OHQC Ontario Health Quality Council

COQSS Conseil ontarien de la qualité des services de santé

Annual Report and Financial Statements 2007/2008

Ontario

Ontario Health Quality Council

Conseil ontarien de la qualité des services de santé

Ontario Health Quality Council
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Letter of Transmittal

September 22nd, 2008

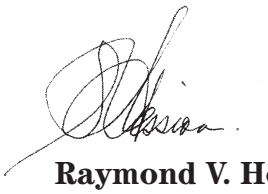
Honourable David Caplan
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto ON M7A 2C4

Dear Minister:

On behalf of the Ontario Health Quality Council, I have the honour to present you with our 2007-2008 annual report. The report reviews the council's performance for its second full year of operations and provides audited financial statements.

Thank you for your support of the Ontario Health Quality Council's work.

Respectfully,



Raymond V. Hession
Chair

About the Ontario Health Quality Council

Mandate:

The Ontario Health Quality Council, established in September 2005, was created under the *Commitment to the Future of Medicare Act, 2004*. The council is an Operational Service Agency that reports to the Minister of Health and Long-Term Care. Section 4 of the Act sets out its mandate:

(a) to monitor and report to the people of Ontario on:
  (i) access to publicly funded health services;
  (ii) health human resources in publicly funded health services;
  (iii) consumer and population health status; and
  (iv) health system outcomes; and

(b) to support continuous quality improvement.

Section 5 of the Act requires the council to deliver a yearly report to the Minister on the state of the health system in Ontario, and any other reports required by the Minister.

Mission:

A trusted, independent voice dedicated to informing the public about the quality of its publicly-funded health system. A catalyst for improving our health system and our population's health.

Vision:

A high-performing health system committed to continuous quality improvement. A system that is there for you when you need it, and involves you in maintaining and improving your own health.

Values:

- Passionate about quality improvement
- Objective, guided by evidence
- Public involvement
- Health system partnerships
- Embracing diversity

2007-2008 Performance Highlights

The ultimate aim of public reporting is to stimulate improvement. Reporting is most effective when it is based on sound performance measurement and integrated with action to improve quality. Leading into the 2007-08 fiscal year, the Ontario Health Quality Council's board made key decisions to pursue this aim:

1. Strengthen the council's performance measurement capacity by entering into a partnership with Ontario's powerhouse in health services research, the Institute for Clinical Evaluative Sciences. The council also established the Performance Measurement Advisory Board, comprised of experts from research institutions across the province.
2. Concentrate research in an area where the results could have significant impact. For the 2008 report, the focus was chronic disease management, specifically the extent to which evidence-based best practice was actually being followed.
3. Develop the council's leadership and capacity to support continuous quality improvement across the health system. The council's board launched this initiative by hiring one of Canada's leading figures in quality measurement and quality improvement in the health sector as its inaugural chief executive officer.

By the end of the first quarter of fiscal 2008-2009, these decisions resulted in increased media attention for the council's report findings (and significant interest among health-care leaders and providers in improving on these findings), outside requests to the council for expertise and assistance, and a request from the Minister of Health and Long-Term Care for the council to measure and publicly report on quality of care and resident satisfaction in long-term care homes. These are significant steps along the way to achieving the ultimate goal of real, measurable improvement in Ontario's health system.

Performance measurement

Informing the public about quality is the bedrock of the Ontario Health Quality Council's mission. The council's yearly report — titled *QMonitor: Report on Ontario's Health System* — examines the quality of Ontario's publicly-funded health system across nine attributes of a high-performing health system, which are the extent to which the system is accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated, and focused on population health.

In order to do this effectively, the public must have confidence that the council remains independent and is not subject to influence from external parties who may be reluctant to disclose information about quality shortcomings in the system. The council reinforced this by partnering with the Institute for Clinical Evaluative Sciences in April 2007 and, in the following month, establishing the council's Performance Measurement Advisory Board.

Over 2007-2008, the set of indicators used to measure, assess and explain performance in each of the nine attributes identified above has become more comprehensive. Much more developmental work remains, however the key limiting factors are:

- the availability of useful data: the council and the Institute for Clinical Evaluative Sciences continue to pursue new data sources as they become available, and continue to advocate for the creation of province-wide electronic information systems; and
- the need for consistent, comparable performance indicators from the ministry-level down to individual organizations that reflect system priorities and share a common framework.

Chronic disease management

In partnership with the C.T. Lamont Primary Health Care Research Centre in Ottawa, the Ontario Health Quality Council was able to present data on the extent to which Ontarians were receiving the recommended care between 2004 and 2006 for two common chronic diseases: diabetes and coronary artery disease. As has been found in many jurisdictions around the world, the results are startling.

For example:

- Only about half the tests and treatments recommended for people with diabetes were being performed, and only 5.5 percent of Ontario's diabetics received all the recommended tests and treatments.
- People with coronary artery disease received two-thirds of the drugs recommended to keep their blood vessels from clogging, and only 35 percent received all the recommended drugs.

The council was fortunate to be able to produce this study. Through chart reviews and in-person surveys from a cross-section of primary care practices in Ontario, the C.T. Lamont centre had already collected the data as part of another study. Because of a lack of shared province-wide electronic information systems, this labour-intensive data collection exercise would need to be repeated in order to assess Ontario's progress in chronic disease management.

Supporting quality improvement

Having produced two successful reports in its first 18 months of operation, the Ontario Health Quality Council board turned its attention in early 2007 to the second half of its mandate — supporting continuous quality improvement. The council interpreted this part of its mandate to mean being a "catalyst for improvement." Ownership of quality improvement resides with front-line providers, managers and policy makers throughout the system. To fulfill its role as a catalyst for improvement, the council champions evidence about how to achieve the best possible care, encourages the adoption of quality improvement methods, and provides quality improvement expertise as requested from external bodies.

The search for the council's inaugural chief executive officer culminated in the appointment of Dr. Ben Chan, who began his duties on November 1, 2007. As the

former CEO of the Health Quality Council in Saskatchewan, Dr. Chan led an ambitious agenda to: report to the public on quality and implement quality improvement programs to improve chronic disease management; reduce wait times in cancer care, emergency departments and family practice; and prevent adverse events in intensive care units and long-term care facilities. By the end of 2007, Eileen Patterson also joined the council as its director of quality improvement after leading health care renewal initiatives in Alberta for 15 years.

With this new capacity in place, OHQC has been actively spreading quality improvement knowledge and expertise. In the fiscal year ending in 2008, these efforts included:

- Enabling 1669 people from 110 Ontario health-care organizations to view the plenary sessions of the 2007 Institute for Healthcare Improvement's annual forum by making them available for the first time through the internet;
- Concurrently launching a set of quality improvement tools for use by health-care providers on the council's website (viewed by over 2000 visitors between the December 2007 launch and March 31, 2008);
- Delivering workshops on basic quality improvement skills to various health-care associations on request; and
- Being invited by the ministry to be lead faculty for the "access and efficiency" components of their Quality Improvement and Innovation Partnership with family health teams and community health centres.

Impact

The Ontario Health Quality Council significantly surpassed its expectations in capturing accurate, high-quality media attention for its *2008 Report on Ontario's Health System*. Although the report was released in the first quarter of 2008-2009, all of the work to produce it was completed in the 2007-2008 fiscal year. The performance measures presented later in this report indicate that, compared to the previous year's report release, total media hits increased by 16 percent (from 140 to 163) while the report's reach increased by 60 percent (from 4.4 to 7 million people), and all of the media accurately presented findings from the report.

The council's reports appear to be having impact on those who make decisions affecting Ontario's health system and quality of care. Examples include:

- For the first time, two provincial parties promised to deliver electronic health records in their 2007 election platforms (the critical need for electronic health records was a central finding in the 2006, 2007 and 2008 reports);
- The need to improve chronic disease management, supported with electronic registries were identified as government priorities in the fall 2007 Speech from the Throne (key findings in both the 2007 and 2008 reports);
- The Health Council of Canada, most of the local health integration networks and some health care providers have adopted the council's nine attributes of a high-performing health system as their framework for planning and reporting to the public; and

- As mentioned above, the number of local health integration networks, health care provider associations and organizations seeking quality improvement advice and assistance from the council is increasing.

Fiscal Responsibility

The Ontario Health Quality Council has continued to fulfill its mandate to the fullest while exercising fiscal prudence. The agency receives all of its funds from the Ministry of Health and Long-Term Care, plus interest earned on these funds. In mid-year, the council returned $122,000 to the ministry after cancelling a planned initiative to re-release parts of its 2007 report since it would have delivered insufficient value for money. By year end, the council fulfilled its plan for 2007-2008, launched significant research initiatives for the following two years, and still returned an additional $201,849 to the ministry. The savings arose primarily from a focused and cost-effective approach to communications, which as mentioned above, still succeeded in surpassing the council's performance targets.

In comparison to the previous year, the council's funding from the ministry was reduced from $5.13 million to $3.56 million. The funding difference was virtually all attributed to the release time for the council's yearly public report on Ontario's health system. Two reports were released in the 2006-2007 fiscal year (in May 2006 and March 2007) whereas the next report was released in the 2008-2009 fiscal year (May 2008). Funding for these activities was then flowed in the relevant fiscal year.

Performance Measures

Objectives	Performance Measures	Spring 2006 (Actual)	Spring 2007 (Actual)	Spring 2008 (Actual)
Continue to build awareness of OHQC and its report among the public	Public awareness about OHQC[1]	6%	9%	9%
	Public awareness about OHQC report (unprompted)[1]	N/A	16%	10%
	Awareness about OHQC advertorial (prompted)[1, 2]	N/A	N/A	30%
	Media coverage (newspapers, radio and TV stations) [3]	100 media hits with a reach of 2.0 million people	140 media hits with a reach over 4.4 million people.	163 media hits with a reach of 7 million
Provide objective and accessible information on health care system quality and performance	Percentage of public who are aware of OHQC and considers it a trusted, independent voice[1]	N/A	N/A	46% agree, 6% disagree, remainder are neutral or don't know
	The extent to which the media coverage aligns with OHQC key messages[4]	N/A	90%	100%
Educate and inform Ontarians about the performance of the publicly funded health care system through annual report on Ontario's health system	Website visitors and report downloads following release	In three months following release there were 2,000 website hits and 1,400 report downloads	In three months following release there were 6,500 website visits and 2,600 report downloads	In two months following release there were 6,326 website visits and 3,825 report downloads
	Phone/e-mail requests for report in three weeks following release	N/A	155	267
	Percentage of public who consider the information relevant, containing "issues that matter to me"[1]	N/A	80% of those who had read the insert (8% of survey respondents)	64% of those who recalled the advertorial (30% of survey respondents)

[1] Data source: Telephone survey of 1000 residents across Ontario, conducted through third-party omnibus poll.

[2] Two advertorials summarizing key points from the report ran in daily newspapers across Ontario in the week following the report's release.

[3] A "media hit" is defined as each newspaper article or TV or radio broadcast item that mentions "Ontario Health Quality Council" and one or more key messages from the 2008 report. Reach numbers were calculated by adding print circulation numbers plus broadcast audience numbers, as provided in media monitoring reports from Cision Canada. According to Canadian Public Relations Society's media relations rating system, print circulation number should be multiplied by 2.5 to determine reach. Applying this formula to 2008, total reach is 14 million (4.673 million print circulation x 2.5, plus 2.32 million broadcast audience). OHQC cannot apply this formula to past years since it no longer had the data separating print and broadcast.

[4] 2007 performance was assessed through the Canadian Public Relations Society's media relations rating system. In 2008 all print and broadcast media coverage was completely "on message," therefore the formal assessment was not repeated.

Looking to the Future

The Ontario Health Quality Council is pursuing four strategies to fulfill its mandate.

Public reporting and engagement

The council's reports will analyze quality in Ontario's health system by pursuing the following questions:

Is care quality improving over time? To address this, the council will continue to track certain core indicators regularly, and will identify whether targeted quality improvement initiatives or policy changes may have been related to significant improvements in quality.

Which groups are most vulnerable to having lower quality of care? To answer this question, the council will search for differences in quality by age, gender, geographic location, socioeconomic status, First Nations status and ethnocultural background, wherever feasible.

Is care quality at a level acceptable to Ontarians? The council will address this issue by seeking out the highest level of care achieved by jurisdictions or organizations around the world, and work with the assumption that Ontarians deserve similar quality care.

Creating indicator frameworks and strategic alignment

Successfully improving quality of care requires action at both the policy level and the care-delivery level. The policy level typically involves policy makers who make regulations and decisions about how to allocate resources. The care-delivery level typically involves managers and/or front-line providers and users of the system who are informing their hands-on care decisions with proven clinical best practices.

To inform quality improvement, the council will continue to report on quality at both the policy and care-delivery levels of the system. One example of previous work in this area can be found in the council's 2008 report to the public, where it reported on the overall state of chronic disease management in Ontario, and at the same time described specific drugs and tests for diabetes and coronary artery disease which were not being performed consistently enough. The council will also describe the relationship between potential improvements at the care delivery-level and improvements in policy-level measures. This will help identify which specific actions will drive improvement and help in planning improvement initiatives.

The council looks forward to taking on a critical role in improving the indicator frameworks used to measure and assess health-system quality across the province at both the policy and the care-delivery levels. Ideally, these publicly reported indicators will also be used to drive health-system management decisions. The council is particularly aware that this work must be carefully co-ordinated with concurrent efforts within the system by the government, health-care provider organizations,

regulatory agencies, and researchers to align measurement with strategy. Ultimately, the indicator frameworks created across the province must be a shared vision between these partners so that the frameworks can work together to create a consistent picture of Ontario's health-care system.

Wherever possible, the council will use previous work done on quality indicators to help improve Ontario's indicator frameworks. It will also look to get involved in current work being done to improve these frameworks. Specific activities may include participating in or facilitating indicator development and selection activities, and assisting in aligning indicators across accreditation processes, accountability agreements, major quality improvement initiatives and public reporting.

Building quality improvement capacity

Leading health-care systems in the world invest heavily in their staff to develop the skills required to use quality improvement science and tools. These skills are necessary for driving system-wide change and for developing a culture of quality improvement throughout an organization.

Quality improvement also depends on connecting different quality improvement teams working on similar topics so that they can effectively share experiences on how to implement change. This is essential to developing quality improvement capacity, and can take on multiple forms such as formal learning collaboratives, virtual collaboratives, and communities of practice in which people with shared work interests can learn from and inspire each other.

On request by health-care provider organizations, the council will also offer assistance with developing quality improvement skills in the workforce and with facilitating networks between quality improvement teams. In its role as a catalyst, the council will also strive to transfer the capacity to teach quality improvement skills to the more local level.

Supporting leadership in quality improvement

Ideally, quality improvement leaders will monitor results for indicators identified by the council and others as important to quality. These leaders will also be setting targets for improvement and planning how to achieve these targets. At the board level, for example, this may mean setting global targets to improve an institution's quality indicator scores, allocating funds and other resources to support this improvement and holding management accountable for the results.

On request the council will assist organizations in developing and using their indicators to support quality improvement. This may include helping promote reasonable, evidenced-based targets for improvement and providing examples of good leadership and governance from elsewhere. These leadership development activities will be conducted in partnership with other organizations that also promote leadership and effective governance.

Taking these four strategies together, the council anticipates it will contribute to achieving the vision of a high-performing health system by fully delivering on its mission to inform the public and act as a catalyst for improvement.

OHQC Governance and Management

As at March 31, 2008

Under the regulations related to the Commitment to the Future of Medicare Act, 2004, the affairs of the Ontario Health Quality Council are governed by the council members, appointed by the lieutenant governor in council, acting as the agency's board. The Deputy Minister of Health and Long-Term Care or his/her designate sits as a non-voting ex-officio member. At least one member is cross-appointed to both the Ontario Health Quality Council and to the Health Council of Canada.

Council members (Ontario Health Quality Council board of directors)

Dr. Arlene Bierman (Toronto), Chair, Performance Measurement Advisory Board
Shaun Devine (Waterloo)
Paul Genest (Ottawa), Chair, Communications Committee
Victoria Grant (Stouffville), Council Vice-Chair
Raymond V. Hession (Ottawa), Council Chair
Zulfikarali Kassamali (Toronto)
Raymond Lafleur (Hearst)
Lyn McLeod (Newmarket), Provincial Representative to Health Council of Canada and Chair, Management Resources Committee
Dr. Janice Owen (London)
Laura Talbot-Allan (Kingston), Chair, Audit and Resources Committee

Governance structure in support of OHQC's board

AUDIT & RESOURCES COMMITTEE: Laura Talbot-Allan (Chair), Shaun Devine, Zulfikarali Kassamali, Raymond Lafleur

COMMUNICATIONS COMMITTEE: Paul Genest (Chair), Zulfikarali Kassamali, Dr. Janice Owen, Lyn McLeod

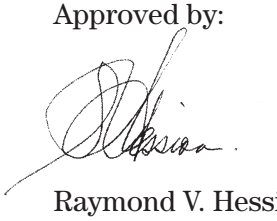
MANAGEMENT RESOURCES COMMITTEE: Lyn McLeod (Chair), Raymond Hession, Paul Genest, Victoria Grant, Laura Talbot-Allan

PERFORMANCE MEASUREMENT ADVISORY BOARD: Dr. Arlene Bierman (Chair), Dr. Janice Owen, plus expert members appointed by the council's board

OHQC administration

Dr. Ben Chan, Chief Executive Officer
Angie Heydon, Chief Operating Officer
Eileen Patterson, Director of Quality Improvement
Andrée Mitchell, Research and Policy Analyst
Phuong Truong, Office Manager
Emilia Ciurea, Bilingual Communications Assistant

Ontario Health Quality Council
Annual Report 2007-2008
Approved by:



Raymond V. Hession, Chair

LOFTUS ALLEN & CO.
CHARTERED ACCOUNTANTS

1388C Cornwall Road
Oakville, Ontario
L6J 7W1

Telephone & Fax: 905 566 7333
Website: www.loftusallen.com

AUDITORS' REPORT

To the Directors of:
Ontario Health Quality Council

We have audited the statement of financial position of Ontario Health Quality Council as at March 31, 2008 and the statements of revenue and expenses, and cash flows for the year then ended. These financial statements are the responsibility of the organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the organization as at March 31, 2008 and the results of its operations and the changes in its cash flows for the year then ended in accordance with accounting principles described in note 2.

Loftus Allen & Co

Oakville, Ontario
June 10, 2008

LICENSED PUBLIC ACCOUNTANTS

STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2008
(with comparative figures for 2007)

	2008	2007
ASSETS		
CURRENT		
Cash	**$ 472,910**	$ 1,287,701
CAPITAL ASSETS		
Office furniture and fixtures	**20,313**	19,457
Computers and equipment	**62,309**	42,020
	82,622	61,477
Accumulated amortization	**82,622**	61,477
Net - Capital Assets	**-**	-
	$ 472,910	$ 1,287,701
LIABILITIES		
CURRENT		
Accounts payable and accrued liabilities	**$ 271,061**	$ 357,834
Due to Ministry of Health, Note 3	**201,849**	929,867
	$ 472,910	$ 1,287,701

APPROVED ON BEHALF OF THE BOARD:

Laura Talbot-Allan, Director

Raymond V. Hession, Director

The attached notes are an integral part of these financial statements

STATEMENT OF REVENUE AND EXPENSES
FOR THE YEAR ENDED MARCH 31, 2008
(with comparative figures for 2007)

	2008	2007
REVENUE		
Ministry of Health	**$ 3,560,742**	$ 5,131,360
Interest	**63,355**	69,734
	3,624,097	5,201,094
ADMINISTRATION EXPENSES		
Salaries and benefits	**889,469**	575,182
Council honoraria	**83,693**	71,043
Rent	**68,237**	49,502
Human resources services	**55,516**	6,463
Office supplies, postage, courier and printing	**33,849**	15,512
Travel	**31,490**	29,641
Publications and memberships	**27,612**	7,356
Computer expenses	**18,022**	10,299
Financial services	**16,071**	15,449
Legal and audit	**12,264**	16,884
Telecommunications	**11,186**	8,347
Insurance	**7,871**	5,247
Office equipment	**856**	399
	1,256,136	811,324
RESEARCH	**1,486,107**	400,233
COMMUNICATIONS		
General communications and web	**241,837**	296,343
Community outreach	**164,857**	123,660
Report dissemination	**151,311**	1,539,667
	558,005	1,959,670
TOTAL EXPENSES	**3,300,248**	3,171,227
	323,849	2,029,867
INTERIM RETURN OF FUNDS TO MINISTRY OF HEALTH	**122,000**	1,100,000
EXCESS OF REVENUE OVER EXPENSES, Note 3	**$ 201,849**	$ 929,867

The attached notes are an integral part of these financial statements

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2008
(with comparative figures for 2007)

	2008	2007
CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES		
Cash received from MOH	**$ 2,508,875**	$ 3,561,946
Cash from interest	**63,355**	69,734
Cash paid for administration	**(1,278,357)**	(1,115,028)
Cash paid for research	**(1,550,659)**	(491,543)
Cash paid for communications	**(558,005)**	(1,959,670)
(DECREASE) INCREASE IN CASH	**(814,791)**	65,439
CASH, beginning of year	**1,287,701**	1,222,262
CASH, end of year	**$ 472,910**	$ 1,287,701

The attached notes are an integral part of these financial statements

1. THE ORGANIZATION

The Ontario Health Quality Council is an independent agency, created under Ontario's Commitment to the Future of Medicare Act on September 12, 2005. Its role is to enhance accountability to Ontarians by independently and objectively reporting on the quality of the health system and to help Ontarians better understand its underlying factors.

Its vision is to be a "trusted, independent voice dedicated to improving the health and healthcare of all Ontarians."

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) **General**
The financial statements are prepared in accordance with Canadian generally accepted accounting principles except for capital assets which are amortized 100% in the year of acquisition. This policy is in accordance with the accounting policies outlined in the Ontario Ministry of Health and Long-Term Care funding guidelines.

(b) **Revenue recognition**
The deferral method of accounting is used. Income is recognized as the funded expenditures are incurred. In accordance with Ontario Ministry of Health and Long-Term Care guidelines, certain items have been recognized as expenses although the deliverables have not all yet been received. These expenses are matched with the funding provided by the Ministry for this purpose.

(c) **Donated materials and services**
Value for donated materials and services by voluntary workers has not been recorded in the financial statements. These services are not normally purchased by the organization and their fair value is difficult to determine.

(d) **Capital assets**
Capital assets purchased with government funding are amortized 100% in the year of acquisition in accordance with funding guidelines.

During the initial months of operations furniture and fixtures totaling approximately $28,900 and leasehold improvements totaling approximately $138,900 were purchased directly by the Ministry of Health and Long-Term Care on behalf of the Ontario Health Quality Council. These assets are on loan from the Ministry and are not reflected in the balance sheet. These assets cannot be disposed of without Ministry approval and are the property of the Ministry and not Ontario Health Quality Council.

3. DUE TO MINISTRY OF HEALTH AND LONG-TERM CARE

Excess revenue over expenses must be repaid to the Ministry of Health and Long-Term Care unless specific carry over authorization is provided for all or part of the funds. The organization received authorization from the Ministry of Health and Long-Term Care to carry over $374,522 of excess of revenue over expenses from the year ended March 31, 2007 to be used in the 2007-08 fiscal year.

4. LEASE OBLIGATIONS

The Council is obliged under a long term property lease which commenced October 1, 2005 and expires September 30, 2010. The first ten months of the lease was rent free. Payments of $5,417 and administrative fees began August 1, 2006.

The landlord invoices Ontario Realty Corporation (ORC) as the tenant and ORC charges the Council rent. There is no formal lease between ORC and the Council. Annual payments under the lease include estimated rent of $67,000. The annual total of rental premises and other obligations during the next five years of the lease are estimated as follows:

	Property	Office Equipment
2009	$67,000	$5,689
2010	$67,000	$5,297
2011	$33,500	$ 862
2012	$ -	$ 862
2013	$ -	$ -

5. ECONOMIC DEPENDENCE

The Council receives all of its funding from the Ministry of Health and Long-Term Care.

6. FINANCIAL INSTRUMENTS

Fair value
The carrying value of accounts receivable and accounts payable are substantially the same as their fair value.

7. COMMITMENTS

The organization is committed to contracts with various arm's length parties over the next period of time to provide services which will enable the organization to fulfill its mandate. These contracts involve future payments as follows:

2009	$786,092
2010	72,250

8. FUTURE ACCOUNTING STANDARDS

In April 2005, the Canadian Institute of Chartered Accountants (CICA) published new accounting standards on financial instruments. These are Sections 1530, "Comprehensive Income", 3855 "Financial Instruments – Measurement and Recognition", and 3251 "Equity". Section 1530 establishes standards for reporting comprehensive income while section 3251 establishes standards for the presentation of equity and changes in equity during the year. Section 3855 establishes standards for recognizing and measuring financial instruments and non-financial derivatives in financial statements. Furthermore, in December 2006, the CICA published new Sections 3862, "Financial Instruments – Disclosures" and 3863, "Financial Instruments – Presentation", which establish standards for the presentation and disclosure of financial instruments and non-financial derivatives.

These new standards are effective for fiscal years beginning on or after October 1, 2007 and the organization will implement them as of April 1, 2008.

The organization is currently assessing the impact that the application of these new standards will have on the financial statements.

SCHEDULE OF REVENUE, EXPENSES AND BUDGET
FOR THE YEAR ENDED MARCH 31, 2008

	ACTUAL	BUDGET
REVENUE		
Ministry of Health	$ 3,560,742	$ 3,560,742
Interest	63,355	-
	3,624,097	3,560,742
ADMINISTRATION EXPENSES	1,256,136	1,151,820
RESEARCH	1,486,107	1,279,522
COMMUNICATIONS	558,005	1,129,400
TOTAL EXPENSES	3,300,248	3,560,742
EXCESS OF REVENUE OVER EXPENSES	323,849	-
INTERIM RETURN OF FUNDS TO MINISTRY OF HEALTH	122,000	-
DUE TO MINISTRY OF HEALTH	$ 201,849	$ -

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