BC HEALTH CARE RISK MANAGEMENT SOCIETY

ANNUAL REPORT
FISCAL 2001/2002

Submitted by: **Janice Markin, Executive Director**
BC Health Care Risk Management Society
#318 - 1175 Cook Street
Victoria, BC V8V 4A1

As Approved by the Board of the BC Health Care Risk Management Society
June 28, 2002

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OVERVIEW OF THE ORGANIZATION

History:

In 1986, the private insurance market experienced a "liability crisis." At that point, hospitals were facing premium increases of up to ten-fold for their liability / medical malpractice insurance as well as reductions in limits and coverage available. In many cases, insurance coverage was simply no longer available for hospitals. In response to this crisis, a risk management program (the Program) was established for hospitals that included the development of a risk transfer mechanism or self-insurance vehicle (the Hospital Protection Program or HPP). The BC Health Care Risk Management Society (BCHCRMS or the Society) was created to establish a membership base and to administer the Program. Regionalization in the mid to late 90s resulted in an expansion of the Program as member health care organizations became responsible for public health, mental health and continuing care. In 1998, as a response to this integration of health care, the HPP (which, originally, had been primarily directed at acute care hospitals and other approved long term care facilities) became the Health Care Protection Program (HCPP).

BCHCRMS is established under the *Societies Act* and is directed as a co-operative venture by 15 Directors. The Society is operationally funded by the Ministry of Health Services and its directors represent the BC health care industry as well as the provincial government. The environment in which the Society's member health care entities operate includes expansive legislation – members must be aware of the risk implications of the *Freedom of Information and Privacy Protection Act* (FOIPPA), *Hospital Act, Hospital Insurance Act, Health Authorities Act, Societies Act* (or other specific governing pieces of enabling legislation), *Adult Guardianship Act, Community Care Facilities Licensing Act, Water Act, Health Care (Consent) and Care Facility (Admission) Act*, and the *Transport of Dangerous Goods Act* to name a few. The list continues to expand and the environment within which we, and our members, operate continues to become increasingly more complex.

Mandate:

The Society's mandate currently reads:

> *To provide Risk Management Services (including liability coverage) for hospitals, Regional Health Boards ("RHBs"), Cluster Boards, Community Health Councils ("CHCs"), Community Health Service Societies ("CHSSs")[1] and other designated health care agencies within British Columbia.*

In general terms, Risk Management Services can be defined as including the administration of the Health Care Protection Program as well as the provision of direct or indirect risk management advisory services to members.

[1] Reference to Cluster Boards, Community Health Councils and Community Health Service Societies is slated for future amendment based on December 2001 restructuring of health care organizations.

Core Functions:

Specifically, the core functions of the Society can be described as:

Administration of the Health Care Protection Program (HCPP) or other similar risk, insurance or loss funding programs which may arise:

The Society, in conjunction with the Risk Management Branch of the Ministry of Finance, participates in the administration, interpretation and application of HCPP. The coverage agreements, which provide the basis for the Program, include the Health Care Comprehensive Liability Agreement, the Health Care Crime Agreement and the Health Care Property Agreement (collectively the Coverage Agreements) and describe the terms, conditions and limitations of protection afforded to members of the Society. The Society provides members with direct advisory services relating to questions or situations which arise relative to coverage under the Program.

Risk Management Advisory Service:

The purpose of the Society's Risk Management Advisory Service is to assist in the identification, analysis, evaluation and management of risks. Advisory services are provided in a broad range of areas – as the direction of health organizations change as a result of the integration of health care and other initiatives, the Society's advisory services must also be adjusted and fine-tuned in order to draw on or bring in appropriate experience and expertise. The service has four components:

Centralized Consultation:

The Society provides guidance, advice and information regarding issues, problems or situations arising in the operation of the member health organization which constitute perceived or actual risk exposures.

Risk Management Education:

The Society organizes resources for the provision of basic and custom educational programming to member agencies on risk management topics, principles and practices. The services are organized to match expertise to specific audiences, care settings and desired topics.

Communications:

The Society produces routine and "as needed" publications and other media related to the management of the Program, as well as communications relevant to risk, coverage, claims and operational issues faced by our members.

Loss Control Inspection Services:

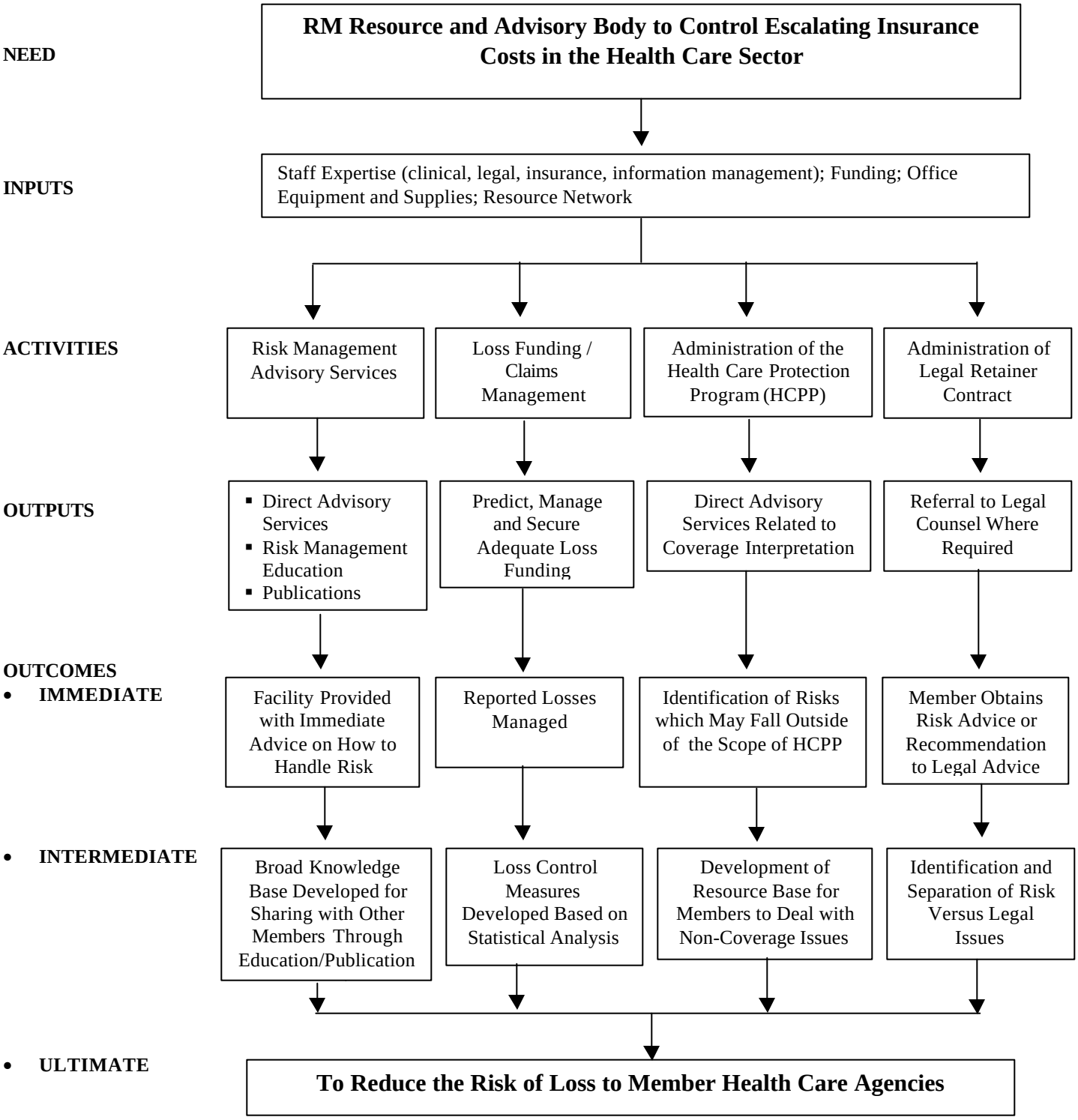
The Society currently contracts with Marsh Canada Inc. to provide loss control inspection services for all facilities.

Administration of Legal Retainer:

In April of 2000, the Society's role was expanded to include the administration of the legal retainer for public health, mental health and continuing care. As these community health services are now provided by health authorities (and not directly by government as was the case prior to 1997) the legal services of the Attorney General's office were no longer available to health organizations.

After the consolidation in December of 2001 of CHCs and CHSSs into the newly divided health authorities, effective April 1, 2002, health authorities will be expected to absorb the costs of legal services for public health, mental health and continuing care through their overall budgets. While risk management advice continues to be provided in these areas, the Society will no longer be administering a central legal retainer.

LOGIC MODEL BC HEALTH CARE RISK MANAGEMENT SOCIETY



MESSAGE FROM THE PRESIDENT

June 2002

Message from the President

2001/02 can be characterized as a year that has seen the beginnings of significant change. Changes have occurred in our own internal environment, in the operating environment of our member health care entities and, not insignificantly, in our global surroundings.

Significant issues facing the Society and its staff in the past year have included the provision of risk management advice for member health care agencies relative to nurses' job action and, more recently, physicians' job action. The Society was actively involved in raising the profile of contingency planning at both facility and regional levels.

The restructuring of the health care system across the province in December 2001 has also impacted the Society. As the newly defined health authorities work to establish their organizational frameworks, new relationships must be established and existing ones solidified. In the process, we have had to say goodbye to many talented individuals whose experience and presence will be missed.

The events of September 11 continue to have a profound effect on our world. Tremendous pressures are percolating within the private insurance market and, as a result, there are market capacity problems, unprecedented premium increases and coverage restrictions. The largest medical insurer in the US has withdrawn from the marketplace. BC's health authorities remain insulated from these market fluctuations through the continued existence of the Health Care Protection Program (HCPP).

Performance targets set for the 2000-01 planning period were realistic and success has been achieved in all areas: a workload analysis tool has been developed and data is currently being gathered; the Society's website has been completely revamped with information now available on-line to members; and significant work has taken place through the Society's Loss Control Committee in the development of educational objectives.

To close, at the time of writing the Society has been contemplating its own structure. Options are being considered which will allow HCPP to continue as a program yet gain efficiencies through alternative service delivery models. We look forward to the changes this new challenge will bring and anticipate that the future holds significant promise for expanded growth in our program and our services.

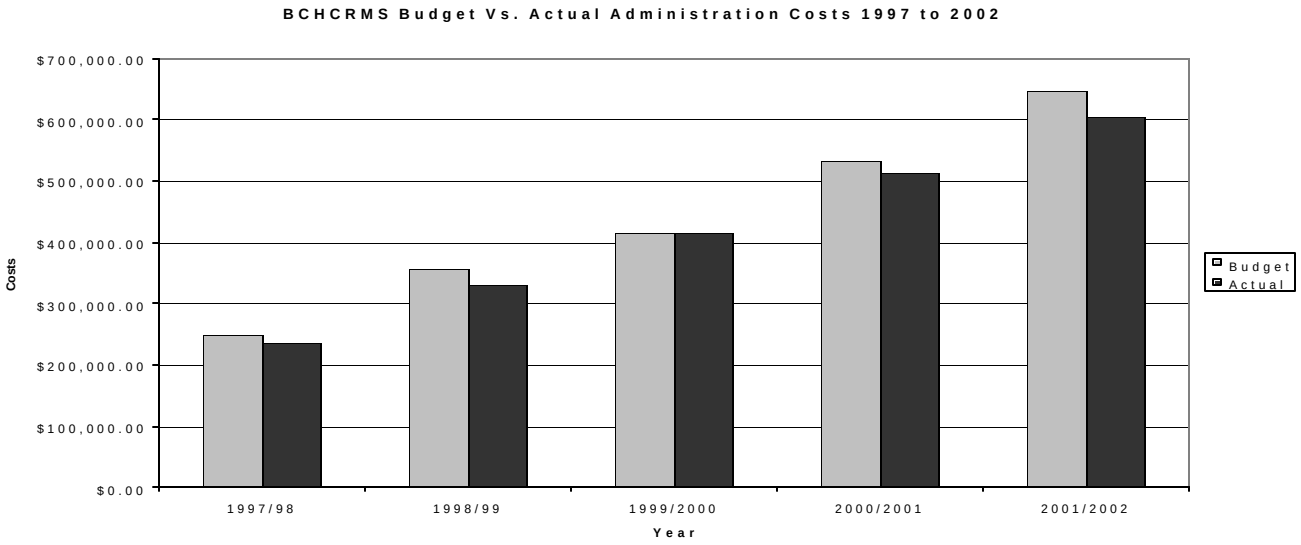
Dr. Ernie Higgs
President
BC Health Care Risk Management Society

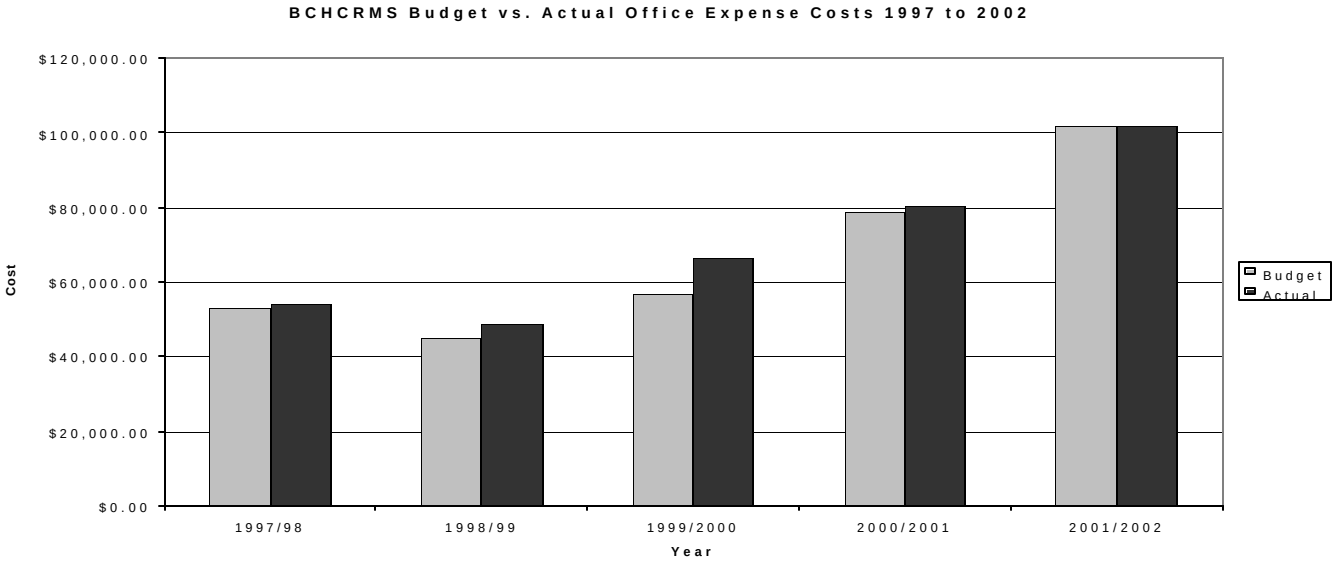
THE YEAR IN REVIEW

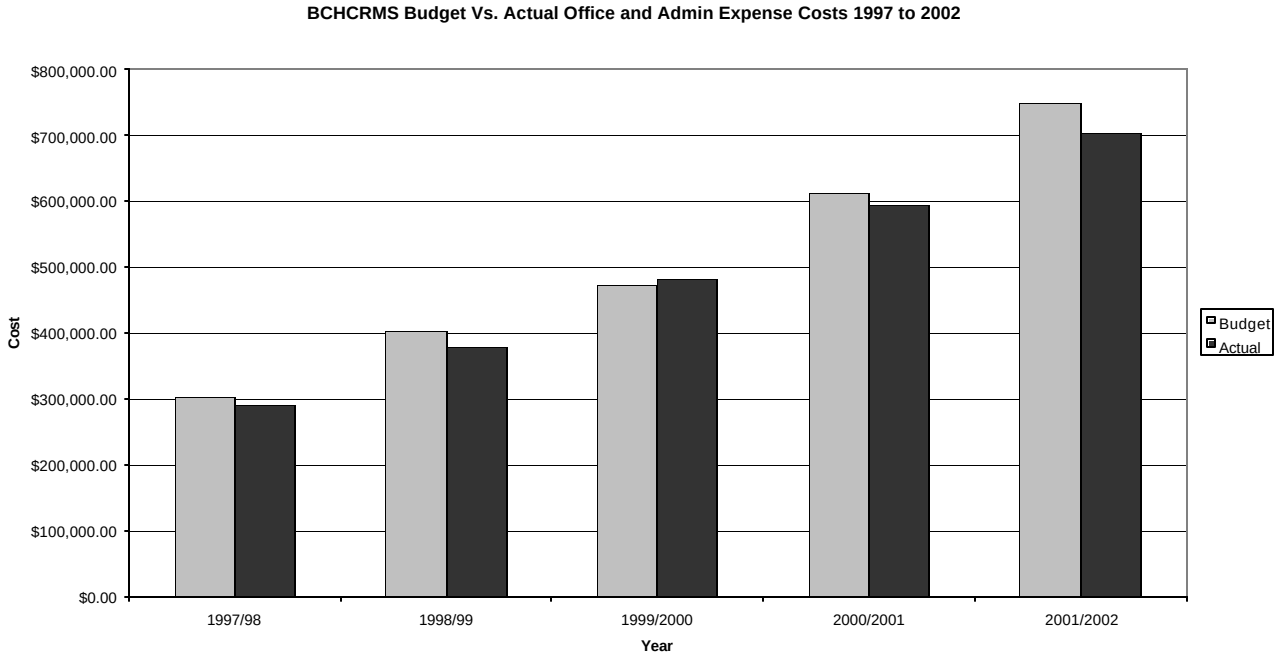
Key Financial and Operational Highlights and Trends:

Comparison and analysis with similar organizations remains difficult as the Society's operations are fundamentally unique within the Canadian health care system. Comparisons would typically be made based on historical insurance-driven data and would be reflective of a marketplace in which insurers (or in many cases, reciprocals) have the ability to assess premium based on various criteria such as services provided, claims experience, industry trending etc. Equally important is the fact that private health liability / malpractice insurers in Canada and the U.S. have the ability to actively seek out particular sets of clients and to base their program and its costs on a selected spread of risk. Participation in HCPP is mandatory for the various health authorities in BC and funding for the Program (provided by the Ministry of Health Services) is based purely on an actuarial analysis of reported claims. This means that the usual comparisons of loss ratios and operating expense ratios (percentage of claims paid and/or operating expenses versus gross premium written) are inappropriate.

The following graphs illustrate BCHCRMS' budgeted versus actual costs of administrative (salary costs) and office expenses over the past five years. The graphs show the steady increase in the Society's costs over the growth of the program. Based on anticipated budgetary restrictions of a zero percent increase over the next three years, the Society will need to respond to cost pressures while maintaining the levels of service provided. Focus will need to be maintained on initiatives that provide members continued access to services while requiring minimal cost increases to the Society.







Major Initiative or Development:

2000/01 was dedicated, in part, to the creation and establishment of a website geared to reduce pressure on staff while providing HCPP members with access to relevant and timely risk management information. The services of a firm who specialized in information-based website development (as opposed to marketing and product-driven website development) were sought. Restructuring of the health care sector in December of 2001 required a temporary re-allocation of Society resources, putting the project several months behind. A review of available information for posting was undertaken with a view to ensuring relevancy, accuracy and priority. The final product was tested with select members over March-April of 2002 with full access being provided to members in May of 2002.

REPORT ON PERFORMANCE

Following are the goals, objectives and performance measures as set out in the Performance Plan for BCHCRMS for the planning period of 2001-2004.

Goal	**Objective**	**Performance Measures**		
		2001 / 02	**2002 / 03**	**2003 / 04**
Further develop and maintain an organizational infrastructure (including resources, systems and staffing) to deliver core BCHCRMS services	To assess our current resources, determine the adequacy of same, and identify the deficiencies that need to be addressed in order to deliver our core services	Develop a means by which to appropriately measure and monitor workload levels: *catalogue requests for advisory services including priority level *development of workload timesheets	Measure workload against the resources available systems staffing Identify deficiencies and assess resources required to rectify	Modify systems / staffing as necessary in order to deliver core BCHCRMS services. Monitor and modify workload tracking systems as necessary.
Provide leadership in the development and delivery of risk management education to the health care industry	To generate an educational strategy in collaboration with our membership Expand and improve existing website	Manage existing commitment to educational sessions given current resources Province-wide: *Section 51 of the BC Evidence Act *Adult Guardianship Legislation Review member feedback Identify areas for inclusion under enhanced website Secure competitive pricing / options Core components of website up and running by end of fiscal year ½	Member survey for educational needs with annual targets to be developed Explore alternative forms of educational delivery Analyze resource levels to determine necessary adjustments Monitor website use through analysis of “hits” and member feedback Expand core components based on member feedback	Member survey for educational needs with annual targets to be developed Development of joint educational initiatives with various bodies / organizations Explore options for monitored member discussion board Provide elements of core educational services “on-line”

Changes Made to Goals, Objectives and Targets and the Rationale for Same:

In response to the requirements of the Budget Transparency and Accountability Act (BTAA), the Society crafted its first Performance Plan for the planning period 2001 - 2004. While the underlying premise behind the goals has remained essentially unchanged, a closer review of objectives, (strategies), performance measures (and targets) during the creation of the Service Plan for 2002 - 2005 identified deficiencies in the earlier plan. Consequently, while a considerable amount of work was done toward establishing outcome-based performance measures and targets for future years a determination was made not to revise the previously established performance measures.

Analysis:

In general terms, the goals established for 2001-02 were met as follows:

Measurement and Monitoring of Workload: The existing in-house activity-log database, through significant staff input, was revised to include both a priority-based rating tool as well as a workload-based monitoring feature. Requests for advice, or Service Requests (SRQs), are now prioritized based on a dual category system:

Primary Category	Member's level of urgency for response (priority-based)	1- high 2- medium 3- low
Secondary Category	A combination of resources required and time spent by staff (workload-based)	**1 – Limited Resources/Time** Less than three hours to complete, information immediately accessible **2 – Limited Resources/Moderate Time** Three hours to five days to complete, information immediately accessible **3 – Moderate Resources/Limited Time** Less than three hours to complete, Information located after search **4 – Moderate Resources/Time** Three to five days to complete, Information located after search **5 – Moderate Resources/Significant Time** Greater than five days to complete, Information located after search **6 – Significant Resources/Moderate Time** Three to five days to complete, Information not present **7 – Significant Resources/Time** Greater than 5 days to complete, Information not present

It is hoped that longer-term quarterly reviews of these statistics will provide a closer view of the workload trends of staff and, ultimately, will allow for a review of the types of SRQs which are a) requiring urgent attention from our members and may be indicative of educational materials which

need to be developed on a proactive basis and b) identify SRQ areas which are taking up significant amounts of time for staff relative to time and resources, allowing us the ability to analyze areas where expertise may need to be expanded and/or resource materials made more readily accessible to both members and staff.

An analysis is to be completed quarterly (based on a calendar year) and the first analysis is expected to be completed shortly.

A database was also established to track staff time relative to various pre-determined activity categories. The idea was not to monitor staff or oversee the number of hours worked – the idea was to monitor what areas of work the various staff members are spending time in. Staff themselves were divided into four categories:

Management
Advisory Services
Systems
Support Services

Workload was then classified into several areas and each area would constitute different types of work dependent upon the classification of the staff member involved.

Advisory Service
Claims
Communications
Education - Members and Others
Education - Self
Legislation
Human Resources
Planning & Development
Governance
General Administration
Management – Marketing & Promotion
Other

In the process, the ability to monitor work being performed outside of the expected or anticipated levels was established. An early-identified trend is that Advisory Services and Management staff were spending a high percentage of their time handling the claims reporting and processing issues. Consequently, the position of Risk Management Consultant was created to relieve some of the pressure and to ensure a positive link between the claims processes and loss control efforts through a weekly reporting link to advisory staff.

Development of Educational Strategy: The Loss Control Committee worked hard during 2001/02 to review its function and role and to re-establish itself through a revitalization of its terms of reference. One of the purposes of the Loss Control Committee can be described as follows:

> *Within the vision, mission and strategic direction of the Society, the Loss Control Committee will act in an advisory capacity to the Board regarding … promoting the delivery of education, communication and consultation / advisory services of the Society.*

This purpose supports one of the fundamental goals of the Society as outlined in the Performance Plan for 2001 / 02 – to provide leadership in the provision of risk management services. During the planning processes of the March 2002 quarterly meetings, the Loss Control Committee established its own set of goals, objectives and strategies (see attached **Appendix A**). The process was an exciting one and one which we look forward to continuing into the coming year. It is anticipated that membership of the Loss Control Committee will be restructured in the coming months to ensure representation from the risk managers in the various newly defined health authorities as well as other member health care agencies. This will allow us to ensure that our educational strategy is developed in concert with our membership's input.

Publications: After considerable effort and consultation with legal counsel, the Society provided members with educational materials relevant to specific areas of legislation in 2002. A follow-up survey will be sent to members within the next six months to determine their perspective on the user-friendliness of the publications, the usefulness of the document and the survey will also solicit general feedback from members. Verbal indications received to date have been that the documents have been well-received and are a useful risk management tool.

Website Development / Enhancement: The Society's initial launch of the BCHCRMS website in 1999 was done with little resources and did not include the precautions necessary to provide members with a comprehensive resource base (such as password protection). Early in the planning stages for 2001 it was recognized that the benefits of a substantially enhanced website were significant, and that to not capitalize on our ability to provide pro-active risk management advice in this capacity would result in the eventual inability of BCHCRMS staff to respond to the increasing demands for day-to-day risk management advice. In short, we could not afford to ignore the upgrading requirements of our site.

The services of a website development firm with expertise in the creation of an information-based site (as opposed to a marketing / sales driven site) were sought. A service provider was chosen and the process officially began in September of 2001. The project was delayed somewhat as the Society had to divert staff resources during the restructuring of health authorities in late 2001, however, the final site was tested by select members over March - April of 2002 with the official site being launched for members in May of 2002. In addition to the site having a member-specific component, there is also a staff only area which, in the future, will allow staff to access a broader range of in-house materials which can be housed on the internet.

Over the latter half of 2001, a review of some of our educational and in-house resource materials was undertaken. Years of accumulation of information meant culling through reams of files to determine the continued relevancy and applicability of material. In March of 2002, a priority list of topics was developed based on a review of our SRQ information over the previous two years. Similar exercises are ongoing and we expect to be regularly reviewing information for subsequent posting on our site over the next year or so.

The initial performance measures for this objective centered around output-based measures such as number of hits and expansion of website elements. During the planning exercises for 2001-2004 we realized that the fundamental goal we were trying to achieve was to increase our members' internal reliance – i.e. we wanted to be able to provide them with readily accessible information so that their own internal programs would be enhanced. Said another way, the ultimate outcome would be an increase in the knowledge levels of our members. Accordingly, performance measures and targets for the coming years have been re-evaluated and redefined to take this amended perspective into consideration.

FINANCIAL REPORT

Management Discussion & Analysis:

Historical Comparison: The Society's budget can effectively be separated into two categories. The first is indemnity funding (liability and property). The second is administrative and office expenses. Indemnity funding is based on an actuarial analysis and has, historically, been fully funded by the Ministry of Health. During fiscal years 2000/2001 and 2001/2002 the Ministry of Health did not fully fund the administrative / office expenses and, accordingly, the Board of the Society authorized use of a small, accumulated surplus.

In its budget processes during fiscal year 2000/2001 the Board authorized use of $99,351 in accumulated surplus, however, actual expenditures were less than planned resulting in a deficit of only $65, 185. During fiscal year 2001/2002 the Board authorized use of $100,000 in accumulated surplus based on the Ministry's equivalent under-funding of administrative and office expenses. Actual figures for fiscal year 2001/02 have come in at a surplus of $32,696 which means that the Society actually underspent on its projected budget by $132,696. This underspending can be directly attributed to costs saved from salary adjustments based on maternity leaves, as well as savings in costs which were anticipated in fiscal 2001/2002 for increased lease agreement costs and/or moving expenses but which will be delayed likely until fiscal 2002 / 2003.

External Business and Policy Environment / Future Outlook: The fiscal environment during 2001 / 2002 was one of cautionary restraint. The health care industry in general was bracing for budget announcements – the Society itself did not receive a formal indication of budget allocation from the Ministry of Health until August of 2001. The government's core review process had many stand-alone agencies and societies contemplating their future and, at minimum, exercising caution in the movement and development of new initiatives.

The end of fiscal year 2001/2002 saw the Society questioning the effectiveness and efficiency of its own structure. While HCPP itself had already undergone and passed the core review process (solidifying its role as a fundamental part of the overall programs of government), the most effective method for delivery of the HCPP program came under discussion. The Board of the Society felt very strongly that a pro-active approach was appropriate as opposed to a reactive approach. Accordingly, as we move into fiscal 2002/2003 discussions are underway concerning the possibility of a restructuring of the method of delivery of services currently offered under the direction of the BCHCRMS as a non-profit society.

B.C. HEALTH CARE RISK MANAGEMENT SOCIETY

Financial Statements
For the Year Ended March 31, 2002

Norgaard Neale Camden

Norgaard Neale Camden
Chartered Accountants

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Deron T. Freer, B.Comm., C.A.*

R.W. Denson, B.Comm., C.A.

AUDITORS' REPORT

To the Members of
B.C. Health Care Risk Management Society

We have audited the balance sheet of B.C. Health Care Risk Management Society as at March 31, 2002, and the statements of operations and surplus, and cash flows for the year then ended. These financial statements are the responsibility of the Society'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 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 Society as at March 31, 2002 and the results of its operations and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles. As required by the British Columbia Society Act, we report that, in our opinion, these principles have been applied on a basis consistent with that of the preceeding year.

Norgaard Neale Camden Ltd.

CHARTERED ACCOUNTANTS

Victoria, B.C.
May 30, 2002

** Incorporated professional*

B.C. Health Care Risk Management Society

Balance Sheet
As at March 31, 2002

	2002 $	2001 $
ASSETS		
Cash	331,867	287,455
Accounts Receivable	1,080	853
Prepaid Expenses	28,400	25,823
Capital Assets (note 3)	13,060	17,944
Due from Province of British Columbia (Ministry of Health)	5,937,431	5,680,000
	6,311,838	6,012,075
LIABILITIES AND SURPLUS		
Accounts Payable and Accrued Liabilities	73,107	63,472
Due to Province of British Columbia (Ministry of Finance and Corporate Relations)	5,937,431	5,680,000
Surplus	301,300	268,603
	6,311,838	6,012,075

SIGNED ON BEHALF OF THE BOARD

Director

Director

Norgaard Neale Camden

B.C. Health Care Risk Management Society

Statement of Operations and Surplus
For the Year Ended March 31, 2002

	2002 $	2001 $
Revenue		
Grants - Province of British Columbia (Ministry of Health)	15,640,678	15,419,381
Interest	4,416	10,894
	15,645,094	15,430,275
Expenses		
Administration of legal retainer	204,573	235,330
Audit	3,140	3,034
Conferences	6,455	3,391
Contract personnel	650	1,800
Contracted administration - Province of British Columbia (Ministry of Finance and Corporate Relations)	157,500	157,500
Depreciation	7,994	9,013
Indemnification costs - Province of British Columbia (Ministry of Finance and Corporate Relations) (note 4)	12,110,000	12,180,000
Insurance costs	25,175	23,400
Legal fees	21,083	42,594
Loss inspection/property pooled fund - Province of British Columbia (Ministry of Finance and Corporate Relations) (note 4)	2,367,019	2,215,728
Office	72,032	71,326
Salaries and benefits	602,776	513,818
Travel	34,000	38,526
	15,612,397	15,495,460
Excess (Deficiency) of Revenue over Expenses	32,697	(65,185)
Surplus - Beginning of Year	268,603	333,788
Surplus - End of Year	301,300	268,603

Norgaard Neale Camden

B.C. Health Care Risk Management Society

Statement of Cash Flows
For the Year Ended March 31, 2002

	2002 $	2001 $
Cash Provided from (Used for)		
Operating Activities		
Excess (deficiency) of revenue over expenses	32,697	(65,185)
Item not affecting cash:		
Depreciation	7,994	9,013
	40,691	(56,172)
Changes in non-cash working capital balances related to operations -		
Accounts receivable	(227)	(268)
Due from (to) Province of British Columbia (Ministry of Health)	(257,431)	10,404,000
Due to (from) Province of British Columbia (Ministry of Finance and Corporate Relations)	257,431	(10,404,000)
Accounts payable and accrued liabilities	9,635	33,350
Prepaid expenses	(2,577)	1,599
	47,522	(21,491)
Investing Activity		
Purchase of capital assets	(3,110)	(15,743)
Increase (Decrease) in Cash	44,412	(37,234)
Cash - Beginning of Year	287,455	324,689
Cash - End of Year	331,867	287,455

Norgaard Neale Camden

B.C. Health Care Risk Management Society

Notes to Financial Statements
For the Year Ended March 31, 2002

1. Purpose of the Organization

The B.C. Health Care Risk Management Society ("Society") is a non-profit organization and was incorporated under the Society Act on October 21, 1986. The purpose of the Society is to provide risk management services for Regional Health Boards ("RHBs"), Community Health Councils ("CHCs"), Community Health Services Societies ("CHSSs"), their amalgamated entities, non-amalgamated acute and extended care hospitals and other select health care entities. These risk management services include the administration of the Health Care Protection Program ("HCPP") and other risk, insurance or loss funding programs which may arise, the provision of direct or indirect risk management advisory or inspection services including consultation, education, loss control, and communication support for its member RHBs/CHCs/CHSSs, health care agencies and providers. The Society has taken over the property and crime coverage programs of HCPP which were previously provided by B.C. Health Services.

2. Significant Accounting Policies

The Society follows the deferral method of accounting for contributions.

Basis of Accounting

The Society records transactions on an accrual basis. Under this basis, revenues are recorded in the period in which they become due and expenses are recorded when goods are received or services rendered.

Capital Assets and Depreciation

Capital assets are carried at cost less accumulated depreciation. Depreciation is charged against income using the straight line method in amounts sufficient to amortize the cost of capital assets over their estimated useful lives at the following annual rates:

Computers	33.3%
Furniture and equipment	20%

A half year of depreciation is taken in the year of acquisition.

Measurement Uncertainty

Financial statements are based on representations that often require estimates to be made in anticipation of future transactions and events and include measurements that may, by their nature, be approximations.

Norgaard Neale Camden

B.C. Health Care Risk Management Society

Notes to Financial Statements
For the Year Ended March 31, 2002

3. Capital Assets

	2002			2001
	Cost	Accumulated depreciation	Net	Net
	$	$	$	$
Computers	47,016	41,243	5,773	8,846
Furniture and equipment	24,516	17,229	7,287	9,098
	71,532	58,472	13,060	17,944

4. Indemnification Costs

The Society has arranged with the Province of British Columbia to provide RHBs/CHCs/CHSSs and other specifically identifiable health care facilities with an indemnification for liability claims against the facility. The cost of $12,110,000 (2001 - $12,180,000) is intended to protect the Society's member entities against liability claims where the incident occurred during the fiscal year ended March 31, 2002. In addition, there was a transfer of funds of $2,367,019 (2000 - $2,215,728) from the Province of British Columbia to provide the pooled fund to pay the property losses of the member entities.

5. Operating Leases

The Society's total obligations under operating leases are:

	$
Year ending March 31, 2003	35,408
2004	1,778
2005	1,778
2006	445
	39,409

6. Financial Instruments

The Society's financial instruments consist of cash, accounts receivable, amounts due to and from the Province of British Columbia, and accounts payable and accrued liabilities. Unless otherwise noted, it is management's opinion that, under normal circumstances, the Society is not exposed to significant interest, currency or credit risks arising from these financial instruments.

Norgaard Neale Camden

CORPORATE GOVERNANCE

Mandates of Board of Directors

In accordance with the By-Laws of the Society the property and affairs of the society shall be managed by a board of directors in which shall be vested full control of the assets, liabilities, revenues and expenditures of the Society. The Board shall have the control and management of the affairs of the society and may make rules or regulations governing its operations which are not inconsistent with the directives of the Ministry of Health, the provisions of these By-Laws, or of any statute or the regulations passed thereunder.

Mandate of Board Committees:

Executive Committee: Subject to the control of the Board, the Executive Committee shall have the power to transact all business of the Society between the meetings of the Board as well as oversee the financial function of the Society in accordance with approved Financial Policies. Executive Committee members consist of the President, Vice President, Treasurer and the Chairs of the Loss Control Committee and the Claims Committee.

Claims Committee: The purpose of the Claims Committee is to oversee the planning, management and direction of the claims services of the Society (as part of the administration of HCPP) as well as to expedite the settlement of specific claims on behalf of the Board of the Society.

Loss Control Committee: The fundamental purpose of the Loss Control Committee (LCC) is to oversee the planning and management of loss control services of the Society. As part of this process, the LCC has responsibility for promoting the delivery of education, communication and consultation / advisory services of the Society.

MEMBERSHIP OF BOARD OF DIRECTORS

Dr. Ernie Higgs, President
Corporate Medical Director
Vancouver Island Health Authority

Ms. Tamara Vrooman, Vice President
Assistant Deputy Minister
Ministry of Health Services

Mr. Murray Jacobs, Treasurer
A/Director
Finance & Decision Support – Regional Grants
Ministry of Health Services

Mr. Phil Grewar
Director
Risk Management Branch
Ministry of Finance

Ms. Lynn Griffith
Director, Systems & Capital
Fraser Health Authority

Dr. James Lu
Medical Health Officer
Interior Health Authority

Ms. Ellen Pekeles
Chief Operating Officer
North Shore Coast Garibaldi Health Services Delivery Area
Vancouver Coastal Health Authority

Ms. Dora Nicinski
Former CEO
North Okanagan Health Region

Mr. Peter Van Rheenen
Executive Director, Regional Programs
Ministry of Health Services

Ms. Mary McGovern
Retired Nurse

Currently 4 Vacant Positions

Secretary to the Board
Ms. Janice Markin
Executive Director
BC Health Care Risk Management Society

MEMBERSHIP OF BOARD COMMITTEES

Executive Committee Members:

Dr. Ernie Higgs (Chair)
Ms. Tamara Vrooman
Mr. Murray Jacobs
Mr. Phil Grewar
Ms. Lynn Griffith

Claims Committee Members:

Mr. Phil Grewar (Chair)
Dr. Ernie Higgs (Ex-Officio)
Dr. James Lu
Ms. Dora Nicinski
Ms. Mary McGovern
Ms. Ellen Pekeles
Ms. Kim Oldham (Ex-Officio)

Loss Control Committee Members

Ms. Lynn Griffith (Chair)
Dr. Ernie Higgs (Ex-Officio)
Dr. James Lu
Ms. Mary McGovern

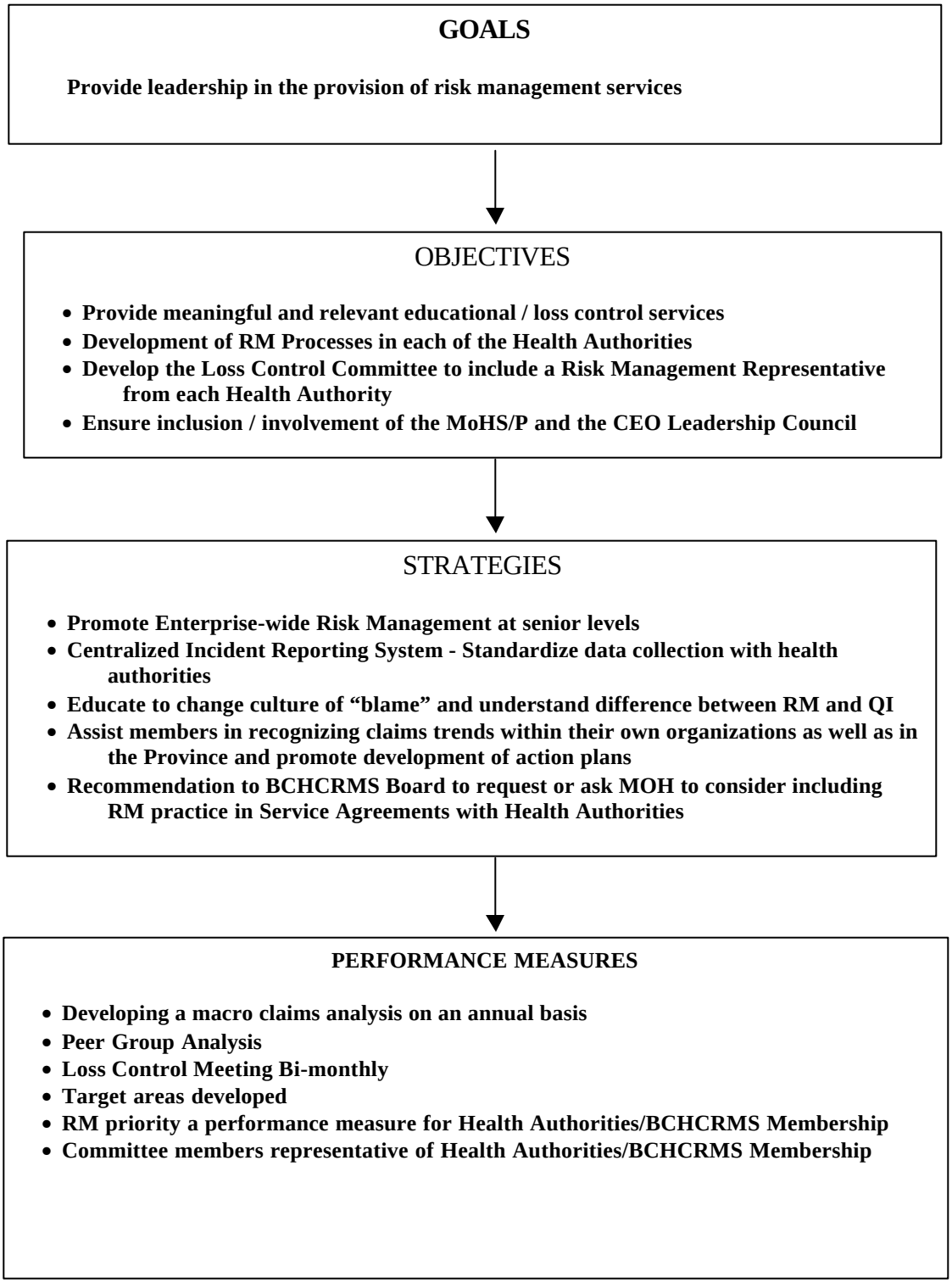
Non-Board Members
Mr. Warren Hart,
Director, Medical Affairs
Providence Health Care

Ms. Helen Healey,
Manager for Risk Management Systems
Fraser Health Authority

SENIOR MANAGEMENT

Ms. Janice Markin
Executive Director

APPENDIX A BCHCRMS / LOSS CONTROL COMMITTEE GOALS, OBJECTIVES AND STRATEGIES



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