

*Enhancing the effectiveness of health care
for Ontarians through research*

ICES Institute for Clinical
Evaluative Sciences



Changing Perspectives

2006 ANNUAL REPORT

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About ICES—Ontario's Resource for Informed Health Care Decision-Making

ICES (Institute for Clinical Evaluative Sciences) is an independent, non-profit organization that conducts health services evaluations on a broad range of topical issues to enhance the effectiveness of health care for Ontarians. Internationally recognized for its innovative use of population-based health information, ICES knowledge provides evidence to support health policy development and changes to the organization and delivery of health care services.

Unbiased ICES evidence offers fact-based measures of health system performance; a clearer understanding of the shifting health care needs of Ontarians; and a stimulus for discussion of practical solutions to optimize scarce resources.

Key to ICES' work is our ability to link anonymous population-based health information on an individual patient basis, using unique encrypted identifiers that ensure privacy and confidentiality. This allows scientists to obtain a more comprehensive view of specific health care issues than would otherwise be possible. Linked databases reflecting 12 million of 30 million Canadians allow researchers to follow patient populations through diagnosis and treatment, and to evaluate outcomes.

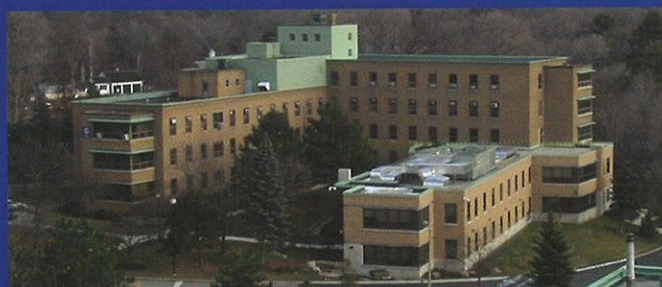
ICES brings together the best and the brightest talent under one roof. Many of our faculty are not only internationally recognized leaders in their fields, but are also practicing clinicians who understand the grassroots of health care delivery, making ICES knowledge clinically-focused and useful in changing practice. Other team members have statistical training, epidemiological backgrounds, project management or communications expertise. The variety of skill sets and educational backgrounds ensures a multi-disciplinary approach to issues management and creates a real-world mosaic of perspectives that is vital to shaping Ontario's future health care system.

ICES collaborates with experts from a diverse network of institutions, government agencies, professional organizations and patient groups to ensure that its findings are relevant.

ICES goals

In support of our mission, **ICES' key objectives** are to:

- **Carry out population-based health services evaluation** that is relevant to clinical practice and health policy development;
- **Document province-wide patterns and trends in health care delivery;**
- **Develop and share evidence to inform decision-making** by policy makers, managers, clinicians, planners and consumers;
- **Promote linkages among health services researchers and decision-makers; and,**
- **Train researchers and promote a wider understanding of clinical epidemiology and health services evaluation.**



Message from the ICES Board Chair and Chief Executive Officer



For many years, ICES has produced knowledge to help inform policy makers, the health care community and the general public about Ontario's health care system. With this information, it has been possible to establish a clearer picture of health care in Ontario as it currently exists and to develop viable options for addressing pressing issues. Armed with this knowledge, policy makers and planners can develop strategies to address current system challenges and needs, as well as prepare more effectively for the future.

Changing perspectives in an evolving health care system

Given limited resources and increasing consumer demands, as well as new technological and drug developments, measures of health system performance are crucial to determine which services, practices and policies improve outcomes, and which do not. The knowledge produced through ICES studies provides important insight into many issues facing decision makers, provider organizations and clinicians—using sound scientific methods and anonymous data, ICES is able to identify trends, gaps and areas for improvement. With this objective approach, which distinguishes facts from perceptions, ICES has become an essential part of Ontario's health care landscape.

ICES' capacity and areas of expertise continue to grow to meet the need for objective, fact-based evidence to help support important health care decisions, and to meet the demands of our changing system. Current solutions are no longer adequate; we must adjust our thinking and go beyond conventional boundaries to develop new models of and approaches to health care delivery.

In the year ahead, ICES will continue to focus on developing evidence-based information that is aligned with many of the core health care delivery challenges facing Ontario including accountability, improved clinical management and outcomes, assessment of new technologies, health human resources planning, data quality and management, and effective resource use. Using data to produce evidence to shed new light on existing issues, dispel misconceptions, and present opportunities and solutions for the future, ICES is changing perspectives.

Dr. Brian Golden
Board Chair

Dr. Andreas Laupacis
President and CEO

Board of Directors

ICES is governed by a voluntary Board of Directors, whose collective range of experience and expertise guide our strategic direction and research priorities.

Chair

Dr. Brian Golden

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EXECUTIVE DIRECTOR, COLLABORATIVE FOR HEALTH SYSTEM PERFORMANCE, UNIVERSITY OF TORONTO

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Professor Carolyn Tuohy

SENIOR FELLOW, SCHOOL OF PUBLIC POLICY AND GOVERNANCE, UNIVERSITY OF TORONTO

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Mr. John Wright

SENIOR VICE-PRESIDENT, CANADIAN PUBLIC AFFAIRS DIVISION, IPSOS-REID CORPORATION



Changing Perspectives

Evidence for Decision-Making

Given the increasing demand for expensive new drugs and diagnostic tests, an aging population with increasing incidence of chronic diseases, and shortages in health human resources, Ontario's health care system currently faces many challenges. From a public perspective, timely access to safe, high quality health care services is the top concern. Policy makers must develop effective and affordable strategies to address these challenges within our publicly funded system.

To balance these priorities and meet the needs of Ontarians, objective evidence from Ontario-specific, population-based data is necessary to support effective decision-making and guide the future direction of health care.

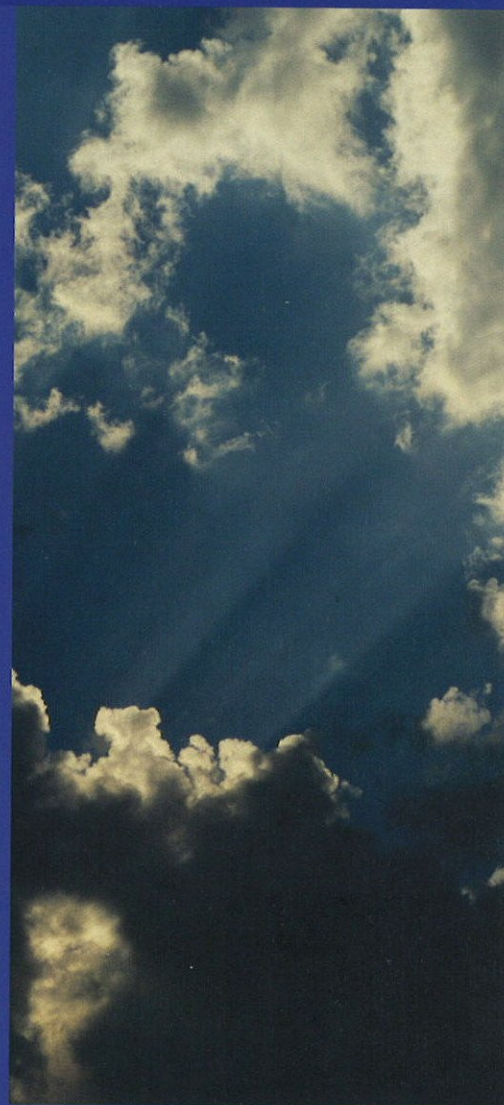
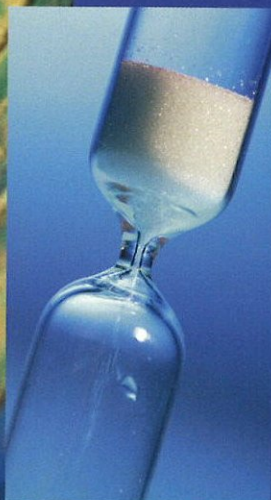
Over the past year, ICES has made significant contributions, providing the necessary evidence to support decisions in areas of importance to the health care community and the public, within a constantly evolving health care system.

The following is a sampling of projects from the past year that demonstrates how ICES supports policy development, planning and improved health care for Ontarians.

Access to care and reduced wait times for key services

In early 2005, ICES released a landmark report that measured, for the first time in Ontario, wait times for key services identified in the government's Wait Times Strategy. Following up on this report, in 2006, ICES released the second edition of its Atlas, *Access to Health Services in Ontario*. The first report presented a framework to examine access to care across six dimensions so that baseline data could be gathered to determine current volumes and associated wait times. The updated findings in this year's report are important to assess the effectiveness of provincial efforts to reduce wait times in the targeted areas, and are also significant for decision-makers as they work to create a more equitable and responsive health care system for Ontario.

The 2006 report showed that although wait times have not grown since 2003/04, there are still significant inequities in access to key services depending on where a person lives and depending on their income. The second edition of the Atlas specifically focused on changes in rates of service provision and wait times between 2003/04 and 2004/05. In addition, this report included wait times by age and gender, and socioeconomic status, as well as patient outcomes for joint replacement surgery, cardiac bypass surgery and cataract surgery.



Key findings of the Atlas included the following:

- Over the past decade, and between 2003/04 and 2004/05, rates of service provision increased for all of the key services identified in the Ontario Wait Times Strategy.
- Wait times for key services have not increased, and have in fact decreased for cardiac procedures.
- There continue to be significant variations in rates of service provision for key procedures across Local Health Integration Networks (LHINs), with some LHINs having rates of service that are more than twice as high as rates in other LHINs.
- Compared to 2003/04, individuals from wealthier neighbourhoods were more likely to access services in 2004/05. Wealthier individuals were also more likely to receive nine out of the 12 procedures examined.

The report also suggested that, in the future, particular attention should be focused on expanding the services for which valid data are collected, so that Ontario can measure indicators of appropriateness; monitor inequities in access by socioeconomic status and geographical region; and track the impact of resource allocation decisions on wait times.

Drug strategy and review

With an increasing number of new drugs being introduced at a rapid pace and often with only limited clinical evidence, drug therapy continues to represent an enormous and controversial health care cost. Policy makers across the country are faced with the challenge of making evidence-based decisions that adequately address equitable and reasonable access within a publicly funded health care system. ICES scientists have contributed to this process by providing decision-makers with significant knowledge obtained from studies that assess utilization and outcomes of various drug therapies.

One such example is an ICES study which showed that a commonly used antibiotic, gatifloxacin, can cause potentially fatal blood sugar abnormalities. Gatifloxacin, one member of a class of antibiotics called fluoroquinolones (currently the most prescribed antibiotics in North America), was associated with an increased risk of potentially life-threatening high and low blood sugar levels, compared to other antibiotics in the same drug class. The results showed that patients treated for low blood sugar levels were more than four times more likely to have received gatifloxacin, and patients hospitalized with high blood sugar levels were almost 17 times more likely to have been treated with this medication in the preceding 30 days, compared to other common antibiotics. Clinicians were cautioned to carefully weigh the risks of gatifloxacin,

particularly because many other antibiotics are available that have little or no risk of dangerous effects on blood sugar levels. Within two months of this study having been published in the *New England Journal of Medicine*, gatifloxacin was taken off the market.

In another study, ICES found a substantial increase in the number of antipsychotic drugs being prescribed, with significant cost to the health care system. The number of elderly Ontarians using antipsychotics increased proportionately by 35% over the study period, from 2.2% at the beginning of 1993 to 3.0% at the end of 2002. This modest increase was associated with a 230% increase in total antipsychotic prescriptions (from 308,149 in 1993 to 1,015,450 in 2002), and a 749% increase in total cost (from \$3.7 million in 1993 to \$31.4 million in 2002). The study also found that atypical antipsychotics, which were only made available in Ontario in the late 1990s, made up 83% of the antipsychotics dispensed and 95% of antipsychotic drug costs by 2002. This pattern is of



particular concern because previous ICES research has suggested that atypical antipsychotics are only associated with modest improvements in dementia patients and may be associated with adverse events. As our population ages and more people develop dementia and are treated with antipsychotics, particularly atypical antipsychotics, consideration will need to be given to the cost versus the benefit of these medications.

Drug strategy and review will continue to be a focus for ICES in the future, as this is one area in which costs continue to escalate, and where opportunities exist for reducing adverse events and improving patient safety.

Evidence for Decision-Making

Health human resources

Government, the health care community and the public alike all recognize that an adequate supply of health human resources is vital to the effective functioning of any health care system. Strategic human resource planning is essential to ensure that the system is prepared for the needs of Ontarians in the future. Using the best available data to inform health human resources planning and policy reform initiatives maximizes effectiveness because it allows for assessment of the present system, determination of future areas for growth and improvement, and measurement of progress along the way.

An example of ICES' work in this area is the investigative report, *Health Human Resources for Neurosurgical Services in Ontario*. Neurosurgical conditions are a major cause of morbidity and mortality in the population, with a high cost to individuals, their families and to society. Yet neurosurgical resources have been stretched to capacity, and, in some circumstances, beyond. This report identified system-level medical staffing and technology issues that impact access to neurosurgery, complex spinal surgery and interventional neuroradiology. Among the findings, five years after graduation, approximately 50% of Ontario neurosurgery graduates have left to practice in the United States or in other provinces. Also, Ontario neurosurgeons have among the highest level of on-call hours of service of all physician groups. This report indicated that Ontario could soon face a severe shortage of neurosurgeons and related specialists unless important changes are made immediately. A series of recommendations as well as system-wide policy options were suggested, including training program development and funding, recognition of regional variation and limitations on working hours.

Similarly, ICES produced a report this year examining the supply and utilization of general practitioner and family physician services in Ontario. This document presented important new information on how Ontarians are accessing primary care services, and how the supply of general practitioners and family physicians has evolved in recent years. The study found that: the supply of family physicians in Ontario continues to decline; there has been some geographic redistribution of the family physician workforce within Ontario; patients are seeing a family physician less often than before; and, many patients continue to see their family doctors for minor ailments. This knowledge highlights the need for health human resources planners to regularly monitor the impact of their policies, as well as social trends. Policies governing the number of physicians in the workforce, as well as the models of care used to deliver primary care services, need to be re-evaluated as new information becomes available in order to have an effective system that is responsive to changing needs.

In a third study, ICES scientists looked at factors influencing family physicians with rural and urban backgrounds entering rural practice. The study survey found that many doctors currently working in rural areas actually grew up in larger cities; rural education has a more pronounced impact on the decision to enter rural practice for urban-raised rather than rural-raised physicians; both urban-raised and rural-raised physicians are attracted to the challenges of rural practice and the rural lifestyle; and, money plays a relatively small role in getting physicians to work in rural areas. These results highlight the fact that exposing physicians who grew up in urban areas to rural medical education or residency programs can be an important strategy in helping to increase the number of physicians who will want to practice in often under-serviced rural areas.

Accountability, improved quality and better patient outcomes

Efforts to improve quality and processes of care are undertaken with a view to improving outcomes for patients. Performance measurement not only assesses the effectiveness of care delivery and improvement initiatives, but also serves to demonstrate and promote health system accountability. ICES has proven experience in translating raw data into accountability measures, and a strong track record in providing knowledge to identify and support improvement opportunities.

Cardiovascular disease places a huge cost burden on our national health care system. This past year, ICES scientists estimated how the 2003 Canadian guidelines for the management and treatment of dyslipidemia would affect the Canadian population in terms of people screened and recommended for statin therapy, and the potential benefits from these drugs for those at low, moderate and high risk of coronary heart disease. They found that the guidelines would lead to hundreds of thousands more people at relatively low risk of heart disease being prescribed statins, resulting in only very small potential benefits for patients but very significant costs to the health care system. Revisions to the guidelines were strongly urged to avoid this potentially costly outcome.

Also, a recent ICES study found an important link between the number of fast-food outlets in a region and the rate of heart disease and mortality in that region. For instance, if a region had 10–19 fast-food outlets per 100,000 people, the mortality rate went up by 35 people per 100,000. For regions with 20 or more fast-food outlets, mortality went up by 62 people per 100,000. For heart attacks and chest pain, 10–19 fast-food outlets per 100,000 people translated into an increase in hospitalizations of 28 people per



ICES is changing perspectives.

Evidence for Decision-Making

100,000, while 20 or more fast-food restaurants led to a jump in hospitalizations of 47 people per 100,000. The relationship between fast-food and adverse outcomes was similar in low and high income neighbourhoods. Although this study was based on an analysis of Ontario data, its findings carry a critical message that can be generalized across regions in Canada and other jurisdictions where fast food is readily available. With fast-food being so accessible and convenient, given the busy lifestyles that people lead, ICES scientists stressed that there is an urgent need for targeted health promotion and prevention strategies to communities with the poorest health profiles and the poorest lifestyle behaviours, and that disincentives—such as exploring tax-based or other reform initiatives—need to be put in place to curtail fast-food demand and promote the consumption of healthier food in high-mortality regions.

In another ICES study, it was found that although Ontarians with diabetes are at lower risk of developing a heart attack or stroke today than they were 10 or 15 years ago, the dramatic growth of diabetes in the population has increased the number of people with heart disease in the province. The overall number of cardiovascular events occurring in the Ontario population grew substantially because of the increase in diabetes cases, despite the fact that heart disease and associated mortality rates fell. Since one-third of all heart attacks and strokes occur in people with diabetes, it is essential that complications of diabetes be considered when looking to reduce overall rates of heart disease. Policy makers and clinicians need to focus on preventing diabetes itself in order to avoid a further rise in the overall burden of heart disease on our health care system and on society as a whole.

Several other studies were released this past year that contributed to the knowledge base on cardiovascular clinical treatment and outcomes, while also offering areas for quality improvement:

- Heart failure patients who are at the highest risk of death were shown to be the least likely to receive life-saving medications such as angiotensin-converting enzyme inhibitors (ACEIs), angiotensin receptor blockers (ARBs) or beta-blockers. Higher-risk patients have a great need for effective treatment and the benefits of these medications are well-established. Increasing the use of these drug therapies in higher-risk patients may improve outcomes.
- New data were provided regarding the disparity between women and men in long-term, non-fatal cardiac outcomes up to 11 years following bypass surgery in Ontario, which showed that women were more likely to have a worse outcome than men. The results showed that, compared to men, women were 1.5 times more likely to be readmitted for unstable angina and heart failure in the first year after

bypass surgery, and their readmission rates remained higher than men's after that. The need to understand the best revascularization strategy for women and to create an optimal management plan that helps to close this gender gap in non-fatal outcomes was highlighted.

- Significant differences in the care provided to elderly heart failure patients hospitalized in Ontario versus the United States (U.S.) were demonstrated. Heart failure is an important condition to study because it affects millions of Canadians and Americans, and evaluating the processes of care and outcomes of heart failure patients treated in both countries may provide insights into the relative performance of these two health systems. The intensity of hospital care in the U.S. could explain the better short-term mortality rates in U.S. heart failure patients, while the similar long-term mortality rates between Ontario and the U.S. may reflect better access in Ontario to outpatient follow-up and prescription drugs. Further studies are needed to explore the reasons underlying these differences in outcomes and to gain additional insights to improve the care and outcomes of heart failure patients in both countries.

In children, up-to-date immunization status is an important measure of the effectiveness of the primary health care system. In a universal health care system such as Canada's, there are few structural barriers to immunization. Therefore, the low immunization rates found in a recent ICES study were concerning. The study showed that many Ontario two-year-olds are not up-to-date with their immunization coverage, despite having a high number of primary care visits—only 66% of children had up-to-date immunizations by age two, despite an average of 19 primary care visits in the first two years of life. Children who were up-to-date were more likely to live in a higher income neighbourhood, have more "well-baby" and primary care visits in the first two years of life, and have high continuity of care. The up-to-date children were also more likely to have a primary care provider who performed a high volume of primary care for children. The study reinforced the importance of a regular care provider who sees a lot of children in their practice and has likely developed office-based practices focused on immunizations. However, the study proposed that the best method for improving immunization rates is through investments in information technology and electronic health records that can function as recall and reminder systems, as well as data repositories to easily track coverage. Such systems have been shown to be very effective in increasing immunization coverage in other jurisdictions.

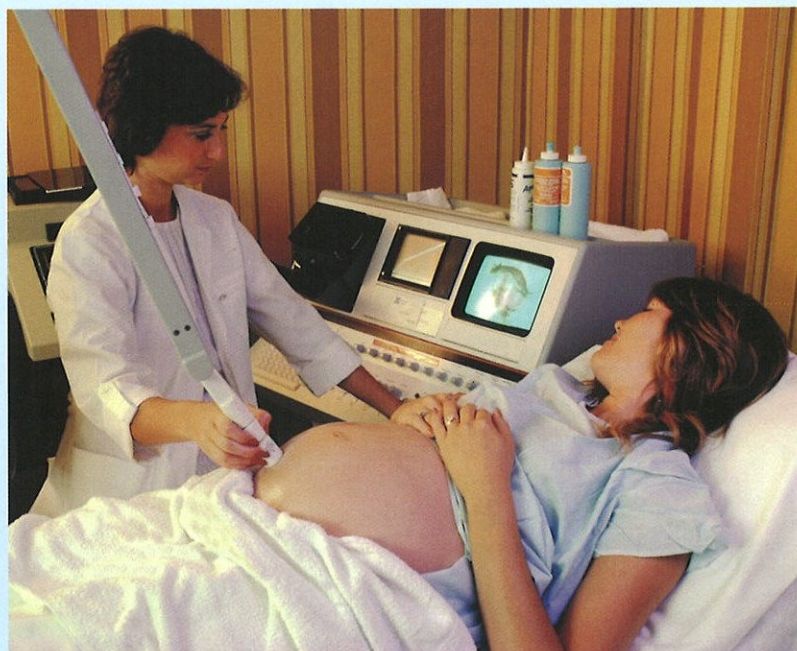
Women's health

Despite increasing acceptance that women have very unique health care needs and that treatment and outcomes for women are often different than for men, one area of research where there is not currently a strong body of knowledge is in the area of women's health. In recent years, though, this area has been slowly growing as a result of public interest and government funding. Over the past year, ICES has made valuable contributions to this developing evidence base by producing a number of reports focused specifically on women's health-related issues.

For example, one study showed that women who develop certain pregnancy complications may be at higher risk of developing heart disease and stroke after the birth of their baby. It was found that the incidence of heart disease doubled for women with a maternal placental syndrome, compared with women who had no such complication. This risk was further increased in women who also had poor fetal growth or death of the fetus while in the womb, and in women with pre-existing risk factors for heart disease such as smoking, hypertension, diabetes, obesity and high cholesterol. Because the risk is similar to conventional heart disease risk factors, ICES scientists believe that maternal placental syndrome should be considered an additional risk factor for heart disease. Clearly, a woman's health before, as well as during, her pregnancy can affect her risk of developing heart disease later on. The study findings highlight the fact that women should try to ensure that they are at a healthy weight and avoid smoking before they enter their reproductive years. As well, those who do develop a maternal placental syndrome should be checked following the birth of their baby to ensure that they are maintaining a healthy weight and blood pressure.

A sister study examined more than one million women in Ontario who had a first delivery between 1990 and 2002, and found that the more features of metabolic syndrome a woman had including obesity, diabetes, and high blood pressure and cholesterol, the greater her risk of a placenta-related complication. Women with one feature—for example, diabetes—were three times more likely to have a placenta-related problem; women with three or four features were almost eight times more likely to experience a problematic pregnancy. The study authors suggested that placental complications might be detected earlier in women who exhibit more than one feature of the metabolic syndrome. Therefore, greater surveillance of women with several features of metabolic syndrome was recommended, including regular testing for high blood pressure and pre-eclampsia at all prenatal visits, and one or two ultrasounds in the third trimester of pregnancy.

A separate ICES study showed that women with diabetes are significantly less likely to receive mammograms to screen for breast cancer, compared with women who do not have diabetes, despite more health care visits. Only 47% of women had at least one screening mammogram, and approximately one-third fewer women with diabetes had a mammogram than women without diabetes. These results translate into approximately 20,000 women with diabetes in Ontario who were not screened over a two-year period, yet might have been if they were free of diabetes, and about 120 new breast cancer cases that may have been



missed over this period. These findings suggest that diabetes care has become significantly more complex and time-consuming over the past decade and that management of this chronic disease could be diminishing the attention paid to long-term disease prevention for conditions such as breast cancer. However, simple inexpensive interventions (e.g., letters to patients, mailed educational materials and phone calls) have been shown to significantly improve mammography screening rates. Therefore, it is important that standardized strategies be implemented, not only to improve breast cancer screening rates in women with complex diseases such as diabetes, but to improve screening across all target populations.

Evidence for Decision-Making

Data quality

ICES has always been on the forefront of advocating for improved data quality in Ontario. As our health system undergoes significant transformation, the comprehensiveness and quality of our health care data is more critical than ever before in the development of evidence-based information needed to inform decision-making and drive health system improvements.

With a view to profiling opportunities for enhancing data quality in Ontario, ICES released the following two reports: *Improving health care data in Ontario* and *Moving toward a better health data system for Ontario*. The latter report expanded on the findings of the first report by providing “real world” scenarios that demonstrate how the current organization, availability and quality of health data impact

our ability to effectively evaluate different aspects of our health care system. The recommendations for moving forward identified the following areas as priorities for improving Ontario’s ability to evaluate health system performance: updating and validating demographic information; providing timely access to up-to-date Vital Statistics; and developing comprehensive databases for primary care services, laboratory services and prescription drug information.

ICES and other organizations involved in the collection and use of health care data continue to work in collaboration with the Health Results Team for Information Management of the Ministry of Health and Long-Term Care, who has undertaken numerous and significant efforts to address Ontario’s data issues.

Our Products— Evolving to Meet Changing Information Needs

Knowledge derived from our ongoing efforts to improve health care for Ontarians is disseminated through regular dialogue with stakeholders; presentations at conferences; participation on committees; and, through distribution of a variety of product lines, including: *At A Glance*, Atlases, Investigative Reports, *informed* and peer-reviewed journal publications.

This year, ICES placed an emphasis on enhancing its electronic communications. The ICES website (www.ices.on.ca) was given a bold new look to better reflect the dynamic and

leading-edge nature of the organization. The newly created *ICES Alert* feature allows website visitors to register to receive e-mail notification of new content, in their identified areas of interest, as soon as it’s added to the website.

A comprehensive *Media Room* was also added to the website to provide visitors with new and archived information on studies of particular interest to the public.

As well, a feature for online notification of new *informed* issues was added. This publication offers a synthesis of best evidence for treating a variety conditions and continues to be very popular among primary care providers.

And, as always, all ICES publications are available *free of charge* on the website.

Going forward, we will continue to focus our efforts on making the knowledge derived from ICES studies useful and accessible.

ICES Alert

Be alerted to new information
as soon as it’s available.

Enter keyword/phrase:

Your e-mail:

ALERT ME!



ICES is changing perspectives.

Auditor's Report on Summarized Financial Statements

To the Board of Directors of the Institute for Clinical Evaluative Sciences

The accompanying summarized statements of financial position, operations and cash flows are derived from the complete financial statements of the Institute for Clinical Evaluative Sciences as at March 31, 2006 and for the year then ended on which we expressed an opinion without reservation in our report dated May 19, 2006. The fair summarization of the complete financial statements is the responsibility of management. Our responsibility, in accordance with the applicable Assurance Guideline of The Canadian Institute of Chartered Accountants, is to report on the summarized financial statements.

In our opinion, the accompanying financial statements fairly summarize, in all material respects, the related complete financial statements in accordance with the criteria described in the Guideline referred to above.

These summarized financial statements do not contain all the disclosures required by Canadian generally accepted accounting principles. Readers are cautioned that these statements may not be appropriate for their purposes. For more information on the entity's financial position, results of operations and cash flows, reference should be made to the related complete financial statements.

PricewaterhouseCoopers LLP
Chartered Accountants

SUMMARIZED FINANCIAL STATEMENTS

Statement of Financial Position

As at March 31, 2006

	Capital and Operating Fund \$	2006 Restricted Fund \$	Total \$	Capital and Operating Fund \$	2005 Restricted Fund \$	Total \$
Assets						
Current Assets						
Cash	380,817	4,379,796	4,760,613	1,611,410	3,814,363	5,425,773
Other receivables	494,772	-	494,772	557,755	186,870	744,625
Prepaid expenses	20,971	-	20,971	37,562	-	37,562
	896,560	4,379,796	5,276,356	2,206,727	4,001,233	6,207,960
Property, plant and equipment	927,824	-	927,824	536,513	-	536,513
	1,824,384	4,379,796	6,204,180	2,743,240	4,001,233	6,744,473
Liabilities and Deferred Amounts						
Current Liabilities						
Accounts payable and accruals	323,083	-	323,083	342,310	16,738	359,048
Due to MOHLTC	1,687	-	1,687	472,565	-	472,565
Deferred revenue	-	-	-	11,027	-	11,027
Due to Sunnybrook and Women's College Health Sciences Centre	554,090	-	554,090	308,977	-	308,977
	878,860	-	878,860	1,134,879	16,738	1,151,617
Post-retirement benefits other than pensions	17,700	-	17,700	17,100	-	17,100
Deferred operating grant	-	-	-	1,054,748	-	1,054,748
Deferred capital grant	927,824	-	927,824	536,513	-	536,513
Deferred expense grants	-	4,379,796	4,379,796	-	3,984,495	3,984,495
	1,824,384	4,379,796	6,204,180	2,743,240	4,001,233	6,744,473

Full audited statements are available upon request.

Statement of Operations

For the year ended March 31, 2006

	Capital and Operating Fund		Restricted Fund		Total	
	2006 \$	2005 \$	2006 \$	2005 \$	2006 \$	2005 \$
Revenue						
Grants-operating	5,663,437	4,846,184	-	-	5,663,437	4,846,184
Interest income	22,041	10,137	-	-	22,041	10,137
Other revenue	2,399,647	2,604,739	-	-	2,399,647	2,604,739
Amortization of deferred expense grants	-	-	4,658,150	1,210,788	4,658,150	1,210,788
	8,085,125	7,461,060	4,658,150	1,210,788	12,743,275	8,671,848
Expenditures						
Salaries and benefits	5,672,401	5,396,661	3,111,937	674,000	8,784,338	6,070,661
Consultative services	666,790	280,034	1,067,871	236,533	1,734,661	516,567
Computer supplies and software	349,521	288,359	167,759	45,521	517,280	333,880
Office and general	305,837	401,751	128,274	25,871	434,111	427,622
Travel	70,727	62,817	85,709	8,664	156,436	71,481
Amortization of property, plant and equipment	242,308	210,197	-	-	242,308	210,197
Professional	52,498	120,833	2,070	-	54,568	120,833
Administrative	380,868	367,093	74,478	-	455,346	367,093
G-Wing expansion costs paid to Sunnybrook and Women's College Health Sciences Centre	-	-	-	210,169	-	210,169
Other	344,175	333,315	20,052	10,030	364,227	343,345
	8,085,125	7,461,060	4,658,150	1,210,788	12,743,275	8,671,848
Excess of revenue over expenditures for the year	-	-	-	-	-	-

Statement of Cash Flows

For the year ended March 31, 2006

	Capital and Operating Fund		Restricted Fund		Total	
	2006 \$	2005 \$	2006 \$	2005 \$	2006 \$	2005 \$
Cash provided by (used in)						
Operating activities						
Excess of revenue over expenditures for the year	-	-	-	-	-	-
Items not affecting cash						
Increase in post-retirement benefits other than pensions	600	2,200	-	-	600	2,200
Increase (decrease) in deferred operating grant	(1,054,748)	883,674	(5,746)	(1,335,279)	(1,060,494)	(451,605)
Amortization of deferred capital grant	(242,308)	(210,197)	-	-	(242,308)	(210,197)
Amortization of deferred expense grants	-	-	(4,658,150)	(1,210,788)	(4,658,150)	(1,210,788)
Amortization of property, plant and equipment	242,308	210,197	-	-	242,308	210,197
Change in non-cash working capital	(176,445)	441,245	170,132	80,157	(6,313)	521,402
	(1,230,593)	1,327,119	(4,493,764)	(2,465,910)	(5,724,357)	(1,138,791)
Investing activities						
Transfer from operating grant to deferred capital grant	633,619	270,285	-	-	633,619	270,285
Purchase of property, plant and equipment	(633,619)	(270,285)	-	-	(633,619)	(270,285)
	-	-	-	-	-	-
Financing activities						
Deferred grants received plus interest income	-	-	5,059,197	1,895,400	5,059,197	1,895,400
Increase (decrease) in cash for the year	(1,230,593)	1,327,119	565,433	(570,510)	(665,160)	756,609
Cash—Beginning of year	1,611,410	284,291	3,814,363	4,384,873	5,425,773	4,669,164
Cash—End of year	380,817	1,611,410	4,379,796	3,814,363	4,760,613	5,425,773

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