their care and in the implementation of the report’s recommendations was key. Though empowerment of grassroots leadership has not been a hallmark of AHS, the AMA outlined physician engagement as another necessary success factor. Provider wellness is a final element for system transformation, and this requires focused attention as the Quadruple AIM model for health care improvement shows.

An implementation plan for the report recommendations was expected in late summer, but had not been released at time of writing. There are likely to be significant implications.

**Changes to Laboratory Services:**

AHS announced that in the fall of 2020 they would be seeking proposals from third-parties for the provision of community lab services in Alberta. A third-party will facilitate the Request for Proposal process, and in June AHS posted an RFP to source a facilitator. The Alberta Society of Laboratory Physicians was interested in being involved in both of these decisions and the AMA helped explore how to best accomplish this.

**Provincial Physician Liaison Forum:**

The PPLF is a senior advisory forum between AHS administration and the AMA. Representation from AHS includes the Vice President Quality and Chief Medical Officer, Dr. Francois Belanger, and a number of senior medical and quality affairs staff. Representatives from AMA are:

- Michael Gormley, Executive Director and Co-Chair
- Dr. Christine Molnar, President, term ends September 2020
- Dr. Shelley Duggan, Board of Directors appointment, terms ends April 30, 2023
- Dr. Ernst Schuster, Council of Zonal Leaders, terms ends December 2020
- Dr. Michel Sauvé, Representative Forum, term ends March 31, 2022
- Vacancy, Representative Forum, term ends September 30, 2023

Since the Spring 2020 RF, PPLF has met on June 19. The next meeting is scheduled for October 30.
The following items have been discussed:

- AMA Representative Forum Resolution
- MRI/CT/Endoscopies
- Physician Supply
- COVID-19
- Clinical Stipends and Z Codes
- Overhead Costs in AHS Facilities

Knowledge

With COVID-19 limiting opportunities for face-to-face events, the AMA offered webinars to support members in the areas of physician wellness, clinical ARP’s, business viability and virtual care. Over 3,500 members participated in the webinars.

Development of the AMA’s information management platform “Compass” continued with the new Membership and Accounting modules moved to production during the year. The implementation of new learning management and event management tools helped improve the AMA’s capability to deliver our mission and serve members.

A survey of members identified a number of opportunities to improve member’s website experience. This will allow us to focus on content and tools that are of highest priority to members. The selection of a content management tool is underway, with redevelopment of the website to begin in the new year.

Other Matters

Canadian Medical Association updates

The 2020 CMA Annual General Meeting was held virtually on Sunday, August 23. This marked the 153rd Annual General Meeting of the CMA. The 2020 AMA delegation consisted of 34 representatives:

- President-Elect
- Immediate Past President
- Speaker or Deputy Speaker
- Thirteen representatives from the Board/Representative Forum
- Eleven representatives named by the Nominating Committee
- Two deans of medicine (U of A and U of C) or designates
- One student representative
- One PARA representative
During the CMA Annual General Meeting, Dr. Ann Collins was installed as the CMA President for 2020-21.

Dr. Collins runs a full-time family practice in Fredericton, New Brunswick, which she started after serving three years with the Canadian Armed Forces in Kingston, Ontario. In addition to providing office and hospital care, she also provides nursing home care and was a family medicine residency teacher at Dalhousie University from 1998-2019. Dr. Collins graduated from Dalhousie University in 1985.

Dr. Collins has served as president of the New Brunswick Medical Society (NBMS) and spent five years as chair of the NBMS Board of Directors. She has led two NBMS governance reviews and served on the 2008 CMA Governance Review Committee Task Force. Her community involvement has been highlighted by a six-year term (two years as chair) on the board of governors of St. Thomas University, a leading liberal arts school in Fredericton.

President's Letters
In terms of member communications, there were 78 President’s Letters to members throughout 2019-20.

Member Surveys
In 2019-20 the AMA took the opportunity to reach out to members through two member surveys.

From April 14-24 the AMA conducted a detailed member survey, Urgent Needs and Preparing for What Comes Next 2020, to understand how members felt about critical issues facing the AMA. Almost 4,500 members (32%) responded. The results gave the AMA a clear picture of what was important to members and provided a foundation for our advocacy and planning. There were over 550 pages of verbatim comments and these thoughtful responses from members were greatly appreciated. A May 19 President’s Letter captured the major findings of the survey.

As many physicians struggled to keep afloat in their professional, financial and personal lives, the AMA conducted a member survey from June 30-July 3, Your Practice, Your Plans: Tell Us How You’re Doing, to take stock of how physicians were coping during these exceptionally difficult times. The survey yielded an excellent representative sample, with over 1,472 responses received. The results are accurate within +/- 2.4 percentage points. Meaning 19 times out of 20 the survey results are what they would be had the entire population of Alberta physicians participated. The July 9 President’s Letter provided members with an overview of the results. On July 10, the AMA issued a media release to inform the public about the concerning findings of the survey.

Alberta Doctors’ Digest
Alberta Doctors’ Digest continued to be a valuable and informative resource for members. From August 2019, the site was visited 60,000 times, regularly seeing over 2000 page views alone on the launch day of each issue, from a total of 31,000 unique visitors. This represents an increase of 10,000 pageviews over the previous year, and 15,000 new, unique visitors.

Board of Directors, Executive Committee and Representative Forum
During the 2020 AMA AGM, Dr. Paul Boucher will be installed as president for the 2020-21 year.
Dr. Boucher is an intensive care specialist in Calgary where he is also a clinical assistant professor in critical care medicine at the University of Calgary. Dr. Michelle Warren was the AMA Nominating Committee’s nominee for president-elect 2020-21.

2019-20 Board of Directors:

- Dr. Christine P. Molnar, President
- Dr. Paul E. Boucher, President-Elect
- Dr. Alison M. Clarke, Immediate Past President
- Dr. Shelley L. Duggan, Board member
- Dr. Howard Evans, Board member
- Dr. Tobias N.M. Gelber, Board member
- Dr. Sarah Hall, Board member
- Dr. Robert Korbyl, Board member
- Dr. Lloyd E. Maybaum, Board member
- Dr. Derek R. Townsend, Board member
- Dr. Wendy Tink, Board member
- Dr. Rick Ward, Board member
- Dr. Jennifer J. Williams, Board member
- Dr. Zia Saleh, PARA representative
- Khadija Nasser, MSA observer

The Board met as follows in 2019-20 (* denotes the regularly scheduled meetings):

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<th>2019</th>
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<td>April 11 (prep sessions for RF Breakout Groups)</td>
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2019-20 Executive Committee Officers:

- Dr. Christine P. Molnar – President
- Dr. Paul E. Boucher – President-Elect
- Dr. Alison M. Clarke – Immediate Past President

Executive Committee Board Representatives

- Dr. Sarah Hall, Board Member
- Dr. Jennifer Williams, Board Member

The Executive Committee met as follows in 2019-20 (* denotes the regularly scheduled meetings):

45
2019-20 Representative Forum Information:

The Spring 2020 RF March 13-14 was cancelled due to COVID-19. An RF Information Session was held on April 15 and ten follow-up Board RF Breakout Group sessions were held between April 17-21. A Special RF Session was also held on July 18.
Executive Director’s Report 2019-20

It has been an unprecedented year.

I appreciate that this first sentence could, in other years, appear somewhat tired and perhaps hyperbolic. A reading of this Annual Report, however, would be adequate in dispelling that view.

Underlying this year’s challenges lie two key events. The first was the COVID pandemic. The second was the government’s unilateral decisions to fundamentally disrupt the basic underpinnings of its relationship with physicians. These two events are not completely separate: physicians deserved greater support in the early months of COVID.

Despite the many challenges of this year, there were also positives and I want to ensure that these are also recognized.

First, the outstanding work of physicians and their health colleagues in fighting COVID needs to be celebrated. It’s during these times of crisis that one learns who can be counted on and health professionals certainly demonstrated their commitment to the health and well being of Albertans.

Second, physician leadership shone throughout the year. Within the AMA this includes the Board, Representative Forum, sections, committees and the Joint Task Force, but also those physicians who spoke out and took action in social media and directly within their communities. Combined with efforts from the zone medical staff associations and groups that have sprung up, such as Alberta Doctors for Patients and others, the harm being done to our health care is being laid out clearly. Public opinion surveys done by the AMA and others show that the messages are being heard.

Third, the work and support of the Canadian Medical Association is greatly appreciated. Provincial medical associations across Canada have also lent their voices expressing concerns about the situation we face in Alberta.

Fourth, AMA staff have been directly impacted by this year’s challenges. Their willingness to pitch in, participate in difficult conversations and then adapt in the best overall interest of the AMA membership has been an inspiration for me.

It’s certainly possible that next twelve months will have a lot in common with this last twelve: COVID is not going away anytime soon; government is still relatively early in its mandate. The commitment of physicians to their patients and their profession, however, is both of greater duration and endurance. Our plans going into 2021-22 need to reflect and build on this, remaining flexible in responding to challenges while also promoting value for patients wherever we can. Ultimately, this will carry the day.
Proposed Amendments AMA Bylaws

Memorandum
Date: July 21, 2020
To: Alberta Medical Association Members
From: Dr. Brock Debenham, Chair, Committee on Bylaws
Subject: Proposed changes – AMA Bylaws

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

Virtual AGM

- Clause 10.2 can reasonably be interpreted to permit an e-meeting and further the bylaws allow attendance at meetings to be by electronic means. However, the suggested revision provides further clarity with respect to convening of the AGM electronically.

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<th>PROPOSED WORDING</th>
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<td>10.2 The AGM shall be convened at such time and place as determined by the Board and may be held electronically.</td>
<td>10.2 The AGM shall be convened at such time and place as determined by the Board.</td>
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Alberta Nominees to the CMA Board of Directors

- To be a division of the CMA the AMA is required to amend its bylaws where necessary to place them in harmony with the CMA.
- In April 2020 the CMA board approved changes to its Operating Rules creating a joint CMA/Divisional process for the nomination of provincial board members.
12.2 Each year, the CMA Nominations Committee will notify the provinces/territories of upcoming vacancies on the Board of Directors.

12.2.1 The Nominations Working Group composed of CMA Nominations Committee Chair and CMA Appointments Committee Chair and 2 provincial/territorial individuals is responsible for reviewing expressions of interest received by the province/territory and to select one candidate to recommend to the CMA Nominations Committee. It consists of two representatives each from the CMA and the province/territory. It may interview one or more candidates as part of its review of the nominations.

12.2.2 The CMA will issue a call for nominations, and provide the provinces/territories which have upcoming vacancies on the Board with:
   (a) a schedule for the nominations process,
   (b) nominations documents (including a nomination form and self-assessment skills questionnaire), and
   (c) a list of the skills and experience that reflects the Association’s needs.

The call for nominations will stipulate candidates who are willing to hold office for up to 6 years.

12.2.3 A province/territory for which there is an upcoming vacancy on the Board of Directors will initiate the following nomination process:

   (a) Appoint 2 members to the Nominations Working Group.
   (b) Select a deadline date for accepting nominations, allowing time for the Nominations Working Group to meet and possibly interview candidates prior to the CMA’s deadline for submissions.
   (c) Upload the nominations documents provided by CMA to the province/territory’s website (or link to CMA’s site), and communicate requirements for additional documents to be submitted, such as a message of intent, skills questionnaire and a short biography.
   (d) Prepare a schedule of communications for promoting the call for nominations in the jurisdiction.
   (e) Review the nominations against the selection criteria and provide to the Nominations Working Group.

Therefore, to maintain the involvement of the Forum in the process while harmonizing the AMA bylaws with the CMA bylaws two change are proposed.
<table>
<thead>
<tr>
<th>PROPOSED WORDING</th>
<th>PRESENT WORDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.12 “CMA’s Nominations Working Group” means the nominations working group established by the CMA to select one candidate from amongst the nominations received to recommend to the CMA nominations committee to serve as the provincial CMA board member.</td>
<td>12.3 (v) The Forum shall elect the Association’s representatives to the CMA Board of Directors.</td>
</tr>
<tr>
<td>12.3 (v) The Forum shall elect the Association’s representatives to the CMA’s Nominations Working Group.</td>
<td></td>
</tr>
<tr>
<td>23.7 (iv) The committee shall provide to the Forum, a list of nominees for the representatives to the CMA’s Nominations Working Group.</td>
<td>23.7 (iv) The committee shall provide to the Forum, a list of nominees for the Directors of the CMA Board.</td>
</tr>
</tbody>
</table>

Increase to the number of alternates to the Nominating Committee

- This recommendation was received from the Nominating Committee.
- The “alternate” system was introduced several years ago to avoid having Nominating Committee members recused from parts of meetings if they were standing for nomination. One alternate is chosen by each of the Board, RF and AGM.
- The Nominating Committee noted that frequently alternates are unavailable and suggested that the pool of alternates be increased to six from the current three, i.e., two alternates from each contributing group.
**PROPOSED WORDING** | **PRESENT WORDING**
---|---
23.2 two additional alternate members to serve in place of or elected or appointed committee members who wish to be considered as a committee nominee for an elected position. The One of the alternates from the same electing or appointing group as the member being considered for an elected position (selected through a process determined by the Board) will serve as the alternate for that meeting if reasonably possible, otherwise from the remaining alternates through a process determined by the Board. | 23.2 one additional alternate member to serve in place of or elected or appointed committee members who wish to be considered as a committee nominee for an elected position. The alternate from the same electing or appointing group as the member being considered for an elected position will serve as the alternate for that meeting if reasonably possible, otherwise from the remaining alternates through a process determined by the Board.

**Determination of the timing for election of Zone Delegates and AMHSP Arrangement Representatives**

- Currently the bylaws require the Board to determine the timing of elections for zonal Delegates to the Forum and AMHSP Arrangement Representatives.
- To ensure elections need not be delayed until the next board meeting it is recommended that the timing of elections for zonal Delegates to the Forum and AMHSP Arrangement Representatives be determined by the Executive Director.

**PROPOSED WORDING** | **PRESENT WORDING**
---|---
36.1 Election for zonal Delegates to the Forum and AMHSP Arrangement Representatives shall be under the management of the Executive Director and shall be held at such a time as shall be determined by the Board Executive Director. | 36.1 Election for zonal Delegates to the Forum and AMHSP Arrangement Representatives shall be under the management of the Executive Director and shall be held at such a time as shall be determined by the Board.
Appointment of scrutineers for referenda and elections

- Current AMA Bylaws require the Board to appoint scrutineers at election.
- To ensure elections need not be delayed until the next board meeting it is recommended that the Executive Director appoint the scrutineers.

<table>
<thead>
<tr>
<th>PROPOSED WORDING</th>
<th>PRESENT WORDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.3 The Executive Director shall appoint two or more Members to act as scrutineers at the election.</td>
<td>34.3 The Board shall appoint two or more Members to act as scrutineers at the election.</td>
</tr>
</tbody>
</table>

Editorial Amendments
Non-substantive changes were also made to correct page numbering and/or typographical errors.
Independent auditor’s report

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

Our opinion

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of Alberta Medical Association (C.M.A. Alberta Division) and its subsidiaries (together, the Entity) as at September 30, 2019 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.

What we have audited
The Entity’s consolidated financial statements comprise:

- the consolidated statement of financial position as at September 30, 2019;
- the consolidated statement of changes in net assets for the year then ended;
- the consolidated statement of operations for the year then ended;
- the consolidated statement of cash flows for the year then ended; and
- the notes to the consolidated financial statements, which include a summary of significant accounting policies.

Basis for opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor’s responsibilities for the audit of the consolidated financial statements section of our report.

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

Independence
We are independent of the Entity in accordance with the ethical requirements that are relevant to our audit of the consolidated financial statements in Canada. We have fulfilled our other ethical responsibilities in accordance with these requirements.

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

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with Canadian 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.

In preparing the consolidated financial statements, management is responsible for assessing the Entity’s ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Entity or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Entity’s financial reporting process.

**Auditor’s responsibilities for the audit of the consolidated financial statements**

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

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

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

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

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

PricewaterhouseCoopers LLP
Chartered Professional Accountants

Edmonton, Alberta
February 6, 2020
Alberta Medical Association (C.M.A. Alberta Division)
Consolidated Statement of Financial Position
As at September 30, 2019

<table>
<thead>
<tr>
<th></th>
<th>General Fund</th>
<th>Contingency Reserve Fund</th>
<th>Premium Reserve Fund</th>
<th>Total $</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>6,231,131</td>
<td>7,304,574</td>
<td>1,208,428</td>
<td>17,801,330</td>
<td>7,141,359</td>
</tr>
<tr>
<td>Funds held on deposit note 10</td>
<td>-</td>
<td>-</td>
<td>1,178,413</td>
<td>1,178,413</td>
<td>1,178,413</td>
</tr>
<tr>
<td>Accounts receivable and prepaid expenses</td>
<td>828,225</td>
<td>-</td>
<td>78,552</td>
<td>828,225</td>
<td>828,225</td>
</tr>
<tr>
<td>Due from administered programs note 2</td>
<td>1,095,857</td>
<td>-</td>
<td>1,098,857</td>
<td>1,095,857</td>
<td>1,095,857</td>
</tr>
<tr>
<td>Due from Alberta Medical Foundation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Due from AAMA Health Benefits Trust Fund (note 11)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>10,915,194</td>
<td>7,304,574</td>
<td>2,463,793</td>
<td>20,683,561</td>
<td>10,147,237</td>
</tr>
<tr>
<td><strong>Portfolio investments</strong> (note 4)</td>
<td>-</td>
<td>15,075,802</td>
<td>12,331,185</td>
<td>27,406,987</td>
<td>27,406,987</td>
</tr>
<tr>
<td>Due (to) from other funds</td>
<td>9,084,448</td>
<td>9,372,814</td>
<td>(189,270)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employee future benefits (note 5)</td>
<td>5,015,814</td>
<td>-</td>
<td>-</td>
<td>5,015,814</td>
<td>5,015,814</td>
</tr>
<tr>
<td>Property and equipment (note 5)</td>
<td>8,152,768</td>
<td>-</td>
<td>-</td>
<td>8,152,768</td>
<td>8,152,768</td>
</tr>
<tr>
<td></td>
<td>15,018,333</td>
<td>32,656,190</td>
<td>12,520,309</td>
<td>60,194,832</td>
<td>45,256,937</td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>7,022,639</td>
<td>2,408</td>
<td>1,209,366</td>
<td>8,634,413</td>
<td>6,333,153</td>
</tr>
<tr>
<td>Due to Alberta Medical Foundation</td>
<td>1,974</td>
<td>-</td>
<td>-</td>
<td>1,974</td>
<td>-</td>
</tr>
<tr>
<td>Payable to Canadian Medical Association</td>
<td>333,659</td>
<td>-</td>
<td>333,659</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Deferred membership revenue (note 5)</td>
<td>4,966,613</td>
<td>-</td>
<td>-</td>
<td>4,966,613</td>
<td>-</td>
</tr>
<tr>
<td>Deferred leasehold inducements and other (note 7)</td>
<td>145,995</td>
<td>-</td>
<td>145,995</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>12,289,457</td>
<td>2,408</td>
<td>1,209,366</td>
<td>14,905,229</td>
<td>6,333,153</td>
</tr>
<tr>
<td><strong>Deferred leasehold inducements and other</strong> (note 7)</td>
<td>1,092,375</td>
<td>-</td>
<td>-</td>
<td>1,092,375</td>
<td>1,092,375</td>
</tr>
<tr>
<td></td>
<td>13,381,832</td>
<td>2,408</td>
<td>1,209,366</td>
<td>15,099,606</td>
<td>7,425,528</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,034,571</td>
<td>32,656,190</td>
<td>12,520,309</td>
<td>60,177,552</td>
<td>45,256,937</td>
</tr>
</tbody>
</table>

**Commitments** (note 17)

Approved by the Board of Directors

[Signatures]

The accompanying notes are an integral part of these consolidated financial statements.
<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Fund</strong></td>
<td><strong>Contingency Reserve Fund</strong></td>
<td><strong>Premium Reserve Fund</strong></td>
</tr>
<tr>
<td>Net assets – Beginning of year</td>
<td>8,204,329</td>
<td>22,438,729</td>
</tr>
<tr>
<td>Net revenue (expense) for the year</td>
<td>2,449,109</td>
<td>779,461</td>
</tr>
<tr>
<td>Remeasurement of employee future</td>
<td>1,624,117</td>
<td>-</td>
</tr>
<tr>
<td>benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund transfers (note 16)</td>
<td>(9,242,984)</td>
<td>9,434,504</td>
</tr>
<tr>
<td>Net assets – End of year</td>
<td>1,034,571</td>
<td>32,852,894</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, 2019

<table>
<thead>
<tr>
<th></th>
<th>2019 Total</th>
<th>2018 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member dues (note 6)</td>
<td>10,068,310</td>
<td>17,034,464</td>
</tr>
<tr>
<td>Fees and commissions</td>
<td>3,076,818</td>
<td>2,548,296</td>
</tr>
<tr>
<td>Investment income (note 9)</td>
<td>265,705</td>
<td>1,151,589</td>
</tr>
<tr>
<td>Other</td>
<td>1,153,182</td>
<td>1,313,114</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23,562,013</td>
<td>22,047,462</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expenditures (schedule 1)</strong></th>
<th>2019 Total</th>
<th>2018 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate affairs</td>
<td>6,862,972</td>
<td>8,619,811</td>
</tr>
<tr>
<td>Executive office</td>
<td>3,780,999</td>
<td>2,901,679</td>
</tr>
<tr>
<td>Committees (schedule 2)</td>
<td>2,106,621</td>
<td>2,316,796</td>
</tr>
<tr>
<td>Health policy and economics</td>
<td>2,102,237</td>
<td>1,976,674</td>
</tr>
<tr>
<td>Public affairs</td>
<td>1,989,688</td>
<td>2,051,050</td>
</tr>
<tr>
<td>Priority projects</td>
<td>1,922,595</td>
<td>2,833,467</td>
</tr>
<tr>
<td>Professional affairs</td>
<td>1,003,666</td>
<td>953,356</td>
</tr>
<tr>
<td>Southern Alberta Office</td>
<td>743,923</td>
<td>652,285</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20,312,741</td>
<td>22,308,052</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Realization of insurance experience (note 10)</th>
<th>2019 Total</th>
<th>2018 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3,249,272</td>
<td>2,438,036</td>
</tr>
<tr>
<td></td>
<td>779,481</td>
<td>(260,590)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee future benefits</th>
<th>2019 Total</th>
<th>2018 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(800,133)</td>
<td>(800,133)</td>
<td>(788,867)</td>
</tr>
</tbody>
</table>

**Net revenue (expense) for the year**

- 2019: 2,448,109
- 2018: 1,730,884

4,179,993

2,208,805

---

The accompanying notes are an integral part of these consolidated financial statements.
Alberta Medical Association (C.M.A. Alberta Division)
Consolidated Statement of Cash Flows
For the year ended September 30, 2019

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash provided by (used in)</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Operating activities</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Net revenue (expense) for the year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>2,449,109</td>
<td>527,671</td>
</tr>
<tr>
<td>Contingency Reserve Fund</td>
<td>779,461</td>
<td>517,779</td>
</tr>
<tr>
<td>Premium Reserve Fund</td>
<td>1,730,864</td>
<td>(3,254,255)</td>
</tr>
<tr>
<td><strong>Items not affecting cash</strong></td>
<td>4,959,464</td>
<td>(2,268,805)</td>
</tr>
<tr>
<td>Amortization (note 5)</td>
<td>1,340,879</td>
<td>1,165,055</td>
</tr>
<tr>
<td>Gain on portfolio investments (note 9)</td>
<td>(558,863)</td>
<td>(258,240)</td>
</tr>
<tr>
<td>Gain on pension benefit</td>
<td>(554,968)</td>
<td>(366,938)</td>
</tr>
<tr>
<td><strong>Net change in non-cash working capital items (note 13)</strong></td>
<td>7,459,464</td>
<td>(2,444,092)</td>
</tr>
<tr>
<td><strong>Investing activities</strong></td>
<td>12,648,176</td>
<td>(4,111,020)</td>
</tr>
<tr>
<td>Additions to property and equipment</td>
<td>(1,266,660)</td>
<td>(1,171,054)</td>
</tr>
<tr>
<td>Purchase of portfolio investments</td>
<td>(1,498,228)</td>
<td>(8,825,947)</td>
</tr>
<tr>
<td>Proceeds from sale of portfolio investments</td>
<td>774,466</td>
<td>10,184,588</td>
</tr>
<tr>
<td><strong>Increase (decrease) in cash during the year</strong></td>
<td>(1,988,462)</td>
<td>2,187,587</td>
</tr>
<tr>
<td><strong>Cash – Beginning of year</strong></td>
<td>10,659,774</td>
<td>(1,023,433)</td>
</tr>
<tr>
<td><strong>Cash – End of year</strong></td>
<td>7,141,359</td>
<td>9,064,792</td>
</tr>
<tr>
<td></td>
<td>17,801,133</td>
<td>7,141,359</td>
</tr>
</tbody>
</table>

The accompanying notes are an integral part of these consolidated financial statements.
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. (AMahi), a wholly owned subsidiary, which during most of the year owned and operated 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, revenue 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, 2019, which is the most recent fiscal year of the programs, and amounts owing from these programs as at September 30 are as follows:

Summary by program

<table>
<thead>
<tr>
<th>Program</th>
<th>Revenue</th>
<th>Expenses</th>
<th>Net change in reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistance and Support Programs</td>
<td>109,210,024</td>
<td>109,210,024</td>
<td>-</td>
</tr>
<tr>
<td>Physician Locum Services</td>
<td>26,868,867</td>
<td>26,868,867</td>
<td>-</td>
</tr>
<tr>
<td>Electronic Medical Records Completion Project</td>
<td>2,388,093</td>
<td>2,388,291</td>
<td>(108)</td>
</tr>
<tr>
<td>Primary Health Care Opioid Response Project</td>
<td>838,517</td>
<td>838,517</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>141,915,501</strong></td>
<td><strong>141,915,699</strong></td>
<td><strong>(108)</strong></td>
</tr>
</tbody>
</table>
Due from administered programs

<table>
<thead>
<tr>
<th>Program</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistance and Support Programs</td>
<td>1,088,427</td>
<td>52,093</td>
</tr>
<tr>
<td>Alternate Relationship Plan Program Management Office</td>
<td>-</td>
<td>867,305</td>
</tr>
<tr>
<td>Primary Care Initiative Program Management Office</td>
<td>-</td>
<td>64,429</td>
</tr>
<tr>
<td>Other</td>
<td>88,430</td>
<td>82,112</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,068,857</strong></td>
<td><strong>1,075,939</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 (ASNPC). 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.
Changes in accounting policy

The Capital Reserve Fund was originally established to sustain and maintain the property and equipment requirements of the Association, which included funding the additions and amortization of those assets. During the year, AMA made an accounting policy choice to integrate the Capital Reserve Fund with the General Fund to better reflect the unrestricted net assets available for AMA to support the ongoing activities and present the financial information in a more useable format.

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 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 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, due from AMA Health Benefits Trust Fund 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 Type</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>Software</td>
<td>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, 2018.

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 of 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 improvement (note 7) 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.

4 Portfolio investments

<table>
<thead>
<tr>
<th>Fund</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerald Canadian Short-Term Investment</td>
<td>19,071,571</td>
<td>18,143,530</td>
</tr>
<tr>
<td>Fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emerald Low Volatility Global Equity</td>
<td>2,826,717</td>
<td>2,762,678</td>
</tr>
<tr>
<td>Emerald Global Equity Pooled Fund</td>
<td>2,857,138</td>
<td>2,869,319</td>
</tr>
<tr>
<td>Emerald Canadian Equity Index Fund</td>
<td>1,602,902</td>
<td>1,484,258</td>
</tr>
<tr>
<td>Total portfolio investments – at quoted fair value</td>
<td>26,309,308</td>
<td>25,020,983</td>
</tr>
<tr>
<td>Total portfolio investments – at cost</td>
<td>25,083,122</td>
<td>25,165,600</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></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Land</td>
<td>660,000</td>
<td>660,000</td>
<td>660,000</td>
</tr>
<tr>
<td>Building</td>
<td>5,270,000</td>
<td>1,886,580</td>
<td>3,383,420</td>
</tr>
<tr>
<td>Fixtures and improvements</td>
<td>2,831,291</td>
<td>1,280,807</td>
<td>1,550,484</td>
</tr>
<tr>
<td>Computers</td>
<td>4,781,944</td>
<td>3,406,844</td>
<td>1,375,100</td>
</tr>
<tr>
<td>Software</td>
<td>1,891,399</td>
<td>426,724</td>
<td>1,464,675</td>
</tr>
<tr>
<td>Office furniture and equipment</td>
<td>1,355,837</td>
<td>1,077,745</td>
<td>278,092</td>
</tr>
<tr>
<td></td>
<td>16,140,271</td>
<td>7,971,482</td>
<td>8,168,789</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
<th>Accumulated amortization</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td></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>1,475,790</td>
<td>3,794,210</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>3,674,239</td>
<td>3,038,188</td>
<td>636,052</td>
</tr>
<tr>
<td>Software</td>
<td>1,035,817</td>
<td>103,002</td>
<td>932,815</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></td>
<td>14,873,611</td>
<td>6,630,603</td>
<td>8,243,008</td>
</tr>
</tbody>
</table>

Amortization for administered programs is recognized in the administered programs. In the current year, amortization was recognized in the General Fund for a total expense of $1,340,879 (2018 – $1,165,055).

During the year, the Board of Directors of AMA Holdings Inc. approved the transfer of net assets from AMAHI to the Association. As the fair value of the property and equipment was in excess of the adjusted cost base, a capital gain was recognized for tax purposes. Included in accounts payable and accrued liabilities is $358,911, which represents the estimated taxes payable related to this transaction. The estimated tax expense is included in corporate affairs expenditures in the consolidated statement of operations.
# Alberta Medical Association (C.M.A. Alberta Division)
## Notes to Consolidated Financial Statements
### September 30, 2019

### 6 Deferred membership revenue

<table>
<thead>
<tr>
<th></th>
<th>Balance – October 1, 2018</th>
<th>Net amount received</th>
<th>Recognized as revenue</th>
<th>Balance – September 30, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fund</td>
<td></td>
<td>$ 24,033,125</td>
<td>$ 19,086,310</td>
<td>$ 4,066,815</td>
</tr>
</tbody>
</table>

### 7 Deferred leasehold inducements and other

<table>
<thead>
<tr>
<th></th>
<th>Balance – October 1, 2018</th>
<th>Net amount received</th>
<th>Recognized in net revenue</th>
<th>Balance – September 30, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Medical Foundation</td>
<td>35,195</td>
<td>118,010</td>
<td>126,521</td>
<td>26,684</td>
</tr>
<tr>
<td>Other</td>
<td>2,500</td>
<td>122,328</td>
<td>44,664</td>
<td>80,164</td>
</tr>
<tr>
<td>Leasehold inducements</td>
<td>1,385,149</td>
<td>-</td>
<td>253,667</td>
<td>1,131,482</td>
</tr>
<tr>
<td></td>
<td>1,422,844</td>
<td>240,338</td>
<td>424,852</td>
<td>1,238,330</td>
</tr>
</tbody>
</table>

<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 Foundation</td>
<td>70,325</td>
<td>217,805</td>
<td>261,935</td>
<td>35,195</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>1,848,273</td>
<td>-</td>
<td>283,124</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>

Deferred membership revenue represents membership dues collected during the fiscal year but related to the subsequent membership year.

Leasehold inducements and other to be settled within one year of September 30, 2019 represent $145,655 (2018 – $279,874) 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, 2018, and the next required valuation will be as at December 31, 2019.

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets</td>
<td>$35,041,672</td>
<td>$31,248,856</td>
</tr>
<tr>
<td>Accrued benefit obligation</td>
<td>$30,625,858</td>
<td>$28,412,147</td>
</tr>
<tr>
<td>Plan surplus</td>
<td>$5,015,814</td>
<td>$2,836,709</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:

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>4.75%</td>
<td>4.75%</td>
</tr>
<tr>
<td>Rate of compensation increase</td>
<td>3.00% + SMP</td>
<td>3.00% + SMP</td>
</tr>
<tr>
<td>Inflation</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

Total cash payments for employee future benefits for 2019, consisting of cash contributed by the Association to the registered pension plan, was $1,603,789 (2018 – $1,445,842). Cash contributions received from administered programs and remitted to the pension plan were $683,796 (2018 – $575,724).

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

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee future benefit – opening balance</td>
<td>$2,836,709</td>
<td>$2,130,500</td>
</tr>
<tr>
<td>Net benefit plan expense</td>
<td>(1,267,726)</td>
<td>(1,160,229)</td>
</tr>
<tr>
<td>Remeasurement of employee future benefits</td>
<td>1,873,043</td>
<td>400,563</td>
</tr>
<tr>
<td>Gross employer contributions</td>
<td>1,003,738</td>
<td>1,445,842</td>
</tr>
<tr>
<td>Employee future benefit – ending balance</td>
<td>$5,015,814</td>
<td>$2,836,709</td>
</tr>
</tbody>
</table>
Alberta Medical Association (C.M.A. Alberta Division)
Notes to Consolidated Financial Statements
September 30, 2019

9 Investment income

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio interest and dividend income</td>
<td>820,105</td>
<td>718,701</td>
</tr>
<tr>
<td>Gain on portfolio investments</td>
<td>556,863</td>
<td>258,240</td>
</tr>
<tr>
<td>Interest income</td>
<td>265,736</td>
<td>178,648</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,642,473</strong></td>
<td><strong>1,151,589</strong></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 gain of $3,321,681 (2018 – loss of $1,159,348) was recognized during the year with $1,179,413 (2018 – $1,176,413) recorded as funds on deposit.

As a result of the historical positive experience in aggregate, the Association has provided premium rate reductions for a number of years. The 2019 premium reduction of $2.3 million (2018 – $2.5 million) is funded from the Premium Reserve Fund.

11 Related party transactions

During the year, the Association recognized administration fees totalling $432,393 (2018 – $408,224) from the AMA Health Benefits Trust Fund. The $333,665 owing to AMA Health Benefits Trust Fund at the end of the year relates to a service provider paying the Association as opposed to AMA Health Benefits Trust Fund. This amount was paid from the Association subsequent to year-end to clear this amount owing. In the prior year, $35,213 remained due from the AMA Health Benefits Trust Fund related to the collection of administration fees on the Association’s behalf.

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 $1,896,597 (2018 – $1,989,158).

Cost recoveries relate to costs incurred on behalf of the programs administered by AMA. Cost recoveries include administrative expenses, support staff salaries and benefits, insurance, rent and hosting fees. The costs are allocated to the programs based on cost drivers that appropriate the underlying nature of the transactions. These cost drivers are applied in a consistent manner from year to year.

13 Net change in non-cash working capital items

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>1,901,285</td>
<td>333,845</td>
</tr>
<tr>
<td>Due from/to AMA Health Benefits Trust Fund</td>
<td>368,878</td>
<td>80,299</td>
</tr>
<tr>
<td>Deferred membership revenue</td>
<td>4,666,815</td>
<td>(3,040,579)</td>
</tr>
<tr>
<td>Payable to Canadian Medical Association</td>
<td>317,839</td>
<td>(855,920)</td>
</tr>
<tr>
<td>Due from administered programs</td>
<td>(20,918)</td>
<td>983,635</td>
</tr>
<tr>
<td>Accounts receivable and prepaid expenses</td>
<td>106,525</td>
<td>426,183</td>
</tr>
<tr>
<td>Deferred leasehold inducements and other</td>
<td>(184,514)</td>
<td>(304,754)</td>
</tr>
<tr>
<td>Funds held on deposit</td>
<td>-</td>
<td>(40,535)</td>
</tr>
<tr>
<td>Due from/to Alberta Medical Foundation</td>
<td>3,624</td>
<td>(5,206)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,459,494</strong></td>
<td><strong>(2,444,062)</strong></td>
</tr>
</tbody>
</table>

14 Government remittances

Government remittances consist of amounts other than income taxes (such as sales taxes and payroll withholding taxes), which are payable or receivable from government authorities and recognized when the amounts become payable or receivable. Included in accounts payable and accrued liabilities are government remittances payable of $234,081 (2018 – receivable of $48,067) related to sales taxes. Income taxes payable have been outlined in note 5.

15 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.

(10)
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.

16 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, $9,454,504 (2018 – $1,120,935) was transferred to the Contingency Reserve Fund. The transfer relates to the building transfer (note 6), employee future benefit appreciation and others items noted during the year.

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. For the fiscal year ended September 30, 2018, $191,520 (2018 – $254,620) was transferred from the Premium Reserve Fund.
17 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:

\[
\begin{array}{ll}
\text{Year} & \text{Rent} \\
2020 & 648,772 \\
2021 & 648,772 \\
2022 & 650,156 \\
2023 & 670,022 \\
2024 & 628,564 \\
Thereafter & 884,139 \\
\hline
\text{Total} & 4,237,325
\end{array}
\]

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

Consolidated Schedule of Expenditures

For the year ended September 30, 2019

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>7,107,642</td>
<td>6,628,010</td>
</tr>
<tr>
<td>Purchased services</td>
<td>3,818,497</td>
<td>4,001,813</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>2,302,671</td>
<td>2,288,267</td>
</tr>
<tr>
<td>Insurance discount premium</td>
<td>2,134,000</td>
<td>2,403,883</td>
</tr>
<tr>
<td>Committee per diem and travel</td>
<td>2,106,821</td>
<td>2,318,708</td>
</tr>
<tr>
<td>Amortization</td>
<td>1,223,382</td>
<td>1,082,454</td>
</tr>
<tr>
<td>Zone grants</td>
<td>759,708</td>
<td>748,935</td>
</tr>
<tr>
<td>Facilities</td>
<td>728,229</td>
<td>406,022</td>
</tr>
<tr>
<td>Equipment maintenance</td>
<td>640,210</td>
<td>513,317</td>
</tr>
<tr>
<td>Investment and bank fees</td>
<td>451,548</td>
<td>233,441</td>
</tr>
<tr>
<td>Travel and accommodation</td>
<td>407,321</td>
<td>478,867</td>
</tr>
<tr>
<td>Scholarships</td>
<td>111,000</td>
<td>147,000</td>
</tr>
<tr>
<td>Communications production</td>
<td>90,204</td>
<td>162,357</td>
</tr>
<tr>
<td>Stationery and office supplies</td>
<td>91,138</td>
<td>64,750</td>
</tr>
<tr>
<td>Postage and courier</td>
<td>83,375</td>
<td>112,245</td>
</tr>
<tr>
<td>Section support</td>
<td>78,340</td>
<td>71,525</td>
</tr>
<tr>
<td>Subscriptions and publications</td>
<td>74,693</td>
<td>95,802</td>
</tr>
<tr>
<td>Sundry</td>
<td>70,101</td>
<td>76,867</td>
</tr>
<tr>
<td>Insurance</td>
<td>67,202</td>
<td>68,131</td>
</tr>
<tr>
<td>Telephone</td>
<td>58,628</td>
<td>58,741</td>
</tr>
<tr>
<td>Equipment purchases</td>
<td>10,643</td>
<td>26,110</td>
</tr>
</tbody>
</table>

22,500,745  22,308,052
# Alberta Medical Association (C.M.A. Alberta Division)

## Consolidated Schedule of Committee Expenditures

For the year ended September 30, 2019

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representative Forum</td>
<td>873,667</td>
<td>1,110,011</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>583,818</td>
<td>661,442</td>
</tr>
<tr>
<td>CMA General Council</td>
<td>290,278</td>
<td>196,175</td>
</tr>
<tr>
<td>Executive Committee</td>
<td>23,265</td>
<td>24,129</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,770,768</td>
<td>2,000,757</td>
</tr>
</tbody>
</table>

| **Other committees**   |          |          |
| Compensation           | 67,437   | 115,621  |
| AMHSP Advisory Committee| 50,283  |          |
| Other committees       | 52,426   | 33,999   |
| Nominating Committee   | 39,551   | 37,950   |
| Committee on Financial Audit | 31,359 | 27,000  |
| Health Issues Council  | 26,138   | 26,821   |
| Indigenous Health      | 23,169   | 12,636   |
| Council of Presidents  | 14,948   | 8,648    |
| Primary Care Alliance  | 12,090   | 10,489   |
| Specialty Care Alliance| 3,594   | 2,807    |
| Provincial Physician Liaison Forum | 3,431 | 5,501 |
| Committee on Student Affairs | 1,278 | 850    |
| Committee on Bylaws    | 1,239    | 2,265    |
| Committee on Government Affairs | -    | 6,259  |
| Property & Casualty Insurance Review | -    | 14,018 |
| Primary Care Network Executive Committee | - | 11,288 |
| **Total**              | 335,853  | 316,039  |

**Total: 2,106,621**

**2018: 2,316,798**