Health Council of Canada | Conseil canadien de la santé

CORPORATE ANNUAL REPORT

Health Council of Canada
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Health Council of Canada | Conseil canadien de la santé

Health Council of Canada 2004-2005

Corporate Annual Report

September 2005

Our goals are to monitor and make annual public reports on the implementation of the 2003 First Ministers' Accord on Health Care Renewal and the 2004 10-Year Plan to Strengthen Health Care. We comment on the progress of health care reform in Canada with particular attention to the accountability and transparency provisions inherent in these agreements.

INTRODUCTION

Why a Health Council of Canada?

Canadians have invested a great deal of money and trust in their universally accessible, publicly-funded health care system. It is important for them to have a clear, easily understood and impartial assessment of what is going on. The Health Council's mandate is to monitor and report on the progress of health care renewal. This is a role it takes very seriously.

To fulfill its mandate, the Council will draw upon consultations and relevant reports, including government reports, the work of the Federal/Provincial/Territorial Advisory Committee on Governance and Accountability, and the Canadian Institute of Health Information (CIHI).

As Health Council Chair Michael Decter said in the Council's first report to Canadians, *Accelerating Change* (January 2005): "We see our job as one of witness and advisor. We firmly believe that we will serve no purpose if we do not present an unvarnished view of reality."

ACKNOWLEDGEMENT

Production of this report has been made possible through a financial contribution from Health Canada. The views expressed herein represent the views of the Health Council of Canada acting within its sole authority and not under the control or supervision of Health Canada and do not necessarily represent the views of Health Canada or any provincial or territorial government.

COUNCILLORS

Government Representatives

As at March 31, 2005:

John Abbott (March 2005 -)	Newfoundland and Labrador
Bernie Blais	Nunavut
Duncan Fisher (February 2005 -)	Saskatchewan
Albert Fogarty	Prince Edward Island
Alex Gillis (November 2004 -)	Nova Scotia
Donna Hogan	Yukon
Michel C. Leger	New Brunswick
Lyn McLeod	Ontario
Bob Nakagawa	Canada
Elizabeth Snider (December 2004 -)	Northwest Territories
Les Vertesi	British Columbia
Vacancy	Manitoba

Past:

Deborah Fry (January - December 2004)	Newfoundland and Labrador
Dave Murray (January - November 2004)	Northwest Territories
Milton Sussman (January 2004 - January 2005)	Manitoba
Tom Ward (January - October 2004)	Nova Scotia
Arlene Wilgosh (January - March 2005)	Manitoba
Glenda Yeates (January - December 2004)	Saskatchewan

Non-Government Representatives

As at March 31, 2005:

Jeanne Besner
Ian Bowmer
Nellie J. Cournoyea
Michael Decter (Chair)
Jean-Guy Finn
Simone Comeau Geddry
Roberta Jamieson (Vice Chair)
Jose Kusugak
Steven Lewis
Robert McMurtry
George L. Morfitt
Verda Petry
Brian Postl

Past:

J. Camille Gallant
(January - August 2004)

Members of the Secretariat

Judy Bentham
Paul Cantin
Peter Diakopoulos
Fadi El-Jardali
Cathy Fooks
Francesca Grosso
Shirley Hawkins
John Housser
Gursharn Kandola
Kathryn MacDonald
Mary Maniates
Lisa Maslove
Nasreen Naidu
Virginia Parraga
Donna Segal

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I. Overview

MESSAGE FROM MICHAEL DECTER, CHAIR, HEALTH COUNCIL OF CANADA

The Health Council of Canada was created by First Ministers as part of their 2003 Accord on Health Care Renewal. While the Accord called for the Council to be established within 90 days, it took time to reach agreement with the participating jurisdictions on the composition of the Council and an operational framework. The Council was formally announced in December 2003 and we then undertook a number of operational tasks: pursuing incorporation, negotiating a financing agreement with the Government of Canada and holding meetings with the newly appointed Councillors to set a strategic direction for the Council's work.

From the Council's point of view, it seemed we were working very hard although I recognize that, from an external point of view, it may have looked like things were moving slowly. During this organizational stage, the Council also established working groups to address the six priority areas identified in the 2003 Accord.

In effect, the Council is an accountability mechanism for the health system. The Council's original mandate was to monitor and report to Canadians on the progress of reforms in the 2003 Accord, which focused on improving health care services. Our mandate was subsequently expanded by the First Ministers' 2004 10-Year Plan to include reporting annually to Canadians on health status and health outcomes. The Council's roots can be found in the report of the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Report, October 2002) and the Romanow Commission on the Future of Health Care in Canada (November 2002). While there are other bodies at the national level that have important roles in health and health care delivery, the Council's mandate makes it unique.

The Council works collaboratively to report on progress in achieving health system objectives. This would simply not be possible without good access to data. To a very large extent, the Council is dependent on the willingness of the provinces, territories and the federal government to provide the Council with the necessary data on which to report. Without the cooperation of governments and the people delivering care, it would be impossible for us to be transparent with the people of Canada.

To gain a truly national perspective, the Council decided to travel around the country so that we could connect directly with people and get a first-hand idea of what they were facing. In 2004-2005, the Council has met in Toronto, Vancouver, Winnipeg, Ottawa, Halifax and Iqaluit. These visits have become an important component of the Council's work. Our visit to Nunavut, in particular, was an eye opener. There we were not witnessing problems of overcrowded emergency rooms in a big city; we were seeing first-hand the issues of getting care in smaller, isolated communities where, in some cases, there is an absolute absence of some types of services and very poor health status. The visit emphasized the importance of maintaining a population health focus.

The Council released its first annual report to Canadians in January 2005. While the report focused on the progress of implementing the 2003 Accord, our main message to the leadership - not just Ministers and First Ministers but to the people managing and leading health services across the country - was hurry up. Reforms are going in the right direction but they are not moving fast enough. The report focused on four areas: health human resources; modernizing technology (information management and the electronic health record);

moving toward more multi-disciplinary teams; and addressing broader disparities. But our core message was we've got to move faster.

What will it take to move faster? More political will. There is a now a good deal of money committed although there are still individual places where more funding could be used effectively. As well, we have been through a period of reducing services. Now, with funding restored and stabilized, there must be a will to make fundamental changes to ensure our health care system is sustainable.

In the wake of the Romanow Commission, people renewed their faith in a publicly-funded system because the report clearly said the system could be fixed. They then heard First Ministers say "we want to fix it and we are willing to take the necessary steps." There was a rebound in public optimism and enthusiasm.

We risk losing that sense of optimism and enthusiasm if the pace of reform continues to be slow, if service continues to be uneven. There are some very good things happening, but they are often in tiny pockets rather than being right across a jurisdiction or right across the country. We highlighted many of these innovations in our first report. For example, the Saskatchewan Surgical Wait List program has proven to be a positive program for better managing people in need of treatment. Yet it has not been adopted across the country. Seeing these isolated examples, the Council has a sense that the health care system is not being modernized fast enough.

The first full year of operations has been very rewarding, and perhaps the best part has been getting to know the Council. It is a remarkable collection of Canadians who come from all walks of life and different parts of the country, and it has been a privilege for me to get to know them. Our first report to Canadians received favourable attention on many fronts, not the least of which was feedback from the media. André Picard of the Globe and Mail said the Council had shown it had "bark" and that time would tell whether it had "bite." This is perhaps the Council's greatest challenge.

To have real impact, we must remain credible and work effectively with three important audiences - the people who pay for the system and use it (taxpayers and citizens); the people who provide care; and the people, through government, who make most of the allocation decisions. The priorities of these three groups are often not aligned which adds complexity to the Council's role. It is easily the biggest challenge I have taken on in health care.

I extend my thanks to the dedicated Councillors, Council staff, federal, provincial and territorial officials, health care providers, researchers and individual Canadians who have contributed to the work of the Health Council of Canada. We look forward to working together to achieve and maintain a sustainable, accessible, affordable and quality health care system and to improving the health of all Canadians.

Michael Decter

MESSAGE FROM CATHY FOOKS, EXECUTIVE DIRECTOR, HEALTH COUNCIL OF CANADA

Like many of you reading this report, I spent much of my time in 2003 advocating for a national level organization that could report to Canadians on health care renewal across the country. And like many of you, I was hopeful, when the initial Council and its Chair were announced in December 2003, that the organization would become a respected voice in the Canadian health policy world.

It is my pleasure to report on the establishment of the Health Council of Canada and the way in which we have found our voice in our first full year of operations. Through the work of 26 councillors and a small secretariat, we issued our first report to Canadians in January 2005 exactly one year after our first meeting as a Council.

As the secretariat was formed and became operational, a number of infrastructure and governance issues were addressed including the development and approval of by-laws to guide the work of the Council and the signing of a five-year funding agreement with the Government of Canada. A Coordinating Committee was formed along with a Communications Advisory Committee and a Finance and Audit Committee. As well, working groups were established to begin examining the six priority areas identified in the 2003 Accord: the health of Canadians, primary health care, pharmaceuticals management, home care, health human resources and wait times.

Secretariat staff were recruited, office space was leased and retrofitted, accounting and information technology systems were established and the basic tools for communication put in place including the development of a visual identity for the Council, a public website and a councillor web portal.

By the fall of 2004, we were really in business!

During 2004-2005 the Council travelled across the country meeting with health care providers, policy makers and planners, regional health authority staff, and citizens. We learned a lot. We learned how passionate Canadians are about health care and health care renewal. We heard many good ideas that needed champions. And we realized that good ideas don't cross borders as often as they should. This led us to the belief that part of our reporting on progress on health care renewal should include the showcasing of innovation.

Much has been accomplished in the Council's first 15 months and that would not have been possible without the ongoing support of the Chair, Councillors and staff. I thank them for their dedication to the work of the Health Council of Canada and I look forward to their continued support as we move into the next busy year.

Cathy Fooks

II. The Council at Work

COUNCIL OPENS ITS DOORS

The secretariat opened its present office officially on September 8, 2004, having been in temporary quarters since January 2004.

MEETINGS

The Council held six full meetings in its first year of operation in the following locations:

January 2004	Toronto, ON
March 2004	Vancouver, BC
May 2004	Winnipeg, MB
September 2004	Iqaluit, NU
November 2004	Halifax, NS
January 2005	Ottawa, ON

WORKING GROUPS AND COMMITTEES

At its initial meeting, Council decided that the most appropriate way to tackle the Council's monitoring and reporting mandate was to create six Councillor working groups, each of which would address the renewal efforts and progress of particular priority themes as stated in the 2003 First Ministers' Accord on Health Care Renewal. In September 2004, following the First Ministers' 10-Year Plan to Strengthen Health Care, the Council took on additional responsibility for reporting on health status and health outcomes.

All of the working groups were responsible for researching and developing original content in their thematic areas for the Council's inaugural report to Canadians, *Health Care Renewal in Canada: Accelerating Change*. This report was launched in January 2005 and has continued to be distributed in various venues and through access to the Council's website www.healthcouncilcanada.ca.

Working Groups

The following is a summary of each working group's focus for 2004-2005 and its membership.

Primary Health Care

Chair - Ian Bowmer

To assess progress of Primary Health Care reform in Canada, this working group prepared a background paper providing evidence and informed analysis to support the Health Council's general observations on primary health care in the Council's inaugural report to Canadians (January 2005), *Health Care Renewal in Canada: Accelerating Change*. Both the background paper and inaugural report can be found on the Council's website, www.healthcouncilcanada.ca.

The working group emphasized that, while there is much agreement on what needs to be done, and some progress has taken place, reforming primary health care is far from complete. It highlighted the need for common definitions to enable the assessment of progress; the removal of regulatory barriers that may be preventing multi-disciplinary teams from flourishing; new education and training models to support the extension of collaborative practices; and the acceleration of the implementation of electronic health records and other information technology to support commonly accessible data for practitioners addressing the health of a patient.

Members

Jean-Guy Finn
Simone Comeau Geddry
Bob Nakagawa
Donna Hogan
Lyn McLeod

Health Human Resources

Chair - Jeanne Besner

The Health Human Resources Working Group examined the current state of health human resources in Canada. The working group recommended a focus on improving the capacity to plan and practice in teams, educate and train in teams, work in teams and plan locally and regionally for team-delivered care.

The working group reviewed the many pan-Canadian initiatives on health human resources being fostered through Accord funding. It observed, however, that much of this progress was not well known to practicing professionals and to the general public. As a result of its findings, the Council recommended among other things that a national health human resources summit be held. Technical papers in support of this event can be found on the Council's website, www.healthcouncilcanada.ca. The event was held in June 2005 and a report is forthcoming.

Members

Michel C. Leger
Albert Fogarty
Elizabeth Snider
Duncan Fisher
J. Camille Gallant (past)
Dave Murray (past)
Tom Ward (past)

Pharmaceuticals Management

Chair - Bob Nakagawa

The Pharmaceuticals Management Working Group commissioned a paper to provide an analytical overview of pharmaceuticals management in Canada. The paper is available on the Council website at www.healthcouncilcanada.ca. The findings helped to shape the comments and advice from this working group for the Council's inaugural report.

The working group focused on those in Canada without any form of public and private coverage for medications and suggested that a minimum standard should be established across the country. The group also suggested that drugs that cost more than $5,000 a year per person should be identified and current levels of public coverage for these drugs across public plans should be assessed.

Members

John Abbott
Jean-Guy Finn
Alex Gillis
Verda Petry (past)
Glenda Yeates (past)

Wait Times and Access

Chair - Robert McMurtry

In its efforts to inform the important public debates on access to health care, the Working Group on Wait Times and Access produced a paper describing why waits occur and what more can be done to improve timely access to appropriate care. This paper formed the basis of the wait times advice in *Health Care Renewal in Canada: Accelerating Change* and, as a background paper, is available on the Council's website, www.healthcouncilcanada.ca.

The working group developed key elements for the successful management of a wait times program. These elements included ensuring a comprehensive approach to preserve equity between areas of demand, making as much information public as possible, evaluating outcomes to ensure that the services being provided are appropriate, involving key players in reviewing each step of the process, and aligning incentives to reward people in reducing wait times.

Members

Deborah Fry (past)
Steven Lewis
Les Vertesi
Glenda Yeates (past)

Home Care

Chair - Verda Petry

The Home Care Working Group commissioned a paper, Technical Report of the Working Group on Home Care, which catalogues government home care programs across Canada as of fall 2004. This background paper is available on the Council's website, www.healthcouncilcanada.ca, under the title Home Care.

The working group focused on the commitments in the First Ministers' 2003 Accord and made a number of suggestions for improvement. They suggested that mental health issues need to be addressed as part of primary health care reform and that people with chronic diseases need to be included in home care commitments for the future.

Members

Jeanne Besner
Albert Fogarty
Simone Comeau Geddry
Tom Ward (past)

"The Health Council has done a commendable job of producing a thoughtful first report," wrote André Picard in the Globe & Mail.

"The approach is refreshing, and welcome. Rather than bemoan all that is wrong in the health system, the Health Council is celebrating what is right, and calling for the approaches that work to be broadly adopted in an accelerated fashion."

Healthy Canadians

Chair - Chief Roberta Jamieson

The Healthy Canadians Working Group decided to focus their attention on those groups with the greatest health disparities. They first focused on the Aboriginal peoples. A background paper, The Health Status of Canada's First Nations, Métis and Inuit Peoples, was developed and can be found on the Council's website, www.healthcouncilcanada.ca.

The working group focused on the need for an Aboriginal health workforce and the supports required to create one. As well, they looked at primary health care models that could address the broader social determinants of health that are particularly relevant to Aboriginal communities.

Members

Bernie Blais
Nellie J. Cournoyea
Jose Kusugak
Brian Postl
Verda Petry
Milton Sussman (past)

Committees

In addition to the Working Groups, the Council established three Standing Committees: Finance and Audit, Coordinating and Communications Advisory.

Finance and Audit Committee

Chair - Michel C. Leger

Members

Bernie Blais
George Morfitt
Les Vertesi

Coordinating Committee

(formerly Monitoring System Performance)

Chair - George Morfitt

Members

Jeanne Besner
Ian Bowmer
Michael Decter
Cathy Fooks (ex-officio)
Roberta Jamieson
Robert McMurtry
Bob Nakagawa
Verda Petry

Communications Advisory Committee

Chair - Bernie Blais

Members

Nellie J. Cournoyea
Jean-Guy Finn
Lyn McLeod
Bob Nakagawa

STAKEHOLDER ENGAGEMENT

Building relationships and beginning the process of engaging key stakeholders to contribute to the work of the Council was a priority for 2004-2005. Throughout the year the Chair, Councillors and senior secretariat staff met on numerous occasions with representatives from federal, provincial and territorial governments, health care provider organizations and professionals and organizations profiling the interests of patient groups. Council's primary objective was to seek the perspective of these organizations and individuals regarding the challenges and successes of the system in addressing health service improvements.

The initiatives below highlight some of Council's early engagement efforts.

Health Care Community Networking

In conjunction with Council meetings taking place across the country, the Council endeavours to meet with local health care provider groups, local policy advisors and decision-makers and groups presenting patient issues to learn of local concerns, priorities and interests. This approach has served to ground Council's advice and to identify local efforts which innovatively contribute to successful reform. For example, in:

Nunavut

Council and staff visited nursing stations, social service units and schools in Pangnirtung and Kimmirut to learn first hand of their successes, concerns and suggested solutions. As well, the Council met with elders in the communities to talk about the unique challenges they face in accessing health services.

Halifax

Council heard from local care providers and government officials on a range of topics, including:

- a successful strategy to recruit and retain recent nursing graduates;
- an overview and evaluation of a nurse practitioner project that has been introduced into four local communities; and
- a discussion of recently established Community Health Boards which provide evidence-based platforms for health care planning while increasing involvement of, and accountability to, the public.

Relationship Building

From its inception, Council determined that the federal, provincial and territorial governments were one of its primary audiences. Staff met regularly with government officials to share insight and observations. Initially, these were held with the Deputy Ministers of Health and their immediate advisors; more recently the focus has been to meet with senior program staff. In 2004-2005, senior Council staff held:

- Meetings with jurisdictional staff in Prince Edward Island, New Brunswick, Ontario, Saskatchewan, Nova Scotia, Nunavut, British Columbia, and the Government of Canada;
- A workshop for provincial/territorial representatives on wait times;
- Over 25 individual meetings with national health care organizations and professional associations.

As well, the Council's inaugural report was launched in January in a constructive manner, deliberately reaching beyond the content of the report to showcase innovative or locally successful ventures enabling health care reform.

The Canadian Medical Association called the Council an "essential tool to ensure the First Ministers' Accord on Health Care Renewal leads to action," and the Registered Nurses Association of Ontario said the Council "has found the right focus to kick start health-care reform across Canada."

Informing the General Public

The Council remains concerned with providing the public with accessible information on the progress of health care renewal. We have established a website that is easy to navigate and we use every opportunity to promote it to Canadians. As the Council continues to develop original content, the pages of the website will become more and more valuable to the public and health care providers. Throughout 2004-2005, traffic to the site has been steadily building and we are able to report monthly statistics indicating how and what information people access.

For example, we know that the Council's website received close to 1,000 hits within the first 24 hours of the uploading of the inaugural report to Canadians (in French and English) on January 27, 2005, as compared to between 10 and 20 hits per day prior to that launch. As a result of publicity and media coverage, this report was downloaded more than 60,000 times by the end of March 2005.

Individual Councillor Efforts

In addition to these larger scale opportunities, individual Councillors and the Chair made presentations in a number of different venues, including:

Taming of the Queue (Ottawa, April 2004)

Primary Health Care Transition Fund Commission (October 2004)

First Ministers' Meeting (October 2004)

Commonwealth Fund - International Symposium on Health (October 2004)

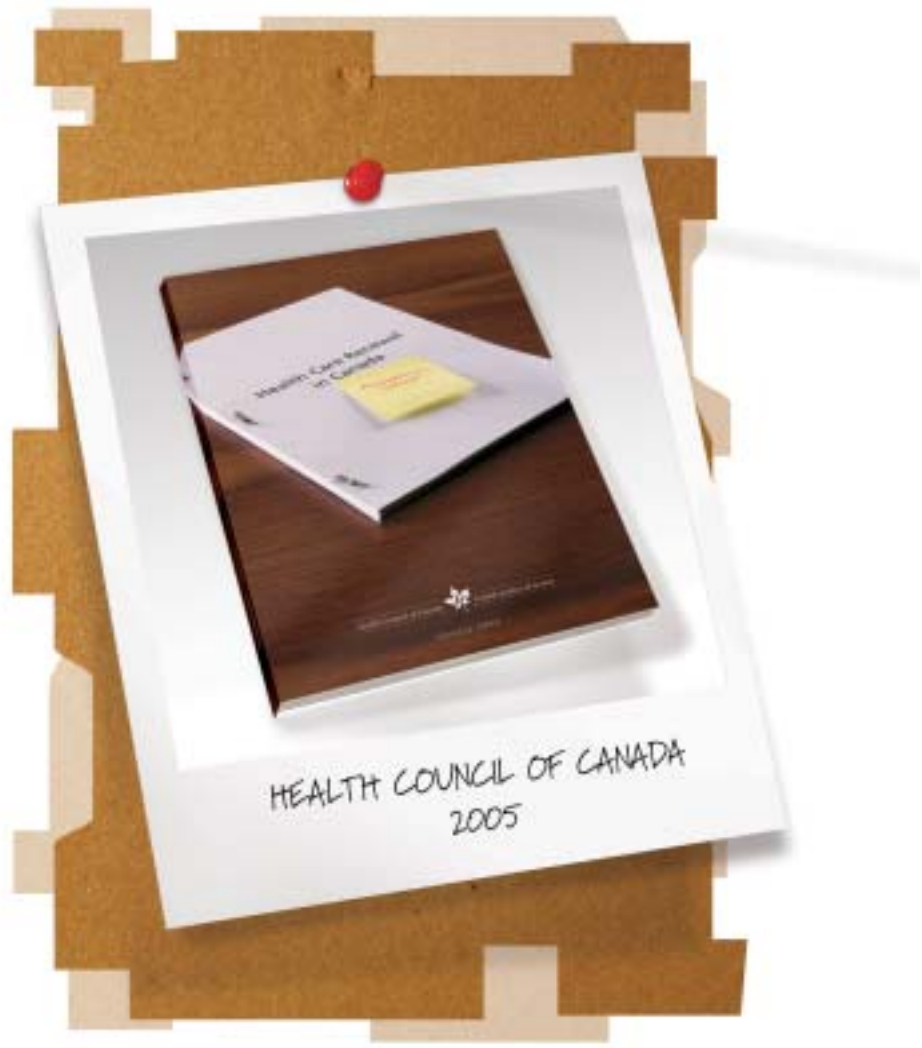
National Union of Public and General Employees (November 2004)

Conference of Deputy Ministers (December 2004)

Standing Committee on Health (February 2005)

Councillors also spoke to numerous local interest groups, highlighting the work, objectives and role of the Council.

III. The Council's First Report



THE COUNCIL'S FIRST REPORT TO CANADIANS

The Health Council of Canada delivered an important message to Canadians in its first annual report - the time for debate is over, and the country needs to move forward quickly to renew health care.

The report - *Accelerating Change* - was successfully launched to the Canadian public and over 150 key stakeholders on Thursday January 27, 2005, at a luncheon in Ottawa's Chateau Laurier hotel. The release of the 97-page report was supported by a series of videos that illustrated with real, human stories key points the Council raised in the report.

The report's messages were direct and constructive:

Canada's health care system must speed up the pace of renewal or risk losing the progress that is being achieved.

There are four key areas to improving Canada's health care system to achieve the goals of First Ministers' Accords on Health Care:

- strengthening health human resources planning
- expanding the use of multi-disciplinary teams in primary health care
- using information technology for patient record keeping
- reducing health disparities particularly in Aboriginal communities.

Following the launch event, Council Chair Michael Decter and Councillor Jeanne Besner spoke with the media at a press conference. The response to the report from the public, the media and stakeholders was overwhelming and positive.

In the months following the release of the report, Chair Michael Decter, Executive Director Cathy Fooks and select Councillors made close to 20 presentations using a combination of report content and the six innovative practice videos.

The Toronto Star wrote that the Council "did us all a favour this week by forcing the issue (of electronic patient records) onto the national agenda," and the Regina Leader Post lauded the report's call for a national health human resources summit as a notion "that can't come a moment too soon."

IV. Looking Ahead

LOOKING AHEAD

As we engaged with health care providers, representatives from participating governments and the public over the past year, it became evident that there is genuine effort being made to improve and sustain our publicly-funded health care system. We witnessed the dedication of front line workers; we saw examples of innovative practices that we feel can and should be shared across the country. The reports of the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Report, October 2002) and the Romanow Commission on the Future of Health Care in Canada (November 2002) outlined the need for an impartial body to report on health care renewal based on evidence and we are most grateful for the cooperation of participating health care organizations and governments for responding to our requests for information in a cooperative and timely fashion.

The process continues into 2005 and we look forward to even greater collaboration across the country. In the 2005 report, *Accelerating Change*, we called for direct and immediate action on the ever-increasing health human resources issues which are being compounded by an aging population and an aging health care workforce. As we approached the closing of our first full year of operation, much of the effort at the secretariat level was focused on staging a summit on health human resources that attracted educators, professional organizations, researchers, regulators and front-line workers. We anticipate that this summit will merely be a starting point for further collective action and planning at a national level in order to address the myriad of challenges inherent in health human resources.

Additionally, the Council will continue to focus on recommendations made in the 2005 report to Canadians. For example, we will:

- Pursue the opportunity to co-sponsor an international conference on information technology to support efforts to accelerate the adoption of electronic health records in Canada;
- Work collaboratively with national health care providers and stakeholder groups to seek opportunities for joint initiatives;
- Investigate further the achievements to date on the implementation of multi-disciplinary teams in primary health care reform.

In our next corporate report, we look forward to providing you with details on the success of this summit and other Council initiatives in 2005-2006.

V. Audited Financial Statements

MESSAGE FROM MICHEL C. LEGER CHAIR, FINANCE AND AUDIT COMMITTEE, HEALTH COUNCIL OF CANADA

We are pleased that the Health Council of Canada ended its first year of operation with a surplus. Effective control of the funding allocations from Health Canada allowed the Council to balance the needs of a growing organization while allowing us to fulfill our mandate to monitor and report to Canadians on the progress of health care renewal.

The organization continues to grow, but remains mindful of its responsibility not to duplicate work of others. We have a sound financial base and an approved strategic business plan to move forward. Responsibilities of the Council were augmented with the 2004 10-Year Plan to Strengthen Health Care, and I have every confidence that this enhanced work load will be well managed by the Council team in a fiscally responsible manner.

Sincerely,

Michel C. Leger

Michel C. Leger, LLB

Financial Statements of

THE HEALTH COUNCIL OF CANADA/ CONSEIL CANADIEN DE LA SANTÉ

March 31, 2005

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-643-8998
www.deloitte.ca

Auditors' Report

To the Board of Directors of

The Health Council of Canada/Conseil canadien de la santé

We have audited the statement of financial position of the Health Council of Canada/Conseil canadien de la santé as at March 31, 2005 and the statements of operations and changes in net assets for the year then ended. These financial statements are the responsibility of the Council'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 Council as at March 31, 2005 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

The financial statements as at March 31, 2004 and for the period then ended were audited by other auditors who expressed an opinion without reservation on those statements dated October 19, 2004.

Deloitte & Touche LLP

Chartered Accountants

Toronto, Ontario
June 28, 2005

HEALTH COUNCIL OF CANADA/CONSEIL CANADIEN DE LA SANTÉ

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March 31, 2005

HEALTH COUNCIL OF CANADA/CONSEIL CANADIEN DE LA SANTÉ

Statement of Financial Position

March 31, 2005

	2005	2004
		(Note 3)
ASSETS		
CURRENT		
Cash	**$ 3,353,551**	$ –
Accrued interest receivable	**6,385**	–
Accounts receivable *(Note 4)*	**58,850**	1,078,000
Prepaid expenses	**50,451**	–
	3,469,237	1,078,000
CAPITAL ASSETS *(Note 5)*	**519,009**	–
	$ 3,988,246	$ 1,078,000
LIABILITIES		
CURRENT		
Accounts payable and accrued liabilities *(Note 6)*	**$ 250,809**	$ 478,965
Capital lease obligation – current *(Note 7)*	**24,661**	–
Lease inducements – current *(Note 8)*	**17,482**	–
Deferred revenue *(Note 9)*	**3,567,631**	599,035
	3,860,583	1,078,000
LONG-TERM		
Capital lease obligation *(Note 7)*	**70,846**	–
Lease inducements *(Note 8)*	**56,817**	–
	3,988,246	1,078,000
NET ASSETS		
INVESTED IN CAPITAL ASSETS	**373,480**	–
OPERATING FUND	**(373,480)**	–
	–	–
	$ 3,988,246	$ 1,078,000

HEALTH COUNCIL OF CANADA/CONSEIL CANADIEN DE LA SANTÉ

Statement of Operations

Period ended March 31, 2005

	Year ended March 31, 2005	Period from December 2, 2003 to March 31, 2004 (Note 3)
REVENUE		
Health Canada (Note 9)	**$ 3,180,305**	$ 478,965
Interest income	**50,386**	–
	3,230,691	478,965
EXPENSES		
Compensation	**950,195**	–
External professional services	**699,350**	143,921
Councillor expenses and meeting facilities		
Councillors' travel	**186,345**	76,828
Councillors' honoraria	**157,213**	54,583
Meeting facilities	**93,313**	30,392
Guest travel	**5,301**	17,774
Administration – supply and services		
Occupancy	**185,280**	2,140
Financial management	**111,053**	12,091
Computers and telecommunications	**105,146**	1,349
Amortization	**52,731**	–
Office services and supplies	**38,702**	6,658
Legal fees	**32,789**	12,662
Human resources	**31,439**	75,243
Insurance	**7,244**	–
Miscellaneous	**2,311**	30
Reports and communication		
Supplies and services	**375,173**	23,613
Promotion and media	**118,312**	21,681
Secretariat – travel	**78,794**	–
	3,230,691	478,965
EXCESS OF REVENUE OVER EXPENSES	$ –	$ –

HEALTH COUNCIL OF CANADA/CONSEIL CANADIEN DE LA SANTÉ

Statement of Changes in Net Assets

Period ended March 31, 2005

	Period ended March 31, 2005			Four-Month Period Ended March 31, 2004
	Invested in Capital Assets	**Operating Fund**	**Total**	Total
BALANCE , BEGINNING OF PERIOD				
As previously reported	$ –	**$ 599,035**	**$599,035**	$ –
Prior period adjustment (Note 3)	–	**(599,035)**	**(599,035)**	–
As restated	–	–	–	–
EXCESS (DEFICIENCY) OF REVENUE	**(52,731)**	**52,731**	–	–
ADDITIONS TO CAPITAL ASSETS	**571,740**	**(571,740)**	–	–
CAPITAL LEASE – net	**(95,507)**	**95,507**	–	–
LEASEHOLD INDUCEMENTS PAYABLE – net	**(50,022)**	**50,022**	–	–
BALANCE, END OF PERIOD	**$ 373,480**	**$ (373,480)**	$ –	$ –

HEALTH COUNCIL OF CANADA/CONSEIL CANADIEN DE LA SANTÉ

Statement of Cash Flows

Period ended March 31, 2005

	Year ended March 31, 2005	Period from December 2, 2003 to March 31, 2004 (Note 3)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Excess of revenue over expenses	$ –	$ –
Items not affecting cash flows		
Amortization of capital assets	**52,731**	–
Amortization of two-month rent-free lease inducements	**(5,236)**	–
	47,495	–
Changes in working capital items		
Accrued interest	**(6,385)**	–
Accounts receivable	**1,019,150**	(1,078,000)
Prepaid expenses	**(50,451)**	–
Accounts payable and accrued liabilities	**(228,156)**	478,965
Deferred revenue	**2,968,596**	599,035
	3,750,249	–
INVESTING AND FINANCING		
Capital lease obligation assumed	**107,778**	–
Capital lease payments	**(12,271)**	–
Lease inducements received	**88,363**	–
Repaid lease inducements	**(8,828)**	–
Purchase of capital assets	**(571,740)**	–
	(396,698)	–
NET INFLOW OF CASH	**3,353,551**	–
CASH BEGINNING OF YEAR	–	–
CASH, END OF YEAR	**$ 3,353,551**	$ –

HEALTH COUNCIL OF CANADA/CONSEIL CANADIEN DE LA SANTÉ

Notes to the Financial Statements

March 31, 2005

1. DESCRIPTION OF THE BUSINESS

The Health Council of Canada/Conseil canadien de la santé (the "Council") was incorporated on December 2, 2003 under the Canada Corporations Act. The Council's mandate is to monitor and make annual public reports regarding the implementation of the 2003 First Ministers' Accord on Health Care Renewal and the 2004 10-Year Plan, particularly its accountability and transparency provisions.

The Council is registered as a not-for-profit organization under the Income Tax Act and, accordingly, is exempt from income taxes.

2. SIGNIFICANT ACCOUNTING POLICIES

(a) Financial Statement presentation

These financial statements have been prepared in accordance with Canadian generally accepted accounting standards for not-for-profit organization published by the Canadian Institute of Chartered Accountants.

(b) Revenue recognition

The Council is funded solely by the Minister of Health, Health Canada in accordance with the regulations of the Health Care Strategies and Policy. Federal/Provincial/Territorial Partnership Grant Program, expiring on March 31, 2008.

These financial statements reflect agreed arrangements approved by Health Canada with respect to the period ended March 31, 2005.

The financial statements have been prepared in accordance with the accounting standards for not-for-profit organizations published by the Canadian Institute of Chartered Accountants using the deferral method of reporting restricted contributions.

(c) Description of funds

Operating Fund - records the ongoing operations of the Council

Invested in Capital Assets Funds - records the capital assets of the Council and the related financing activities.

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

(d) Capital assets

Capital Assets are recorded at costs and are amortized on a straight-line basis using the following rates:

Information Technology and Telecommunication	20%
Office Equipment and Furniture	10%
Leasehold Improvements	Term of lease

In the year of acquisition, 50% of the amortization rate is used.

(e) Deferred lease inducements

Deferred lease inducements, consisting of leasehold improvement allowances and free rent, is amortized on straight line basis over the term of the lease.

(f) Deferred revenue

Deferred revenue represents amounts received from Health Canada which have not been expended on the council's mandate.

(g) Use of estimates

The preparation of financial statements in accordance with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from management's estimates as additional information becomes available in the future.

3. PRIOR PERIOD ADJUSTMENT

The Council changed the method of recording revenue from the restricted method to the deferred method of recording restricted contributions. As a result of this change in accounting policy, revenue and closing net assets balance for the period ended March 31, 2004, was reduced by $599,035, deferred revenue was increased by $599,035.

The effect of this change in accounting policy on the current year's financial statements is as follows:

	Year Ended March 31, 2005
Revenue – decreased by	**$ 2,968,596**
Excess of revenue over expenses decreased by	**$ 2,968,596**

	March 31, 2005
Deferred revenue increased by	**$ 2,968,596**
Operating Fund decreased by	**$ 2,968,596**

4. ACCOUNTS RECEIVABLE

Included in the balance is an amount of $ Nil (2004 – $1,078,000) which represents grant funding outstanding from Health Canada.

5. CAPITAL ASSETS

	2005			2004
	Cost	**Accumulated Amortization**	**Net Book Value**	Net Book Value
Information Technology and Telecommunication	**$ 259,485**	**$ 25,948**	**$ 233,537**	$ –
Office Equipment and Furniture	**110,135**	**5,507**	**104,628**	–
Leasehold Improvements	**202,120**	**21,276**	**180,844**	–
	$ 571,740	**$ 52,731**	**$ 519,009**	$ –

Capital leases

Capital assets include Information Technology equipment under capital lease, expiring in September 2008 with a cost of $107,779 and accumulated amortization of $10,778.

6. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

Accounts payable includes $711 (2004 – $478,965) of funds owed to the Canadian Institute for Health Information ("CIHI"). The Council received financial assistance from CIHI for the initial period on a cost recovery basis. CIHI funded all activities of the Council, including staffing, administration and council/committee meetings until the Initial Funding Agreement was signed on March 29, 2004.

7. CAPITAL LEASE OBLIGATIONS

The Council has equipment under capital leases expiring September 30, 2008. Future minimum payments under capital leases are as follows:

Year ending March 31	
2006	$ 31,770
2007	31,770
2008	31,770
2009	14,872
	110,182
Less amount representing interest at approximately 8.7%	(14,675)
Present value of minimum lease payments	95,507
Current portion	(24,661)
Long-term portion	$ 70,846

Interest recorded in the Statement of Operations related to the capital lease obligations is $4,630 (2004 - Nil).

8. LEASE INDUCEMENTS

The balance of lease inducements includes the following:	
Lease inducements payable (a)	$ 50,022
2-month rent-free inducement (b)	24,277
Total	74,299
Less: amount due within 1 year	
Lease inducement payable (a)	(11,770)
2-month rent-free (b)	(5,712)
	(17,482)
Long-term portion	$ 56,817

8. LEASE INDUCEMENTS (continued)

(a) The Council negotiated a repayable leasehold improvement allowance over the term of the lease with an interest rate of approximately 4%. The repayable allowance is being repaid over the term of the lease at $13,035 per annum. Interest expense of approximately $1,800 is included in the statement of operations.

(b) The Council negotiated a long-term lease agreement for its corporate offices in 2004 that included a 2-month rent-free period. The lease inducement benefits are amortized on a straight-line basis over the term of the lease as a reduction to rental expense.

9. DEFERRED REVENUE

	2005	2004
Balance, beginning of year	**$ 599,035**	$ –
Funds received	**6,148,901**	1,078,000
Less: amounts recorded as revenue	**(3,180,305)**	(478,965)
Balance, end of year	**$ 3,567,631**	$ 599,035

10. FAIR VALUES OF FINANCIAL ASSETS AND FINANCIAL LIABILITIES

The carrying values of current assets and accounts payable approximate their fair values due to the relatively short periods to maturity of these items or because they are receivable or payable on demand. Other liabilities are recorded at their fair values.

11. COMMITMENTS

(a) Leased premises

During the year, the Council entered into a lease for premises located at 90 Eglinton Avenue East, Toronto, Ontario. The lease commenced on May 1, 2004 and is for a period of five (5) years and two (2) months, expiring on June 30, 2009. The period from May 1, 2004 to July 1, 2004 is gross rent-free. Future minimum commitments for basic rent and repayment of the leasehold improvement allowance under the lease are approximately as follows:

Year ended March 31	
2006	$101,000
2007	102,000
2008	107,000
2009	108,000
2010	25,000
	$443,000

11. COMMITMENTS (continued)

(b) Other commitments

Additionally, the Council has entered into other commitments, including contracts for professional services with various expiry dates to September 2008. The annual payments are approximately as follows:

Year ended March 31	
2006	$ 208,000
2007	69,000
2008	49,000
2009	6,500
	$ 332,500

12. GUARANTEES

In the normal course of operations, the Council enters into agreements that meet the definition of a guarantee. The Council's primary guarantees subject to the disclosure requirements of AcG-14 are as follows:

(a) The Council has provided indemnities under a lease agreement for the use of operating facilities. Under the terms of this agreement the Council agrees to indemnify the counterparties for various items including, but not limited to, all liabilities, loss, suits, and damages arising during, on or after the term of the agreement. The maximum amount of any potential future payment cannot be reasonably estimated.

(b) The Council has indemnified its present and future directors, officers and employees against expenses, judgments and any amount actually or reasonably incurred by them in connection with any action, suit or proceeding in which the directors are sued as a result of their service, if they acted honestly and in good faith with a view to the best interest of the Council. The nature of the indemnity prevents the Council from reasonably estimating the maximum exposure. The Council has purchased directors' and officers' liability insurance with respect to this indemnification.

13. COMPARATIVE FIGURES

Certain of the prior year's figures have been reclassified to conform to the current year's presentation.