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Northwest Territories Legislative Assembly

12th Assembly
Third Session

Standing Committee on Public Accounts

Proceedings

Public Hearings on a Review of Tabled Document No. 5-12(3), *Report of the Auditor General of Canada on a Comprehensive Audit of the Department of Health.*

Henry Zoe, M.L.A.,
Chairperson.

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

PUBLIC MEETING

PROCEEDINGS

WEDNESDAY, JANUARY 6, 1993

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

WEDNESDAY, JANUARY 6, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Other Members of the Legislative Assembly In Attendance

Mrs. Jeannie Marie-Jewell
Mr. Dennis Patterson

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

Mr. Raymond Dubois, Deputy Auditor General, Ottawa, Ontario

Mr. Roger Simpson, Principal for Auditor General's Office, Edmonton, Alberta

Mr. Michael Martin, Senior Auditor, Office of the Auditor General

Dr. David Kinloch, Deputy Minister, Department of Health

Mr. Nelson McLelland, Director, Hospitals and Health Facilities, Department of Health

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

JANUARY 6, 1993

Members Present

Mr. Bernhardt, Mr. Dent, Mr. Gargan, Mr. Koe, Mrs. Marie-Jewell, Mr. Ningark, Mr. Whitford, Mr. Patterson, Mr. Zoe

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): Good afternoon, I believe I have a quorum. I would like to call the public meeting of the Standing Committee on Public Accounts to order. My name is Henry Zoe and I am the Chairman of the Standing Committee on Public Accounts. I would like to take a few minutes to ask my colleagues on the Standing Committee on Public Accounts to identify themselves for the record.

MR. GARGAN: My name is Sam Gargan and I represent the constituency of Deh Cho.

MR. BERNHARDT: I am Ernie Bernhardt and I represent the Kitikmeot.

MR. KOE: Fred Koe, Inuvik.

MR. WHITFORD: Tony Whitford, constituency of Yellowknife South.

CHAIRMAN (Mr. Zoe): Thank you. I am Henry Zoe representing North Slave, Chairman. I have my staff, Alan Downe our researcher and Rhoda Perkison the committee clerk. The Standing Committee on Public Accounts has been established by the 12th Assembly to review matters which relate to the administrative operation of government in the Northwest Territories. This usually involves review the public accounts which are tabled by the government to show spending patterns within the various government departments. This task is generally carried out through our review of the report which the Auditor General is obligated by law to supply, following his review of the government's financial statements and the Auditor General's Report on Other Matters, which is tabled annually. In addition to reviewing the Auditor General's Annual Reports however, the standing committee also performs an important function in terms of reviewing specific administrative matters within identified departments. The committee can undertake such a review on its own authority or when matters are referred to it by the Assembly. One of the interesting features of the standing committee is that it deals directly with senior department officials who are responsible for administrative and spending decisions. This contrasts with most of the other standing committees of our Legislative Assembly which deal primarily with elected Members of Cabinet.

In October of last year the Legislative Assembly received a report from the Auditor General of Canada which outlined findings and recommendations arising from a Comprehensive Audit for the Department of Health. Our purpose today is to commence the public review of that audit report. For the record the report is indexed as a Tabled Document 5-12(3) and was officially tabled in the Legislative Assembly by the Speaker on November 17, 1992.

The Standing Committee on Public Accounts considers this report to represent a very important piece of work. The delivery of health care programs and services has raised critical issues for provincial and territorial governments all across Canada and the Northwest Territories is no exception. To illustrate that I would like to quote briefly from the opening comments of the Auditor General report "At present health is the single most expensive program in the Northwest Territories and at annual costs of close to $200 million it consumes some 16 per cent of the entire government budget."

It is clear to me, and I think my colleagues on the standing committee will agree, that with the magnitude of this financial commitment the Department of Health must be structured and operating in a way that is effective, efficient and economical. There is another and more important reason, however, and that is that this department more than any other carries a mandate which impacts on the wellness of the people who live in the Northwest Territories. It is a department that must be organized well enough to deal with life and death issues and to look ahead to the future health of people in all our communities. I do not believe that any other single department of this government touches as many people as much of the time on issues that are as important as those dealt with by the Department of Health.

Again, for this reason, it is a vital necessity that our departmental resources should be well enough established to allow services and programs to be delivered in a dependable and high quality fashion. I would like to comment on yet another reason for ensuring that the Department of Health should operate in an effective and efficient manner. That has to do with the fact that the people of aboriginal descent make up a majority of the population of the Northwest Territories.

Throughout the history of aboriginal peoples' relations with the Government of Canada and more recently with the Government of the Northwest Territories of the delivery of health services has held a special significance. In many cases throughout the north communities were founded for the first time only in order to provide a single central location from which health and education programming could be dispensed.

In the Indian Act and in the terms of many treaties, fiduciary responsibility for the delivery of health services to Dene and

Inuit people were accepted by the Crown. During the transfer of health services and programs from the federal government to the Government of the Northwest Territories in 1988, aboriginal people were assured that they would have a greater say in the management of health programming and that quality of health care would be guaranteed for the future.

A massive financial outlay, a vital role in ensuring community wellness, and a traditional relationship between aboriginal nations and Canada. It is important that the current territorial Department of Health should be equal to the task of meeting the responsibilities imposed on it by all these factors. At the request of the 11th Legislative Assembly the office of the Auditor General of Canada was asked to conduct an audit of the Department of Health to ensure that this remains the case.

The audit was carried out in late 1991 and early 1992 and has now been reported upon. It is our job, as Members of the Standing Committee on Public Accounts to review the audit report and to provide the House with our response and recommendations regarding the Auditor General's findings. This is something that could not be done without talking openly with the department and the Auditor General about the findings of the audit.

However, the review process should not stop there. It is important for this committee to also hear the views of stakeholder groups throughout the Northwest Territories. This includes the Board of Management established for health regions and facilities as well as other government departments that have a role to play in supporting the delivery of health services and programs. It also includes the professional associations which represent the doctors, nurses and administrator who work within the health system, and it includes the public at large.

Our public hearings this month will allow us to accomplish that. We will be meeting here in Yellowknife this afternoon, tomorrow and Friday to hold public hearings. Later during the week of January 25, 1993 we will be travelling to Rankin Inlet and Inuvik for more public hearings. We will then be finishing with an additional day of public hearings in Yellowknife on January 29, 1993.

These hearings will each involve asking certain people to appear as witnesses and comment on the audit results. I hope that Members of the standing committee will be able to use this opportunity to question our witnesses and to comment on the information they bring before us. When we finish receiving this input the committee will deliberate and then proceed to bring a report before the Legislative Assembly during the upcoming winter session.

The process we will use for our public hearings will be as follows. I will invite witnesses to come forward to the witness table. Witnesses will be asked to identify themselves and where appropriate to proceed with any opening remarks. Then I will allow a period of time for questions and comments by Members of the standing committee.

At this time I wonder if the Members of the standing committee have any comments to add before we proceed with our first witnesses.

If not, we will now hear from our first witness representing the office of the Auditor General of Canada, Mr. Dubois.

MR. DUBOIS: Thank you, Mr. Chairman. Before we comment on the audit report on the Department of Health, Mr. Chairman, we would like to take a few moments to discuss the background of the report.

One and a half years ago, we had a written request from the Legislative Assembly to undertake two comprehensive audits on the Department of Health and on the Department of Economic Development and Tourism. The genesis of this request was from the Standing Committee on Finance, which among other issues was concerned about a number of matters including rising costs, demands for service, hospital utilization and the continued number of referrals to the south for hospital treatment.

First we would like to talk about the comprehensive audit process. Economy, efficiency and effectiveness have various definitions, but for the record we want to share with you our definitions of each.

Firstly, economy. This refers to the terms and conditions under which an organization acquires financial, human, physical and information resources. Economy means getting the right amount of the right resource, at the right level of quality, at the right time, in the right place and at the right cost. Lack of economy in acquiring resources could result in a higher than necessary cost of products or services, or products or services of inappropriate quality, quantity or timeliness.

Efficiency refers to the relationship between the quality and quantity of goods or services produced, or output, and the cost of the resources used to produce them at a required service level to achieve program results. An efficient operation either produces the maximum quantity of output of a given quality for any given resource inputs, or uses minimum inputs to produce a given quantity and quality of output.

Lastly, program effectiveness is the extent to which program objectives or intended consequences are achieved, commonly called outcomes. Where unintended negative effects occur, effectiveness must be judged on the balance of positive and negative consequences.

In the case of the Department of Health representing your government, Mr. Chairman, the economy question might be asked, "are you paying too much for what you get, both in terms of services from people and the tangible goods used to delivery programs?"

Similarly, efficiency can be regarded as getting the best payback for what you spend. When posed as a question, it could be, "are you wasting resources," or, "are you cost effective?"

In the case of health, effectiveness could mean providing the best possible health care to northerners, on an equitable basis, at the least cost. There may be other ways to define effectiveness in the health care area.

Translating these three Es into health terms means for the budget you approve, "are the department and the boards

getting the best quality of health care at the best price?" "Are services efficient" and most importantly, "are the people getting the best care for the dollars and effort invested?"

Another highly important thing to bear in mind is that money is getting tighter and demands for services are increasing. There are many stakeholders in health care service including the department, the boards, the doctors, dentists, nurses and other professionals, along with their organizations and representatives, but not least of the stakeholder group is of course the people being served by the system.

It is reasonable to say that there are many different opinions on how the system should work. There are those who see a centralized process as best, others see decentralized being better. Health administrators may see things differently from doctors, nurses may have yet another viewpoint, and often professional organizations have their own perspectives. Too often, in these vigorous debates, the people may get overlooked, or others may feel that they know what is best for the people and advocate a particular approach. Inevitably, all of these viewpoints have to come together and be adjusted in the reality of who pays and how much is available to pay the bills.

In our audit we have no doubt that some stakeholders will have different view from us. This is to be expected. It is not our intention to dictate to the N.W.T. which health care model it should adopt. Yet there is a need for the groups to talk and try to reach agreement on many of the pressing problems facing your government. For example, what is the right balance between board run facilities and independent doctors? We doubt that anyone can answer this question yet, because your government is still uncertain about what health care model is appropriate and affordable for the people of the N.W.T. We see some similar problems to the south, but also many unique ones in the north. The incidence of alcoholism, suicide, family violence, among other issues is greater in the north and there is no clear plan yet for dealing with them. The medical profession in its entirety is divided between the preventative and curative approaches, yet there is not enough money to do both well. Just about every government is struggling with how to deal with rapidly increasing health care costs. It was a major platform issue in the recent U.S. Presidential elections and President-Elect Clinton has looked at the Canadian model for inspiration. Yet the Canadian model itself is also in trouble as we cannot afford to serve all the demands from our people. How then does this relate to your Department of Health? We want to emphasize a few points here. We audited Health, not the board and professional associations, although we visited four boards and they kindly helped us to understand the complex issues from their perspectives. We have used some examples to illustrate economy, efficiency and effectiveness problems. We want to stress that they are illustrated examples of bigger issues, not issues in themselves. Thus, it is important for you to realize that we do not take sides in the issues mentioned in our report.

We have had some discussions subsequent to our report with the Keewatin board about their dental contract, and we do have to clarify one point in our report. The board has provided information about the contractual arrangements being with a not for profit, aboriginal joint venture under the name of the Kiguti Dental Clinic. We wanted to recognize this, Mr. Chairman, because it represents a new trend in providing services to the people. However, in reporting this case, we had concerns that the players were not working together, and this is why we use the example to illustrate that there are, in our view, major problems between the department and the boards, and significantly different views on their roles and responsibilities. In fact, Mr. Chairman, a central theme of the report is a series of recommendations that the players, overcome their perception differences and improve their working relationships to cut down on bureaucracy, improve coordination and communication and work cooperatively to achieve the best with the available resources.

However, Mr. Chairman, before a truly effective working relationship can be established, some key decisions are needed to decide on the most appropriate health care model for the territories. This, in our view, requires all the stakeholders to have input; the government, the medical profession, the boards, the associations and the people. Only with a full and complete consultation can the big issues be resolved. For example, a current buzz word is "The N.W.T. Way". We have not been able to obtain a definition of what this means and what its impact might be on the present health care delivery system. Yet if this is to be the government's model, defining it, communicating it and assessing the implications on the present system and stakeholders is vital.

Thus, Mr. Chairman, we have organized our report into seven different sections plus an executive summary, hopefully for easier digestion. These are as follows: organizational structure; planning for the future, managing people; managing information; capital assets; financial issues and management reporting and accountability. We want to stress again, Mr. Chairman, that all of these identified concerns related to economy, efficiency and effectiveness.

One other point, Mr. Chairman, at our request the department identified an outside advisor for us with whom we could consult during our audit. Our advisor was Mr. John Noble, a former deputy minister in British Columbia and I believe an advisor to the Standing Committee on Agencies, Boards and Commissions in some of its deliberations. Mr. Noble is familiar with the important issues facing health care in the Northwest Territories and his advice was very useful to us. We would like to thank the department for suggesting Mr. Noble.

The first chapter I will deal with is organizational structure. This is not an easy area to analyze and comment upon. We spent a lot of time trying to understand the history, both before and after devolution. We had as an advisor, Professor Bob Hinings from the University of Alberta, who is both an expert on organizational analysis and experienced in the health industry.

From our analysis of the way the department is organized and functions and the feedback we received from the boards we visited and spoke to each has a different view of what is needed and what is the most effective. The boards have gained more experience since devolution and appeared to be able to do more for themselves without the department needing to be as involved in all the areas that it is. Also, the responsibilities of the boards need to be spelled out more clearly as the present policies can be interpreted in different ways, often with the board seeing the issue one way and the department another way. Throughout this, Mr. Chairman, we

believe there is a need to invest more time by both sides to recognize and respect the roles of the other, if those roles can be clarified. We also feel that the department and the boards, along with the other stakeholders, that is the health related associations and the people, should be more intimately involved in making the key decisions facing health care in the north. While we feel that the department has to adjust some of its operational policies and controls to better involve the boards, there also seems to be a need for the boards to recognize the valid role of the department so all can work together effective. Both the department and the boards should consult with the people, the ultimate users. On issues pertaining to preventative medicine the department assures us that its staff are in regular effective communication with other G.N.W.T. departments that have an impact on health.

The next chapter is on planning for the future. This is a fundamental problem. While the department has recently started some studies, we found a lack of meaningful planning that would be useful in defining the future structure of the Northwest Territories health care system.

Presently there is no master plan for health care in the Northwest Territories, yet Legislative Assembly committees in various hearings are acutely conscious of rapidly rising costs together with the competing demands for resources. Planning also must include considerations of health care professionals and how they can provide the most effective service at the best cost. As mentioned previously, there is no consensus on whether health care resources are best invested in preventing illness, or treating them when they occur. This is not a unique issue to the Northwest Territories, but with a clear vision of what is best for your northern society, planning could help to achieve effective results.

The next chapter is on managing people. The biggest single asset in health care is people. A well balanced system needs an appropriate mix of the right disciplines and the management process needs to serve individuals' interests as well as those of the organization. There are problems throughout the people management system from poor information to questions about attracting and retaining the best people, about training effectiveness, less than ideal methods of appraisal, motivation, indoctrination, work loads and others.

While people management needs good human interaction, it must also be supported by meaningful processes to monitor performance and provide the right kind of feedback to all those involved. We find that several of these processes are not being used well and their effectiveness needs to be improved.

We have commented on the need to appraise the performance of doctors. This is somewhat of a controversial issue. Clearly, Mr. Chairman, we are not suggesting in any way that the confidential communications or records between doctors and their patients become the basis of such appraisals, but all salaried employees are public servants and as such their performance on the job should be appraised against reasonable standards to ensure that the taxpayers are getting their money's worth. Thus, Mr. Chairman, we do not see any difference between different professional groups employed by your government. We presume, Mr. Chairman, that your lawyers, engineers and accountants are appraised periodically without interfering with the professional prerogatives.

Another interesting area is training and development. Presently there is not enough money available to provide all the training and professional development that is needed by all your health care professionals. Training and development is expensive and the limited funds do not seem to be spread equitably among all the groups.

The next chapter is managing information. Next to people, information is one of the most valuable assets, yet it is an area often neglected. In the health business the scope of necessary information is immense, from the confidential records kept by doctors on their patients, to overall measures of system effectiveness, with many points in between. The information systems need a major overhaul. Information that is available is often inaccurate, extremely difficult to retrieve and analyze, and may be compromising efforts to control costs. There is an ongoing disagreement about which is the best accounting system for boards, still to be resolved. There may be opportunities for economies if agreement can be reached.

In essence, the systems are needed to process payments to health care professionals for the services they provide, and at the same time to generate useful statistics and information for planning and day to day management, on the one hand, and for providing management information including financial and cost accounting. There is no agreement on which is the best accounting system, some support one and others support another. In our view, Mr. Chairman, the various users should agree amongst themselves on the best system for their needs and consider standardizing so that all their information will be compatible, comparable and interchangeable. For bill paying and collecting with the side benefits of usable and useful information, improvements are needed to speed up data production and improve its accuracy.

The next chapter is capital assets. We have added some comments about capital assets but the situation in health is similar to the issues we reported last year on a government-wide basis.

We could not find any record of capital assets in the department. Although the boards operate such capital assets, the department is the owner on behalf of the government and should work with the boards to identify and control these expensive items. We are not suggesting, Mr. Chairman, that the department's role is anything other than owner with the boards being responsible for day to day operational custodianship.

The next chapter is on financial issues. As we pointed out earlier, Mr. Chairman, rising costs and the government's ability to pay are a major concern. Compounding this problem is the difficulty the department has in predicting certain costs accurately, often necessitating requests for supplementary estimates. Certain elements of the budget do not appear to have been evaluated, such as whether the Stanton Hospital gearing up has had a significant impact on referrals to southern facilities. In fact, Mr. Chairman, there are many similar issues where the most cost- effective mix of services and resources is not known definitely. These concerns have been raised and discussed in the Legislative Assembly and by its various committees for a considerable time. Yet they still occur. The Financial Management Board has called for better identification of costs, but accurate forecasting still eludes the department.

We have been asked whether, in our opinion, the devolution on health care from the federal government was done as well as it could. Mr. Chairman, this is not an easy question to answer. We do not feel we are in a position to answer this question. Given the elapsed time since the major negotiations it may be that no one will be able to answer the question now. However, Mr. Chairman, one ongoing problem that can be traced to devolution relates to federal funding for Indian and Inuit health care which is disputed by the federal government. At March 31, 1992 the claims disputed and unpaid by Canada were some $51 million. The fact is, Mr. Chairman, that your government has funded the services provided but has not been paid for them. The large outstanding sum of money is putting a major strain on your government's resources and may jeopardize your ability to pay for services in the future.

Medical travel continues to be expensive and unpredictable. There are two medical travel programs, one for government employees and the other for non employees. The continuing need for travel, particularly to out of territory facilities, may not be resolvable until you have a clear and acceptable model of how health care will work in the future and how your available resources are invested to get the best results.

The last chapter deals with management reporting and accountability. Many governments are grappling with management reporting and accountability to Parliament or the Legislative Assemblies, with your government being no exception. Basically you need this data to be able to assess if your programs are effective. Are they reaching the people as you planned, and are they also cost effective? Without data you cannot answer such questions. Unfortunately, management systems tend to focus on what people do, not what they achieve. Measuring what people do is relatively easy. We call these outputs. Measuring real results, what we call outcomes, is harder, but essential. Presently, Mr. Chairman, the department has not developed good measures of outcome. Without such measures legislators and decision-makers have to rely upon other information which often does not tell the story. For example, if people have to rely on complaints as one way of seeing how well they are doing it gives a biased story. Rarely do individuals write in to praise government services, so complaints are a biased form of data.

The department faces a major challenge to identify the kinds of information they need to account properly to the Legislative Assembly both to report on fast progress and help to justify new initiatives by providing an accountability framework up front. However, even with a well defined system it is only useful if it is nurtured and used. We found too many of the department's measurements not actioned.

Finally, Mr. Chairman, in an integrated health care system such as yours, the boards also have to produce data measuring and evaluating their performance. Throughout all of this need for data is the overriding consideration of cost. Systems to produce and analyze information must themselves be cost effective, otherwise they will divert too much from the primary need.

This concludes our opening statement, Mr. Chairman. We hope our report is useful to the Legislative Assembly and the other stakeholders in addressing the many challenges that lie ahead. We will be happy to answer any specific questions the Members may have. I take this opportunity to introduce my colleague, Mr. Roger Simpson, who is the principle responsible for the audit of the Government of the Northwest Territories. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. The Chair would like to apologize for not properly introducing you, Mr. Dubois. Mr. Dubois is the Deputy Auditor General of Canada. He came all the way from Ottawa to be here with us, and his other Edmonton office colleagues are Mr. Simpson and Mr. Martin are also here with him.

Maybe I can lead off with a question. From the comments in your statement, Mr. Dubois, your report has a lot of information and recommendations but what is the bottom line? Is the Department of Health operating in an effective, efficient and economical way, or how are we doing in other words?

MR. DUBOIS: Mr. Chairman, it is very difficult to put any kind of numbers on an answer to that type of question. The major problem we have observed and which runs throughout the report is the difficulty of all the stakeholders involved in working together. The fact that there are forces that pull in different directions clearly demonstrates, as far as we are concerned, the lack of efficiency in the health care system. However, we are not in a position to quantify that.

As far as the effectiveness issue is concerned which regards the quality of care of the people, our audit did not go to the extent of measuring that, but we do conclude that the information- base that the department has does not permit the department either to know if it is effective or not, and if the N.W.T. health care system is effective or not. We think that is a serious discrepancy.

CHAIRMAN (Mr. Zoe): Thank you. General comments from Members? Mr. Koe.

MR. KOE: Thank you, Mr. Chairman. The audit report outlines, explains and illustrates that there are a lot of serious issues relating to health care and health delivery in the north. The report basically verifies what we have been hearing from the people involved in the health business, what they call the stakeholders throughout the north. As Chairman of the Standing Committee on Agencies, Boards and Commissions we have also been investigating the roles of health boards. In our interim report in early December the Standing Committee on Agencies, Boards and Commissions stated that, "a very serious state of affairs presently exists within the administration of the territorial health care system and that there are strong signals that the entire scheme of the delivery of health care is not unfolding as it should. Unless significant adjustments are made in the approach used by the Department of Health, and the development of a community based foundation the administration of health care services may be headed for failure."

In our discussions, and personally my discussions in sitting in this committee and the other committees I sit on, I have to agree with the Auditors, the bureaucrats, the health board representatives and the recipients that there are serious problems with the system. Collectively we have to look at what we have, where are we going, how are we going to get there, and in the words of the Auditors in the most effective, efficient

and economic way. We are also concerned about the quality of health care, especially for our people who live in the communities. There are many communities that do not have ready access to a hospital. They do not have ready access to specialists of all kinds and aboriginal people have been led to believe this and have been expected, or always expect, a certain level of care. Throughout the years, especially in more recent years, these expectations are changing because of demands, basically money demands, and the ability of the system to pay for the type of health care system that we have. I guess one of the results is that we are in a dispute with the federal government over a certain amount of money. It varies.

The auditors mentioned $51 million. That was quite a few months ago. I think it is more up in the $80 or $90 million range and those are for health services for non-insured services basically to Indian and Inuit people. Being one of those, I guess I have concerns that the level of care that we had when the federal government managed the system and promised our forefathers and people forever that they would provide is changing. It is serious, not only for aboriginal people but for all people in the north. The costs, as explained in the audit report, are getting too high. We have facilities and a system with new techniques and new diseases that are costing a huge amount of money putting new pressures on the delivery system and how we treat those diseases. We have to collectively look at this and come up with some recommendations and revamp the system. On this committee, I assume we will be making some recommendations based on what we hear in this public process and from my other hats I wear on the Standing Committee on Agencies, Boards and Commissions and on the Special Committee on Health and Social Services, that we would be coordinating our findings and coming up with hopefully some good recommendations on how to deal with this. I think we are all responsible and we all have some say and hopefully some solutions as to how we respond to these issues. That is all I wanted to say now as they allot more time as we get into the chapters and details of the audit. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Any other general comments from Members? The Member for Deh Cho, Mr. Gargan.

MR. GARGAN: Thank you. Mr. Chairman, I just wanted to mention, years ago when I was not a politician, many people used to lobby in Ottawa. I think Maurice Aked was one of the persons we used to work with.

The whole focus of direction we were taking at that time was Indian control of Indian health. One of the biggest things that we have asked is that we are allowed to control our resources. We said, having self-determination does not mean that we start training Indian doctors, Indian nurses. It just means that as long as it is still under the control of the government, it does not mean anything. We just change the colours of the people.

One of the realities in the north is that not every community is going to have a doctor, a psychiatrist, or a specialist of some kind, but we could start training people to become paramedics, for example, or C.H.R.s or even C.N.A.s. The other one is dental therapist, and then we decided dental therapy training here is needless and that did not have to happen.

The problem right now is that we are spending a lot of money administering health services instead of delivering health programs to the communities. I think that as long as that occurs, we are going to see a bottomless pit with regard to expenditures for health services. Mr. Chairman, the reason I say that is that the reality right now is that life goes on and people will die.

When I talked to the Members here before I asked about my own father, for example, who got sick and went to the nursing station and spent about four hours there. He was getting worse so he went to Hay River and he hung on for about 18 hours before he finally died. If you look at the T.V., you see all these life-supporting machines; breathing apparatus and stuff that keeps your heart going. It was a situation in which a doctor could not do anything. They gave him medication and he could go faster than if they did not do anything. They said the reality is that even if we create the amount of hospitals that are required to serve the north, hospitals are there for people that need emergency care or specialized care.

Most of the stuff that is happening right now is based on a crisis situation. I think we must get away from that and start teaching, about traditional foods, for example. We do not see that in the communities. We do not see people in the communities go to an elder and ask what they could use out there to get better. We always have these little plants in the house that we boil when we get sick or have tonsillitis. It works and you do not need to go to the hospital or nurse to get that but we still do that because a lot of people have grown accustomed to what western technology has to give us.

I think the cost that is accumulating now really sends out a strong signal to Yellowknife and to the Department of Health that we are going to have to stop now and look at how we are going to best serve the communities. I think the best way we are going to do it is to start promoting traditional food, preventive type of programs, possibly in the classrooms. We need to do that.

We also have to look at the crisis type of situations at the local level because what happened to my Dad is that he had to go fly half and hour, but there are places where they have to fly four hours to get to a medical centre if the situation arises and maybe those people do not have that much time to be medevaced for that long period of time. The waiting period in between those emergencies is a critical point. We do not have anything to respond at the local community. I think this should be addressed. We do not have trained medical interpreters in the communities. We still have C.H.R.s who are not training specifically to be professionals in that area but they serve in that capacity. The interpretation of a kidney and a liver is just about identical. There could be a mix up in the interpretation of that. This is critical. The kind of practices that the centres are using are totally unacceptable here in Yellowknife. We have janitors who take x-rays in the communities. If I were to go to the nursing station and need an x-ray they would ask the janitor to fix up the machine. He has a graph which he looks at and then he zaps me. This is the kind of thing that the communities are putting up with. You would never see that here in Yellowknife in the hospital. A doctor would not grab the janitor and tell him to give me an x-ray, that is totally unacceptable. I think we have double standards here. I wanted to bring this up because I realize that the reality is that

this is they way it is right now in the communities. We cannot have a radiologist in every communities. Those are areas in which the communities could control and take responsibility for, if they were allowed to do it. Thank you.

CHAIRMAN (Mr. Zoe): Mahsi. Does the Auditor General's office have any comments pertaining to Mr. Gargan's comments? If not, are there any further general comments from Members? Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. Everyone is aware that transportation is costly in providing health care in our system. Transportation between the home community of the patient to the central medical facility, such as Yellowknife or Edmonton, is costly. It is especially costly for patients who are in an emergency situation requiring medevacs. This has become very costly but unavoidable. This is something which has to be done. One of the ways in which we can cut costs in the area of transportation is by building good medical centres within each region with qualified doctors, specialists and the required equipment. This would be very costly but in the long run we may be able to save the government money.

Another way in which I think we can cut the costs are by providing good communications between the patient and the doctor. Since I became a Member of the N.W.T. Legislative Assembly, about three years ago, I have been approaching and requesting the Government of the N.W.T. Department of Health to provide a translator/interpreter at the Stanton Hospital for the people from Pelly Bay and Gjoa Haven. People from Pelly Bay, Gjoa Haven and Spence Bay speak the Netsilik dialect. They have been utilizing that hospital for over 20 or 30 years. To this point in time the system has not provided an interpreter/translator who will speak the language of the patients from the Natilikmiot communities. This could prolong the healing of the patients. If there is a misunderstanding between a doctor and patient it will take that much longer for the patient and doctor to understand one another. This makes things more difficult for both of them to be able to understand.

One other thing which I would like to point out is the early prevention of diseases that are common in each of the communities in the N.W.T. I think that if the doctors are able to visit communities more regularly they will be able to detect the diseases which could provide a chronic illness of people.

It is very important that we emphasize to the federal government that we do not have adequate funding to meet the need to provide health services to our communities. I think that some people are frustrated to the point where they feel the federal government should take back the health programs and services. It is costing this government a lot of money and the federal government is not meeting their obligation to provide funding since we have taken it over.

One of the disputes we are having between the federal and territorial government is that the money that was promised by the federal government to the territorial government before we took over the services is not being met by the federal government. It is going to get more and more difficult as the funding is harder to get within the national scene. I think this government and this committee have a very difficult job to do especially in the area of the health system. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Mahsi Cho. Are there any general comments from Members? Mr. Dubois, do you have any comments pertaining to Mr. Ningark's remarks?

MR. DUBOIS: Thank you, Mr. Chairman. I would like to make a general comment based on several of the remarks that were made. In the report we talk about the need to define a health care model and the need for all the stakeholders to get together to discuss and agree on the health care model. Naturally this model would have to be based on accurate and timely information, but I think that many of the remarks just put even more emphasis for the need for that particular model as to what kind of structure should the health care system have, where should the services be given, and at what level should the services be given in the different communities or regions. Many of the issues that I brought out scream out for a need to get an agreement on that. If all the stakeholders would get together and agree on a health care model then perhaps this would be the first major step towards resolution of some of the issues.

Naturally it may not resolve the differences of opinion between the government and the Government of Canada. However, if the model is developed and if proper information is developed as a base then the Government of the Northwest Territories can probably be in a much better position to make its case to the federal government as to the type of health care system that it wants to sustain and maintain.

CHAIRMAN (Mr. Zoe): Are there any general comments? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I would like to make a few comments about the process we are undertaking and the review of the department. The comprehensive report illustrates the complexity of the Department of Health. It not only shows that this is a life and death type of program, it goes to extremes but it also has to accommodate the humanity in it that it has to give; the service in a humane way and it has to undertake this mandate in a very complex environment. It is not only a physically demanding environment, but it is also complex in terms of language and culture spread across the greater part of Canada. It has to meet people's demands and their expectations in not only a technological way but also in a very rapid way. We have come into the twentieth century very quickly where I think people had a little bit more lead time in other parts of Canada, where we have picked up the technology and have had to distribute and disseminate that very quickly across the north and people's expectations have changed about seeing all of the techniques that are available. For instance, open heart surgery, you can strap a person to a machine and keep that body alive forever. We have just come out of an era where death was inevitable. People died at home and now they are not even allowed to do that. In most cases the technology wants to keep them in a facility to try to prolong life. So we are having to make those cultural changes as well as our expectations are now that if you cut off your finger you can get it sowed back on because you have seen it done elsewhere. I guess the department has been trying to deliver as good a service as it can.

We do all of that within a very large budget, but never enough to do everything that it can. This audit does illustrate the problems the department is facing with all of these things:

people, technology and money, and trying to get a service to the north. I have been quite fortunate to have gone through the whole series of health care systems that we have had in the north from quite primitive to much more sophisticated. In the past 30 or 40 years it has gone from a church run system with a little medicine chest in the corner somewhere, to something quite sophisticated. We have taken it over from the federal government, who designed the system, from Ottawa and introduced that to the north. I only learned recently how it came about. It probably was not the best way of picking up a system like this, it was kind of forced onto the territorial government in a sense. I suppose we could have said no, but the fact is we did not and we have acquired the system with all its problems and its good points. We are going to try to make the best of it. The audit points out some of those areas that are and have been giving us problems. In all fairness, again, I am quite fortunate to have been involved for a very short time in a position where I would have liked to have seen some changes made, and those problems still prevail. I think we will get into them a little later on as we go on here.

Certainly one of the areas that I compliment the department in is delivering a health care system to the north and its complexities in a good fashion. There are still areas, having been closely associated as I have been for the years, I regret not seeing more northern people involved in. I think if you look at the closeness that health is to the people, there are very few native peoples looking after native peoples. I am not sure why this is. I do not think there is a native dentist in the whole of the territories. There are a few dental assistants, and there were more when the dental program was run out of Fort Smith, but it is not quite the same. You do not see many native nurses. You go to the hospital and you see very, very few. I do not think I can recall any myself, but there may be in other communities, but very, very few. I am not sure what the problem is, have we tackled this thing with the vigour that we should have?

Years ago there was a program run by the hospital in Fort Smith for C.N.A.s and out of that resulted a few. I would probably be very liberal to say that 25 or 30 per cent of the people who started the program eventually went on to be R.N.s. That program seemed to have faded away and I do not know if it was ever taken up with anything else. That is one of the disappointments over the many years that I have seen, a program that the department has never been able to achieve. In the administration part as well, there are not quite enough native people within administration. There are programs that could be undertaken to change that, but I am not sure why they are not. We may be able to extract from this some ideas as how to go about doing that, but there also has to be a will there to do it. I think that current thinking in the territories is that we should be encouraging more aboriginal peoples to become a part of the system so it can be delivered in a fashion that communities and native peoples want.

I am not sure if we have, in the territories, anything unique as far as diseases are concerned. We acquired all of the known ailments that western civilization acquires as it becomes sophisticated. When we live a more simple life, maybe we do not live as long, but it seems now that we have acquired a number of diseases and illnesses that take all too many people. Maybe northern people are more susceptible to some things. I think one of the other Members mentioned that there is a higher rate of cancer deaths and heart diseases than previously. I, as a young person, recall very few people dying of cancer, but now it seems to be common place. I just wonder if there are some things that we have acquired in our adaptation of a southern life- style that makes us more susceptible to those kind of things. More research could possibly go into that, research of a northern nature. I did mention a couple of things but I am not going to go through that at the moment.

Regarding administration, the report points out that we have boards that run on medical centres and there seems to be, a certain friction between departments and boards. This causes extra costs, maybe not so much in terms of large amounts of money, but in time, and bad feelings. It takes up a lot of time and adds to the cost and reduces efficiency and effectiveness of an operation when people are battling out with each other over turf, if you will. There has to be some resolve to that and I am not sure how that will come about and whether the responsibility for that ultimately lies with the department and with the Minister. There are certain limitations to what the department and the Minister can do with boards. So we have to look at that a little bit more carefully and come up with a middle of the road or better solution.

One of the things that I do want to mention, because it has caused concern with some of my colleagues in the past and still does to a certain extent is the hospitals in the communities. At one time, the churches ran the hospitals and they set them up wherever, Fort Providence had its own hospital and Resolution, Fort Smith and Aklavik and, eventually, they fell under the department's responsibility. Now there appears to be a movement to shut some of them down because they are not being utilized. I would like to see these hospitals remain open. The facility is there already, but if they are not being used for the purpose they were intended to be used for, a hospital for births and deaths, they could become specialized in some areas, and I have always referred to Fort Smith and the chronic care unit that is there.

I was very moved by the care that was given to the elderly and those that were incapable of looking after themselves through illness or age. There is no reason why a facility like that cannot be enhanced to accommodate this kind of a service and leave the more active hospitals to do the types of things that they can do best. We should take a look at the hospital in Hay River and see how that can be utilized. If it cannot be utilized as a hospital for births, deaths and illnesses, it can be used for some other purpose in the medical field. Simpson as well, rather than shut it down, use it in the area of chronic care. I do not think a person with Alzheimers really gives a damn where they are as long as they are being well looked after. There is a difference if the person is well and cognizant and they are not with their friends and relatives. It is harder for them to be moved somewhere else. There are a lot of hospitals that can be used for other purposes rather than closing down facilities to meet the budgets that you are constrained to.

I guess I have gone on further than I should but those, by way of comments, are things that have come out of the audit that we will probably be looking at the rectifying or bringing to the attention of the department. Those are things that I think are key to what was in this audit. There are a few more as we go through the chapters that I will comment a little bit more on.

CHAIRMAN (Mr. Zoe): Thank you. Are there any more general comments? Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. Mr. Chairman, I guess there is a way that this government, our government, can help the people of the N.W.T., especially the native people in the community, when people are saying that the illnesses and diseases are much more prevalent in the native community than the rest of the communities within the system, within Canada. No wonder, Mr. Chairman. The health of the individual depends on the kind of life style they have.

I remember many years ago before the animal right activists were active within their demands, the people who made their living by hunting and trapping who spent most of their time out on the land were very healthy. Since the animal rights activities have penetrated the system, come to our community, affected the life-style, people's health has been deteriorating up to this point in time, probably due to not spending much of their time outdoors. Secondly, depressed because their life-style is being taken away and, thirdly, people who are unemployed in a community are more likely to get sick than people who are employed, even when they are the same age. I think the life-style has a lot to do with the health conditions of the people and we, the government of the N.W.T., should realize that and help them out, if we have the means to do that. All we need is the political will to do it. I just wanted to make a point, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Are there any other general comments, any responses or remarks? Before we go into the chapter by chapter, the Chair would like to take a five minute break. We will go chapter by chapter. I think some Members have certain specific questions they want to ask the Auditor General for clarification.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): I would like to call the committee back to order. We will go briefly through the Auditor General's report. Would the committee like to go through chapter by chapter to see if they need any clarification on the recommendations or some of the content in each chapter. Does the committee want to go chapter by chapter? After we conclude that we can move on to the opening remarks to the Department of Health. Agreed?

SOME HON. MEMBERS: Yes.

CHAIRMAN (Mr. Zoe): Does the committee have any questions or require clarification with regard to chapter one? If I could ask the Auditor General's office to give us a short summary of chapter one. Chapter one is the executive summary. I wanted to make a comment with regard to that. In chapter one in the last paragraph of page one you commented that "it should not be construed that any individual has received inadequate health care as a result of these issues." Can you really conclude that since the audit scope did not permit an operational audit of health facilities or programs? Can you really say this in your executive summary? Mr. Dubois.

MR. DUBOIS: Mr. Chairman, what that sentence attempts to do is to advise the reader that we did not look at the quality of health care that is given to the users of the system. The sentence maybe slightly restrictive in the sense that it could say it should not be construed as suggesting that any individual has received inadequate health care. We could also have said or has received adequate health care. We do not know. The sentence is there to say that the audit did not permit us to make any observations on the quality of the health care at the user level. It is a scope limitation in reality. We could not make any observation one way or the other on the quality of the health care because we did not audit that particular aspect of the health system.

CHAIRMAN (Mr. Zoe): In other words then this sentence should have read something such as it should not be construed as suggesting that any individual has received inadequate or adequate health care as a result of these issues.

MR. DUBOIS: I believe it would have been more complete if we had used both expressions.

CHAIRMAN (Mr. Zoe): Thank you. Are there any questions on chapter one, the executive summary? Are there any questions or comments on chapter two? Mr. Dubois, I wonder if you could give us a summary on chapter two.

MR. DUBOIS: Mr. Chairman, could I pass this on to Mr. Simpson.

CHAIRMAN (Mr. Zoe): Mr. Simpson.

MR. SIMPSON: I guess I am the end of the line here, Mr. Chairman. What we attempt to do in chapter two, Mr. Chairman, is to look at the way the health care system is organized and structured and the relationships, roles and responsibilities of the players that are involved in the health care delivery system. What we have identified is that there is some significant confusion in terms of the roles and responsibilities that need to be straightened out so that the players in the system are clearly cognizant of their own roles and responsibilities. We have done some analysis in terms of what we see existing and what we think the problem is in terms of the non-specific rules, regulations, policies, etc.

We comment that there is some difference of opinion between the various players. We also observe in paragraph 2.5 that there are some differences in the way that the various players practise their roles. In paragraph 2.6 we make suggestions to help streamline the process by pointing out what, in our view, is necessary to overcome these differences of opinion. We also point out in section 2.7, Mr. Chairman, that there may be opportunities for the department internally to realize some cost savings through amalgamating certain functions which appear to have similar kinds of activities, where the expertise and perhaps even the systems could be pooled.

In section 2.8 we talk about communicating with the boards and some of the difficulties in both camps that have arisen over time. In section 2.9 we talk about communicating with the public and how important that is to get the message out. In 2.10 we talk about coordination with other departments, which the department has informed us that they do regularly. We have some problems in the sense that we cannot find any records of those discussions. In section 2.11 we talk about board members and some of the needs for improving the role,

the training and the support for board members. In essence, Mr. Chairman, that is what we have attempted to do in chapter two.

CHAIRMAN (Mr. Zoe): Thank you. Are there any questions or clarification required from Members to the Auditor General's office with regard to chapter two? Any questions? Mr. Koe.

MR. KOE: The report comments on the need for a better understanding and cooperation between the department and the boards but should not be regarded as advocating a position of one as opposed to the other. Can the Auditor General elaborate on whether or not boards have a legitimate beef? If so, why have you included this disclaimer in the last paragraph on page one which states what I just said, that the department and boards should not be regarded as advocating the position of one against the other?

CHAIRMAN (Mr. Zoe): Mr. Dubois or Mr. Simpson.

MR. SIMPSON: Mr. Chairman, I believe there are genuine beefs that are out there, but it is not our policy to advocate the position of one party versus another where there are problems that need to be resolved. Although we recognize, identify and hopefully make constructive suggestions for improving the process, I do not believe it is up to us to say we support the department or we support board XYZ in this particular process. That is the reason we are trying to stay neutral here so that our objectivity in commenting on the system as a whole is preserved. We just do not want to get ourselves into either camp because I believe that the issues here are very significant and need to be resolved by the stakeholders in the system, not by some outside persons like ourselves. I do not know whether that clarifies your concern, Mr. Koe.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions or comments on chapter two? Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Mr. Chairman, throughout this particular chapter there has been various comments in respect to the roles and the responsibilities of boards and how they should be operated. There are even comments as to some boards being more powerful than other boards, probably because of the fact that there are some boards that have been in place long before the transfer came about. However, it seems over the past few years, a couple of years particularly, there has been a lot of confusion on how the boards have operated, recognizing that some boards feel that they have the management authority to operate an institution that they are responsible for. This particular audit has indicated that there is no doubt there has been confusion and there is a lot of power pulling between the boards and the Department of Health, particularly here in Yellowknife. It leaves many questions in the minds of, not only the board members, but the politicians themselves. I would like to ask if we were able to give the boards all the autonomy along with a certain amount of funding to be able to operate their responsibilities, how can the Minister be held accountable and responsible to the Legislative Assembly? I would like to know how can we give them the autonomy, but at the same time publicly make the Minister accountable?

CHAIRMAN (Mr. Zoe): Mr. Dubois.

MR. DUBOIS: Mr. Chairman, the thrust of the report, which encourages the government to develop a health care model, would include all the stakeholders and an agreement by everybody as to what the model should be and how the system should work. It should include an accountability process within that particular definition. The exact way the accountability would flow back up to the Legislative Assembly would have to be defined within that model. Somebody has to bring all the information together, and the way we have seen the organization defined, at least to the extent that it is defined at this time, there is nothing that would keep the information flowing through the department, through the Minister back to the Legislative Assembly. There are different ways that this system could be structured. I think we are back to our main observation, that all the players should agree how this should work. What this report says, particularly in chapter eight, is that whatever is agreed upon should include an accountability process, or a feedback mechanism so that the Legislative Assembly knows if its health care system is working effectively.

CHAIRMAN (Mr. Zoe): Do you have any additional comments to make, Mr. Simpson?

MR. SIMPSON: Thank you, Mr. Chairman. I think it is important to realize that the accountability mechanisms that Raymond is talking about includes not only the stewardship of public funds, but also perhaps the more important aspect of making sure that the Legislative Assembly is reassured that the right kinds of health care is being given to the people. The accountability mechanism has many different facets to it. One is a stewardship of public funds, the other is the broader accountability issue in terms of achievement of objectives.

If I might just make a comment, Mr. Chairman, I believe a start has been made on developing at least an outline of memoranda of understandings or agreements between the departments and the boards, and I think this is a positive step towards outlining some of the responsibilities of all the players who are involved. However, we would have some concerns that the outline as it is presently framed lacks the accountability mechanisms that Mr. Dubois has just referred to, and we would suggest that they be built in before any memoranda of agreement are finalized.

The other comment I think we would make on that, Mr. Chairman, is that such memoranda of agreements also have to be the product of clear communications and negotiations between all the parties, and not something that is just imposed from Yellowknife on everyone else because I think that would just compound the problem. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: The other comment I wanted to make in this particular area, Mr. Chairman, is the fact that many times throughout this whole audit it summarizes the department as being more of a department that addresses a crisis in a reactive way. There are many crisis management approaches to making decisions. Would the Auditor General's office be able to tell us why they feel it is predominantly crisis management, because it certainly is not a pro-active type of management. Even though I realize the audit states that there is a lack of planning within the department, why does it appear that it just continually is played with a crisis management

approach to making decisions. I am wondering whether or not there is the same type of attitude towards the boards that we have across the territories that deliver health. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: That is a good question, Mr. Chairman. I think it probably overlaps a little bit into chapter three where we talk about the need for a clear vision and planning inputs. There is no doubt that certainly in the last year or so the department has had a lot of its time taken up by crisis management or fire fighting types of situations. I think as to whether or not that is the philosophy of the department or how it can or cannot deal with those things, is probably a question better addressed to the witnesses from the department. I am not sure I could give you a value opinion on why that situation exists. It is a problem, in our view, that the day to day crisis management needs to be handled in such a way as to permit appropriate management time and effort into looking to the future and developing a comprehensive and cooperative system that deals with the problems that the health care system, in the Northwest Territories is facing. Again, I do not know whether that is specific enough for the Member's question.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Thank you, Mr. Chairman. I would just like to ask another question. Does the Auditor General's office feel the same applies to the boards across the territories?

CHAIRMAN (Mr. Zoe): Mr. Simpson.

MR. SIMPSON: I am not sure that I really understand the question. Could you perhaps clarify it for me?

CHAIRMAN (Mr. Zoe): Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Does it appear, through your audit, that the boards across the territories that are responsible to deliver health services in their particular region also have the same type of methods in addressing issues, do they have the ability to do long-term planning?

MR. SIMPSON: Okay, thank you for that clarification. Again, I do not think we can answer that one, Mr. Chairman, because we did not audit the boards.

CHAIRMAN (Mr. Zoe): Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: I recognize that the boards were not audited in detail. However, there was some overviews and some type of preliminary discussions with the C.E.O.s of various boards and probably that was not detected through your discussions.

I would like to ask the Auditor General's office, within the health system, since there is so much confusion between the boards' role and the Department of Health's role there is a lot of, I do not know if the word animosity is fair to use, but there is a lot of resistance between the both in wanting to appear to work together towards the delivery of health. How can this particular area be addressed, besides getting clarification for their responsibilities? I mean what you have, in my opinion, is a lot of tugging. I do not know if it because of power, but there is a lot of confusion as to who is responsible for what and it does cause a lot of detriment to the delivery of health. Unfortunately, it is generally the patients that suffer.

How can we address the building of a partnership with mutual respect for each other because I certainly have noticed in the Auditor General's report that mutual respect towards each other leaves a lot to be desired. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dubois.

MR. DUBOIS: Mr. Chairman, the solutions are not easy, however, we feel that as long as the parties do not sit down together in the same room and try to come to an agreement as to what the health care model should look like and who should have responsibility for what and agree between themselves as to who is going to do what to whom and when, and we always come back to the accountability system or the feedback system, are bound to continue to have the same situation as today. I think you are right in saying that everybody has taken certain positions and some of these positions have hardened over time. It may be very difficult for one individual player to back off from a position. However, if everybody goes into it positively, then nobody loses face because everybody sort of comes out to a new deal, let us put it that way, and nobody loses face. It is not one giving out to another one; it is everybody sitting down and finding the best solution for the people.

I realize that is a soft answer but we have no magical formulas to resolve the issue. We agree that it is very difficult.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions or comments? Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: I guess it is probably the old problem of trying to address attitudes and that is somewhat difficult, both with boards and the administration of the health. On another question I did want to ask, Mr. Chairman, was whether or not the health insurance services function could be undertaken by the health and hospital boards within the Department of Health?

CHAIRMAN (Mr. Zoe): Did you get the question, Mr. Simpson?

MR. SIMPSON: Good question. Tough question. Conceptually, anything is possible if the right kinds of systems, processes and safeguards are built in, bearing in the mind that significant amount of public money that is being expended. There may be issues, however, of economy and efficiency. If you split the payment function for physicians and hospitals between the various boards, it may actually increase costs rather than keeping it consolidated in one efficiently running payment system that is in a central location. I hate to sound wishy-washy in terms of an answer here but I think without a specific study on the impact of that, that is probably the best I can say at this point in time.

I would like to come back to the previous question that the Member asked. I would like to add a point. One of the observations we have made that deals with this question of relationships and control, is that since the devolution of the

final health care from the federal government in or about 1988, there has been five years of experience under the system's belt, so to speak. Many of the relationships and controls that were set up in 1988 were probably needed at that time, bearing in mind that many of the boards were new with new people learning the ropes.

It is our view, Mr. Chairman, that after five years, perhaps a fresh look can be taken at that because the boards have undoubtedly gained experience and the people working in these jobs have gained experience and it may be time for the department to back off from some of the detailed controls and take a fresh look at what the situation is today, again, with the proviso that appropriate accountability mechanisms be built in so that the protection of the public dollar is always considered.

In our view regarding the situation at the moment, there is probably too much in the way of detailed process controls and not enough trust and accountability coming back the other way. I do not know whether that helps to answer your previous question. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Any other questions? Mr. Dent. Follow up, Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Mr. Chairman, the only way to ensure that there is an accountability method for clarification of the board's role and authority is to ensure that the department may have to consider that these boards be elected so they can be accountable, as opposed to appointed, and that the Chairman be independent and not a regional director that has been the practise in the past, over the different regions and different boards. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Patterson.

MR. PATTERSON: Thank you, Mr. Chairman. On section 2.7, departmental organization, the Auditor General has recommended that strong links be forged and maintained amongst the finance administration policy and operations. Basically, I think what is being suggested is that there are finance functions in hospitals and health facilities, and in health insurance services divisions, and a serious look should be taken at consolidating these in the department's finance and administration division.

The department has agreed to review the effectiveness of its headquarters organization. You have also noted that there is a major decentralization initiative under way of a major financial function. The health insurance operation which basically pays the doctors and the hospital bills is a big financial operation. As I understand the Auditor General's report, you are saying that the financial functions appear to be fragmented at the headquarters level. My question is, how would the decentralization impact on this? In other words, if there is merit in reviewing the financial organization at headquarters, is now the right time to be subdividing and decentralizing a major financial function such as health insurance? Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. The tennis ball just came back to my side of the net. This is a very pertinent and good question because the decentralization of any unit from an established and experienced base always creates the possibility or a greater amount of risk in the sense that many people choose not to go with decentralized jobs which results in new relatively inexperienced people being hired at the other end to deal with the control and management of the particular aspects of the job being decentralized. In this particular case, the H.I.S. division, as you point out quite correctly, dispenses millions and millions of dollars of public funds in payment of bills from physicians, pharmacists, hospitals and the like. In any decentralization, we, as auditors, would always be concerned to see that the appropriate control mechanisms go along with the decentralization. Such control mechanisms include reporting relationships, the quality and calibre of the people who are going to be handling the job and so on and so forth. Mr. Patterson's question, I think, is a very good one in the sense that we are saying not that the systems are fragmented, but perhaps to take the other point of view that there are similarities that require similar kinds of expertise between the three units that we mentioned that could perhaps result in some cost saving by bringing these units closer together, rather than allowing them to continue in their existing independent fiefdoms. I think the decentralization question is certainly a very valid question at this point in time. If there is an opportunity for the department to gain efficiency by looking at consolidation itself, it certainly must, in our view, consider the risks of decentralizing significant payment functions out to other communities, bearing in mind the conditions I have previously mentioned. I hope, Mr. Patterson, that deals with your question.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Patterson.

MR. PATTERSON: Mr. Chairman, thank you. So would you say that if there is merit in consolidation or examining the feasibility of consolidation, the logical thing would be to review that, consolidate first if there is potential there, and then do your major transfer out. Is that the logical way to approach it?

CHAIRMAN (Mr. Zoe): Mr. Simpson.

MR. SIMPSON: Yes, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: Thank you. In my general comments I quoted a statement made in the Standing Committee on Agencies, Boards and Commissions report and I will quote it again, "a very serious state of affairs presently exists within the administration of the territorial health care system." I would like to ask the Auditor General's office, for the record, as to whether or not their findings parallel the findings or the comments made by the Standing Committee on Agencies, Boards and Commissions as to the seriousness of the state of affairs within the health care system, especially as it relates to the relationships between boards, the Department of Health and the stakeholders.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. I was quite struck when I saw the interim report as to how similar the conclusions in Mr. Koe's committee report were to the broad conclusions that we had reached in our audit report. I would have to agree, fundamentally, yes that we see the same kinds of problems

that need to be fixed. If I can put it in a slightly different way, there is a significant need for renewal of the relationships onto a much more pro-active and positive basis than those that appear to exist at the moment. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: From the audit, in terms of economy as per your definition in your opening remarks, did you find any specific instances where you can put a dollar number on inefficiencies or loss of dollars in terms of bad decisions or untimely actions taken by staff or whoever that can be related to the conflict, confusions and the roles and responsibilities of boards and the department.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Another good question, Mr. Chairman. We have not identified what I would call horror stories in the case of single decisions or incidents that we can point to as having resulted in loss. However, Mr. Chairman, throughout the report we point out a number of areas where greater efficiencies could result in cost savings. In particular, the boards have indicated to us that they spend a lot of staff time answering what they perceive to be very nit picky types of questions and issues. Frankly, Mr. Chairman, if the relationship between the boards and the department could be strengthened where there was greater trust on both sides, again with appropriate accountability, relationships and feedback mechanisms then in my view there is potential for some significant cost savings gains to be made through greater efficiency in the greater use of staff on both sides. In terms of being able to put a dollar quantification on that, that is not as easy a task as I think we would all like to be able to come up with a dollar figure but it is tough to do. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: The Auditors talk about building a partnership. In your opinion what are the specific steps that you see in accomplishing this?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. I feel a bit like the Israelites being called on to build the pyramids at this point in time. It is a tough task and will probably take a long period of time. However, the department has taken the first step, subsequent to our audit, in outlining the 15 steps which it has outlined on the memorandum of agreement process. As I have pointed out previously, however, I think there needs to be additional steps and safeguards built into that. Frankly, as Raymond has mentioned, several times, there is really no substitute for getting people together in a room and talking through the problems, issues and building the kinds of trusts and relationship that really is a fundamental ingredient in this whole rebuilding process which appears to be necessary here and striking the right kind of partnership deal. I would have to support everything that Raymond has said up to this point in time. Really there is no magic wand. We cannot come here and give you a formula to say to do something and it will work, because frankly that would be imposing our views on really what is a domestic issue to be solved by all the stakeholders and partners in this process. I would advocate that talking, getting together and listening to each other and being sensitive to each others points of view, recognizing as I keep coming back to the need to preserve the integrity of spending of public funds. I think this is the right way to go, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: That leads me to this last question. The auditor mentioned the Memorandum of Agreement and the 15 elements. These elements were outlined in one of our former Minister's comments to the health care association. In these elements, in your opinion, are adequate and do they cover everything that should be covered in a Memorandum of Agreement? I do not want to outline them all here today.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. I think I just mentioned that while we think the list of 15 elements is a good first step, we believe there are other steps or ingredients that should be built in for a comprehensive relationship and protection of the public purse. One of the key issues as we see it, Mr. Chairman, is that there has to be a basis for mutual respect. The major elements of the Memorandum of Agreement, or the complete elements of the Memorandum of Agreement should not be imposed by the department on the boards but should be the product of some comprehensive discussions and negotiations where the views and concerns of all the parties are taken into account.

Another important ingredient in this Memorandum of Understanding, Mr. Chairman, relates to the health care model. Unless there is a consensus and common understanding of how the health care service is to be delivered in the Northwest Territories, I am not sure that the Memorandum of Understanding will really account for very much. I think this is also an important prerequisite.

A third point that should be considered, Mr. Chairman, relates to appropriate mechanisms for the accountability for the performance of all parties that are part of this agreement. This includes setting goals and objectives that are clear and unambiguous so that everybody knows what their expectations are. Finally, again having only had a little while to think about these 15 points, next week I may have some additional suggestions. There has to be a common core of good management information, both in the sense of the dollars and cents management information that we all conventionally think of but all of the other kinds of management information that is essential to a good and effective health care system working, particularly with all the number of stakeholders and partners who are involved here. As we point out in one of our chapters, Mr. Chairman, there is a significant need to improve the management information processes, structures and systems and in our view this is an important element of a good memorandum of understanding. Again, I would like to repeat one point that I have made. It has to be the product of negotiations between all the parties and not be seen as an imposition from Yellowknife on the boards. Otherwise I think it is doomed to fail. Thank you.

CHAIRMAN (Mr. Zoe): Are there any further questions on chapter two? If not, we will continue to chapter three. The Auditor General's opening remarks gave us an outline of

chapter three so I will not call upon them to give us a summary. Are there any questions from Members on chapter three with regard to planning for the future? Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. Throughout this report the Auditor General made it clear that some of the biggest problems that they see with the department is that there is no strategic plan or policy statements on health resources. The Auditor General has recommended quite strongly that a functional or organizational review should take place. I was wondering if the Auditor General could advise us if they heard from the department on whether or not there was a commitment made to undertake this type of review.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. I think the short answer to that is yes, the department in its management responses to the observation, has committed to a functional or organizational review of its own activities.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I was wondering if we could find out from the Auditor General's office then in their opinion how long should such a review take?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dubois or Mr. Simpson.

MR. SIMPSON: I think I am up to the second level of the pyramids at the moment, Mr. Chairman. I am not sure that anyone can give an answer on that. In looking at its own organization I believe that the department will have to also look at the relationships that we have just talked about in terms of the other stakeholders. Determining those relationships may significantly influence whatever decision in terms of its own organizational structure. In every reorganization one always likes to think that these things can be done quickly. I think the reality is that they do take a lot more time than all of us would like. On the other and we have all seen, including Members of this committee, many instances of procrastination by departments in getting things done. I would suggest, Mr. Chairman, that this question be banked and addressed to Dr. Kinloch when he has an opportunity to respond to this. In my view it is a very important issue and I believe that we can actually learn a lesson from Mao Tse-Tung in this. I hate to get into philosophical statements but one of Mao's little red book philosophies was that we should not be afraid to periodically review ourselves and recognize that we do need to change to deal with emerging situations. The department has been in existence, in its present form, since major devolution five years ago and, frankly, I believe it is time to take a leaf out of Mao's little red book and take a look at ourselves. I do not know whether that helps or confuses the situation. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I think Dr. Kinloch can count on getting that type of question. I do not think there is any question that will happen. What I am trying to do is take advantage of your experience in other areas and find out if we can get some method of assessing the responses that we might get, if you will, in advance. I guess part of the reason for that is that on page 14 of your report you note several examples of delays in studies or reviews which have been planned and things being changed and that the functional review, it might be suggested by managers of the department, be put off until after the amalgamation of Health and Social Services. In your opinion, is that sort of excuse going to be valid or do you think the functional reviews need to be taking place right now?

CHAIRMAN (Mr. Zoe:) Thank you. Mr. Simpson.

MR. SIMPSON: Mr. Chairman, a short answer is, I do not think any delays are tolerable given the issues that have been discussed so far in this committee. I think the department has no reason to delay getting on with this and coming up with a new model.

CHAIRMAN (Mr. Zoe): Thank you. Just to get back on what Mr. Dent was saying, most projects have a time frame. In your professional opinion, you did not give us any. You said, it is hard to determine a time frame on this type of project. Give us a good shot at it. What do you figure? Is it six months, a year, or 18 months? Surely, you must know through your work with this type of review that there has got to be a time frame. There must be a time limit on it. I wonder if you can give us what your office thinks is an appropriate time frame.

MR. SIMPSON: Again, that is a very tough question to answer, Mr. Chairman. As I just pointed out, reorganizing the department in isolation of dealing with some of these other questions will probably be a bit of a futile exercise. Undoubtedly, there are some things that can be looked at in terms of efficiency gains within the department as it is structured at the moment. Fundamentally, the premise of our entire report is that the structure of the relationship, the partnerships between all the stakeholders needs to be significantly overhauled and that, I believe, will significantly influence the way that the department itself is structured for maximum efficiency and effectiveness.

For me to sit here and say it should take six months, a year, or a year and a half, will be wrong because there is not way I can understand from where I sit all the complexities and difficulties that will be involved in this. I think, Mr. Chairman, the first step is to get a significant commitment from the department that they are going to tackle this and get the department to give you, as Chairman of the committee, some of their estimates. It might be more appropriate for me, at that stage, to come back to say whether I think those estimates are reasonable rather than for me to try and dictate or set some criteria which then the department would feel that it would probably have to challenge. I hate to cop out on an issue but I am not sure that I can tell Dr. Kinloch what he should be doing.

CHAIRMAN (Mr. Zoe): Thank you, that was a good answer. Any questions on chapter three? If not, we will continue. Mr. Gargan.

MR. GARGAN: Just one statement before we finish on chapter two and that is in regard, again, to accountability. I am glad that Roger brought up that whole point about Mao's little red book and about evaluating ourselves, and looking at the realities of today. Obviously, some of these questions are based on a 1990 assumption that the Legislative Assembly is

still going to be the body that is going to be the governing body.

The political reality, right now, is that Nunavut is going to be created, the Gwich'in Land Claim is going to be concluded very soon and the Inuvialuit Land Claim is concluded. So that is the reality and I guess if we look at it from that point, it could very well be that the focus or the direction that the department would be taking would be different.

I am just wondering whether or not you, as the Auditor General, when you are looking at the functions have considered the political realities of today. We just had a division, which is the ratification of Nunavut and seeing as how you really are quite keen on Mao's Little Red Book, would you elaborate a little bit further on that?

CHAIRMAN (Mr. Zoe): Mr. Dubois or Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. I would hate anyone to come away from here thinking I am a card carrying member of the Communist Party, however, there is another communist philosophy which, I believe, is ascribed to Lenin and that is, that organization should be continually in revolt. Revolution is not a fixed thing. It is an ongoing thing. I believe that we can take that philosophy and apply it to efficiency, economy and effectiveness in government operations. Nothing should be fixed in concrete. We should always be challenging ourselves to find better ways of doing things, particularly in periods of serious resource restraint.

Nunavut, as I understand it, Mr. Chairman, will not come into being until 1999 which is six or seven years away from now. The Gwich'in Land Claim may certainly be a little closer in terms of its impact, but I do not think that any of these issues should act as a detriment to getting on with the job and continuing this process of revolution or continual self-appraisal in terms of finding better ways to do things. So I guess my main message, again, little red books, Mao Tse-Tung and Lenin's philosophies aside, there is no excuse for stopping and waiting for these things to go and I would advocate that the start be made as soon as possible.

I would like to add one other comment though. The track record in the department has not been good up to this point in time in terms of starting and finishing things and, again, this might be something that Dr. Kinloch would like to comment on when he gets an opportunity. If there is a commitment to do this, I think the committee can and should expect some realistic time frames for when it can expect some completion.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dubois, have you got something else to add?

MR. DUBOIS: Just a very short comment, Mr. Chairman. Notwithstanding land claims or other things that may be happening, I think one of the other things that may be happening, I think one of the realities is that there are people in the Northwest Territories living in communities and unless there is something I have missed here, I do not think anybody is planning on uprooting communities or totally changing the way the population is dispersed in the Northwest Territories. As long as that is not planned to change dramatically, I see no reason why people should not proceed with haste in arriving at a commonly agreed upon health care model which should really be concentrating on the health care for the people, where the people are. It does not matter what you call the place, the people are still there. They still need health care and I do not see why all these other things should stop the process from proceeding.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: I realize that. I want to respond to Roger's position that in 1999, we are looking at a target date of 1999 for Nunavut to be created. The health transfer occurred in 1988. Obviously from your report there has not been a strategic plan for health care in the north. At the rate of five years with no plan in place, I do not know whether a target date for 1999 is realistic either. I just wanted to bring this up because it has not been progressing. We do not have a plan realizing the political situation.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: Thank you, Mr. Chairman. Health care is not a one dimensional thing. It is something that has to involve all government departments and all the stakeholders, agencies. It has been said time and time again that the quality of life or the health and well being of people relates to housing, education, economic development, employment, hunting and trapping, etc. The Department of Health has stated that some liaison does take place. Can the Auditor General just comment on this? What is your assessment of this liaison between health and other departments and agencies?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dubois or Mr. Simpson.

MR. SIMPSON: One of the documents which we reviewed was authored by Dr. Kinloch, which I thought was a very far seeing document in terms of the philosophy of what the future of health care was to be in the Northwest Territories. It involved a recognition of all the factors that effect the health of the public and the well being. I think I would have to credit Dr. Kinloch with having the vision to articulate those things in his report.

In the sense of the specific relationships that exist between those departments, I think I mentioned previously, Mr. Chairman, that the department assures us that those things do happen. However, we have not been able to find documented evidence as to what was discussed and what decisions were reached. If these meetings are being constructive and productive and if key decisions are being taken, I believe it is important to produce some documentation as to what the nature of the issue was, how it proceeded, and what conclusions had been reached from those interdepartmental and interagency types of meetings. I think we are all aware that health is certainly something that goes beyond the borders of the department and involves many other different aspects of life. I think the fundamental philosophical recognition is there. Proving what actually goes on is the missing link as far as we are concerned. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: Frequent references have been made to "The N.W.T. Way" model of health care. What is your view of the status of "The N.W.T. Way" and is "The N.W.T. Way" really the way to go in terms of health care delivery?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: I think that question might be more appropriately addressed to the department, Mr. Chairman. There does not appear to be a common view of understanding of exactly what "The N.W.T. Way" is. In addition, what the impact of "The N.W.T. Way" might be on the existing infrastructure investments and structure of the health care system in the Northwest Territories. I think there are a lot of questions still out there, Mr. Chairman. I also would like to point out that the last thing we would ever want to do as an office is to suggest or propose any kind of value opinion on the decisions that quite rightly should be taken by people in the north. If "The N.W.T. Way" is to be promulgated and accepted I believe it is a function of all the partners in the process. I do not believe that I can add any value, Mr. Chairman, by making any comments because they would have to be personal comments and not comments on behalf of the office. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: In chapter three it talks about planning and some of the comments that you make in your report, "the system has not been well planned and organized to deliver health care in the N.W.T.", and "We observed a planning to plan posture in the department." In your summary you say that "without a plan the N.W.T. health care has no clear sense of where it is going or how to get there." I have to agree because I can refer back to a few weeks ago when I made a speech in the Assembly talking about planning and how we can never achieve a plan, planning is always in a state of flux. As each day goes on new things come up, new systems, new budget restrictions, or affluent budgets and if we ever have that again it would change things and our population base, ages, demographics change. So the whole thing is always in a state of flux.

In terms of the department, one of the recommendations from the Auditor General is that the department should develop a long-term plan in consultation with the boards. The department has agreed to this with no elaboration. Does the Auditor General have any comment on that? Do you envision a concrete plan and then that is it or do you see this continually changing and being updated, continually progressing?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Mr. Chairman, very few things can ever be cast permanently in concrete. As Mr. Koe points out there are demographic changes occurring continuously. There are changing resource availabilities. There are changing technologies and a whole host of other factors that influence the health care delivery systems, not just in the Northwest Territories but across the world. I do not believe that one can create a plan forever or for any reasonable period of time into the future. However, the effectiveness of the system, in our view, demands that there be a planning process so that these changing conditions can be identified and factored in, in a way that all the parties can buy into. What we have observed at the moment, as we comment on the planning to plan observation, there have been numerous examples of where things have been started but not finished. I am not sure that this is very helpful in the sense of achieving what, in our view, is really required to move the whole thing forward.

We have suggested in one place, Mr. Chairman, that a particular group in the department could become the focus of planning. Again, I would say that if that were to be implemented it would not be a one time plan. It would be an ongoing responsibility for planning. The planning group has to be the eyes and ears of all the changes of all the factors that can influence health care delivery both now and into the future.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions? In regard to "The N.W.T. Way" which Fred was alluding to, I notice that there was a tabled document which was tabled in the House titled N.W.T. Health and Health Services, Tabled Document 35-12(2). Is that the only document that you have seen that describes the "N.W.T. way", or did you find any other documentation which was provided to your office by the Department of Health?

MR. SIMPSON: Thank you, Mr. Chairman. I believe the Beatty Report also discussed "The N.W.T. Way". I cannot recall any other specific documents other than the one you mentioned tabled in March, 1992 and the Beatty Report. Perhaps Dr. Kinloch can add whether there has, in fact, been other documented analysis of "The N.W.T. Way". One comment, Mr. Chairman, is that whatever "The N.W.T. Way" is or becomes there does not appear to be a common understanding of what it is and what the implications for everyone in the territories are of "The N.W.T. Way". I believe that if this is going to be the model, which again has to be a decision of the parties who are involved, then there has to be a clear communication of what the program is and what the implications are from everyone.

CHAIRMAN (Mr. Zoe): Thank you. Are there any other questions on chapter three or other chapters? Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. On page 16 of your report you have a recommendation that the department should develop appropriate workload assessment tools and standards and you have outlined some of the variables which should be considered. There is a management response there which states that most provinces have not been able to develop appropriate work load measurement tools that fit the needs of their own jurisdictions. What is your response to that management response?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. With your permission I am going to ask Michael Martin to comment on that because he has done some specific research into the department's response regarding the comments that provinces have not been able to develop.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Martin.

MR. MARTIN: Thank you, Mr. Chairman. When we looked at this specific management and response we decided to go to

one of our advisors, Mr. Brent Skinner, who is the vice president of care planning at the moment, but he was the executive director of health care planning in Alberta at the time of our audit period. From his assessment it is not so much a problem that the provinces have not had a difficulty in developing appropriate workload measurement tools, but the fact that they have had difficulty in setting guidelines in relation to those work load assessment tools. In other words once the work load assessments have been done it is a question of getting off the fence and deciding what types of resources, whether it be dollars, persons or otherwise, in relation to those guidelines, will be committed in order to meet the health care requirements within a specific system. Those are the difficulties that are being encountered by the provinces according to Mr. Skinner. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions on chapter three and other chapters to follow? Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. Mr. Chairman, it has been a number of months now since T.H.I.S. board was eliminated by the Department of Health. Mr. Chairman, I am wondering from the opinion of the Auditor General, was the dissolution of the T.H.I.S. board was a good move? Do you think it was negative or positive? Has it impacted the department either negatively or positively? Have we saved money or have we lost some of the efficiency because of the result of the T.H.I.S. board being dissolved? Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Simpson, any comments?

MR. SIMPSON: Just a brief one, Mr. Chairman. I am not sure that I can answer the Member's question specifically. Perhaps it would be a better question to address to the department. One can make an observation, however, that it has reduced an extra layer of bureaucracy and maybe that has a positive effect. I am sure that Dr. Kinloch can give you a better answer than I possibly could on that. Thank you.

CHAIRMAN (Mr. Zoe): Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Thank you, Mr. Chairman. This is a comment with regarding the utilization rates of these different hospitals in the territories. At the beginning of chapter three the Auditor General comments that "the current utilization rates makes hospitals extremely expensive thus denying resources to the community based alternatives which could reduce the need for and shorten the length of hospital stay."

I would like to give a form of a briefing of what had happened prior to the health transfer. Many of these hospitals were not run by the government. They were run by the mission and then they came over to the government. When we took over the transfer they were then transferred to the territorial government. Many of these hospitals, years ago, did more surgical work and health delivery work than they do now. For example, the hospital in my riding used to do, without any type of hesitancy, appendix removal, tonsil removal, or any type of minor surgeries. They are now hesitant to do deliveries. There are now a lot of medical referrals. There is no doubt that this has caused an impact of the institution being underutilized.

I am wondering whether or not the Auditor General's office detected from the Department of Health other methods to make use of these hospitals in their planning, or was there just no planning whatsoever and can they reply to the fact that the current utilization rates are expensive and the trend will continue to grow? Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Any comments, Mr. Simpson.

MR. SIMPSON: Just a brief one, Mr. Chairman. The department started a marginal facilities review but I do not believe it was completed. Again, perhaps that is something that Dr. Kinloch can clarify for us. Other than that, I have no comments.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: I would like to also make another comment for clarification. Did the office of the Auditor General take into consideration with the current utilization rate in these hospitals the different type of care giving that is now given by the community people. For example, take the high cancer rate in the territories, there are I believe more patients being taken care of at home as opposed to an institutional setting, thus resulting in a low utilization rate. Did they take these type of things into consideration or did they just take the statistics of hospital beds that were being utilized in these facilities?

CHAIRMAN (Mr. Zoe): Mr. Dubois, Mr. Simpson or Mr. Martin.

MR. SIMPSON: The short answer, Mr. Chairman, is that no we did not get into that kind of analysis. I cannot really add anything.

CHAIRMAN (Mr. Zoe): Thank you. Can we continue on then. Any questions on the following chapters four, five, six, seven or eight? Before we conclude today the Chair was hoping that we would at least get to hear the opening remarks from the Department of Health, if Members do not mind. Any further questions or clarification required on the other chapters from the Auditor General's office? Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Mr. Chairman, there are probably other questions that we want to ask, however, we can ask these question to the Auditor General's office at a later time to allow the Department of Health to make their opening remarks.

SOME HON. MEMBERS: Agreed.

---Agreed

CHAIRMAN (Mr. Zoe): After we conclude with the Auditor General's office I was going to request that they stay while the Department of Health appears before us so we can also question them at the same time when we are asking questions of the department. If that is alright with the Members, shall we proceed to call our next witness? Agreed?

SOME HON. MEMBERS: Agreed.

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch will be our next witness to appear. Dr. Kinloch is the Deputy Minister of Health. Dr. Kinloch, do you have any opening remarks, and

before you start could you introduce the people you have with you.

DR. KINLOCH: Thank you, Mr. Chairman. With me is Nelson McClelland who will be speaking specifically to some of the issues surrounding chapter two and we will be making some brief introductory remarks to that chapter. I have some opening remarks that pertain particularly to the opening section of the Auditor General's report and which have application throughout the other chapters.

CHAIRMAN (Mr. Zoe): Alright, you can proceed, Dr. Kinloch.

DR. KINLOCH: Thank you. The Department of Health welcomes the report of the Auditor General as a means of calling attention to matters that have long been recognized as obstacles to efficient and economical management of the health system, but which have required a serious economic downturn to capture the attention they deserve.

The department also welcomes the opportunity to speak to the report as a means of highlighting some of the challenges unique to the N.W.T., and the special programs and services which have been established to deal with them and also some achievements. The report of the Auditor General provides some helpful comment and useful recommendations. Many of the recommendations can be dealt with through measures already in place or implemented, others are sensible and helpful and will be pursued, recognizing that they have policy and financial implications.

The term "health care" is used extensively throughout the document. This has a very specific meaning to the department. It refers to diagnosis, treatment, rehabilitation and care services. The mandate of the department is for health services, which is much broader and includes health promotion, health protection and disease prevention activities. The department is also dedicated to the improvement of health which is broader still. A state of physical, mental and social well-being, not merely the absence of disease or disability. The importance attached by the department to promotion of health, protection of the public and prevention of disease, seems to have been often overlooked in the report.

The department believes that a comparison of the N.W.T. findings with those of other jurisdictions would demonstrate that many of the reported deficiencies are common experiences. Such a comparison would also demonstrate that the N.W.T. is doing better than most jurisdictions in dealing with its problems. This has involved some admittedly difficult decisions with boards about the allocation of scarce resources, but increasingly collaborative working arrangements exists with boards and other groups.

The department expects that relations with boards will improve with the completion of a Memorandum of Agreement, clearly setting out roles and responsibilities of each. This exercise is expected early in the 1993-94 fiscal year.

The transfer of health services, a phrase which we see repeatedly in the report and I have heard this afternoon, from Canada to the N.W.T. was not an event which occurred in April, 1988. Transfer is a process. It was conceived in 1957 when medical services first established services in the Northwest Territories. It was set officially in motion in 1981, expanded in 1986 and 1988, but it is still continuing today. An indication that the process of transfer is not complete is the current statement of claim in the federal court of Canada to seek $79 million which the G.N.W.T. claims it is owed by Canada to the N.W.T. for the period 1986-87 to 1991-92.

The larger operating environment of the G.N.W.T. as a whole deserves greater attention in the report. Since the transfer agreement of April, 1988, the economic situation has deteriorated dramatically in Canada as a whole, and in the Northwest Territories. This has forced restraint measures that have altered not only resource allocation decisions, but also the working relationships between those with competing demands for limited resources.

The department does not exist in a vacuum. It operates in and is restricted in its operations by an environment that is created for it by others. A major and necessary portion of that environment is the legal and policy framework of the G.N.W.T., some of it a legacy from the colonial period of N.W.T. administration. These important considerations are absent from the report.

The events of the past year, in particular, provide dramatic evidence of the unique nature of N.W.T. government. More than ever before department activities have been affected by day to day events in the Legislative Assembly. No objective review of the department is possible without taking this fact into account. We suggest that the benefit of any future comprehensive audit would be enhanced if greater consideration were given to the special nature of the operating environment of the G.N.W.T. from influences both from within and outside the N.W.T.

In the N.W.T. the responsibility for health services is clouded by the special relationship between aboriginal peoples and the federal government, and further complicated by the reluctance of Canada to fulfil its contractual obligations to pay the total costs of hospital services.

The report references only two acts governing operation of the department, the T.H.I.S. Act and the Financial Administration Act. There are many more. Of the acts which define the scope of the department activities, two are related to enforcement powers for the protection of the public, the Public Health Act, the Mental Act and their pursuant regulations. Two other acts authorize the provision of insured health services, the T.H.I.S. Act and the Medical Care Act. Both of these are controlled in their application by the Canada Health Act. Other acts deal with the regulation of health professionals, including the delegation of functions from one professional group to another. The Dental Auxiliaries Act, the Dental Profession Act, the Medical Profession Act, the Nursing Profession Act, the Ophthalmic Medical Assistants Act, the Optometry Act, the Pharmacy Act and the Psychologists Act. These acts are not specifically cited and have a much greater effect on the day to day operation of the department than either the T.H.I.S. Act or the F.A.A. Act.

Management of the health services system is only part of the department's task. The primary goal of the department is to improve the often poor health status of N.W.T. residents, particularly the aboriginal peoples. This will require the

resources and skills of the G.N.W.T. as a whole and the selective use of professional resources and medical technology. It must also build on the traditional knowledge and strength of aboriginal peoples and their relationship with the natural environment. This is a challenge in part because there is still often a belief that improved health requires more doctors, more hospitals and more high technology. The department believes that further improvement of health in the N.W.T. is dependent largely upon the achievement of socio-economic conditions that produce for example more employment opportunities, better housing, improved nutrition, better sanitation and reclamation of traditional strengths of family and community. Effective intervention will require collaborative efforts between persons and groups both within and outside of government.

The first chapter of the report headed "executive summary" deserves special attention because it is in many ways the most instructive. This is so because it provides insight into the orientation and methods of the Auditor General and provides a basis for assessing the relevance and objectivity of statements and recommendations made later.

Specific authorization for the audit was given by vote of the Legislative Assembly on March 11, 1991 on the recommendation of the Chairman of the Standing Committee on Finance. The Chairman indicated concern with the "requirement for $14.7 million in supplementary funding in 1991", also regarding high medical travel costs, "the lack of criteria for planning new capital facilities and the admission that capital costs were poorly estimated in many cases."

The Standing Committee on Finance sought assurance that department operations "are effective and being carried out with due regard for efficiency and economy." Accordingly, the S.C.O.F. recommended that the Legislative Assembly request the Auditor General undertake a comprehensive audit of the department.

In setting out the scope of the report, the Auditor General indicates that extensive research was carried out on work done in recent years. It is not clear what research was examined but it does not appear to have included the extensive reports commissioned by other jurisdictions over the past several years reviewing their health services systems. These reports all make recommendations which would adopt or adapt some of the features of the current N.W.T. health system. Inclusion of such material in the report would, we believe, have demonstrated the leadership which has been shown by N.W.T. in many important areas of health services. Increasingly, service approaches developed long ago in the N.W.T. are attracting attention elsewhere, the most recent example being the Globe & Mail of December 31, 1992 with a story from Newfoundland.

These service approaches which are now attracting attention nationally, collectively are known as "The N.W.T. Way" which, in its current form are characterized by six elements, as follows:

- First, a broad orientation to health recognizing the contributions which can be made outside the health care system to improving the health of the population;
- Second, emphasis on health promotion, health protection and disease prevention in the delivery of health services;
- Third, operation of health services as a system of linked services;
- Fourth, delegation of responsibility for providing care to socially and technically qualified professionals, not necessarily physicians or dentists;
- Fifth, involvement of the people in planning and management of their health services system; and,
- Sixth, involvement of all ethnic, cultural and linguistic groups as providers of training and service.

In essence, "The N.W.T. Way" is nothing new. It is a description of what has been here for a long time. It is changing. It is developing. It is improving as time passes.

The methodology set out in the report deserves scrutiny. It would have assisted readers if the basis for comments and recommendations had more clearly been specified and if the criteria for the inclusion or exclusion of relevant material had better been stated. It would also have been helpful if time period references had consistent. The subject of the audit is the department but comments frequently refer to matters within the mandate of others; the Legislative Assembly, the Cabinet, central agencies, the departments of Personnel and Social Services and health and hospital boards. The distinctions are not always made clear.

The management of health services in the N.W.T. by Health & Welfare Canada was undertaken in 1957 with a clear understanding that it would continue only until the G.N.W.T. was able to assume this responsibility itself, hence, the beginning of transfer. Necessity dictated the general shape of that system, with delegation of responsibility for providing care in small isolated communities, to nurses and nurse midwives with physician support from regional general hospital and specialist support from southern Canada. That system has served the N.W.T. well to date and remains today in a new and improved version.

The T.H.I.S. Act was proclaimed in 1959. This Act was needed by the federal government as a vehicle for introduction of national hospital insurance in the Northwest Territories. The T.H.I.S. Board was a mechanism to oversee the introduction of the plan into the N.W.T. Since then, radical changes have occurred in the delivery of health services. Amendments were made to the T.H.I.S. Act in 1986 and again in 1988, in support of the transfer of health delivery responsibilities. These amendments expanded the responsibility of health boards to include the management, control and operation of health facilities and the delivery of a full range of health services within their respective administrative regions.

The transfer of services to G.N.W.T. was formally initiated in 1982 when the then Frobisher Bay General Hospital was taken over by the G.N.W.T. It was extended in 1986 to include all Baffin health services and further extended in April of 1988 with the transfer of remaining Health & Welfare Canada services.

While the earlier transfer components had been undertaken cautiously and with considerable lead time, the 1988 Transfer Agreement was pursued in haste. The decision to conclude

the agreement was made in October of 1987 and accomplished on April 20, 1988.

The scope, magnitude and complexity of the transfer process was not sufficiently appreciated by G.N.W.T. in retrospect. It appears the G.N.W.T. knowledge of the health and welfare was simply not adequate to the task. As a precondition to the transfer of administrative and financial responsibilities, there was a specific Health & Welfare Canada requirement for public involvement and a consequent decision by G.N.W.T. to create and support five new health boards. Each of these efforts was a major challenge. Collectively, this constituted a daunting undertaking. Creation of health boards was promoted in the Legislative Assembly as a great leap forward and as an exercise "through which community residents would take control of their health services, making them more responsible and more relevant to the needs and desires of the people."

This was interpreted by many potential health board members as indicating the health boards would be essentially free to make whatever decisions they wishes regarding community health services.

To complicate matters, during the last stages of preparation for the 1988 Transfer Agreement, a major policy change was made by G.N.W.T. regarding support services. These would now be provided by existing G.N.W.T. departments rather than integrated within health, thus establishing two classes of boards, ones with and without delegated functions. The stage was thus set for future difficulties regarding roles and responsibilities of boards and the differential treatment of boards.

An initial task, after 1988, was to assist the new regional boards of trustees to become established and fully operational. The creation of the five new boards is not yet complete because it has not been possible to reach agreement on the composition of the Mackenzie Regional Health Board.

The naming of health board members for the remaining boards was completed by the end of 1988. The appointment of chief executive officers for the new boards was completed early the next year. Within the new departmental structure, significant vacancies at the director level existed well into 1989, thus the effective operating period since the signing of the 1988 Transfer Agreement is considerably less than five years and, during that time, there have been continuing difficulties with the recruitment and retention of important senior positions and boards, notably qualified finance officers. The Inuvik Regional Health Board suffered seven finance officers in one year.

During this development period, some role confusion was attributed to the existence of two headquarters entities; the department and the T.H.I.S. Board. During 1990 and 1991, various boards including the Standing Committee on Public Accounts and the Standing Committee on Agencies, Boards and Commissions questioned the role of the T.H.I.S. Board and the necessity for its continued existence. After carefully considering the matter, the G.N.W.T. dissolved the T.H.I.S. Board and returned its powers to the Minister.

Unfortunately, dissolution of the T.H.I.S. Board has aggravated some department board relationships since cost containment requirements and accompanying unpopular changes are sometimes seen as department heavy-handedness. The Department is pursuing strategies aimed at improving the health of the population and improving the effectiveness and efficiency of health services which I would like to emphasize here:

1. Encouraging the improved health of the population as a fundamental goal of government;

2. Admitting the limitations of the health services sector as a means to improve health and inviting the participation of other sectors in the development of what we are calling healthy public policies;

3. Accepting that there has been relatively little effort to ensure that health services have beneficial effects;

4. Recognizing that management of the health care sector is not an exercise which has failed but rather one which is not seriously been attempted;

5. Identifying in collaboration with health boards, aboriginal groups and professional associations, a set of health issues of common concern and the options for dealing with them.

I hope that caucus will find the time during 1993 as they were unable to do in 1992, to accept the invitation of several Ministers of Health to discuss these matters and their important implications for the future.

In summary, Mr. Chairman, the Department is concerned that when read in isolation the report may leave an unfavourable impression of the health system. This is not warranted by the facts. The department believes that comparison of the N.W.T. findings with those of other jurisdictions would demonstrate that the reported deficiencies are common experiences. Such a comparison would also demonstrate that the N.W.T. is doing rather better than most jurisdictions in dealing with its problems.

The senior managers in the Department of Health have many years of experience in the health services field. This experience was acquired in most provinces, both territories and in foreign countries. It is our collective judgement that the N.W.T. has one of the best health services in the world. Service arrangements in some locations in Newfoundland and Labrador, in northern Quebec and, on a smaller scale, in Yukon are similar to those of the N.W.T., but in the northern areas of other provinces and the isolated areas of the United States, Australia, New Zealand, Pacific Islands, or any part of Africa or Asia, there is no service of comparable scope and quality. The department expects that these hearings will provide an opportunity to place the report of the Auditor General in context but believes that readers should be cautioned about the scope and perspective of the report. They should be reminded that an understanding of the history of health services in the Northwest Territories is necessary to intelligently assess the present situation. The transfer of health services must be recognized as an incomplete process and not as an isolated event in April 1988. There must be a comparison with other departments or jurisdictions for the findings set out in the report to assess their importance. Stated and consistent time frames are necessary to make appropriate

comparisons within the report. The effectiveness of programs and services, whether they actually help people, should receive more emphasis than how efficiently they are provided.

The department accepts the need for and has begun a broad range of tasks that will better prepare it for management problems that have been identified by the report. We look forward to discussing these matters in greater detail in a section by section review at which time we will comment on specific recommendations made by the Auditor General. Thank you very much, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Mahsi. Dr. Kinloch, can we get a copy of your opening remarks so that we can have time to digest everything that you have said to us this afternoon.

DR. KINLOCH: Yes.

CHAIRMAN (Mr. Zoe): That concludes our agenda for today. We will continue tomorrow and resume our questions and comments with the deputy minister of the Department of Health, Dr. Kinloch. The committee will reconvene tomorrow at 9:00 a.m. We will adjourn until 9:00 a.m. tomorrow morning. I would like to thank both witnesses for appearing before us today and we will see you back here tomorrow. Thank you.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PUBLIC MEETING

PROCEEDINGS

THURSDAY, JANUARY 7, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

THURSDAY, JANUARY 7, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Other Members of the Legislative Assembly In Attendance

Mrs. Jeannie Marie-Jewell
Mr. Dennis Patterson

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

Mr. Raymond Dubois, Deputy Auditor General, Ottawa, Ontario

Mr. Roger Simpson, Principal for Auditor General's Office, Edmonton, Alberta

Mr. Michael Martin, Senior Auditor, Office of the Auditor General

Dr. David Kinloch, Deputy Minister, Department of Health

Mr. Nelson McLelland, Director, Hospitals and Health Facilities, Department of Health

Ms. Maureen Morewood-Northrup, Acting Director, Nursing Services, Department of Health

Dr. Ian Gilchrist, Chief Medical Health Officer, Department of Health

Mr. Barry Lange, Senior Human Resources Planning Officer, Department of Health

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

JANUARY 7, 1992

Members Present

Mr. Bernhardt, Mr. Dent, Mr. Gargan, Mr. Koe, Mrs. Marie-Jewell, Mr. Ningark, Mr. Patterson, Mr. Whitford, Mr. Zoe

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): I would like to call the committee to order. Yesterday we concluded with the Department of Health's opening remarks pertaining to the Comprehensive Audit of the Department of Health completed by the Auditor General of Canada. We will proceed with general comments from the Members. Before I go to the Members for general comments could I ask the Auditor General's office if they have any comments or questions pertaining to Dr. Kinloch's remarks of yesterday. Mr. Dubois.

Auditor General's Office General Comments

MR. DUBOIS: Thank you, Mr. Chairman. Mr. Chairman, we would like to react to certain comments made by Dr. Kinloch in his opening statement. At the same time I would like to continue Roger's communist analogies by clarifying what one can term a red herring in Dr. Kinloch's opening statement. The comments I have to make are selective. I certainly do not want to go through the whole document because the committee Members may want to address certain questions. If there are other issues that the committee feels need clarification then we will certainly be glad to provide necessary explanations. I would like to make certain comments about certain parts.

To begin with, the top paragraph on page two makes a distinction between health care, health services and mentions promotion of health, protection of the public, prevention of disease and it says that it is these things that have been often "overlooked in the report." I would like to attempt to explain a little bit about the understanding of comprehensive auditing and also what it is that we did in this particular case.

The term comprehensive auditing, which was established in the mid 1970s, has meant different things over time. In 1977 when the Auditor General of Canada inherited the mandate for value for money work, that is when that term was coined. At that time the definition of comprehensive auditing included attest financial audit, authority auditing or legislative compliance and it also included value for money. When the office first started doing comprehensive audits in 1977-78 we were doing, at that time, what we termed "wall to wall" comprehensive audits. These were very extensive exercises which covered just about all the activities of the given entity. That proved to be very time consuming and quite expensive. Through time the methodology for comprehensive auditing has evolved quite significantly. Most people understand comprehensive auditing for its value for money part and not for the other two parts. The term is mixed because many people look at comprehensive auditing for value for money auditing, while the technical definition was broader.

One other thing that happened over the years is that we went from "wall to wall" to system based audits, which were strictly oriented towards the management systems. In the later years there has been a shift from systems to results based audits. It is a term that has not been fully defined yet as to exactly what a results based audit means. In certain cases it would skip over the systems and go at the end of the tunnel, look at the results and make comments on the results only. Without getting into actual effectiveness, evaluation or program evaluation. The mandate of the office of the Auditor General is interpreted as a full mandate on economy, and a full mandate on efficiency, but on effectiveness we have limited our activities to auditing systems. We do not measure effectiveness ourselves. That has always been the prerogative of the management of the entity to measure the effectiveness of its programs.

In this particular case when we were asked to do a comprehensive audit of the Department of Health we decided that we would concentrate more on the management systems and practices in the Department of Health and that we would not concentrate on the delivery side, or the field operations. We would not look into the quality of the services given, the quality of care or the quality of the promotion for health or protection to the public. We deliberately decided not to do this. I just wanted to clarify that point because there seems to be some confusion as to what it is that we were to do.

The second paragraph on page two refers to comparisons with other jurisdictions. That one is a bit more complex. Let me start with the comment on page eight where Dr. Kinloch mentions that in setting out the scope of the report the Auditor General indicates that extensive research was done on work carried out in recent years. It is not clear what research was examined. I have no problem with that. I think that is factual. In reading the report it is not that clear. He goes on and says that it does not appear to have included the extensive reports commissioned by other jurisdictions over the past several years reviewing their health services system. I would like to clarify for the committee that we did look at all the reports that were commissioned by other jurisdictions in the research exercise.

To go back to page two, Dr. Kinloch mentions that "the department believes that a comparison of the N.W.T. findings with those of other jurisdictions would demonstrate that many of the reported deficiencies are common experiences." We did not do a comparison of the findings from this audit with those

of other jurisdictions because for one thing it would have been an extremely expensive thing to do. We would have had to go back into those jurisdictions to look at what exists there and make an update of all the studies that were done. We did not feel that this was essential since many of the reported deficiencies stand on their own as being serious enough. We thought it was irrelevant if they were worst or better than what exists in other entities or other jurisdictions. We did not feel that there would be value added in making that type of comparison.

On page 16 Dr. Kinloch mentions that according to the senior management of the Department of Health, "it is our collective judgement that the N.W.T. has one of the best health services in the world." We cannot comment on that either positively or negatively. We certainly would be curious to know on the basis of what criteria that statement is made. If it is true then that is fine. Even if it is one of the best we still do not feel that this is a reason to not make it better.

On page three there is a comment in the third paragraph about the larger operating environment of the G.N.W.T. as a whole and that it deserves greater attention in the report. It talks about the economic situation that deteriorates, the restraint measures, the lack of adequate funding, and those types of things.

On page six there is another reference to the same general subject that "the department believes that further improvement in health is dependent largely upon the achievement of socio-economic conditions" and it goes on. We believe that we have recognized that in the report. In fact, we encourage the department to cooperate with other departments in the Northwest Territories, in Section 2.10. and, while recognizing that that environment exists in that many other factors influence health, we did not feel that it was part of the mandate of this particular audit, to get into the socio-economic aspects such as employment opportunities and better housing. This is at a higher level than the Department of Health. This is a Government of the Northwest Territories issue. It is a very broad issue and we recognize it but we do not think it was part of the mandate of this audit. We feel we gave it adequate attention by mentioning it in the report.

On page 5, Dr. Kinloch talks about the fact the report references only two acts, the T.H.I.S. Act and the Financial Administration Act and mentions that there are many more. Now we do recognize that there are many more, however, because of the fact that we concentrated on management systems and practices. We feel that the two acts that we have mentioned are the most relevant to the audit that we did. Now we are not denying the existence of the other acts and they are quite important but we feel that those other acts are more relevant to field operations and quality of care which is an area we did not scope into the audit that we did.

I am skipping over different things here, Mr. Chairman, but if the Members of the committee want us to come back to specifics, we can do that and I am assuming, as we do throughout the report, there will be opportunities to come back to certain comments which are more specific.

My next comment is on page 16, at the bottom where Dr. Kinloch mentions that "the department expected these hearings to provide an opportunity to place the report of the A.G. in context but believe that readers should be cautioned about the scope and perspective of the report", and mentions a list of things that my understanding is they are things that he thinks are inadequate in the report. That is the assumption I am making and I would like just to very quickly go through that series.

Under a), "an understanding of the history of health services in the N.W.T. is necessary to intelligently assess the present situation." We certainly believe that our research gave us an understanding of the history. We believe that the information in the report is sufficient for the Legislative Assembly and the committee to understand the context. Naturally, we could have repeated the full history in the report but we did not feel it was essential. We concentrated mostly on the April 1988 and after period where we feel it is more relevant to the current situation. We still feel quite comfortable with that.

Under b), "the transfer of health services must be recognized as an incomplete process and not as an isolated event in April 1988." Frankly, we have to disagree with this. We feel that the event of April 1988 was the completion of devolution of health services to the Northwest Territories and we look at that as a most important event in the sense of that is where the full devolution happened and that is the base that we have used. Now we do recognize that the transfer was made progressively and that the Frobisher Bay Hospital was transferred before this date but we still believe that the base should be April 1988 where we start with the full devolution situation. The fact that there is a dispute going on with Canada, we do not interpret as being a continuation of the devolution process. That, to us, is a disagreement and the reasons for the disagreement get quite complex and we hope they will be resolved in the future.

Under c), "comparison with other departments and jurisdictions," Again, we feel that the findings are self-standing. We feel the findings are important enough to stand on their own and significant enough. To make comparisons with other jurisdictions is not that useful in the sense that, if something has to be corrected, the fact that it is better than some other jurisdiction is not an excuse not to correct it. We feel that the observations stand on their own.

Under d), as stated, in "consistent time frames are necessary to make appropriate comparisons." I am not totally convinced I understand the thrust here and probably when we get into the details there may be some examples we can react to but, generally speaking, we used the information that existed in the system. In some cases, we had to go back in time to find valid information because current data was not available and the dates we used are the dates of availability of data. I think perhaps the variation of dates may be a reflection of the quality of the information systems that exist. We do make comments on the quality of the information throughout the report and that is something we can come back to in specific detail if we have to.

"The effectiveness of programs and services...should receive more emphasis than how efficiently they are provided." Again, I am not sure we fully agree with the statement the way it is stated. We agree that the effectiveness of programs or the quality of service to the user is very, very important and, in fact, we make the case, in chapter eight, that the measurement of

the systems and practises for measuring the effectiveness of programs are inadequate. Now, I mentioned at the beginning, that under the mandate that we have, we do not do effectiveness auditing ourselves. We just look at the quality of the systems and practises that exist but we feel the responsibility for measuring effectiveness lies with the department. We did not touch that part. The comment in chapter eight is that the department is not doing it, or not doing it adequately, and we think that should be corrected. Now, is effectiveness more important than efficiency? Naturally, the quality of the service to the user is of prime importance and one cannot deny that. However, when you give quality of service to the user, it has to be done at the least cost. So the efficiency is quite important because we are in a time of restraint, so whatever service the department or the hospitals or the health centres are giving it should be done at the least cost possible so that you can give more service to more people. So both are very, very important.

"The basis for conclusions and judgements must clearly be stated." I guess that one we can react specifically as you go through the report. I am not sure I understand what it means but I am sure there are some specifics behind that.

On the last page, page 18, Dr. Kinloch mentions, "I would like to note at this stage, however, that the department's responses to these recommendations which are included in the report were provided on short notice." Just to give some specifics, we sent the draft chapter to the department at the end of July and received responses in the third week of September which was more than six weeks. I do not agree that six weeks is short notice, we think that is sufficient time to think out the responses. The last sentence says "the department has prepared a summary of recommendations, amended supplemented responses and comments." We have not seen that yet so we will react to that when we see it.

This concludes my general remarks, Mr. Chairman. If the committee Members want more specific clarification on any of the points we would be glad to answer questions. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Are there any general comments from Members? Mr. Gargan.

General Comments

MR. GARGAN: Mr. Chairman, I have a comment with regards to the statement that was made by Dr. Kinloch. In his presentation he goes back as far as 1979 and a lot of the comments that were made make the department look good, including comparisons to other jurisdictions and the world and being covered by the Globe & Mail. I wonder if based on a per capita base possibly we have the best physical infrastructure in place for the delivery of health. I am not sure if that is what you are referring to because in my opinion we have the highest rate of suicide, five times the national average. We also have the largest alcohol consumption, even though the price has doubled. It is one of the biggest revenue for this government. What I am interested in is that we know that the Stanton Yellowknife Hospital is under utilized as is the Hay River hospital. I do not know which others are under utilized, I can only refer to those two. What do you mean when you say that we have one of the best health delivery systems compared to other jurisdictions in the world? Is that more of a cosmetic type of a statement you are making or are you actually saying as far as health standards go for the physical, mental and spiritual well-being of an individual we are one of the healthiest people in the world? Could you elaborate a bit more on that?

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I would like to make a few preliminary comments in response to the Auditor General's response to my presentation.

CHAIRMAN (Mr. Zoe): I do not want to get into a debate between the Auditor's report and your comments pertaining to that report. Once we get into the chapter by chapter perhaps you can make specific responses to the concerns raised by the Auditor General to your remarks.

DR. KINLOCH: As you wish.

CHAIRMAN (Mr. Zoe): If we can continue with general comments. Mr. Gargan made a number of comments and he asked for clarification on some of the remarks you have made, Dr. Kinloch.

DR. KINLOCH: Thank you, Mr. Chairman. I am pleased with the question from Mr. Gargan because he properly makes the distinction that I have tried to make in the paper and the department has tried to make repeatedly between health and health services. The health status of the residents of the Northwest Territories is poor. It is much worse than the health status of the southern Canadian population. Within the Northwest Territories the health status of aboriginal residents is worse than that of non-aboriginal residents. This is evident, we have documented it, we have published it, we have spoken about it and we would like to speak about it a whole lot more. I hope we will have the opportunity to do that during this hearing.

For the moment, however, I would like to note that one of our primary responsibilities is the management of health services which can deal with only a portion of the health problems experienced by the people of the Northwest Territories. Within that more limited mandate we argue that the Northwest Territories' system is among the finest in the world. It is amongst the finest in the world because of the elements that are set out in "The N.W.T. Way". I would refer you back to the page of my presentation which sets those out.

What makes the N.W.T. health system good? First of all, it has a very broad orientation to health. It recognizes that what is done under its general mandate can deal only with a portion of the problems that are experienced by the people of the Northwest Territories.

Secondly, within that mandate it recognizes that health promotion, health protection and disease prevention have got a lot more to contribute in many ways than treatment and rehabilitation.

The element which separates our system from most others is the operation of health services as a system of linked services so that entry at any point in the system provides access to any other point in the system.

Fourthly, and this is another major difference in our system. The delegation of responsibility for providing care. By that I mean services that might in other jurisdictions be provided by specialist physicians are provided by general physicians with extra training and guidance in the Northwest Territories. Services that otherwise and elsewhere might be provided by physicians are provided by specially qualified nurses. Services that would be provided by dentists elsewhere are provided by dental therapists here. Services that might be provided by an ophthalmologist, an eye care specialist physician in the south, would be provided in the Northwest Territories by an ophthalmic technician. Services that are not provided by anybody, perhaps, in the south are provided by community health representatives. This is just the beginning of the development of a system of delegated service functions.

Number five also separates the N.W.T. health care system from most others in that there is involvement of people in the planning and management through the creation of boards.

Sixth, involvement of ethnic culture and linguistic groups as providers of training and service. This exists primarily at this point as a goal, as an aim, as an intention that over time the proportion of aboriginal people as providers of care and as teachers will begin to approach the general distribution in the population. That is not the case now. Aboriginal people are under represented as providers of care. They are under represented as senior managers. They are well represented in other categories, but that is not good enough and we aim to create an environment where increasingly aboriginal people will play a larger role in the system. Those are the elements that make this the best system and we are seeing increasingly other jurisdictions picking at one or more of these and saying "yes" we ought to be doing this and we are in a leadership role.

If I can take a bit of latitude with the Chairman's request, I would like to point out that it is appropriate to look at comparisons with other jurisdictions in terms of setting up services, structures and functions that are inherently very difficulty to deal with. No one is doing a perfect job in any one of these areas. We are doing better than most. I certainly accept that however good the system is it can be better and we want to make it so.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: With regard to the delivery, you did mention in your report that there would be a Memorandum of Understanding with regard to accountability. You have about five different boards having five different functions. As far as the leadership roles go, with regard to the department, we do not have a situation where Baffin for example has a lot of autonomy compared to the Mackenzie Health Board. The Mackenzie Health Board is a creation of the department. We do not really have any representatives from the region on it. I would prefer that if we are looking at having more control for aboriginal people then we should allow that and develop a policy that is consistent across the north. We do have jealousies between the regions. They make comparisons with other regions and wonder why some have this and some do not. I think this is one area we should deal with.

The political reality right now is that we are eventually going to have Nunavut and Nunavut should be looking into this to. We have the Gwich'in land claims which will probably be finalized by this fall. We already have an Inuvialuit agreement. Those are the areas in which the department has not done much.

As far as the operations of health services, the large proportion of the delivery of health is for the delivery of health as opposed to the prevention of health. A large proportion of the money that is delegated towards the health of Inuit and status Indians covers a lot of the other areas. In other words the only reason we have a $79 million deficit right now is focused on the non-insured benefits. That tells me that where possible and the dispute is whether or not the right of the Status people and the Inuit people and their health benefits is not cared for then we will put it in this deficit category. This way it would not be a dispute, it would be a right and we will be able to collect it.

Somehow we have been subsidizing other wages, salaries and the operations of this government. I think the Status people or Inuit people are being used in order to get some leverage in getting some monies back. This is my opinion. I do not know whether I am correct or not. There is a statement, "an ounce of prevention is worth a pound of cure." We do not have any programs for prevention or very little if any.

Dental is mentioned in the Auditor General's report. We do not have dental prevention. We do not have this. We have what they call once or twice a year dental prevention going into the communities. This is not good enough. I guess under the circumstances this is a reality. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Any comments, Dr. Kinloch?

DR. KINLOCH: Yes, Mr. Chairman. I would like to comment on several of the points that Mr. Gargan has raised. First of all the Memorandum of Understanding with the boards we believe will resolve the major differences that have existed between boards and departments, and between boards and other boards over the different perception of role and responsibilities. I think that it is also fair to say that a lot of the disagreements and a lot of the debate between board and department have been created not out of ill will by either party but because the system has created an environment in which disagreement is bound to occur. The uncertainties about roles and responsibilities makes it almost inevitable that the board will see the department encroaching on its role and vice versa. We are most anxious that this M.O.A. should proceed as a necessary prerequisite we believe also to a restructuring of the T.H.I.S. Act, which is overdue.

I would like to clarify one point in relation to non-insured health benefits. The debate with D.I.A.N.D. is not about non-insured health benefits. It is the simple failure of the federal government to honour a contract which exists with the Government of the Northwest Territories. Non-insured health benefits are a problem but it is another problem. I would be happy to talk about that in some detail if you wish.

In terms of prevention programs, we believe that the department does have a wide variety of active prevention programs which may not always be evident and certainly can

be improved. We would be happy to discuss those in detail also. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: Mr. Chairman, I would like a clarification with regard to the M.O.A. for the boards. Dr. Kinloch mentioned that it would address a lot of the differences and the concerns. I am not too hung up on the Memorandum of Understanding for each board. I am hung up on the fact that there are differences between all the boards. Some of them have a lot of power and some of them do not. I would think that the department's role in taking the leadership is to ensure that there is consistency between all the boards. It is good to have a Memorandum of Understanding but if you have five different Memorandum of Understanding the problems will still exist.

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, the aim of the Memorandum of Understanding or of agreement is to even out the powers and the responsibilities of the board. There will be a master Memorandum of Understanding that will govern all boards so that the distinction which now exists between commissioner agreement boards and those without commissioner agreements will disappear.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I have some general comments about the health audit and the department's response. What I have found in reading the Comprehensive Audit of the Department of Health and what struck me the most was that the auditors are saying that they do not see a comprehensive plan from the department in terms of where they are going and what they are trying to accomplish. I think Dr. Kinloch will remember that as a Member of the Standing Committee on Finance that is exactly what I said a year ago when we were reviewing the capital budget. This has been a major concern. Before the department gets defensive it is something that I have been struck by, few departments in this government do have comprehensive plans. I think it is appalling.

At last years Standing Committee on Finance we said to the department that we expect to see a plan, if you want to see any more projects approved. That led to in March the tabling of this document which was presented as an outline of what is "The N.W.T. Way". We heard about "The N.W.T. Way" for the first time in the capital review last winter.

Dr. Kinloch in his presentation implies that "The N.W.T. Way" has been evolving since 1957. Mr. Chairman, if this a product of evolution since 1957 I think it is an argument against there ever being devolution. I do not consider that a plan. I do not think it is reasonable for us to be presented this type of document and have it defended as being "The N.W.T. Way" and what is guiding the Department of Health. As a business person, I am expecting, something that is more akin to a business plan and, as a legislator, I need to have something against which I can measure performance. That is why I need to have a clear plan. I am not privy to the internal workings of the department. I am not a doctor. I have no way of assessing, without that sort of plan, whether the department is working efficiently and economically.

Put very simply, as a very basic thing, a plan needs to have a statement of goals. There are some goals and objectives stated in this document. I see that. A plan has to have some method of attaining those goals laid out. I do not see that set out here. I do not really see much in the way of details as to how we are going to get to the achievement of those goals and, further, I do not see a timetable. No plan is worth anything if there is no timetable for trying to achieve the goals that it sets out.

I recognize that Dr. Kinloch says that a plan has to change. I agree. That is true. "The N.W.T. Way", in its current form, in these six points on page nine, does not help me as a legislator to determine whether or not the department is equipped or capable of achieving the goals that it has set out. Any business plan has to change and I recognize that we are not in a static society and therefore there is always going to be some change taking place to any plan that you set up. I am in business. I set budgets. I change them monthly, depending on the performance of the company. I would expect that sort of review would take place in a government department too.

I guess the question that I have for Dr. Kinloch is that, on page 10, you say we have a new and improved version of "The N.W.T. Way" but is that just the points that you listed on page 9 of your presentation, is it this document that was tabled last March, or has there, in fact, been a comprehensive plan put together than we can now take a look at?

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I agree with the comments that Mr. Dent makes in relation to planning, but the document to which he refers was not presented as a plan. It was presented as an outline of a briefing that had been scheduled by a previous Minister of Health for caucus to deal with then issues of the day, including the "Strength at Two Levels" report, concerns about the expansion of Stanton at the expense of other facilities, and so on. It included a brief outline of "The N.W.T. Way" because, at that point, there was some confusion because of reference to "The N.W.T. Way" and the "Strength at Two Levels" report. It was in no way intended to satisfy the concerns expressed by Mr. Dent. Those are legitimate concerns and they need to be addressed and they will be addressed.

I think "The N.W.T. Way" is simply a description of what we are currently doing. It has changed from its original format developed by the federal government 20 or 30 years ago and that is what I mean in that other document by a new and expanded form. The addition of boards, for example, was an important change in the approach in the N.W.T. system that did not exist under the federal government. They did not even have advisory bodies. The expansion of delegated functions is also an enhancement of the program.

I would go back to a comment that I made in my statement that we have not really had the opportunity to discuss with Members the background and the detail of the material that you have seen only in summary or heard referred to in

snatches and I am not at all surprised that you are not comfortable with what you hear.

CHAIRMAN (Mr. Zoe): Thank you. Are you saying we do not have a document called "The N.W.T. Way"? This is only an outline, a summary? So there is no document that outlines "The N.W.T. Way"? That is my understanding from what I am hearing so far.

DR. KINLOCH: Mr. Chairman. A description of "The N.W.T. Way" is a description of the N.W.T. health care system and it was presented in document form initially in October of 1990, titled "Health and Health Services in the Northwest Territories". The term "N.W.T. Way" was not applied to that at that time. It is, in essence, what we are doing and the six points on page 9 simply summarize what we are doing.

CHAIRMAN (Mr. Zoe): Mr. Dent.

MR. DENT: Just for clarification because I am not familiar with the document "Health and Health Services in the Northwest Territories" that you mentioned was presented in 1990. Would you characterize that as being the sort of thing that I would recognize as a business plan or a plan of action for the department?

DR. KINLOCH: Mr. Chairman, no. I think you would recognize it as a restatement of what you have made this morning, that there is no plan, that we need to begin work on developing strategic goals for the system, we need to consolidate the gains that have been made re-examine what is going on and move on to the future. It was the beginning of the planning process which has been expanded over the past several years now, to an examination at a very detailed level in three areas to date; Fort Simpson, Fort Smith and Hay River, expanding this year to a review of the Baffin Region, the Keewatin Region and the Inuvik Region. The aim, ultimately, is to produce a strategic plan for the N.W.T.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: I think it sounds amazingly like what we see in the Comprehensive Audit when they say the department is planning to plan and there is a problem. What is the timetable then for completing this plan and having a document that can be presented to legislators and the public so we have some idea what the potential is for achieving some of the goals?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I believe that the expectation should be slightly different than that. I would expect that Members would be a part of the planning process since so much of what will be done depends on judgements which are made by you collectively. There is after all a working environment for whatever is done by the department in collaboration with the boards and it is equally important that the Government of the Northwest Territories should have a corporate plan within which the strategic plans of departments can be developed.

Frankly, there has been an air of uncertainty hanging over many of the planning efforts that have begun and are still at a very early phase. There are many uncertainties swirling around every department in the G.N.W.T. There are conflicting demands, demands for consolidation here, decentralization there, movement to communities, land claims and the creation of Nunavut. It is difficult to find firm ground on which to stand and I think it is important that Members are involved in creating that firm ground so that there is an encouragement of the planning process and the prospect of having some consistency for long enough to produce the sort of plan that will produce action.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Mr. Chairman, I know that Dr. Kinloch suggests that Members need to be involved in developing these plans. Given the fact that these hearings are taking place, that the Agencies, Boards and Commissions Committee has been reviewing the activities of hospital boards and that the Special Committee on Health and Social Services are all active this year indicates that Members of this Legislature are extremely interested and want to be involved in the process.

I do not accept that the department cannot start generating plans. Dr. Kinloch notes in his presentation that plans change. That is the implication if it started in 1957, and on page ten he talks about a new and improved version of "The N.W.T. Way". What it takes, I think, is the department starting on a small or piecemeal basis, but at some point in time somebody has to start putting together some detailed plans of action and then presenting them to the legislators to say here is what the department feels are our goals in this specific area, here is how we plan to achieve them and here is the timetable over which we think it is possible. At that point in time the legislators can say yes we think this is a good goal, we accept your method of getting there, but no we think your timetable is too short or too long or whatever. You cannot expect that the legislators are going to be ones who are going to say that this is what you should be doing. This is a situation where your department has the expertise and should be preparing a plan, even if it has to be on a piecemeal basis. I think the bottom line is that if you are going to wait for us to be out of turmoil that may never happen. Government is always going to be, I think, from now on in a constant state of flux. Just as plans change all the time, governments are going to change all the time. Your work plan will have to change just as the government will have to change. If we do not start putting down some ideas on paper, if we do not start formalizing where we are going or how we are going to get there and what the timetable is, we are never going to do anything except sit around and spin our wheels.

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: I think perhaps I should point out that the planning effort is primarily at this point directed to working with individual communities and boards rather than attempting to impose our judgement on what we think is best for the N.W.T. This is a necessary time consuming and sometimes painful process. It is necessary first of all to make sure that everybody is working from a common understanding of what the issues are. Given the difficulties of putting together information on many subjects that in itself is a task. I think an examination of the three documents that we have produced to date for Fort Simpson, Fort Smith and Hay River will indicate the broad nature of the exercise, the intention seriously to involve

communities in examining their own problems and how they are going to deal with them, and an effort to pull those individual plans together into ones that will initially serve a regional and ultimately the N.W.T.

At the same time it is possible to look generally at the system from a departmental viewpoint to provide some general guidance for plans that might be developed elsewhere. We were authorized by a previous Minister to pursue the development of a "white paper" on health. This would set out the principles, goals and strategies for health services in the Northwest Territories. Since February of 1992 we have been working with a group of outside agencies and organizations to develop what we are calling guiding principles for the N.W.T. health system. These outside groups include the N.W.T. Health Care Association, the N.W.T. Medical Association, the N.W.T. Registered Nurses' Association and the Canadian Public Health Association. We are close to conclusion of a draft guiding principles which we would expect to take forward in the normal process through the Minister through Cabinet and the Legislative Assembly. We hope in this coming fiscal year to have a paper for discussion with the Legislative Assembly as a "white paper" on health or as a "green paper" which might subsequently go for public discussion.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions or comments? Mr. Dent.

MR. DENT: Thank you. Mr. Chairman, I could go on but I have another meeting to get to and I think some of the other Members have some comments they would like to get in before that meeting too.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell. Mr. Koe.

MR. KOE: I have been an auditor in my previous careers and I can appreciate the work that the Auditor General and his staff have done in this audit. I can also reflect on the type of response that we received yesterday by the department. When a report of this nature, and I referred to it yesterday as very serious, has many comments on how the department is or is not doing things, the department then comes back very defensive in terms of questioning the role of the audit, the scope of the audit and not taking into consideration things that have gone on since 1957 or things that may go on in the future. The deputy minister mentioned that the responses were done quickly, possibly not without full due consideration and they will be preparing a summary of responses and comments on the audit. From my experience, when I look at the audit report and the management responses in no case do they question the issues that you raised in your response yesterday. In many cases they agree.

At the end of the management response they agree with a recommendation or are doing something in agreement with the audit recommendations, but they do not question the issues that you raised yesterday which I find strange. There was an opportunity for management responses to the audit recommendations and yet the report which is made public did not have any of the comments or tone of the comments that you made yesterday. I have to agree with the comments that Charles made regarding where we are at, where are going and how we are going to get there. The plan has to be worked on and worked on quickly.

I have one question, on page four of the Deputy Minister's remarks, you talk about "more than ever before departmental activities have been affected by day to day events in the Legislative Assembly." No objective review of the department is possible without taking this fact into account. My question would be why would you be making this comment with the events that are going on, with the various committees that are looking at the Department of Health, various actions and decisions that have been taken by Cabinet in terms of amalgamation and devolution, with the federal government, devolution and the decentralization to boards and regions. An audit is a snapshot of events that are taking place in a certain timeframe. Recommendations are made on what auditors find at that time. I have to question Dr. Kinloch on why he would say that what is happening in the Legislature is affecting and should have reflected in what is happening in the audit report. That is the question I raise.

DR. KINLOCH: Mr. Chairman, I will only respond with one comment. During the last 12 months the department has served five Ministers of Health.

CHAIRMAN (Mr. Zoe): Any further comments? Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Mr. Chairman, I have another meeting to attend so I will not make lengthy remarks. I apologize for coming in late however I was tied up on other issues. Mr. Chairman, I have general comments on the response. I took these remarks home and reviewed them. Yesterday when I heard the remarks I was questioning whether or not I was believing what I heard. I asked for a copy of these and reviewed them last night. I should not be surprised with the response but at the same time recognizing Dr. Kinloch's experience, I am still surprised at the type of response that he has given to the Auditor General's report.

Maybe the reason for having five Ministers is his lack of sensitivity towards the Legislative Assembly. I do not know if he recognizes that we are the people responsible to the public for the way in which the Department of Health runs. Whether it is your Minister or not, we are the people who get a lot of the flack when things do not go right.

I first looked at page three where you said the transfer of health services was not an event that occurred in April 1988. The transfer process was conceived in 1957 when the territorial government was not even started and set officially in motion in 1981, which was 10 years ago. It came to question in my mind if you started and the department said "set officially in motion in 1981" when there was not even a department, this whole transfer should have taken place in a fairly smooth and efficient operation. Your department should be in tip top shape. You should have a plan and you should have goals set forth. You do not have either.

My colleague commented more than ever before have they ever been affected by day to day events. You are questioning the fact that we take too much of your time in the department, then maybe we are not going to be doing our jobs. I think it is only right that if we do not find that things are right, which

obviously things are not right as a result of this Auditor General's report, that it had to take up our time to question in the Legislative Assembly. I get very irritated and irate when bureaucrats tell me what I should question and what I should not question, or to suggest such a thing.

Further, Mr. Chairman, I went through this report and could go into detail on many of the comments but I have decided not to. I just about called the past Minister or the Government Leader last night and asked if she felt in her opinion that the 1988 Transfer Agreement was pursued in haste because she was responsible for signing the document of the transfer. I do not know whether or not she would even appreciate that type of remark. I do not think that she does a lot of her work in haste.

Mr. Chairman, I find this whole response a very defensive one and I think that is the problem with the department, their attitude towards whatever suggestions you want in regard to developing and delivering your health services. That the department is too defensive. I do not know if you have taken over that attitude as a result of being a federal bureaucrat. Being in the territories now you should come to some sensitivity towards delivering your services and try to make every effort to deal with those attitudinal barriers, because it is a barrier in delivering the health services.

Mr. Chairman, I have stated throughout the past couple of days while we were in meetings that there is no doubt, and I have to echo the concern of my colleagues, that there is a lack of plan. Until a plan is developed the department will continue in chaos. Until the attitudes are somewhat worked with to be encouraged to recognize board roles and responsibilities and to be sensitive to the people of the north and how they want to approach the health services, that we will be able to make any progress into the delivery of health services in the territories.

I also want to state that in respect to management, they should make some effort and attempt to do pro-active planning and management as opposed to crisis management which is always reactive. I find that their crisis management is resulting in many band aid solutions to many problems. Overall this is costing the people of the north, not only through dollars but through time. That is probably when we resulted in such a terrible audit that the Legislative Assembly had requested.

I know, Mr. Chairman, if I was one of those Minister of Health, which I was not, I would be ashamed of the type of audit that the Auditor General has produced. Mr. Kinloch has been in the department since the responsibility of the transfer was taken over. I would suggest to him not to be so defensive but to take into consideration many of those recommendations and try to work with them as quickly as he can. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Any comments, Dr. Kinloch?

DR. KINLOCH: Yes, Mr. Chairman. The department does take the report seriously, Mrs. Marie-Jewell. We have indicated that we intend to accept and pursue the recommendations that were made by the Auditor General recognizing that there are policy decisions which must be taken by Cabinet and resources allocated in order to pursue some of these matters.

I would like to respond to one specific point that you made in terms of the transfer processing beginning in 1957. My reference there, and I think I made it later in the text, was that the medical services branch of Health and Welfare Canada agreed to set up the system with the clear understanding, right from the beginning, that it would be transferred to the Government of the Northwest Territories as soon as G.N.W.T. was in a position to take it on. That is the reference to 1957. The other dates refer to the initial, the second Baffin component of the transfer and then the final agreement in 1988. There was no other implication.

I would also like to apologize if there is any inference in my comment regarding the ability of the Legislative Assembly to question, to comment, or to criticize the activities of the department. I recognize that those are your responsibilities. I simply pointed out in my opening statement that the events of the past year have necessarily impacted on the department. It was simply for that reason.

CHAIRMAN (Mr. Zoe): Any further comments? Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: No, unfortunately our other meeting started at 10:15 a.m., and I am late for that one again. So I apologize, but I have to leave, Mr. Chairman.

CHAIRMAN (Mr. Zoe): The Chair will take a five minute break and reconvene at 10:30 a.m.

—SHORT BREAK

CHAIRMAN (Mr. Zoe): General comments. Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. The presenters of the report have made comments regarding how native people in the country and much worse off than our southern neighbour, in terms of health. We realize that. Mr. Chairman, I would like to make a few points on some things that bother me very much, they bother other people, too.

Given the scenario, Mr. Chairman, the native population is not fully immune to many of the diseases that have been imported from the south. About 100 per cent of the non-native people in smaller communities, I am speaking for Pelly Bay, Spence Bay, Gjoa Haven and other smaller communities, are very lucky because approximately 100 per cent of those people are employed. They are provided with housing, furniture and everything else. About 80 to 90 per cent of native people in the communities are not employed, as opposed to the non-native people. About 80 per cent of the native people's homes are overcrowded. They are not provided with furnishings. About 100 per cent of the non-native people in the small communities do not, Mr. Chairman, experience overcrowding in their homes. About 100 per cent of the native people, the population in the small communities can afford good nutritional food that is provided in the local stores.

Another thing that has been mentioned in the report is sanitation. About 80 per cent of the native people in the small communities who experience overcrowding do not have adequate sanitation, basically because there are so many people in one household they constantly keep running out of water. It is basically the fault of the municipalities because

most of the municipalities in the N.W.T. do not have all that money to provide basic services in the small communities. Most of the native people who do not have, I am talking about 80 per cent in the small communities, cannot afford to buy good nutritional food from the store.

Mr. Chairman, we also talk about the N.W.T. having good medical facilities as opposed to our southern neighbours, but we do not have the specialists and doctors at our fingertips. It is not just a matter of having to look in your phone book and phone the doctor for an appointment, or going across the street and seeing a doctor. If a native person who lives in an isolated community is not feeling well, that person has to go to the nursing station. If the nurse is not able to find out what is wrong with that person, he or she will have to make a long distance phone call to places like Yellowknife and Edmonton, and that person will have to wait possibly months before they are able to see a specialist.

It has been only about 30 years, Mr. Chairman, that the native people in the small communities have been introduced to housing. It has been only 30 years since we have been herded into one central location. It has been only 30 years, Mr. Chairman, that we experience suicide. It has been only about 30 years since we were introduced to many household items which have chemical compounds that native people are not aware of. Mr. Chairman, I am not saying that the modern technology is not welcome in our community. Each and every person who I talk to in my community appreciates the fact that government provides housing, education, infrastructure and whatever the government can provide for our communities. Mr. Chairman, it has been only about 30 years since a lot of the artificial things have been introduced into our communities. Even pollution was unheard of about 30 years ago. We cannot undue the things that have been done in the past, but we have to realize that we have to give our people time to adjust. Because of the many things that were not there 30 to 40 years ago, native people in the communities tend to get stressed.

One of the many problems that we have, in our communities, are the lack of educational introduction to the new society to which we were introduced.

People are very much aware that it is costing the government a great deal of money providing medical services to them. We also have to realize that many of the diseases that we have today are imported from the south. Many of the facilities we have in the small communities are under utilized by the specialists. We do not have proper equipment to serve the people in the communities. We have specialists coming in: eye doctors, ears, nose, etc. They come into our communities, as most of the Members here know, for maybe two or three days. Many of the people who would like to see doctors do not get to see them because they are gone two or three days later. Whenever a person is seriously ill, that person has to be medevaced to places like Yellowknife and Edmonton. Subsequently, that person is in a strange environment. If the person is unilingual the person does not have the proper communications. When I say communities, I would like to mention again the Natilikmiot communities: Pelly Bay, Gjoa Haven and Spence Bay. We have been using the hospital here for maybe over 30 years. We have yet to see an interpreter/translator at the Stanton Hospital that speaks the Natilikmiot dialect. About three years ago when I became a Member, I brought that matter to the House. Up to this point in time, Mr. Chairman, we are still waiting for a person who is qualified and capable of speaking the dialect of Natilikmiot.

Mr. Chairman, I guess one of the ways that we can provide better health care in our community is, first of all, to educate people. Secondly, to listen to the people in the community and find out what their concerns are. We have to find out what the problems are. We talk about smoking being the leading cause of cancer. I realize that. We realize that. We also talk about alcohol being one of the worst social problems in the N.W.T. among the native people. We realize that. I do not think we should be looking at what contributes to the social problem. I hate to bring this up but most of the people in the small communities love to gamble. I guess most of the native people like to gamble but I know parents that stay up all night until the morning. I am talking about between Monday to Friday and the kids are at home, either babysitting or not old enough to baby sit and have no baby sitter. That seems to be a small fraction of the social problem, I say.

I think, Mr. Chairman, we appreciate and I would like to emphasize again all the help that we get from the federal government, the territorial government, in terms of medical care. I think the first thing we have to do is get into prevention as it was mentioned in the report. Secondly, education is very important for both the government of the day and the people who live in the communities. Mr. Chairman, I think that about covers what I basically wanted to bring up but, again, I would like emphasize very strongly when we compare between the native and non-native people in terms of health, about 100 per cent of non-native people in our communities are employed. About 80 per cent of the native people are not employed and experience overcrowding at home, experience lack of sanitation and are not properly represented in the system.

If we want to start improving the health, we have to start looking at other social functions like providing employment, providing better education in the area of health and providing very good medical facilities, but they are under utilized, as my colleague Mr. Sam Gargan has stated. These medical facilities can be utilized by alcohol and drug workers. They can be utilized by the elders who know about the health in their own environment. Another thing we should start looking at is the cost of basic food prices at the local stores we have at home, especially the foods that are essential for an individual's health. As I mentioned earlier, about 80 per cent of the native people in the community cannot afford to buy good, nutritional food. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Just to remind Members, although I let Mr. Ningark conclude his general statement, I would like to remind Members if they can kindly concentrate more on the auditor's report rather than the general health related issues. We are dealing with the operation of this department, how the department is operating and we are commenting on Dr. Kinloch's remarks that he made yesterday and we will get into the specifics of the report of the A.G.s office when we go chapter by chapter. I have let Mr. Ningark continue on because I did not want to stop him. It is a related issue. I do not know if Dr. Kinloch would like to make any comments in regard to what Mr. Ningark is saying. I felt it was

important enough to let him continue, that is why I let him continue. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I would like to thank you for thinking it important enough to let Mr. Ningark continue because I think the remarks are very important and I think they are the issues that we need to deal with. He has very eloquently amplified the summary remarks I made on page six of my response. It is important that we bear this in mind. My earlier reference to the apparent neglect of health promotion, disease prevention issues in the Auditor General's report is, I believe, still very much on target and I thank Mr. Ningark for his remarks. May I add one thing? I am advised that the Stanton Yellowknife Hospital does now have an Inuktitut interpreter, or an Inuit interpreter that speaks the Natilikmiot dialect. Is the response to your concern, Mr. Ningark?

MR. NINGARK: Thank you, Mr. Chairman. Thank you, Dr. Kinloch. Mr. Chairman, during the last session, I asked the Minister of Health regarding the interpreting staff at the Stanton Hospital that speaks the Natilikmiot dialect. The answer that I got from the Minister was, yes, we do provide an interpreter at Stanton Hospital who speaks the dialect of my three communities and subsequent to that I checked the name of the person who is providing the interpreting for the people of Natilikmiot but to my disappointment the name that was provided to me is not original from Natilikmiot. The person is from Cambridge Bay and the person's name is Aida Todd, I am told. I do not know if we have hired a person who does speak the dialect. I do not know.

DR. KINLOCH: Mr. Chairman, just to conclude that. If, in fact, the services are not adequate as described here, we will make every effort to ensure that they are and quickly. Thank you.

CHAIRMAN (Mr. Zoe): General comments. Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. That is one hour and 50 minutes ago. I would like to say a few words too, however, Mr. Chairman, like you said before, I am going to stick to the agenda. My colleague and I, we do not have a hospital so our views on the Auditor General's report, I am echoing what he has already said.

Because we do not have a hospital, because the region's population is so small, our views on the Auditor General's report are different than the other regions in the territories. I give you an example, Mr. Chairman. When Dr. Kinloch was communicating with Mr. Dent, he never once mentioned the Kitikmeot region. Now where do we fit in this government? You see, that is what I mean. To the government, we do not exist. Rightfully, we belong in society in the government's plan, however, the majority of the time we are neglected, rightfully or wrongly. The bureaucracy has to change. You cannot look at us as always the consumers. We are the consumers of your jobs, yet give us a chance to improve so that we can take some of their jobs. I would like to make a few comments even though it might be a little bit off the track or the agenda. I would like to find out from Dr. Kinloch how dedicated the Department of Health is on the high suicide rates which the territories are experiencing. I understand that the department is understaffed and we do not have any kind of trained native workers in the smaller communities to tackle this problem. Do you recognize this problem? I think the bureaucracy is the stumbling block. We have too much red tape. The decisions are made mainly on racial lines depending on where you come from. Am I a little bit browner than you or am native or non-native. It seems like the people who are employed have a better service than we do. I am sorry to say this but this is the things I am seeing in my communities.

On page six, we do not have a hospital and I would like to see your department work hand in hand with the Department of Social Services. You are going to have to now, like it or not. You have to improve the nutrition system. I see young mothers giving their babies pop for breakfast in their bottles. It is not getting better, it is deteriorating. Yet we cannot, like my colleague said, afford it because our people are on the welfare scale of society. Although the native foods do exist people deserve a change in their diet. I think we have to go back to family values in the community. Too many of our native people have a different focus on life now. They want to find a job yet they are unable to because they are not educated enough. When they do find work it is mainly based on nepotism. The mother and the father work and the next thing you know their child is placed with their relations or in daycare. This is where some of the problems come from. Our children are not experiencing the growth that the rightfully deserve, such as the hugs and the kisses and how to be intimate with their parents. Instead of learning it from other children in the daycare, they become more open to the general society. In the meantime the parents forget that they are losing that personal touch with their own child, which is so important.

I lived in a convent. I was in the convent from 10 months old until 15 years of age. I never once had a hug from a nun or from a father. Therefore I am stuck. I have to retrain myself on how to be intimate to my children. I think society has to change how we see health in general. Therefore, if we do that in the right way, in a manner which utilizes a lot of our native peoples with the skills that we have as a caring and sharing people, our problems are going to deteriorate slowly. We have to get our own people involved in the process not at the Yellowknife or regional level but at the community level where all the problems do exist.

If you are going to make decisions here it is not going to have a positive effect as it is supposed to. It will be your values and beliefs ahead of ours because you guys hold the dollar sign. It is like that all over the world. When you have money you have power and we are left with your decision-making. I think that we have to change that attitude. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. If you listen carefully to what Mr. Bernhardt is saying it is basically touches all the concerns that have been raised in the Auditor General's report in terms of planning, the attitude of the department, etc. Would you like to make any comments, Dr. Kinloch?

DR. KINLOCH: Yes, Mr. Chairman. I would interpret those remarks somewhat differently and I support them. I believe that Mr. Bernhardt correctly recognizes the need for activity at the family and community level to deal with many of the problems now experienced in isolated communities. I apologize for omitting the Kitikmeot from the list of planning endeavours for the next year. They will certainly be included and it will be a planning exercise I think you will approve of. I

hope you will approve of. It involves community representatives initially in deciding what their problems are, what the options are for dealing with them, and how they would like to proceed. This is not something imposed from Yellowknife on the Kitikmeot.

I have asked Dr. Ian Gilchrist the medical director of the department to join me. I would ask that he comment briefly on several of the specific items that were raised both by Mr. Ningark and by Mr. Bernhardt about imported disease and the specific issue of suicide which we do recognize as a very important problem. Would that be acceptable, Mr. Chairman?

CHAIRMAN (Mr. Zoe): If he makes it very brief. Dr. Gilchrist.

DR. GILCHRIST: Thank you, Mr. Chairman. I will try to be brief. I just wanted to say that I really appreciate the comments of Mr. Bernhardt and Mr. Ningark, and I think Mr. Gargan actually started off with this whole issue of prevention. To my way of thinking that is one of the areas that the Auditor General's report has failed a little bit on in the sense that we had a statement in the beginning that in fact socio-economic issues were not considered to be a mandate. I think that as a Department of Health those are, as have been pointed out by the three Members, intimate parts of health systems.

Secondly, with regard to the legislative part of it, the Auditor General's report also indicated that from their point of view the T.H.I.S. Act and the Financial Administration Act were the important bits of legislation and the others are less important. One of these of course is the Public Health Act which deals with the whole issue of environment which has been considered less important and has not received any significant consideration in the report. Also, not considered is the Disease Registry Act which deals with cancer. I think there are lots of bits and pieces that are really important that in fact perhaps have not been able to appear in the report and have been picked up by the Members. I appreciate that.

I think personally the department has to recognize that health is not the department's responsibility. It is the responsibility of everyone. The department, the doctors and the nurses, are not going to stop suicides and they are not going to get rid of pollution in the environment, and they are not going to stop cancer. The only way we are going to achieve anything is by carefully sitting everybody down and talking. The doctors who have something to do with making people better possibly trying to prevent diseases with vaccinations and people who can adapt their life-styles, their culture and their knowledge can bring people together. Those groups of people have to deal with these issues because health issues are basically social, socio-economic and cultural issues. I think that these points which were raised by the Members are extremely important. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. To follow-up on what Mr. Bernhardt is saying I think that it does reflect in the section 3.3 of the report. In that section the Auditor General points out that the budget allocations may not be meshing with each other and the need to target the cause of ill health. It says that health care staff and money are not always invested in areas of greatest health care needs as indicated by the department. What it is saying is basically what Mr. Bernhardt is also saying. Can you comment on that paragraph under section 3.3? That basically follows up on what Mr. Bernhardt is saying.

DR. GILCHRIST: I can only say that I agree with him entirely. This is one of the areas where we absolutely have to come together. This paragraph mentions Social Services. We have to come together with community Social Services and other departments and reallocate these resources to the areas of prevention and disease avoidance. I just agree entirely with the statement.

DR. KINLOCH: Mr. Chairman, I would like to add one point, we can agree with the statement, effective efforts to curb this tragic loss of life are unsuccessful. In part, they are unsuccessful because we do not know how to prevent suicide.

CHAIRMAN (Mr. Zoe:) Are there any other comments pertaining to Dr. Kinloch's remarks from yesterday? Mr. Gargan.

MR. GARGAN: Well, just one, with regard to his last remark concerning to Mr. Ningark's statement that we do not know how to prevent suicide. We do know how to prevent suicide. I think it is the way we interpret the delivery of health to the communities and the physical, the mental and the spiritual well-being of the person is what I guess the Auditor General's office did not touch on, not realizing that we know what is causing these suicides and we know how to prevent it.

The other thing, in your statement, Dr. Kinloch, you mention that the department believes that further improvement to health is dependent largely upon the achievement of socio-economic conditions that produce, for example, more employment opportunities, better housing, improved nutrition and better sanitation and the reclamation of traditional strength of families and communities. Effective intervention would require collaboration if it is between persons and groups within and outside the government. It is a good statement but what is your department doing? Like it stops there. It is not saying the way we are going to be doing it. It is just talk. It stops there and goes into the scope of these remarks. I guess I am finding a lot of problems but really no solutions, there is nothing to address them.

CHAIRMAN (Mr. Zoe): Any comments, Dr. Kinloch.

DR. KINLOCH: Yes, Mr. Chairman. The comments in my response to the Auditor General's report were necessarily brief and could be expanded at great length. I think, initially though, the effort to establish health as something much broader than health services was set in motion with that 1990 report. It is continuing with efforts to work collaboratively with other departments in areas where they, we believe, can contribute more to improving health status than we can. It will continue through the development of these guiding principles I referred to earlier and to the preparation of a "white paper."

CHAIRMAN (Mr. Zoe): Okay, general comments pertaining to the A.G.'s report and Dr. Kinloch's remarks. Mr. Whitford.

MR. WHITFORD: Yes, thank you, Mr. Chairman. I just wanted to make a couple of brief comments before we get into the meat of the A.G.'s report and other things that we need to do. I am new to the committee and I have listening carefully to my

colleagues and what they had to say about their concerns and I cannot speak, Mr. Chairman, for the smaller communities because I do not live there, but I have been there. I have come out of a smaller community at one point in time and I have been to the smaller communities so I know that what they are saying is quite correct. The perspective that is being brought by my colleagues from the smaller communities is quite correct and, again, from my point of view perhaps and from my colleague Mr. Dent's, we live right across the street, literally, from one of the largest and best equipped hospitals in the Northwest Territories and I may even say, the best equipped hospital anywhere. So we have a different perspective on medical care and medical services in the territories and I think that we have a unique system here that has been evolving. I said this yesterday, that we have got to recognize that it is an evolving system, this whole transfer of responsibilities from what was a very colonial operation to one that is self-contained is happening. Whether we recognize and agree with it or not, it is happening. There are going to be growing pains and we are experiencing those growing pains, but I think we need to recognize there will be times like this when everything seems that it is very disorganized and disruptive. I guess we just have to have faith in ourselves that we can see these things through these times and evolve into a system that is going to serve the communities like the communities want.

To shed that mantle or cloak of paternalism that Ottawa used to have on the north is going to be a tough job that the department will, at some point in time, have to do and recognize that some control for the delivery of health services must come from the communities and from the people that it is going to serve. I think for too long we had to sort of live with it, in any system that we had in the north, be it education, social services or health or highways, it was all something that was conceived somewhere else and transplanted to the north and we have had to make these adjustments. I hope that what we are going through now is one of those times where we are going to experience difficulties with this transition but we will come out in the end. I am optimistic that we will come out in the end.

I say these things quite awkwardly, Mr. Chairman, because I am in an awkward position. As I said, I do not live in a small community. I live in the largest of communities and, not only that, but with my colleague Mr. Patterson who was here yesterday, in a unique position that we were for a short time at least in the position of Minister Responsible for Health and it was too short a period of time. I had great expectations for the department. I still have and I want to say it here that I will work to see those expectations continue on to fruition.

The Auditor General's report that we are discussing and which brings us here, raises some very fundamental, very important concerns. I think that it is quite important to look at those questions and those comments in the spirit of what the Auditor General's mandate is. He is to look at things from a stand back view, an independent point of view, and look at something and make these comments that are important and fundamental. I hope that they will point out some of the problems that maybe we, being close to the scene, may not be able to recognize. It will help us to build a good service, a better service, if you will, if we recognize that no one system is perfect and it always needs improvement. I kind of sense that the department was defensive from the reply of Dr. Kinloch's yesterday. I do not think the department should be defensive, I think they should be quite proud of their achievements over the past while. As this evolution has been taking place you have some very dedicated people working in a very complex system, you have hard working people and they are trying very hard to deliver a service in a touch environment. It is a cross-cultural thing, medicine is very complex to begin with and the health care system is very complex, has become more complex and will become even more so.

I think one of the things we may have, and we are at fault here in the north too for not maintaining some of our uniqueness and things that could have blended with this. I think the transition was far too abrupt. We threw out the baby with the bath water so to speak when we neglected to incorporate some of the things we used to do. There is nothing wrong with putting Vics vaporub on your chest when you have a cold instead of going to get a shot of penicillin. Sometimes you just have to live with these things. There are old remedies that we have never incorporated into the system. Forgive me for saying the smaller communities, but the communities in the regions have not had an opportunity to introduce that into the system we have here now.

We look now to a doctor and nurse as the only source of cure for all our problems. Maybe we have set aside something, we have lost something and that is causing some problems. I am not sure whether that is contained in this report, but what I am trying to say here is that it should not be looked at as a criticism of the department so much as a reflection of what, in fact, is the perspective from the regions and a perspective of someone who is mandated to look at these things independently and unbiased. I think the department could be well advised to listen very carefully to that and work with some of those concerns in here towards making some improvements.

Again, I say quite proudly that the department has nothing to be ashamed of. It has done, in my opinion, a magnificent job over the past in a very tough environment. In order not to reflect too biased one way or the other I would like to end this now and allow us to deal with some of the specifics. It is important to recognize where we have been in the past and recognize where we are now, in order to recognize and accept where we have to go. There is some point in time, I know there has been a lot of criticism about the department always being in a planning to plan mode. Maybe we are planned to death. Maybe we are planning too many plans. Maybe it is time we stopped now and said "look, it is time to get on with it and move on with some of these things". I think it is incumbent on us to be able to support the department to move on with some of these things they may have done or want to do and to recognize the concerns and the aspirations of the people who you are delivering a service to.

I presume I will have more time later on to elaborate on some of the things that my colleagues have been saying, that this is not and should never be recognized as somebody else's problem. My health is my concern. My health is my responsibility, and as quite correctly pointed out, a lot of things that we may not have had any say in is why we are ill because things have been introduced against our will through accident or neglect. I am referring to certain air contaminants and pollution and ways of life. Some of the things that we are

suffering from and are going to suffer from are self-inflicted. If I drink too much and I end up with liver problems, I have a problem. If I smoke too much and end up with lung problems, it is not your fault, it is my fault. I think we need to work not only just with the cure of that but also the education part of it. We are faced with a lot of things here that we have never had any experience before. Smoking is only one of the things, but the effects of certain types of food, are causing problems that were never a problem before because we had adapted to a certain way of dealing with and doing things. So education is very important and must be continued.

I wanted to make these general remarks about what I see that we are doing here and I hope we do not just look at this as a kind of debate as to who is right, whether the Auditor General is right, whether the Department of Health is right or whether this committee is right. I think we have to look at these things because they are problems, and say "yes" there is a problem here that we must work to resolve. We must let people have more say. We agree with that, and this kind of thing, and we can start off from here in order to get there. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch, any comments?

DR. KINLOCH: Yes, Mr. Chairman, if I may respond. I thank Mr. Whitford for his comments. There is one point I wanted to pick up on and that is in relation to the responsibility to the individual for his or her own health. That is certainly true, but there are some limitations on that. In the example of smoking, for example, I think there is a collective responsibility to make sure that young people do not have access inappropriately to tobacco and other addicting products that can commit them to long-term health effects. That is where society has a role to play in helping the individual make wise decisions.

CHAIRMAN (Mr. Zoe): Thank you. I think most of my committee Members have made general comments. I would like to make some comments at this time. I want to move back because we have been moving off the topic a little bit which is related to all the issues that are in the report. A number of my committee Members have alluded to some of the points that were made by Dr. Kinloch. I need more clarification, specifically on page seven of your remarks. You indicate that "the first chapter of the report headed "executive summary" deserves special attention because it is in many ways the most instructive section. This is so because it provides insight into the orientation and methods of the Auditor General, and provides a basis for assessing the relevance and objectivity of statements and recommendations made later."

Where you state that it is necessary to assess the objectivity and statements and recommendations, it is rather unfortunate that if you as a deputy minister of this government, to me it appears that you are questioning the objectivity of the Auditor General. I think this is very serious. That is why I am saying that I am going back because Fred, Jeannie and even Charles alluded to it. We need this committee to clarify what you were trying to say. Was the intent of your comments yesterday to raise questions about the credibility of the Auditor General or were you suggesting that the audit had not been carried out in an objective way? Dr. Kinloch.

DR. KINLOCH: No, I was certainly not raising that issue of the objectivity of the report or of the Auditor General, but simply of suggesting that the introductory section in setting out its methodology provides an idea as to how the audit is approached. Indeed, let us go back to the initial comment of the Auditor General in responding to my comments in defining comprehensive audit. To most people "comprehensive" has a perfectly straightforward meaning. It means all encompassing, but that is not what "comprehensive audit" means. Therefore, it is important that we should be sure of what the definitions are so that we can assess what comes out the other end. If the report is viewed as a "comprehensive" document, it is inadequate because it is not a "comprehensive" document and the Auditor General has said it was not intended to be a "comprehensive" document in the ordinary sense of the term. It is important that people understand that. I expect that this report is going to be read as an isolated document. It is not going to be read in the context of a knowledge of the background of the history of health services in the Northwest Territories, or an understanding that health is a lot more than what is set out here, or that there are many more acts that govern the activities of the department that are spelled out here. That was the reason for concluding my remarks by setting out those cautions for the reader. No more than that, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Any comments? Mr. Dubois.

MR. DUBOIS: Yes, Mr. Chairman. I understand and I agree with what Dr. Kinloch just said. However, I think his choice of words are as problematic as he says our choice of words are. We have problems on both sides are. We would take strong exception to a comment that we are not objective in the work that we do. I am happy to hear that that is not meant here.

I have tried to explain the limitation of the exercise that we did. We have to limit these audits to something that can be dealt with. It is impossible to do an audit of this nature -- I should not say impossible -- but it would be a massive task to do this type of exercise and include an audit of all the socio-economic issues that surround health in a generic sense. That could lead us into all sorts of fields which would include treaties and the obligations of Canada to our native people. There is no limit to that so naturally we have to circumscribe.

The other limitation which I explained at the beginning, and I thought was clear but still does not seems to be, is that we do not do effectiveness evaluations. We do not evaluate the effectiveness of services whatever they are, health care, health services, promotion or prevention. That is the responsibility of the department. I think we do cover the subjects however, in the sense that throughout the report we make comments on things that have to be or should be improved and chapter eight is quite explicit in terms that we do not believe the department is doing the effectiveness evaluation of its services and we believe that it should.

The audit is not an exercise that will do the department's work for them. That is not the intent of auditing. We try not to get into the management process ourselves. We comment on it and some say that is an easier job than to do the management itself, and I do not necessarily disagree. Some of the problems we identify are not easy to resolve and they are going to need a lot of work and we recognize that. However, that is the way

it is and I do not see how I can change it. I thought the explanations were clear, but we seem to be continually going back to what we did not do. I think that is getting off the subject. I think the report contains enough substance to get into that and discuss it. If those deficiencies are corrected, it will help all of the other problems that have been tabled. I will stop there, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. There are a couple of other items in Dr. Kinloch's remarks yesterday that I was going to touch on. One was pertaining to criteria. After talking with my colleague, Mr. Koe, who knows about auditing and their requirement for criteria I was not sure what Dr. Kinloch was trying to say when he was talking about methodology with regards to criteria for inclusion or exclusion of relative materials. I think what you were trying to say was what criteria did the Auditor General use to draw the conclusions that are in the report. Is that what you were trying to say? I questioned my friend Mr. Koe because he has a financial background and I said, "what is the norm when people do audits? Do they specify all the criteria that they are using?" I do not think that is relevant in this case. I do not think it is necessary for them to conclude criteria.

DR. KINLOCH: That might be acceptable to me if this report were being handled in the normal process for an audit, for example, going from the Auditor General to an agency for its internal use. This audit was done for the specific purpose of being a public document to be read by non-auditors and non-professionals. I could collapse the comments to which you referred earlier and these by saying it would have been very helpful if there were a more detailed explanation at the front end of the Auditor General's report to explain to the non-specialist precisely what was being done. In the absence of that, I felt it necessary to call attention to these things so that people might not get the wrong impression of what was being said simply because they were unfamiliar with the scope and nature of this audit. Again, tied to the use of "comprehensive" which is unfamiliar to most people.

CHAIRMAN (Mr. Zoe): I would like to move on to some of the comments. I have picked one out on page 15. Dr. Kinloch, under item 4, current and future strategy of the department it says "recognizing that management of the health care sector is not an exercise which has failed but rather one that has not seriously been attempted." I am having a hard time trying to understand what you are trying to say with this.

DR. KINLOCH: Virtually since the introduction of universal hospital insurance and particularly since the introduction of medicare it has been recognized by those administering and managing it that there were emerging problems. The failure to properly identify what was meant by necessary medical services, by the failure to introduce the control mechanisms on payments, by the failure to develop information systems, and by the failure to do a whole lot of things. Quite frankly there really was no serious attempt to manage those programs because times were good, the money was available, they were popular programs and there was not the political will to manage those programs. Over time they have gone out of control to some extent and I believe it is largely because we have a very tight financial situation that it has now become necessary and possible to take control of measures that could have been implemented 20 years ago. You will find this sort of statement set out in a whole range of publications in the last 10 years or so about how to get control of Canada's health care system. Second Opinion is a more recent publication which goes into this in excruciating detail. It has been clear for a long time that we were not managing the health care system. It is only now that jurisdictions across the country are starting to pay serious attention to it.

CHAIRMAN (Mr. Zoe): Any comments from the Auditor General's office with regard to the explanation that we have pertaining to number four. I had a difficult time trying to understand what Dr. Kinloch was trying to say. Mr. Simpson.

MR. SIMPSON: Thank you, Mr. Chairman. I think in the light of Dr. Kinloch's elaboration on what he meant there, he points out yet again how to pick up on Mr. Whitford's comments, an audit like this which is independent can be a constructive document towards fixing the problems and building to the future. I would just like to endorse what Mr. Whitford said because I think as we explained to the department from day one, while there would be things that would undoubtedly come out as criticisms of the department, the whole process is intended to be constructive and not combative or destructive. If I can put it in another way, we try to avoid becoming involved in urinary projection contests. I hope that we can continue through the rest of this hearing, Mr. Chairman, in the spirit that Mr. Whitford elaborated. That the objects of the audit report are to point out problems and difficulties and to suggest ways that they can be improved for the future. I think if we all approach it that way there can be very positive results come out of it. If not we are just going to get into the aforementioned contest and nobody wins. Thank you.

CHAIRMAN (Mr. Zoe): I have a couple of more comments if committee Members will bear with me. Earlier today during our discussions Dr. Kinloch mentioned that work has started on facility planning and you indicated that there were three reports which have now been completed: Fort Simpson; Hay River; and Fort Smith. I wonder if you can provide our committee with those three reports which have been concludes so that we can at least see what the department is doing in this whole area.

DR. KINLOCH: Yes. Mr. Chairman, could I correct the impression that the reports are completed or that they are facility reports. They are health services reports and they represent the initial phase of a planning process which is designed to have communities or regions identify their health problems, the resources they have to deal with them, the options they have for the future, and the basis for conclusions and recommendations that might come along. The reports that we have prepared are called community profiles. They represent the outcome of discussions with members of the community about how they see their problems. These have been added to data available from the Department of Health and from other government departments that bear on these problems with a summary of findings but no recommendations or conclusions. That now goes back to the communities for further discussion. That is what I was referring to when I indicated that this process is lengthy, time consuming, and sometimes difficult. It is the only way to make sure that everybody understands what is being discussed. I would be happy to provide copies of those three reports to you.

CHAIRMAN (Mr. Zoe): Thank you. Another comment that I wanted to make was a specific question pertaining to the Legislative Assembly. My colleague, Mr. Koe, asked you a similar question. You mentioned that the department has been affected by the activities of our Legislative Assembly. When my friend asked you to elaborate on that you stated that you have gone through five Ministers in 12 months. I have been thinking about this while other Members were questioning you on other issues. That has sort of been bothering me all morning. I think that if the department had a well working plan and a better organization relationship between various boards and some of the other things that the Auditor General's office recommended, then perhaps the transition at the political level would not have effected the department's operations. Would you not agree?

DR. KINLOCH: Mr. Chairman, no I do not agree. Mr. Chairman, the transition from one Minister to another is a very difficult process, both for the Minister and for the department. They must learn to accommodate to each other and they must find out a basis for providing updating on an enormous range of subject material. The briefing binders are half the length of one of the sections of this table. It is a time consuming process that interferes with other long-term commitments. There is no escape from that. The Minister cannot do his or her job without that kind of preparation. A ministerial change during the course of the year disrupts the activities of the department no matter how well matters are planned. There are necessary activities that have to take place at every transfer.

CHAIRMAN (Mr. Zoe): I tend to not totally disagree with you but I do disagree to some extent. If you had all those well working plans in place and better relationships with various boards, and all the things that the Auditor General's report recommended, the problems should not be so great even though we do have changes at the political level. You have indicated that you have gone through five Ministers. I am sure that this will disrupt you a little bit but not to the extent as I think you are trying to say to us. You are trying to say that because of all these ministerial changes it has affected the department's operations. That should not be the case if all these other things were in place. That is the point I am trying to make.

DR. KINLOCH: Mr. Chairman, I would agree. If all of those things had been in place it would be less disruptive, but it would still be disruptive.

CHAIRMAN (Mr. Zoe): Any further comments? Mr. Gargan and then Mr. Ningark.

MR. GARGAN: I wanted to make one comment with regard the changes in the political environment. During the last election, life went on and I guess it did go on to a point where we ran into a deficit. I do not know how we managed to do that because even the Ministers out there on the campaign trail, and the Members were not aware. We had a meeting just before the election in August sometime to deal with the petroleum issue. Even at that time, it did not look like we were going to have a deficit until after the fact. So what I sense you are suggesting is that it does cause a political disruption but the operations of the department still goes on. If it did not, then we would not be into the situation where we are and that is the deficit was about $50 million by the time new Members go it. So I think that just to say it caused some, but not that much, disruption.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. Just a short point, I did not see prevention in the report, Mr. Chairman. I would like to be very short, very brief, and say something about care givers, the nurses we have in our communities, which are very much a part of the health system. They are very important in our communities where we do not have doctors and hospitals and stuff. Now, some of the nurses we have had in the past have been overworked to a point where they are working on weekends, 24 hours a day, during a flu season going through a crisis when they are not adequately able to function. They get edgy, cranky and sometimes either they are not qualified to do the job or they are overworked.

Many times we hear people in our community, and from my other colleagues, that the nurses sometimes tend to tell the patient to go home and take an aspirin or come back and see me Monday. Today is Friday and I do not work on weekends. I am not putting all the blame on the nurses because sometimes you have only one nurse to a population of 400 or 500 people and I think we should, if we really care about our health care system, seriously consider the well-being of the nurses we have in the system.

When we travel to different communities from the Health and Social Services Committee, on three occasions we were told there were patients going up to the nursing station and told they were not sick. Many would find out later when they were diagnosed by the doctor that they were seriously ill. When we talk about the health care system and do our report, we should keep in mind the care givers we have in our community and find out from them, in their own words, what they think of the health system. I think they should be very much a part of the process, they are part of the process, and they should be part of the report.

CHAIRMAN (Mr. Zoe): Before you respond, Dr. Kinloch, I think the concern that my colleague is raising could be better handled when we go into it chapter by chapter. Chapter three, under section 3.2 I think maybe you could respond to my colleagues concern when we go into the chapter by chapter.

DR. KINLOCH: After lunch?

CHAIRMAN (Mr. Zoe): Well, because of the number of Members who have expressed an interest in making general comments in response to Dr. Kinloch's statement this morning, we basically focused on that item. I think that has been a very valuable discussion but I think we have to, for my committee Members here, reorganize our schedule, our agenda. I would like to suggest to my committee Members to reschedule the Department of Finance, Government Services and Personnel for tomorrow afternoon and that way it will free this afternoon to do chapter by chapter with the Department of Health. Do you agree?

SOME HON. MEMBERS: Agreed.

CHAIRMAN (Mr. Zoe): Well, with that, let us adjourn until 1:30 p.m. We will proceed right away, after we reconvene, at 1:30, with the chapter by chapter of the A.G. report.

---LUNCH BREAK

CHAIRMAN (Mr. Zoe): Good afternoon. I would like to call the committee back to order. We are dealing with the Comprehensive Audit of the Department of Health. We concluded the general comments and questions this morning to the remarks made by the Deputy Minister of Health.

This afternoon we will continue on and go chapter by chapter on the Auditor General's report. Chapter one, we covered as it pertains to the executive summary of the report and chapter two deals with organizational structure. Could I ask Dr. Kinloch if he has any remarks pertaining to chapter two?

Organizational Structure

DR. KINLOCH: Yes, Mr. Chairman. At your suggestion, I have invited appropriate directors to accompany me for the chapter by chapter review. I would like to ask Mr. Nelson McClelland, who is the Director of Hospitals and Health Facilities to make some introductory remarks.

CHAIRMAN (Mr. Zoe): Thank you. Mr. McClelland.

Department of Health Introductory Comments

MR. MCCLELLAND: Thank you, Mr. Chairman. Mr. Chairman and Members of the committee, statements have been made by the Auditor General and some Members of the Standing Committee on Agencies, Boards and Commissions that the roles and responsibilities between the Department of Health and hospital and health boards are in confusion, that they are competing for power, that there is an inequity in the power amongst boards that may cause jealousy and resentment and that the root of the problem is the fundamental question on the model of how health care should be delivered in the Northwest Territories under a board structure or not a board structure.

In the few minutes that I have been allowed introductory remarks, I cannot fully address the issues in the report in any detail, but I would like to provide an initial background perspective that is very relevant but has not been mentioned in the report. Then I would like to spend some time going over the various sections that I believe the Members want to hear about.

Looking at the bigger context it is essential to understand the broader perspective of what is happening in the health sector across Canada as we are closely linked to that broader spectrum. Recently Caldwell Partners Amrop International contacted hospital board members across Canada to survey their perceptions of issues and the results represent the informed opinion of 100 business leaders across Canada who served as hospital trustees. In fact, these individuals have served for a great many years so they are not new trustees. Their report, which I will be glad to provide a copy of to the committee, is called "Governance in Canada, A Power Struggle" and it makes several relevant and informed observations. In the summary of key findings, the report makes this observation, the majority opinion of hospital trustees, and it says:

> "There are two distressing aspects of board service. The first is the slow bureaucratic decision-making process both within the hospital, or the health board, and especially between the hospital and the Ministry of Health;
>
> The second is the need to make tough resource allocation choices. Frustration results from having no control over your destiny. It is not like a business you are at the mercy of the Ministry of Health and they do not reward good management."

The second section of the report, under government fiscal relations, a further relevant key finding is made and it says:

> "Trustees indicate significant and increased government involvement in determining operating budgets, capital spending and new program development. The Caldwell report notes that in the 1990s hospital trustees are faced with the challenges of severe financial restraint with consequential agonizing decisions over bed closures, program reductions, the postponement of technology and the postponement of capital construction."

We, in the Northwest Territories, have been shielded somewhat from this and only in the past several years have fiscal restraints and cutbacks become a hard economic reality in the territories. With the system already struggling with the transfer process, which I will detail for you, you will appreciate that this news was not warmly welcomed either by the Department of Health or the hospital and health boards themselves. We have been far too long in good economic times, Mr. Chairman, so this is why I am saying the news was not warmly welcomed.

Mr. Chairman, there is much other evidence in the form of major health studies that have recently been completed by their provincial jurisdictions. These demonstrate that we, in the Northwest Territories, are not alone in the problems of a health care system in transition finding the right balance of controls to satisfy the public's expectation for fiscal accountability and the competition for scarce resources in very tight times.

For our next point of reference, Mr. Chairman, I would like to focus on the health transfer process. In his opening remarks, Dr. Kinloch provided an overview of the transfer process and that it has been a long period of time. The most recent transfer agreement was by far the most complicated process and, to say the least, it was very stressful for members of the Department of Health, for the board members and their staff that had to make it all happen. Six months was clearly not enough time to do an adequate job. In my view as an operations person, a minimum of one year was needed to do the job correctly. However, that was not available. So both the department and the health boards did the very best job they felt they could under the time and circumstances available to make it happen. I could go into some details about how many job descriptions we had to develop, how the pay package was worked and all of the myriad of details that had to happen in six months. There was a great deal of effort made by everyone concerned. The most important thing at transfer time we felt was that the individuals that were transferring to us saw that the salary and benefit package was equitable. You probably remember the discussions at the time that there was a lot of work going on behind the scenes with the unions and the

members to try and make sure that we had as many health people transferring over to us as was possible.

The Auditor General, in the report, asks after four years has the idea, that is the use of health boards, worked. Given the jump start and the lack of adequate planning time, the comment I feel should rather be, it is a wonder things have worked as well as they have. We were quite surprised by statements that from various discussions with department folks, board folks and other departments that the Auditor General had encountered an attitude that showed a lack of respect for board members and that the department wanted to retain all the control at headquarters. In fact the department has dedicated its efforts to the proposition that the delegation of management and control of health services operations through boards of management can be a most effective vehicle of administering the complex field of health care.

Through the appointment of citizen trustees we envisioned local residents being involved in health matters in a meaningful way and for services to become more relevant to the individuals in the communities and the regions. We envisioned staff of the hospitals and health centres would become more sensitized to local issues because there was a board that would provide that information, which was not happening under the Health and Welfare system. We also envisioned that there was an appreciation of how government funds were spent. However, not enough information was disseminated on how much health care costs and that kind of detail so that people did not have an understanding of that. We also hoped that many local issues could be resolved at the local level and regional level as opposed to centrally in the Department of Health.

We also envisioned that there would be a focal point for identifying the needs of the regions so that clear statements of their requirements could be put forward to government. Mr. Chairman, there is a saying that when you are very busy fending off the alligators it is most difficult to remember that the original objective was to drain the swamp, or at least find the plug to drain it. Mr. Chairman, in the report the Auditor General refers to a number of concerns that basically boil down to these: the degree of autonomy for boards; the concern over resource allocation and the definition of the services that should be provided; the transfer policy arrangements and the effects that this had over the last couple of years; and financial management and control concerns. Dr. Kinloch has already touched on the legislative concerns so I will not go into that in my remarks, Mr. Chairman, but those are the key points which I would like to address each in turn, perhaps with a break in between so that Members questions could be answered, and also so that I do not go rambling on without your input.

The most common areas of hospital and health board disagreements with the Department of Health both here and in other jurisdictions fall in the areas of allocation of operation and financial fiscal resources, and the issue of controls and accounting for expenditures. Mr. Chairman, the department has always attempted to minimize disagreements with boards and their administrators. It is certainly in no one's best interests to have great discontent between the department and the boards. However, given the many problems that have been encountered with the recent transfer process, which I will go into, these fiscal resources have become more and more limited and the seeds of discontent have been growing. You are hearing about that in several of the committee meetings that you are participating in.

Difficult and unpopular decisions have had to be made by the Government of the Northwest Territories in recent years because of our financial situation. The department has in turn had to convey these to boards. I mentioned before, Mr. Chairman, that the financial downturn has not been warmly received but it has not been warmly received by the whole government. Nobody felt it was as bad off as it really was. We have been hearing from our southern counterparts, for a number of years, that they have had to tighten their belts. I guess it was only a matter of time before it hit us. When it did hit, with all of the other problems that we had, it just seemed to compound and make things more complex.

The department realizes that there have been problems. We are also of the belief that the problems that have been identified are not beyond repair and that working together with our boards, our other colleagues in the department, and with the Legislative Assembly, we can find consensus on which we can build. Mr. Chairman, that concludes my short introduction and if you have any initial questions I could take them now. If not I can go into the next section.

CHAIRMAN (Mr. Zoe): Instead of stopping here and questioning you in regard to the comments you have made to chapter two, I think it will benefit Members, and save time, if you were to conclude your presentation. I will then ask Members if they have any questions on your comments. Please continue.

MR. MCCLELLAND: The first issue that I would like address is the issue of board autonomy. At the time of the most recent transfer responsibility of health services to the Government of the Northwest Territories and the accompanying creation of new boards the respective roles of governments and the boards were felt to have been defined with sufficient clarity. The words were there but other perceptions and heightened expectations have coloured the interpretation and the application. Instead of concentrating our efforts in the last four years since that particular transfer, on ongoing development of a model and strategic plan for the future, with the appropriate infrastructure to support the system, both we as boards and the department have engaged in an essentially sterile debate over the infringement issue or board autonomy. That is that we have been at a relative stalemate on the issue but there have been reasons and I will go into those.

This continues to be the preoccupation but boards and the department recognize that we are all bound by statutes and regulations, by policies of the government and by budget allocation. What has the government been doing in order to correct this particular problem and address board autonomy? During this development period some of the role confusion was attributed to the existence of two headquarters entities, the department and the Territorial Hospital Insurance Services Board. Two different creatures for boards to work through a system. During 1990-91 various bodies including the Standing Committee on Public Accounts, the Standing Committee on Agencies, Boards and Commissions questioned the role of this creature called the Territorial Hospital Insurance Services Board and whether or not it was necessary to continue its existence.

After carefully considering that matter the government dissolved the T.H.I.S. board and its powers were returned to the Minister. With this change the Minister was now in a position to deal directly and more comprehensively with hospitals and health boards without having to work through this other particular mechanism. That is the first step in the clarification process which has taken place.

The next step was for Cabinet to clearly define the difference between boards of governance and boards of management. Some hospitals and health boards have viewed themselves as boards of governance, such as those in the south, and not as boards of management. In response to the recommendations contained in the report titled "The Review of Financial Arrangements Between Boards and Agencies" Cabinet had now clearly defined what the difference is between these boards and has affirmed that N.W.T. hospitals and health boards are boards of management.

Mr. Chairman, if you would like I could provide a definition for the committees reference, if you wish.

The third step in the process was that after Cabinet has solidified in its own mind what boards of management include, then the Minister of Health, mostly notably I guess, Nellie Cournoyea, met quite a few times with boards over the period of her involvement as Minister of Health. In her remarks to respective boards, she recognized the boards' legitimate desire for increased control over policy development and implementation over health services delivery and matters of funding and she clarified the context in which boards must operate.

Mr. Chairman, to dispel any misunderstanding of what has actually been said, I would like to quote from several speeches that Nellie has delivery over several different occasions to boards. " Boards are reportedly frustrated by what they view as the inability to fulfil their role because decisions taken by the board are questioned at times or overridden by the Department of Health."

Nellie went on to say, "in my remarks, I will examine these concerns, but before I do, I would like to review with you, as members of the board, the nature of accountability in our system. It appears to me that misunderstanding of this matter is the basis for much of the concern over autonomy that has been heard over the last several years. In our system of government authority is vested in the Crown, represented by the Commissioner. In our form of consensus government in the Northwest Territories, the Minister of Health is accountable to the Legislative Assembly. In addition, the Minister is limited by the laws, regulations and customs of both the territorial government and the federal government. The Minister does not have autonomy in carrying out her responsibilities and what the Minister does not have, she cannot give to boards."

She went on to say, "I have stated repeatedly that health boards in the Northwest Territories are not and cannot be autonomous bodies. Their actions are limited by the same legislation and policy that guides the rest of the government system.

In performing its role, the department must ensure that these requirements are met because it is the department which present and defends the budget of the health system and which must answer to the Legislative Assembly for its shortcomings. There is considerable inter-dependence between the department and the board.

While the health board system does permit a certain degree of flexibility in management, the provisions of the health care services to a widely dispersed population can efficiently be achieved only with rational alignment of all administrative and professional functions. We cannot have everyone doing his own thing. System anarchy would be the result.

Boards have a responsibility to manage, through the day to day work of their chief executive officers. The chief executive officers are accountable to boards, boards are accountable to the Department of Health, and the Minister of Health is accountable to the Legislative Assembly.

The so-called autonomy, or management flexibility issue, stems from the need not only to clarify departmental and board responsibilities but to accept that there is a limited range of action for both. Limitations arise in respect to fulfilment of basic roles as defined with legislation, in compliance with territorial and departmental policy, to the definition of service content and delivery, in funding and financial control matters and the desire of boards to exercise management control over specific service functions.

The role of the board is to manage, control and operate facilities and services, but it must be done within legal, moral and ethical boundaries."

Then, Mr. Chairman, she went on to clarify the legal responsibilities, the moral responsibilities and the ethical responsibility that health boards have. I can provide a copy of this information for your committee.

Mr. Chairman, the next item I want to speak about is the issue of resource allocation. Resource allocation and the definition of service content and delivery arrangements provides continuing opportunity for misunderstanding and disagreement within and between boards and between boards and the department.

I mentioned previously that there were great expectations created at transfer time by the taking over of a system and everyone had a lot of ideas on how they would like to immediately change that system. Demands for the resources, the dollars, have been great upon the system and have included many requests to add more physicians to the system, to add more nurses, to add more support staff, to add more administrative staff, to increase the technology that is available and to expand or replace completely some of the facilities. There were many demands, in fact, millions of dollars worth of demands, if you cost them out.

There are, however, some basic considerations which may foster a more collaborative effort to deal with these issues. Only those services which have shown to be effective should be expanded or added as new programs. Boards must appreciate that determining whether a service is beneficial and warranted is a complex exercise and that the service and the cost implications of seemingly trivial additions can be great. Assessment of effectiveness is generally beyond the

capabilities of the Northwest Territories and considerable reliance must be placed on investigations that are conducted in other jurisdictions. We do not have the abilities to investigate all the technology that might be used in the Northwest Territories so we have to rely on others in that. Results from these sources, however, must be reviewed from the Northwest Territories perspective.

It may not necessarily be appropriate to import some particular item here for our use. Even where a service is shown to be effective, the additional benefit obtained may not warrant the increased cost. This must be determined separately through a cost benefit assessment.

Additions to services include the changes and capabilities of Stanton Yellowknife Hospital. Recently we changed the service and added endoscopic cholecystectomy which, for a lay person, I would say, if you have ever had your gall bladder out, is fairly major surgery. I can speak from personal experience. This new method of doing gall bladder surgery is one that is the most recent technology. It uses a very simple technique and it virtually means the individual can get out of hospital in several days as opposed to a six week recuperation period, I think I went under.

So there are lots of considerations. Other ones are ultra-sound. Travelling ultra-sound clinics have been requested in one of the regions. Screening for breast cancer by mammography.

There are many technological issues that we have to deal with. Many health services currently provided have not been assessed to determine their effectiveness, let alone the efficiency or economy on which they have been provided. So in dealing with the needs to contain costs, we should first look at the services which may or may not be effective or which could be provided in a more efficient way.

So, Mr. Chairman, the point of this one is to raise the issue that we need a collaborative effort. There are great demands and expectations out there in the public. They see that there are new techniques that they hear about on T.V. and they wonder why that is not necessarily being imported immediately up here. I am just saying there are many complex things that have to be look at in order to decide whether or not we have the abilities to carry out the technology which is being promoted.

Mr. Chairman, the next item deals with the transfer policy. Since the 1988 health transfer agreement, a number of concerns have been raised about the requirement for new boards to use the full range of support services available from the government departments which were already available in the various administrative regions. The application of similar arrangements to pre-transfer boards, we use the term the old boards which were under the board/commissioner agreement, was also envisioned as part of that transfer policy and also was a matter of considerable concern to the affected health boards at the time.

Within the health system the differing arrangements of support services implemented for the new boards and the delay in applying the requirement to the pre-transfer boards led to complaints about hospitals and health boards having different levels of autonomy and authority. In addition to the concern about how support services should be provided all boards sought clarifications as to which government policies would apply to hospitals and health boards.

The Standing Committee on Agencies, Boards and Commissions conducted a review of support service arrangements with the health boards and presented their report to the Legislative Assembly. The report was discussed and a motion was passed that the Minister of Health, where requested by the regional health board, take all necessary steps to immediately discontinue the practice of requiring regional health boards to use the services of the government departments.

What has been done to clarify this particular concern, Mr. Chairman? There has been four main elements that have been undertaken. Cabinet has reviewed policies to address the concerns which had been raised in respect to preferred arrangements for support services. Cabinet has reviewed the existing financial arrangements between health and education boards and the government. They have clarified the definition of boards of management and have clarified exactly what government policies apply to all hospitals and health boards, as well as education boards.

To enable the government to answer financial arrangement concerns the Financial Management Board had directed that a comprehensive review of those financial arrangements be undertaken. Some of you may recall the Peat Marwick report that was undertaken and this certainly was a good piece of information that helped us deal with the issue. As an integral part of this review process the consultant interviewed the board chairman and chief executive officers, and directors of finance of the health boards, they also dealt with education boards, but I am not going to get into that side of it. They also spoke with department managers in the Department of Health as well as the Standing Committee on Agencies, Boards and Commissions. I believe they spoke with the Chairman at the time. The report was circulated and responses were received. In a series of meetings the project steering committee developed recommendations to deal with the concerns that had been raised by Cabinet, by the Standing Committee on Finance and the Standing Committee on Agencies, Boards and Commissions, as well as the Auditor General.

The steering committee's report was approved by Cabinet and circulated to hospitals and health boards. One of the key directions given by Cabinet was this comprehensive Memorandum of Understanding being developed. In his recent address to the Northwest Territories Health Care Association, the former Minister of Health, Dennis Patterson indicated that the long overdue preparation of this role/responsibility clarification document would be helped by the appointment of a person of stature in the health care field, to undertake this responsibility and to work with the parties to develop the master agreement that Dr. Kinloch has already referred to.

We are happy to report, Mr. Chairman, that after discussions with the Health Care Association, which represents hospitals and health boards in the Northwest Territories, that a call for proposal for this project was drafted and was approved by the parties. The proposal call has been sent out. We have not received a response, which I hope the steering committee for

the project will be able to deal with in the very near future. Besides Dr. Kinloch and myself on the committee as members for the department there are three other health board trustees involved: Gloria Allen from the Inuvik Regional Health Board; Bette Palfrey from the Keewatin Regional Health Board; and Bea Campbell from the Fort Smith Health Centre. Mr. Chairman, if the committee wishes I can provide you copies of an overview of what that project is all about. The Auditor General has already referred to it also. If you wish that as background information I have that available.

The next item, Mr. Chairman, I would like to deal with is the issue of financial management and control. Funding and financial control issues have dominated discussions between the department and the boards. Previous Ministers of Health have met on at least three occasions with the board Chair people and chief executive officers to impress upon them the magnitude and the seriousness of the government's financial situation. From the date of the 1988 transfer process it has been apparent that the structure and funding of the N.W.T. health services system was inefficient and that consistent management and program standards would be difficult to apply given that it was a "marriage" of two dissimilar systems; the health and welfare system and the G.N.W.T. system. This was presumed to be temporary but budgeting and control problems continue to exist.

Weaknesses in the management information systems were compounded by the difficulties in attracting and retaining competent managers. The result had been ongoing uncertainty regarding financial positions of the boards. Given the financial situation of the Government of the Northwest Territories as a whole this situation is both perilous and frustrating for the department and for the Legislative Assembly who are being asked for additional resources.

There are two main elements that I would like to clarify under this heading of financial management and control issues. The first is supplementary funding requests. That, in fact, was one of the reasons why the call for this comprehensive audit started to begin with. There are others but certainly that was one of them. In the report the Auditor General has referred to annual pilgrimages for supplementary funding. No mention was made of the considerable systems problems that were experienced or that there was full justification put forward with these requests. For the record, Mr. Chairman, I would like to examine the primary reasons contributing to the funding difficulties that have been raised. In retrospect, there is considerable suspicion that Health & Welfare Canada was not entirely straightforward in its dealings with the Government of the Northwest Territories. Perhaps taking advantage of the fact that the Government of the Northwest Territories had limited knowledge of the health and welfare system.

Client population and client expectations have continued to increase, resulting in added work load and high demand on resources. Those resources are facilities, staffing costs, drugs and supplies. The effects of overtime and other related provisions of the collective agreement have major implications on the field activities which by their nature cannot be scheduled to take place during normal work hours. For example, accidents happen, births happen, heart attacks happen, and many other things happen and they do not happen on a schedule.

Mr. Chairman, the nurse is the backbone of the community health centre delivery system. Nurse recruitment at the time and retention difficulties and consequent dependency on

agency nurses was considerable after the health transfer and during the period under which the report is made.

Continuing cost increases of drugs, medical supplies, x-ray supplies, lab supplies, food and travel have all contributed, Mr. Chairman, to the requests for supplementary funding for the department.

The next item under financial control deals with systems. The initial financial controls referred to in the report were established in 1982. After reviewing standard health reporting requirements of a number of provinces to ensure that the reporting requirements that the Territorial Hospital Insurance Service Board was asking were reasonable, these controls and reporting requirements have been reviewed and modified several times. Now, Mr. Chairman, consider the scene where financial statements and variance reports are submitted and used by the department to make its year end projections and to adjust board budgets. In one recent fiscal year, I believe it was in 1989-90, the cumulative year end deficit for boards was $1.5 million.

Both the Financial Management Board and the Standing Committee on Finance certainly raised questions of the Department of Health and have sought assurances from the department that the operations of hospital and health boards are effective and being carried out with due regard for efficiency and economy. The committee in its review process was quite critical of the department not being able to provide comprehensive answers and because we did not have comprehensive answers we had to turn to the boards. There is a ripple effect to the particular question. Lack of adequate systems to provide timely financial information and difficulties in implementing and maintaining adequate controls have been significantly contributing to our funding problems.

Mr. Chairman, here is an indication from one of the management letters that we received from auditors in this respect. As you know each hospital and health board has to have an annual audit. It provides a financial information statement and also provides a management letter. I will read to you an extract from some of these letters and it will give you, certainly our accountant friend Mr. Koe will appreciate some of the problems that are here. One of the audit letters says "the accounting systems controls and procedures were not implemented, as a result financial statements produced are materially inaccurate. Senior management of boards do not formally meet to review the monthly financial statements. Billings are three months in arrears. Bank reconciliations were not properly completed. Manual pay cheques were issued but not recorded. At one point over $100,000 in unrecorded cheques existed. Responsible managers did not receive regular monthly financial statements. Fixed asset listings were not maintained." Mr. Chairman, the list goes on and on. I am raising them simply to emphasize the magnitude of the work and the degree of frustration that these have caused both the boards and the department staff.

In fairness to all concerned, all parties have been working diligently and collaboratively to rectify these differences and

difficulties. What actions have been taken by the department? First of all, the review of audited financial statements. On receipt of the boards' audited financial statements and the management letters I referred to, these are reviewed in my particular division. Boards are asked to provide a year end variance report explaining their final year end position and any problems that they had. As well they are asked to provide an action plan to address the concerns raised in the auditors' management letter. We review these and we provide the board administrators whatever support and recommendations we can to help them meet these.

The second item is the budget review process. Hospital and health facility operations division, in collaboration with the board staff, engaged in fundamental but detailed research work on a number of the underlying issues and causes of budgetary problems in consultation with the board. The major findings as a result of this were concerns about management experience and abilities in the effective management of the operations, a need for baseline funding and standards development and a need for congruent management information and financial control systems.

The current priorities that we are working on is this baseline operational review of the budgets. We are working with the boards on that. We are providing advice and we have had several workshops and ongoing telephone support to assist in the development of effective health managers and in the development of a congruent budgeting and health board management information system, which really, Mr. Chairman, is the key ingredient to long-term financial planning and proper forecasting. This is mentioned not only in the Auditor General's report but is also mentioned in the Strength at Two Levels Report. It is not new but, Mr. Chairman, it contributed significantly to the problems and the tension which has existed.

You can appreciate that if you are the chief executive officer and trying to report to your board on what is going on in your operation and you are having systems problems and the reports do not come off on time, all of that frustration at your facility level filters down to the department. We then say, "Look, we have got to make projections for the Financial Management Board, where is your information?" Then we get the information and there are questions and concerns about it, so you have questions about the reliability of the information. As I mentioned, Mr. Chairman, the managers in the field are working very hard to correct the deficiencies. It is not, Mr. Chairman, for lack of trying. It has been a difficult process and they are hampered by this key ingredient which they need, a management information system.

The next item is the financial reporting and periodic variance reviews. The hospital and health boards prepare and submit a number of regular reports to the department on operation matters. For the most part these simply are copies of the routine management reports. They are monthly financial and statistical reports which they themselves must prepare for their own boards and their own management use to perform the functions. As well there are certain reports that are statutory in nature, such as those demanded by Statistics Canada. Periodic detailed variance reports are submitted for routine monitoring to enable the department to meet the Financial Management Board's variance reporting schedule. Of course they have to do that because they have to account to the Assembly for the funds that are being expended.

In the past year, financial reporting requirements were reviewed with the chief executive officers and directors of finance and these have been revised. The current reporting requirements and time schedules have been reached by mutual agreement of the parties.

Mr. Chairman, the fourth element of the financial management section deals with the ongoing consultation and support that my division can provide and does provide. Our personnel provide consultation and support as requested to assist board administrators on many operational issues. The division is also called upon on a number of instances to provide on-site support and assistance to boards who are experiencing financial management difficulties. For instance, if a board is having difficulty with preparing their variance report then I would send a team of financial folk or the health administration folk in together and they would work with the parties so that we could come up together with a variance report or a clarification that might be needed.

Mr. Chairman, those are the main elements that I wanted to raise to the committee. In conclusion, I believe that the approach that we all want to take in dealing with the issues is to create an effective and constructive atmosphere, to clarify any perceptions that exist or misperceptions. We want to focus on the needs of both the boards and the department and how these can be met. We want to build a shared positive power arrangement so that both parties know what is expected of each other. We want to look to the future, but we want to learn from the mistakes and problems we have had in the past. We want to look at the option that we have available and we want to make a mutually beneficial agreement so that we can both get on with the tasks that we have ahead. I sincerely believe that the problems that have been referenced in the report can be resolved in the spirit of mutual cooperation and respect for the assigned roles that each of the parties has.

Mr. Chairman, I think that concludes my remarks and I would certainly be open to any questions now. I am sorry it took so long but I wanted to put the whole scene before you because I think it is important when considering the report and the ramifications of it.

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch, perhaps when you have your managers appearing before us who have long comments, like Mr. McClelland, I would appreciate if you could provide us copies so we can read and follow along, it was kind of lengthy. It did not only pertain to chapter two because it touched on the other chapters too, but I appreciate what you have done because in order to understand the various sections, you have to get the overall picture. That is why I let it go or else I would have cut you off earlier and asked you to highlight only specific points that you wanted to make pertaining to chapter two. That was the intent. What I wanted to do was focus on specific chapters and get into the specific areas that have been highlighted in the report but since you have done an overall thing, I let is go because, in order for the Members to understand, they have to understand the other components of it too.

Could I ask if your staff can provide us with all the quotes? You are making a number of quotes from Nellie's statements and there was another one too, yes, definitions and all those things you kindly gave to our committee. We want them. Can we get all those quotes? Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, you will be relieved to know that the other presentations are very much shorter. We did devote far more attention to this because it is after all the major focus, the board relationships, and Mr. McClelland's responsibilities do spill over into the other areas.

CHAIRMAN (Mr. Zoe): Dr. Kinloch, if my understanding is right, you are using your staff as back-up on specific areas that they are experts in, right? For instance, possibly someone is here from human resource section and possibly someone is here from computer systems, those type of people. Right?

DR. KINLOCH: Yes, Mr. Chairman, yes.

CHAIRMAN (Mr. Zoe): They are not going to make a formal presentation are they?

DR. KINLOCH: Perhaps a brief introduction of the areas they will speak to.

CHAIRMAN (Mr. Zoe): Very brief though, okay. We are going to keep it very brief. Okay, before I ask general comments of Members pertaining to Mr. McClelland's overview, because he jumped over all areas, could I go back to Auditor General's office, if they would like to respond to comments they just heard.

Auditor General's Office General Comments

MR. DUBOIS: Mr. Chairman, there is not much to respond to. I think Mr. McClelland describes the challenge ahead. My understanding is it is a complex situation. It is difficult and I think we recognize that in the report and I do not have any particular comment or reaction to what he said.

CHAIRMAN (Mr. Zoe): Roger, have you got anything else to add?

MR. SIMPSON: I would just like to compliment Mr. McClelland on a good presentation, Mr. Chairman. I thought it was very good.

CHAIRMAN (Mr. Zoe): General comments. Mr. Koe.

General Comments

MR. KOE: Just a quick one, a point of clarification, in response to Mr. McClelland's opening remarks. Early in his presentation, and I do not know exactly where, I thought I heard references to statements made by some Members of the Standing Committee on Agencies, Boards and Commissions. When the Standing Committee on A.B.C.s makes reports, obviously not everyone can present them so we do ask certain Members to make the presentations but the presentations are made on behalf of the committee as a whole and then that report is presented in the Assembly and subsequently accepted and adopted by the whole Legislative Assembly. So it represents the viewpoints of the committee Members and then it is accepted by everybody, so it is not specific individuals. There may be a spokesperson reading the report but it is a collective endeavour. As you can appreciate, we may not all agree on everything but we agree on certain words that are presented and it is the collective view of the committee. It is not individual people.

MR. MCCLELLAND: Mr. Chairman, I do recognize that. I was referring to Hansard and the various comments that various Members had made. I realize that a report that is presented is unanimous in its presentation, but that was the reference I was making. That is all.

CHAIRMAN (Mr. Zoe): Mr. McClelland, you made reference to the Agencies, Boards and Commissions report from the 11th Assembly and it did talk about eliminating T.H.I.S. Board but, also, the recommendation was to repeal that T.H.I.S. Act and to enact new legislation. I was the Chairman of that committee and I have a copy here of my report. It also indicated that we wanted new legislation to be enacted so that it could better reflect the government's philosophy of supporting regional economy. Half of our recommendation has been implemented, but the other half has not. I just wanted to clarify that because your comments sort of alluded that you were following A.B.C.'s recommendations but it is not totally 100 per cent followed because they did only half of it. The other half is not reflected. It was not done because, from just listening to your comments, it sounds like the government and the Department of Health have been adhering 100 per cent to all the recommendations that have been coming from Agencies, Boards and Commissions. I wanted to make those comments just for the record. Only half of it has been done. Mr. Gargan.

MR. GARGAN: The question I wanted to ask is in regard to the request from regional boards regarding these really high tech equipment; scanners and mammography machines I am just wondering, exactly who is asking for this equipment, which region?

CHAIRMAN (Mr. Zoe): Mr. McLelland.

MR. MCCLELLAND: Mr. Chairman, if I could respond to two things. First of all, with regard to your comment about the T.H.I.S. Act that and the changes that need to take place in that. I think what we have been finding and discussing with our boards is that there is more than just the T.H.I.S. Act has to be looked at. The other act that has to be looked at is the Public Health Act which Dr. Gilchrist alluded to this morning. The T.H.I.S. Act, it calls for the creation of boards of management. In the Public Health Act, it calls for the creation of public health boards and so, because there are two acts calling for creation of boards and we have only got one board in the territories called the board of management, the questions comes, which board has which authority over to do what? So it is a complex task of how do we clarify the roles and responsibilities?

Mr. Chairman, we have mentioned the Memorandum of Understanding arrangement that we are pursuing. We had hoped that through sitting down with boards and department and others that need to be involved, that we would come to a very good understanding of all of the amendments we might have to make to these various acts to make it work. We are not neglecting the recommendation of the committee, we just

have a timing problem that we felt we needed to deal with first in order to properly clarify the legislation which would in effect legalize the whole arrangement. It is not a matter that we are wilfully turning our back on the recommendation. It is simply the timing and we felt the logical approach was to deal with organizing the system the way that everybody felt it should be organized and then changing the legislation so that we could marry it and make it all legal together.

In answer to the second question from Mr. Gargan, there are lots of demands for new technology. One particular region has said, we should be going and doing ultra-sound. We should have a ultra-sound travelling clinic that goes around and does ultra-sound on all mothers at least four times during their pregnancy. I could defer to Dr. Kinloch on this issue because he is the medical expert. I am not. If I could, please.

DR. KINLOCH: Mr. Chairman, the whole issue of technology is very complicated. I do not think there is any point to be served in going into it. We would be happy to pursue this at some other time.

CHAIRMAN (Mr. Zoe): I think what Mr. Gargan was asking was, which boards are making these requests.

DR. KINLOCH: All of them, Mr. Chairman. Virtually all boards are seeking high tech.

CHAIRMAN (Mr. Zoe): I think he wanted a list if possible.

DR. KINLOCH: Mr. Chairman, there is an enormous array of high technology, or new applications of science coming on-stream every day so it is not at all surprising that we get the requests. The only ones that are of real concern are those that have vary large downstream cost implications. The acquisition of a piece of equipment may be a relatively minor item, however, the travel and the professional time that are required to utilize that piece of equipment may be significant. I think that is the point that Mr. McClelland was attempting to make.

CHAIRMAN (Mr. Zoe): Are you satisfied with the comments of Dr. Kinloch? I think you were alluding to a list from various boards. Their wish list I guess. Mr. Gargan.

MR. GARGAN: Yes. The thing is that presently, Mr. Chairman, there is a very broad role from boards being autonomous to boards that are primarily just advisory boards that I would think their requests for those type of things would be based on, like for the Baffin Region to have their own budget and they could probably handle something like this. I would think that the less autonomous those bodies are, then the requests would go to the management board. I would think so. I was just wondering which board it was and I was really interested to find out. Come to think of it, I guess it is difficult because of the capacity and the differences in the roles.

CHAIRMAN (Mr. Zoe): General comments, chapter two. Are there any comments on chapter two, regarding boards? Mr. Whitford.

MR. WHITFORD: Yes. Concerning the boards and some of the problems that have been outlined in dealing with them. I want to say thank you, first of all, to Mr. McClelland for his comments outlining the history and history is interesting and quite helpful. It has provided some understanding of where some of the problem area arise but it should have done more than that. I think that we need to focus on what we can do about it. We just cannot go on saying this is a problem and use it as an excuse. I want to go a step beyond that. We do not have a lot of time but we should go beyond, the ongoing problems that the department and board/department relationships are suffering from. What are we going to do about these problems?

MR. MCCLELLAND: Mr. Chairman, in response, I believe what we have outlined is the development of comprehensive Memoranda of Understanding between the Department of Health and the boards. It will go a long ways to clarify the roles and responsibilities of each of the parties. Mr. Chairman, the Minister deliberately choose not to have Department of Health folks in charge of the review. We set it up in such a way that there would be an independent person selected who both parties respected and this person would be, if you will, a mediator to bring the parties together, to talk about the issues, to talk about the role and responsibility of each and come up with a memorandum that satisfied both parties and that clarified all of the issues that had been elaborated in the report.

We are not saying that the Department of Health is all innocent and that we have not done any wrong to the boards. We are prepared to take our lumps, if you will, and be counted as people who can learn from our past mistakes and make the changes that will make it work together smoothly. Rather than it be a possible confrontational approach where the department could be seen to be imposing this on folks, we have elected to select and independent, outside person to come in and work as a mediator to bring the parties together to provide that objectivity that we felt the Members of the Legislative Assembly would certainly want to see in the process.

DR. KINLOCH: Mr. Chairman, could I just add to that comment. The M.O.A. will certainly provide some assistance by clarifying roles but, beyond that, we intend that there should be support provided to boards so that they can get on with their job and that may be as simple as bringing finance officers together on a regular basis so they can share their experiences and learn from one another, to the actual sending out of a financial team from the department to the board to assist them in dealing with budgetary or other problems. We have to recognize that some boards have a continuing difficultly attracting and retaining qualified people and we have to provide whatever support is possible while encouraging the staffing of those units.

CHAIRMAN (Mr. Zoe): Okay, thank you. Mr. Whitford.

MR. WHITFORD: Thank you. I was just going to go back to something earlier on that Nelson had mentioned. You were discussing the differences between the boards of governance and the boards of management, and I might be getting a little bit confused here because there are so many boards and agencies that we are dealing with here, but just bear with me. The difference is the N.W.T. Health Care Association plays a role in this whole thing. Have you discussed the differences between the board of governance and the boards of management with this association?

MR. MCCLELLAND: Mr. Chairman, back some time ago when Peat Marwick was doing the study in the report they clarified what the concerns were so that the steering committee took that into account in making the recommendations to Cabinet. I was a participant in that but the steering committee was of deputy ministers, and unfortunately, Bob Cowcill was our deputy minister at the time and he is not with us now. He could probably go into more background of what had been taking place at the time. Basically, the difference between boards of governance and the boards of management is that boards of governance down south are autonomous bodies that to some degree are controlled by government, but they are not last dollar financed by government. So if they over expend their budget they do not necessarily have the ability to go back to government for the funds. They might have to go to the municipality which elected them in order to pay the deficit.

Boards of management in the territories rely 100 per cent on government funding. There is a close link in what the Minister has to do in his or her accountability to the Legislative Assembly that does not exist the same way in the south.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: You mentioned that you did at some point discuss this with them, but you did not say what their response was.

MR. MCCLELLAND: Mr. Whitford, I do not leave the impression that I personally discussed with the association or I was not involved in all the meetings. The topic did come up as to board members from the health care association saying, "Let us know one way or the other where we fit in the picture, we have to have it defined." So the report made some recommendations as to what the differences would be, and then it left it to Cabinet to make the decision on how it was going to fall out.

MR. KOE: Thank you, Mr. Chairman. The reference has been made to the Memorandum of Agreement between the department and the boards. Again, I will refer back to comments made by the Standing Committee on Agencies, Boards and Commissions on this area. When we met with the members of the boards they were very clear that they wanted to be involved in the development of the terms of reference and the development of the agreements at the initial stage, and not another top down type imposition, "this is what we want, here is the agreement, do you or do you not like it?" That is not involving them. We are at a stage where a few months ago the Minister made a statement and said "here it is, there are 15 elements in this M.O.A.". We have asked questions in the last couple of days to the Auditors whether these 15 elements were all-encompassing and include everything. We have yet to go to the board and their representatives and ask them if anything else should be included. Again, it is from the Minister to the N.W.T. Health Care Association saying these things should be included. I understand there are terms of reference which have been developed already which have gone out to the boards asking if they like the terms of reference. Again coming from the department down, not the reverse. I think the attitude has to change. We have to involve the board members and committees at the regional levels in the development of these things. I just want to make that point for the record.

The other area of concern I have is the relationship between the boards and the department, again, I believe it is one of attitude. Again, maybe not of formal policy. In the audit report including the references on page 11 and 12, dealing with boards, it comments "an attitude showing a lack of respect from board members from the department. They are not viewed as capable of understanding complex issues. Undoubtedly there are many inexperienced members, but a patronizing view of member's capabilities is really an excuse for doing little to help them improve."

On page 12, "during our interviews, departmental managers informed us that they do not plan to delegate more control to regions because they want to retain control in headquarters. This, to a large degree, negates the intent of setting up boards."

Can you elaborate and explain what your position is on these comments, please?

DR. KINLOCH: Yes, I would be happy. Let me begin with the Memorandum of Understanding. In fact, the elements of the Memorandum of Understanding were discussed with and distributed to chief executive officers and board chairmen at a regularly scheduled meeting last year, with the intention that they should be reviewed by the boards and comments returned. Remember these were the outcome of an extensive effort that had been taken by the G.N.W.T., not exclusively the Department of Health, and that they have been reviewed and approved by Cabinet. So there is a certain element of a given here, having been approved by Cabinet.

Subsequently the Northwest Territories Health Care Association offered to act as a vehicle for consolidation of opinions from boards and involvement in the development of this process. Since the N.W.T. Health Care Association is made up almost exclusively of the senior officers of boards, trustees and board chairmen, that seemed like a profitable route to follow. It was on that basis that a draft set of terms of reference were prepared by the department shared with the chairman of the N.W.T. Health Care Association who submitted, after consultation, some amendments which were incorporated and that became the R.F.P. that went out.

Similarly, the N.W.T. Health Care Association was instrumental in putting together the representation from boards who would sit on the steering committee. In our view, we have made every reasonable effort to ensure that board opinion is represented in this exercise at the board chairman, board trustee and C.E.O. level. Short of establishing a constitutional convention of boards, I do not see that we can do a lot more. As I indicated, we are not entirely free in what we can include in this M.O.A. Clearly it must be within N.W.T. law and regulation and be consistent with the other limitation that are imposed upon us. Other than that, everything is on the table for discussion. We are looking forward to an open and constructive exercise under the chairmanship of an outside independent, objective, knowledgable person. I cannot be specific at this point as we have not reviewed the proposals. We do expect to have a meeting of that steering committee within the next week to review the proposal and to get on with it quickly.

Secondly, we would be interested to learn from the Auditor General the basis for the statements that Mr. Koe has quoted because those are not the position of the department of public health, they are not my position, and they are not the position of Mr. McClelland and I do not know whose position they are. Lacking any further information I cannot really comment.

CHAIRMAN (Mr. Zoe): Mr. Koe.

MR. KOE: Just for clarification, maybe the Auditor General can answer. Are you saying that because they are not yours or your staffs' position that those comments are inaccurate?

DR. KINLOCH: No, Mr. Chairman, but it is not clear from the statement itself whether they are attributed precisely to boards or to the department, in one instance. In the second instance, where department managers resist giving anything to boards because they want to retain the power themselves, I would dispute that. I have no evidence of that and I have no knowledge of it. It is not my opinion and it is not the opinion of anyone who I have spoken to on the issue.

CHAIRMAN (Mr. Zoe): Quite interesting. Can I get the Auditor General's office to comment.

MR. SIMPSON: Thank you, Mr. Chairman. During our meeting with Dr. Kinloch and his staff this particular issue was discussed. This is more of a pervasive type of attitude that we have picked up rather than sort of a hard boiled attitude that is institutionalized. It does not come specifically from a group within the department or just from within the department. We have picked it up in talking to a number of people. Because it is a soft type of area, Mr. Chairman, I would not want to name names because I do not think it would be fair to do so. I think it is something that concerned us because it seemed to suggest a division between individuals with power and knowledge and those that perhaps needed to obtain power and knowledge. That is why we looked at the question of was there adequate training and development opportunities extended to board members. I think we found that realistically there was quite a lot of things that could be done to assist the board members to gain the kinds of experience and confidence that they probably would enjoy having in order to play the kinds of role that both Mr. McClelland and Dr. Kinloch have indicated is a target for the future. That is all that I can really say. Thank you.

CHAIRMAN (Mr. Zoe): Mr. Koe, do you have any additional comments or questions? Mr. Koe.

MR. KOE: Yes. As a deputy minister what is your own assessment of the capabilities of boards to "operate, manage and control" as they are supposed to be doing for those areas of the health system for which they have been delegated responsibility?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, the capabilities of boards are clearly related to the amount of time they have spent in managing the operation of health services. The Baffin Board as an old board clearly has an advantage. It has gained considerable experience and sophistication. We should and do expect more of them. We recognize that there is a learning curve for everybody in this exercise, for trustees, for board chairman, for staff in the field, on the boards and in the department. I think the capabilities vary across a spectrum but I for one have been considerably impressed with the improvement which has taken place in the subject matter of board discussions, how discussions are handled, and the management of issues in boards over the relatively short time that I have been observing them. I think that we can expect the learning curve to continue indefinitely because the issues keep changing and because the terms of the board members do expire and new members come on, and must learn from their fellow board members and from others, that the players change in the rest of the system as well. It is a continuous learning experience.

It should be noted that the department commissioned training programs shortly after the 1988 Transfer Agreement for the training of trustees and that some boards have continued this independently. Regrettably the turnover of board members has been greater than the training programs established for trustees, so there are now trustees who have not had exposure to the training program. Also, regrettably the documents which were prepared very thoughtfully at the time in preparation for the creation of boards have turned out to be perhaps less useful than they might have been. Rather too complicated, too long and in some instances not translated appropriately. It is my impression that we need to look at the whole trustee training program from the ground up in terms of trying to make it simpler and something that can be handled by individual boards with the quick translation for unilingual board members and for supplementary continuing education program for board members and staff members preferably conducted jointly so that they can get the same perceptions of issues.

CHAIRMAN (Mr. Zoe): Mr. McClelland do you have something to add to that?

MR. MCCLELLAND: Yes, Mr. Chairman, I would like to make a point about the trustee orientation process. In the recommendations there is a suggestion that it should be the Department of Health that does this process. I agree that in the beginning it was necessary that we put it all in perspective because we were trying to get four new boards up, running and operating and giving them an idea of what there particular job was going to be. I think the Northwest Territories Health Care Association has a big role to play in this. The reason I mention that is that it is not normal that Departments of Health in the south would provide ongoing orientation for trustees. I believe the health care associations in the south feel that this is their responsibility to keep their membership fully informed on all the issues and to provide that level of ongoing training and orientation. I believe the position of the department would be that we would want to foster that through the health care association as opposed to doing it ourselves. We had offered, ever since transfer time, to have individuals from the hospital operations division or others within the department would be prepared to go out and spend time on an orientation session for board members. Frankly the fire fighting on the many other issues has not given us the time that we would like to commit to that kind of activity. I think we need to visit this issue with the health care association and perhaps the additional resources may be necessary for them in order to do a proper job of ongoing orientation. So we will be working with the association on that.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: Just a couple of other comments. In this training and orientation, there should be some sensitivity in cultural awareness. I assume when you talk to trustees and executive directors, and C.E.O.s are included in these, the responsibility for training members is with the department and not the association. I hope that they are learning because they are similar to what we expect of directors. You say it is in a state of flux and what you had before is not necessarily appropriate. I assume you are working then with the Health Care Association and doing something. Is there a strategy or something in the works.

MR. MCCLELLAND: Mr. Chairman, we have been talking with the President of the Health Care Association on the future role of the association. They are currently without an executive director. They have been working on the selection process for an executive director and we have asked them to clarify the budget issues with us and I believe that once they are able to do that for us we can work something out with them that would provide for this ongoing orientation, beginning in this particular year. I think their executive director finished at the end of October.

CHAIRMAN (Mr. Zoe): Any further questions. Mr. Bernhardt. Chapter two.

MR. BERNHARDT: Thank you, Mr. Chairman, I think we should take a break. We have been sitting down for an hour and a half without any cushions.

CHAIRMAN (Mr. Zoe): Just before we do I wanted to ask another question pertaining to section 2.4 of the report. The Auditor General found that some of the department's managers believe that they have complete power control over the boards. Many of the department's policies and procedures reinforce this. Can I ask the Department of Health if they can provide us with copies of their policies and procedural guidelines related to budget control, capital funding, surpluses, year end audit financial statements, management incentive policies, working capital, deficits and also, earned interest, if any.

DR. KINLOCH: Certainly, Mr. Chairman.

CHAIRMAN (Mr. Zoe): With that, we will take a break, as suggested by Mr. Bernhardt. Five minutes.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): I call the committee back to order. Are there any further questions or comments on chapter two? Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman, Doctor. The Auditor General has indicated that the department's attitude often conveys disrespect to boards. Would you consider that the failure to translate the trustee manual into Inuktitut conveys a certain disrespect?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, it might be interpreted that way but I think there was certainly no disrespect intended. Rather heroic efforts were made to carry out the translation. Perhaps I could ask Mr. McClelland to rejoin me here to give you some details of those efforts.

MR. MCCLELLAND: We talked to the Language Bureau in Culture & Communications in Yellowknife and they indicated that they would not be able to undertake such a project at the time. Remember we are talking approximately four years ago. We then talked with several of the boards, notably the Baffin Regional Health Board and the Keewatin Regional Health Board, the Baffin Health Board took the manual and commenced the translation of it but, eventually, we were told they were not able to finish the translation of it and so, the Keewatin Regional Health Board folks offered to have their Language Bureau do some translation work on it. Unfortunately, they also fell behind and were not able to complete the project.

Then, along came the changes with the Territorial Health Services Act which eliminated the Territorial Hospital Insurance Services Board and that meant a whole lot of changes would have to be made to the format of it anyways. So, we see this as one of the projects that we need to do, revise the manual for trustees, bring it up-to-date with all the events that have taken place, shorten it, simplify it and then have it translated, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Any further questions or comments, Mr. Bernhardt?

MR. BERNHARDT: Thank you, Mr. Chairman. Chapter two, I would like to know if Dr. Kinloch can provide you with a breakdown of Kitikmeot allocation of $4,858,664 and also I would like to find out the increase from $4.8 to $4.9 million.

CHAIRMAN (Mr. Zoe): Okay, I wonder if you can just provide that to our committee instead of...

DR. KINLOCH: That is what I was going to suggest, Mr. Chairman. We would be happy to provide you with the budget details.

CHAIRMAN (Mr. Zoe): Any further questions or comments? Mr. Bernhardt.

MR. BERNHARDT: Yes, because I am a former resident of Mackenzie, on page five, does Mackenzie include Aklavik? Does that include Fort Norman?

DR. KINLOCH: Mr. Chairman, Mackenzie includes those areas covered by the Mackenzie Regional Health Service. It does not include the locations you mentioned which are in the Inuvik Regional Health Board.

CHAIRMAN (Mr. Zoe): Yes, it is separate.

DR. KINLOCH: Yes, they are included in the Inuvik Regional Health Board totals.

CHAIRMAN (Mr. Zoe): Ernie. Mr. Bernhardt.

MR. BERNHARDT: Yes, Mr. Chairman, you mean Inuvik is separate? You have a board in Inuvik and one for Mackenzie. Is that two separate boards?

DR. KINLOCH: There are separate boards, yes, for Inuvik. There is no board at the moment for the Mackenzie. It is headed up by a public administrator. I would be happy to provide you with a map to show you where each community is located in relation to the boards.

MR. BERNHARDT: Thank you.

CHAIRMAN (Mr. Zoe): Dr. Kinloch, earlier on, Mr. McClelland made reference that you are doing a revision of the orientation training program. When is that going to be completed?

MR. MCCLELLAND: Mr. Chairman, the reference I made was that we needed to update the trustee orientation manual and program but I also referenced that we felt that it should be worked on in collaboration with the N.W.T. Health Care Association. In fact, Mr. Chairman, they may want to take that on as one of the projects to assign to their executive director. I mentioned before that in the south it is normally felt that health care associations take on the role of orientation and working with trustees directly rather than the Departments of Health. We feel it might be more appropriate to have them do that as a particular project. We would certainly work together with them. Obviously funds are going to be necessary and input from the department is going to be necessary. As an association that wants to promote trusteeship in the Northwest Territories we feel we could work collaboratively with them to do that job.

CHAIRMAN (Mr. Zoe): When do you anticipate undertaking this?

MR. MCCLELLAND: It will really depend on when the association is able to attract an executive director because that would be a fairly major responsibility for the executive director to undertake and get under way as a project. We certainly expect that it will be during this fiscal year, 1993-94. They have recruiting efforts out right now for the executive director but they have not made an appointment.

CHAIRMAN (Mr. Zoe): I would like to move along in the report. There were a number of comments which have already been made by the Auditor General and by Dr. Kinloch in our general discussions with regard to all the problems related to the lack of planning, etc. I think for those reasons I would like to suggest that we can move along to chapter four. Does the committee agree that we move to chapter four?

SOME HON. MEMBERS: Agreed.

CHAIRMAN (Mr. Zoe): Is that okay with the Auditor General's office? I think we have heard enough through our general discussions on chapter three to move along to chapter four. We will move along to chapter four then. Is the Department of Health going to give us a brief opening statement on chapter four? While you are at it, I see two new faces beside you can you please do introductions for the record.

Managing People

DR. KINLOCH: Yes, Mr. Chairman. Providing the brief introduction to chapter four is Barry Lange with the human resource division of the department and Maureen Morewood-Northrup, the acting director of nursing services division, who will contribute as appropriate in the presentation.

CHAIRMAN (Mr. Zoe): Please proceed.

Department of Health General Comments

MR. LANGE: Mr. Chairman, chapter four is managing people and I do have a few brief comments. In section 4.2.1, aboriginal employment equity, the Auditor General's report emphasizes the department's 11 per cent aboriginal representation. Positions in the department are specialized performing a consulting and policy development role. Individuals require field experience and expertise before filling officer level or higher positions. With so few aboriginal peoples trained in health care professions, it will be a long-term process to increase representation at the higher levels.

The department is pleased that the Auditor General's report acknowledges the development of the registered nurse program which will seek to improve access for aboriginal students. The department is also pleased that the Auditor General is complimentary on the success of the community health representative, which is the C.H.R. Training Program.

The use of traditional midwives is contingent upon the success of the Rankin Inlet pilot project and as the Auditor General's report indicates there may be an opportunity in the long run to blend both traditional and modern practices.

Section 4.2.2 refers to the health bursary programs and aboriginals. The health bursary supplements other forms of student financial assistance. With respect to the Auditor General's recommendation that consideration be given to applicants who have been turned down by other sources, this has been the standard practice for several years.

Section 4.2.3 is aboriginal employment in boards. The department is committed to increasing aboriginal employment and realizes that affirmative action cannot address the need for nurses and other professionals if aboriginal residents are not trained in this area. As previously mentioned the C.H.R. Training Program and the Nursing Diploma Program are two examples where this is currently being accomplished.

Section 4.3 refers to boards hiring efficiency. Boards now have their own recruitment function. Staffing delays should be reduced.

Section 4.4 refers to employee orientation. Cross-cultural awareness is a component of the G.N.W.T.'s generic orientation. The Advanced Nursing Skills In-Service Program, also known as A.N.S.I.P., also contains a five day cross-cultural awareness module. Since the fall of 1991, 32 community nurses have participated in the module. Additional programs are planned. The Stanton Yellowknife Hospital recently commenced cross-cultural awareness workshops as well and most direct patient care staff and medical officers have attended these. Cross-cultural awareness will be part of the standard orientation provided to all new staff at Stanton Hospital.

The H.R.M. division complements but does not duplicate the advertising efforts of the boards. Boards have indicated a desire to maintain this relationship.

Section 4.5 is monitoring staff performance. The completion of the staff performance appraisals is an area that requires greater attention.

Section 4.7 is reasons for staff leaving not known. An exit interview process for community health nurses has been implemented during the past year. Although turnover statistics have been kept on nurses, the exit interview data is insufficient for analysis to date.

Section 4.8 is training and development. Section 4.8.1 planning and funding and 4.8.2 inequitable training budgets. The Auditor General makes valid observations regarding the planning and funding of training and development.

Section 4.9 is human resource management system. The Auditor General makes the observation about the benefits of having a standardized integrated information system. Their recommendation is fully supported. That concludes my brief comments.

CHAIRMAN (Mr. Zoe): Thank you. Before I get into general comments does the Auditor General's office have any comments? If not, I will go to general comments on chapter four. Mr. Gargan.

General Comments

MR. GARGAN: I have comments on section 4.8 regarding the training dollars. The training for Advanced Nursing Skills In-Service Program is approximately $400,000. If you divide that amongst 365 nurses, you will have $1,100 per nurse. You also have doctors on contracts who have benefits of two to three conferences per year. This can add up to about $8,000 to $10,000. Can you explain why there is that discrepancy? Since the N.W.T. modules say that nurse practitioners should be taking the lead role in the delivery of community health services.

CHAIRMAN (Mr. Zoe): Mahsi. Dr. Kinloch.

MS. MOREWOOD-NORTHRUP: I would like to respond to that question. You are correct. The Advanced Nursing Skills Program is specifically for community health nurses. The community health nurses are only a portion of the 365 nurses. We have a total of 365 nurses in the N.W.T., that includes hospital nurses, public health nurses and community health nurses. The A.N.S.I.P. program is primarily for community health nurses, approximately 164 nurses. The amount would be approximately $10,000 per nurse.

CHAIRMAN (Mr. Zoe): I think the main point that my colleague is trying to make is that if you compare the dollars, particularly for the Nursing Skills In-Service Program, the amount of money averages out to about $1,100 per nurse. In contrast to that, if you look at the doctors, they are entitled to two or three conferences per year and the amount of money allocated for that is approximately $8,000 to $10,000 per doctor. I think my colleague is trying to ask why this is happening this way? The department is saying nurse practitioners should be taking the lead role.

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: It is an apples and oranges comparison. As Ms. Morewood has indicated, this represents an allocation for a much smaller number of nurses than is identified here. It is not the total expenditure that is related to the A.N.S.I.P. program. We take the point that there needs to be an appropriate allocation of training funds across the system, but the example which is used does not make that point.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: Well, Dr. Kinloch, make that point then.

MS. MOREWOOD-NORTHRUP: Perhaps we should say that the A.N.S.I.P. program actually has $704,000 allocated to it. With regard to the $400,000, I am not sure what that refers to, but I would like to restate that the A.N.S.I.P. program is not for the total 365 nurses in the N.W.T., but it is focused on advancing the scales for those nurses who are in a nurse practitioner role or community health nurses which is actually 164 nursing positions.

CHAIRMAN (Mr. Zoe): Can I ask the A.G.'s office what has been reported on page 26 of the report under 4.82? Mr. Martin.

MR. MARTIN: I would direct the question to Dr. Kinloch, whether it be 365 nurses or 165 nurses in which case he would just double up that figure from $1,100 to $2,200, the discrepancy is still there. If that example does not make the point, or there are other examples that might make the point better, then point to Dr. Kinloch.

CHAIRMAN (Mr. Zoe): Do you have a better understanding of what the question is?

DR. KINLOCH: Yes, seemingly there is a discrepancy in the training funds available to nurses and physicians, but I am not satisfied that that in itself is surprising or requires an explanation. The figure for A.N.S.I.P. is not the total cost of running the A.N.S.I.P. program. The total number of nurses is overstated and as a consequence the discrepancy is diminished rather dramatically. Recognize also that there are additional training opportunities available other than the A.N.S.I.P. program, including conferences and other attendances which have not been taken into account. We can certainly produce those numbers if that would be helpful to the committee, but I think the comparison made here does not serve the purpose intended.

CHAIRMAN (Mr. Zoe): Thank you. I want to ask a general question of the department with regard to section 4.2. The audit report includes a finding in section 4.2 that the department has not significantly increased aboriginal involvement in health care delivery, although this is a policy objective. Could I ask the department if they can explain the reasons why the department has been unable to develop a better record of aboriginal hiring?

DR. KINLOCH: Mr. Chairman, I think it is important that we should make the distinction between the department, the health system and the boards. If the question and the comment are directed to the central administrative offices of the department, the figure of 11 per cent is the appropriate one. As Mr. Lange has pointed out, most of the positions in the central area of the department are management policy and consultation which require normally not only technical and professional training, but also considerable field experience in order that the benefits of that will be available to those with whom they consult in the field. The aboriginal representation in the rest of the system is considerably higher. You will see in board proportions approaching 50 per cent. The reason for the discrepancy is that the boards have a much higher proportion of entry level jobs. I am not satisfied that the normal route to obtaining experience to take on a senior job is going to increase the number of aboriginal people in senior positions soon enough. The department intends to take advantage of programs that are supported by the Departments of Personnel and Education for training programs that would provide on-the-job experience gaining work for individuals who have acquired the technical and professional capability through post-graduate work, but who have not obtained appropriate field experience.

This particular program I am referring to has eight spots allocated to the central offices collectively for all departments, not for the Department of Health. We believe this might be supplemented so that individuals could undergo apprenticeship within the department to buttress skills they have acquired elsewhere and gaining the necessary experience so that they would be equipped to take on one of these senior posts. That is the route we intend to pursue.

CHAIRMAN (Mr. Zoe): I have a lot of hands up here that want to interject. Let me focus in specifically on headquarters then. I know for a fact that we have an Affirmative Action Program in place. I do not know what the department targets are or what the percentage is, but the last time looked at it they were one of the lowest of all government departments. I still think they are. I do not know what the human resource unit has been doing to date. The thing that really bothers me is that it appears that this particular section is not doing their job. Other Members here obviously know that, and it is not only in the field. At the local level there is some participation because we have C.H.R.s, interpreters, janitors and so forth. Their numbers are higher, but particularly in headquarters it is not. Especially in middle and senior management. The rationale that the Department of Health is giving us does not fly with me or any Members here. That is why you see a lot of hands raised here. I am not too sure what the problem is but, in my view, this particular department, even though it is a government-wide policy, I do not know exactly what they are doing. Maybe it is because of the overall plan that we do not have. The department does not know where it is going yet or where they intend to go. This whole section, particularly with aboriginal hiring, is not occurring in the department. I know that. I am sure you know that. Now, if I ask for a request for figures, how many people do they have at headquarters? I bet that there is not more than ten, or maybe not even that. Maybe five, three at the secretarial level possibly. There are none in middle management or senior management. I do not know what you are trying to tell me but to get more specific, can you give me some figures in relation to hiring of aboriginal people at headquarters.

DR. KINLOCH: Yes, Mr. Chairman, I would be happy to that. We may have some numbers to give today.

MS. MOREWOOD-NORTHRUP: Mr. Chairman, I previously made the comment that many of the positions at headquarters require seasoned professionals, people that have a fair bit of experience. Of course, our hiring practice is determined by the government's Affirmative Action Program, so that process is applied to any position that goes to competition. Many activities we are involved in have long-term implications.

Not long ago, the human resource management division of the Department of Health prepared a Health Careers Promotion Booklet which I think has been introduced in the Legislative Assembly outlining health careers. We are trying to develop an interest among the younger generation about the availability and opportunity of health careers. Hopefully, while they go through the school system, they will have an interest and then they will get the training and then the field experience that come into those higher level paying department jobs.

Other activities where it can be shown that we are successful is the C.H.R. Program. Prior to April, 1988, there were less than ten C.H.R.s employed across the territories. As of today, we have 43 C.H.R.s, either they are employed or they are in training to fill C.H.R. positions. Not a pay level 16 job, not a high level job, however, that is your entry level into the health care system with the development of the Nursing Diploma Program. Those are the potential feed stocks into the system to go further into the career ladder down the health road and, again, to fill those higher level paying jobs.

For specific statistics on headquarters, I do have a chart here that I can provide you with. We are one of the lowest, admittedly, I think for the reasons previously stated. Actually, the information I received is as of October 1992. I got it from the Department of Personnel. I will hand this out to the health boards and leave it for the committee Members. The heath boards are substantially higher than headquarters. The Department is the third lowest. Stanton has a quite low participation rate also. The lowest is secondary education. Overall, although headquarters itself is approximately 11 per cent, health boards are running better, so overall we have a 25 per cent aboriginal employee figure. The government as a whole has about a 35.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. It is an area that I have had concern with for some time. The chairman has said it quite clearly and there is a problem in this area. There are different perspectives how the department sees it and how the public sees it. Perhaps it is just as well that I was not allowed to say anything. They are using the same example the Department of Justice uses, we have a big organization but we do have a lot of native peoples and they are working in this one area. The Department of Justice does that with their Justices of the Peace. They say we have 200 J.P.s, but that is not the same as working in the department per se.

I can understand it takes a long time to become a professional, a doctor or nurse but there are other areas, including the health centres and the hospitals. It is, in fact, one. They are

two different things you know. To be a doctor is one thing, to be an administrator is another, but they are related.

To wait for people to migrate to the department is not the right approach. You have got to go out and head hunt. There is much to be said about, and I appreciate your comments about the health careers promotion booklet. I have heard a lot of good comments about it and it is a good thing but it is not enough to get somebody to read this book and say that is a good idea. You have got to get in the schools and encourage the kids that they must look at these things, to encourage the seeds to grow. Those seeds are not going to develop for another 20 years. In the meantime, do we sit and wait for those seeds to grow? No, we do not. We go out there and we head hunt. You have to encourage them monetarily or whatever way to get them into your department. You have got to set targets. You have got to be much more aggressive than the department is at the moment.

Just for an example, the affirmative action targets of 1989 were when the last affirmative action targets were set on page 21, second paragraph of 4.2.3. and it says, "We have examined the department's and boards' affirmative action efforts towards aboriginal representation. The department in Yellowknife submitted its first and only plan in 1989." True, it is just beginning 1993, but surely there should have been some results and you could have said, "Look, even that is not good enough." Maybe we have to focus our attentions on that. Now, of the senior people that are here, there is not one aboriginal person. If you go through the department and you look, it is hard to find. Other departments are doing it, and health fields and health administration must be attractive to people as much as M.A.C.A. and the Department of Transportation or other departments that northern people are migrating to. They must be doing something that is different. There is nothing scary about what you are doing. There is nothing distasteful about what you are doing. For some reason or other, people are not being attracted to it and I do not know why. Maybe it is, I hate to say it, but maybe it is a sense of, well, the Department of Health is here and we are here. You know, transportation is here, you know, as a perception only. I am not saying that this is the case but people look at the Department of Health as something that is unattainable.

Now I say this because I think, as a northern person born and raised and educated in the north, never thought that I would ever acquire a degree in social work because it was something that somebody else did. It turns out now that I have got it, it is really not that great, you know, not that big an achievement. The fact is, I did go out and pursue it and I think what I am trying to say here is that maybe people are saying I cannot ever attain that because there is all this experience that require doctors with degrees and such that I will never get.

There are areas that can be attractive, the technicians, that is a start. They do not seem attractive enough. I know from some examples that where you would want to attract a technical person, bursaries were cut off a little while ago. Those that are there are struggling to stay on and then they drop off because they cannot afford to live like that and they go to work as a plumber. You have to be able to get those people trained at a technical level and that will set the seeds with those already mature people to chase after something. I share that personal experience. I worked for many years before I got the bug to want to go to university to get that degree. There are a lot of mature people out there that you can attract to your department, but you have to go out and find them. You should use a program like Northern Careers did. It is going to cost a little money but in the long run, you can come back two years from now and say, "Look, this is what we have done, we have all these people working with us in these areas and we are training them in specific areas to do these jobs."

I may have gone beyond what I should, but aboriginal employment in the department has to go a step beyond what I think the department is currently doing. I know it is difficult in these tough economic times to do that, but I think that there are a few people at this table right now who would not support your initiatives when we can see something like we are trying to achieve now, much sooner than waiting for the seeds of your medical career promotion with the young students to develop later on. Go after some of the more mature plants and try and attract them then. By example, people will be attracted to join your department in either the professional or administration fields in health. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Any comments, Dr. Kinloch?

DR. KINLOCH: Yes, Mr. Chairman, I welcome Mr. Whitford's comments and I will act upon them. We are in the process of putting forward a proposal that would provide experience for individuals who have obtained training but are unable to acquire the appropriate placement for field experience. I would also like to note the proposal which is being developed for the creation of an R.N. program in the N.W.T. I would ask that we follow-up on that because it is not specifically an R.N. program, but rather there is a front end to the program which brings people to a point where they can enter a number of program areas in addition to the R.N. Maureen.

MS. MOREWOOD-NORTHRUP: This program is still under development, but we are looking at it as a type of access program into a registered nursing program. Currently those programs that we have in place when we are looking at those at the community level are the Medical Training Program and the Community Health Representative Training Program, that is a professional training program. We are hoping with the nursing program that we can have an access area portion of that where it is a program to enhance those prior professionals to another level into a professional program where they will come in and be able to meet the qualifications to then take the nursing diploma program. At the end of the nursing program they will also hopefully be able to transfer credits to go to a southern jurisdiction to be able to obtain their nursing degree.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you. I wanted to clarify a point I had made about my social work degree not being that great. What I meant was not that great in effort to get it. The point I was trying to make there is that it broke the ice to so speak. I was able to obtain that, and by doing that it set an example for at least three other people to do the same things. They pursued things they had never dreamed of. They had never dreamed of getting a degree because it was only something someone else got. I set an example, and I think what I am hearing is that if there were more nurses and doctors of native ancestry then there might be more native people pursuing that.

Look at the field of law, there was a log-jam there for awhile. There were no native lawyers and now there is a whole forest of them because somebody started the ball rolling. We now have five or six or seven lawyers who are of native ancestry in the north. It is the same thing with your medical profession. There seems to be a bit of a log-jam, if somebody breaks that log-jam, and you could find that right person, you might be pleasantly surprised. I just wanted to clarify that and use that as an example.

CHAIRMAN (Mr. Zoe): Maureen.

MS. MOREWOOD-NORTHRUP: I would like to pick up on two points of that. When I mentioned about nurses and ending it with a degree, we are looking at them going and working back in the communities and nurses can move on. The training that is provided in the nursing training program does not mean to say they have to stay with nursing. Within the Department of Health we have a lot of nurses who are in different positions, and they can move up into middle and senior management positions. We would not be preparing northern nurses just to stay at the community level or within the hospital. It is certainly a good training program to move into other areas. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: In order to serve at the headquarters level you do not have to become a doctor, a nurse or C.R. However, you must have the management skills and administrative skills. Those are the kinds of people we should be looking for. One of the things I found out through my experience in working with the health profession is that one of the greatest difficulties that I have found in regards to the hiring of people is in regard to their attitude towards human behaviour. I know in a lot of interviews we have had through the years that I have been involved with, one of the first questions a person will ask is how do you motivate human behaviour change? That is one area that has always touched me because it means that if you can force change then you get hired as opposed to your qualifications. I do not know whether that mentality has been broken as of yet, or are we still looking at people who can force change.

CHAIRMAN (Mr. Zoe): Any comments from the Department of Health? Just to note for the Department of Health, we are also calling in the Department of Personnel. We will be questioning them on how they have been working with your department. Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. Maureen, you said you were going to start a registered nursing program for the territories. What kind of entrance requirements will you have?

MS. MOREWOOD-NORTHRUP: In order to meet the national standards Grade 12 is required. We are providing up front an access program for anybody within the territories that will upgrade them to the level that is required to go into a nurses training diploma program. Access before the program will help to upgrade individuals who do not have that requirement.

CHAIRMAN (Mr. Zoe): Mr. Bernhardt.

MR. BERNHARDT: Mr. Chairman, I grew up in a convent and the education I received was the best that this world could offer. I received my education from the nuns and the priest. To my belief, the money that we are putting into the education system now and the results that we are seeing do not match. The education that the priest, nuns and missionaries gave the north will never be equalled. For the simple fact kids have no discipline at school or at home. To hear what you are saying about getting entrance requirements, I think you have to start at the elementary level these days. Do not start by saying "I will drop out of school for a while and I will be go back as an adult." We have got to have matriculated students right from the start. That is what I call good quality education, not nepotism. The products we are producing right now do not equal the national standards. We, as natives, have just as much ability to obtain whatever we want. Yet, when we attain that goal, we are not even guaranteed a job. The bureaucracy is out of hand. It is not a fair government. It has become a power struggle of us trying to dominate our own people instead of you guys dominating and telling us what to do. That is why the section of human resources is very important to our native people. We need you fellows to give us a hand, and not for fear that you will lose your job, because no one lives forever. I just want a fair and equal opportunity for our people so that when they make it, they are guaranteed a job. It should be written somewhere in your manuals that if you come under affirmative action that you will have a job waiting for you. Even if it is at the expense of grandfathering off of someone.

I would like to ask Dr. Kinloch the usual length of stay for a nurse in a community? Can they stay there forever? Do you say after two years you have to go out for a year and get a refresher course, or are they allowed to stay for more than five years?

CHAIRMAN (Mr. Zoe): Thank you.

MS. MOREWOOD-NORTHRUP: Nurses are hired into indeterminate positions in which there are no time factors. We do have nurses who stay a year, five years and seven years. There is no actual time limit. For nurses who have been out in the isolated communities for any length of time we certainly encourage them to take courses and upgrade their skills to be able to continue working in that setting.

CHAIRMAN (Mr. Zoe): Thank you. Ernie.

MR. BERNHARDT: In my community I am getting complaints because our nurses have been there too long. They have become complacent. I will give you an example. My dad, who is over eighty, went to the nursing station last year because he could not pass water, he told the nurses that and for one month they made him suffer. It went into the second month and finally my dad had the courage to go back and sit there until the nurse saw him. It is a good thing I was not an M.L.A. then. They finally sent him out to Edmonton and the doctor said to him, "you know old man, you only had four hours to live." "How come they let you suffer at home?" That is the kind of thing that you people have to hear. It is not fair and I think some nurses are in the communities too long. Their attitudes change. For the money we spend on the nurses and for the services that we are receiving, it is not fair. There are other examples I could give you, but I am not here to criticize everything.

CHAIRMAN (Mr. Zoe): Thank you. Before the department makes any comment, Mr. Dubois the Deputy Auditor General has to catch a flight this afternoon. I believe Mr. Simpson is also going to be joining you, but Mr. Martin I understand is going to be staying for the next day or so. I know you are very busy, but before you go do you have any final remarks you would like to make, Mr. Dubois, before we see you again?

MR. DUBOIS: That last word before I go out into the cold? No, I just hope that everyone will continue on positively to see solutions to a lot of these problems the next time around. I just want to repeat again that we understand the complexity of the issues and we know that some of them will take time because they have to do with attitudes more than just systems alone. That is why we kept stressing the need for all the stakeholders to sit down together and agree on what the health model should be for the Northwest Territories. If everyone agrees to what it should be then everyone will start putting all of their efforts in the same direction and hopefully this will bring solutions to all the problems that are being discussed at this committee. Thank you very much and I hope to come back soon.

CHAIRMAN (Mr. Zoe): I am sure I will be keeping in touch with you and Mr. Simpson on our report. We will give you a preliminary draft report by the end of January or sometime in February. We still have our second phase of travelling to do in Rankin Inlet and Inuvik. We will see you then, and have a safe trip home.

Dr. Kinloch, you were just about to respond to the comments that Mr. Bernhardt made. Would you like to comment now?

DR. KINLOCH: Yes, Mr. Chairman. I was just going to respond to the comments regarding complaints about perceived deficiencies in patient care. We encourage that complaints be made. We would like to see them closer to the time when the problem occurs and not so long after the fact. It is important that we keep in touch with how people are perceiving their health service. We have a procedure for dealing with complaints. We try to make it known to people and we do it regularly because we know people forget. We would certainly encourage this.

CHAIRMAN (Mr. Zoe): Mr. Bernhardt, any further comments or questions?

MR. BERNHARDT: Thank you, Mr. Chairman. Maureen, can I get a list of your entrance requirements and the subjects that are required to get into your program?

MS. MOREWOOD-NORTHRUP: Into the access program?

MR. BERNHARDT: Yes.

MS. MOREWOOD-NORTHRUP: That is currently being developed with Arctic College, so at this time we do not have a list of qualifications. The access program will allow someone who does not have their grade 12 but has experience in the health field or may be at a lower level than the grade 12 which is required nationally to get into a nursing diploma program. They can enter into the access program to be able to upgrade themselves to a grade level to get them into the nursing diploma program. At the moment, I do not think Arctic College has set any definite qualifications to enter into that access program because it is currently under development.

CHAIRMAN (Mr. Zoe): It is still under development, Mr. Bernhardt, in conjunction with Arctic College.

MR. BERNHARDT: I would like to see what they have done so far.

CHAIRMAN (Mr. Zoe): Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. Just to enhance what Mr. Bernhardt has stated, I would like to point out that we have some good nurses in our communities. Those nurses who are more popular seem to be transferred to other communities and they seem to come and go as quickly as they are needed in other communities. For example, we used to have a very good nurse in Spence Bay and Pelly Bay. I am speaking of none other than Stella, who is sitting back there. She was one of the popular ones and I do not know why she left the area. There are other nurses who are not very popular in the community who seem to stay on forever. Mr. Chairman, I would like to know if the health care system has anything in place whereby the department and the officials can evaluate or monitor the nurses in the communities, by the same token listen to their staff complaints and concerns, and also hear complaints from the concerned residents in the system. If so, how often do you evaluate your employees within your department. I am speaking of the health profession like nurses. Thank you.

CHAIRMAN (Mr. Zoe): Thank you.

MS. MOREWOOD-NORTHRUP: Nurses, the same as any other employee within the government, do have performance appraisals done on a regular basis. There is usually initially a probationary performance evaluation done on the nurse within her first six months in the community, hospital or public health unit, and then the usual annual performance appraisal. Unless there are specific complaints that are brought to the health board that serves that community, it would be done by the nursing officer at the regional health board. Unless comments or concerns are brought from the community to that person then we would not be aware there is a problem with that nurse and that she is not suitable or she is not reacting in the way that she should to the clients she is serving in the community. Certainly her performance appraisal is on her clinical skills, there are chart audits that are done in each of the community health centres, the nursing officers do visits and they interview the nurses and do chart audits to see that the nurses are following the appropriate assessments and treatments.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions or comments? Mr. Gargan.

MR. GARGAN: In regard to what Dr. Kinloch mentioned, did you say you hired a person who is a mediator to work on resolving some of the differences between the boards and the department? I am not sure if you said that, but I am just wondering how soon do you expect him to finish his job and be consulted on it?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: We put out a request for proposal to three consultants who seemed to be very suitably qualified to act in this role. We are going to review the proposal that has been received with the steering committee and would then let a contract if the proposal is acceptable to this individual to moderate or chair the discussions leading to the M.O.A. We expect that would be completed by no later than May, 1993.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: I have one final comment in regard to the human resource management division within the department. What is your general assessment of the function performed by this division? Is it necessary or is it redundant activities? What should it focus on?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, we believe the division performs a useful function. I think the discussions this afternoon focus on what the preoccupation of that should be. We expect to pursue some of the suggestions we have heard here this afternoon.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I spoke briefly about the bursaries, making training and acquiring the skills to be involved in health care attractive. There are a lot of constraints in the north, as elsewhere, and people have to be able to live and they need a certain amount of income in order to pursue these. In the area of the health care bursary fund, the Auditor General has made some excellent comments and recommendations about the health funding. However, when you read on it shows that the department seems to contradict some of the findings. The report recommends that the department should ensure that eligible applicants are denied funding only if they are able to secure support from other sources, not because they may be eligible for other funding sources. The department states that with respect to the N.W.T. Bursary Program the department has been following the recommendations. Eligible applicants were denied funding assistance only if they had received alternate funding. There seems to be a contradiction there, and I was wondering if there is in fact a contradiction?

MR. LANGE: I cannot answer your question, Tony. The Health Bursary Program has a committee that makes the selections as to whom is going to be allocated funding. The Department of Education sits on that committee. A normal source of funding for students would be typically through student financial assistance. When the Department of Education sits on our committee they are able to tell us whether or not a person will get funding from the Department of Education. If they can tell us during the selection process that the individual process will not get funding through student financial assistance, we are then able to give their application consideration. In my opening comments, I did say that we have been following the Auditor General's recommendations for quite some time.

MR. WHITFORD: So they are not denied bursaries simply because they may be eligible. You check with the Department of Education to see whether or not they are receiving it or they will receive it. The Department of Education says, "yes, this person is eligible and will receive it" then you do not duplicate it.

MR. LANGE: That is correct, Mr. Whitford.

MR. WHITFORD: I realize that you may be eligible for these types of funds, but if you look at the Bursary program it is spread thin and in fact may not be quite enough to sustain the circumstances of individuals. I may be out of line by saying that there is a need for duplication. Often times you do not want to say the person qualifies for both so they should get both, but there are circumstances where you do have a high flyer with special needs that may require that exceptions be made to ensure that you get success in the end and the person is not required to drop out because he cannot afford to live. I do not know whether you run into situations like that, but I have heard of them. You have answered the question in that you do check this out right away, but there appeared to be a contradiction.

CHAIRMAN (Mr. Zoe): Regarding the bursary, in 1991-92 we committed $35,000 to this program. Out of 162 applicants, we approved 103 of which five were aboriginal people. My understanding of this program is to promote people that want to get into the health field, hopefully to utilize them within our own health system. My question to Mr. Lange is, are these five aboriginal people in our system somewhere? Even the 103 that were approved, are they in the health system?

MR. LANGE: Typically about half the people that we approve funding for are employees in the health system and it is correspondence courses that they are taking. Of the other half, I cannot honestly say exactly have stayed in the health care field. There would certainly be some.

CHAIRMAN (Mr. Zoe): Are we monitoring all the people that are interested in getting into the health field as to where their career path is going? Obviously, they must have applied to get into the health field, otherwise they would not be applying for money.

MR. LANGE: Yes, Mr. Chairman. We do monitor our successful people through the health program. They are required a service pay back. That is they are required to give three months of service for every $750 of funding that they receive. Once they complete their program, we are in close contact with them to say "how about the service pay back now?" We do monitor them for a period of time to see that we are getting paid back. After they do their service pay back, we do not pay a lot of attention to them. Hopefully they are still staying in the health care system as their chosen career. We certainly monitor their service pay back to see that we are getting our service.

CHAIRMAN (Mr. Zoe): Mr. Lange, you indicated earlier that you were not sure of the 103 that we approved in 1991-92. You indicated that at least half of them were government employees, and the other half were others that were hoping to get into the system.

MR. LANGE: Right. I have a detailed record as to who has applied and when. Since 1988 there have been 103. For

example, there is 26 this year. I could pull the records to see if they were employees or not, but it is about half. The ones that do get supported are required to give service pay back once they complete the program.

CHAIRMAN (Mr. Zoe): Earlier on Ms. Morewood talked about A.N.S.I.P. Could our committee get the breakdown for the training dollars on that plus other expenditures in training initiatives? You said there are other training dollars that are attached and we would like to get that information. If you could also provide a summary of the standard contracting arrangements for doctors' training, including doctors that we have we have a contract with. There are only two or three that are direct employees of ours, so somewhere in our contract there must be a provisions to authorize their training. We would like to see that document. Anything further? If not, I would like to ask Dr. Kinloch another question. Mr. Bernhardt, go ahead.

MR. BERNHARDT: Thank you, Mr. Chairman. Maureen or Barry, has the flow of nurses from the British Empire stopped coming into the territories? To my knowledge they were really good nurses. I am not condemning the Canadian nurses, but these other nurses had something special. They knew how to treat the clients with care, dignity and respect. They had something to give you a good caring feeling when you went to the nursing station.

MS. MOREWOOD-NORTHRUP: I would be delighted to answer that as a British trained nurse who has worked in the north. Unfortunately the immigration laws of Canada now are not allowing us to recruit directly from Britain. The only other way that we are able to obtain nurses from overseas is if they actually immigrate to Canada themselves and then apply for one of our positions in the north. That is quite unfortunate and I think part of it with the British trained nurses is that they had an extensive background in maternal and child care, which is one of our highest programs in the north.

CHAIRMAN (Mr. Zoe): Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. Maureen, I think they should hire a boat and come in as boat people and then we will accept them.

CHAIRMAN (Mr. Zoe): Thank you. Any comments? If not, I would like to ask another question pertaining to nurses. In section 3.2 of the report it indicates that there are problems with the allocation of human resources within the health system. Apparently there is a critical need for an assessment of the nurse work load. This initiative has become stalled within the department. In the management response you have indicated that most provinces have not been able to develop appropriate work load measurement tools.

Yesterday, Mr. Martin from the Auditor General's office provided a somewhat different viewpoint as indicated in your management response on this important issue. I noted at that time that Dr. Kinloch was shaking his head when the Auditor General's office was responding to us. I wanted to bring this up now when we were discussing the management of human resources. I want to know if you would like to clarify or revise your management response which you have given to us in this area. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I think it is a problem with semantics that the difficulty it appears is in the application of the tools rather than in the development of the tools themselves. I think that was the distinction that was being made by the Auditor General. I do not think we have any problem with that. Maureen can certainly amplify those remarks because she has been directly involved in this exercise.

CHAIRMAN (Mr. Zoe): Any additional comments to make?

MS. MOREWOOD-NORTHRUP: I think it is quite right. It is the application of the work load measurement tool. Whatever is in the south is difficult to apply to our unique situation in the north and that is why we are looking at developing our own work load measurement tool taking into consideration the demographics, the population, the different age groups, the gender and the different problems that we have to face as nurses in the communities and the type of role that nurses have to play in that community setting. Certainly community nurses in the south have an entirely different role to the nurses in our isolated communities. Therefore, a work load measurement tool would have to be adapted to suit the needs of the nurses role here and the population that they serve.

CHAIRMAN (Mr. Zoe): Dr. Kinloch, in addition to the nurses work load what do you see as the other main priorities for work load assessment within your department?

DR. KINLOCH: Mr. Chairman, I think the whole issue of work load assessment itself needs to be reviewed in terms of the appropriate application to our unique circumstances. One of the difficulties is that we are frequently operating in very small units where the number of persons required by the application of many tools would be less than one. However, it is not possible frequently to bring people in in numbers less than one. So, the application of some of these tools is not particularly helpful. What is the critical element on deciding what is the appropriate work to be carried out by people with particular skills and qualifications. I think there is much more to be gained in that assessment than in pursuing tools which might be applied to give some uniform number of staff positions in various locations. For example, the increased delegation of functions from physicians to nurses, from nurses to perhaps as yet an unnamed new health care worker, could have a profound effect on how the system operates. I think those are some of the issues that we are going to be exploring in the near future.

CHAIRMAN (Mr. Zoe): Thank you. Again, there is always the question of time frame. I understand that it will be nice if you can do all those type of assessments but what type of time frame would you be looking at? When are you going to be developing all this? When would we be able to see the actual results?

DR. KINLOCH: Mr. Chairman, this is one of those elements that should be part of the continuing discussion on what model is going to be adopted for the future in the Northwest Territories. This is not something that we should design in isolation because it will require a consensus and an acceptance of the workers of the future for the system. If people will not accept them as qualified providers of care then we are doing a disservice by pursuing it. What we are

attempting to do is describing the system as we see it now, "The N.W.T. Way", indicating what we see as generally profitable avenues to explore and then seeking a consensus on that or seeking an alternative approach that would be deemed preferable by many people. On the time frame, we will begin this year.

CHAIRMAN (Mr. Zoe): Good. In speaking about "The N.W.T. Way", over and over your department stated that "The N.W.T. Way" is an illustration of what we are doing and what we have done for the past several years. You have been saying that for the past two days. In your opening remarks on page nine you are saying that the sixth point is a goal for the future. That is not consistent. The fact of the matter is that ethnic, cultural and linguist groups have not been involved. There may be individuals on certain boards that think they are involved but the boards themselves feel they are not being allowed to manage the health system. The Auditor General's report states that the aboriginal hiring performance has been inadequate.

Dr. Kinloch, I would like to ask you to comment on two things. Firstly, on the inconsistency in presenting the six points as something we have been doing and secondly, your plans for increasing aboriginal involvement in the N.W.T. health system. Not a recognition of the goals, but your specific plan. Can I have you comment on those things?

DR. KINLOCH: Yes. Mr. Chairman, the six points represent the characteristics of "The N.W.T. Way". Some of those are firmly entrenched, others are not and, clearly, the number six is not. It is a characteristic of the system that we intend to develop and pursue in a manner consistent with policies which are adopted for the G.N.W.T. as a whole in relation to affirmative action, but, also, in relation to our desire that there should be appropriate representation of the aboriginal peoples in all of the categories whether it is as trustees in boards, as providers of care, or as teachers. That is what we are working toward.

The other elements of "The N.W.T. Way" have been there for varying lengths of time. I think I indicated earlier that number five came about as a result of the 1988 Transfer Agreement or, actually, earlier than that but as a result of actions that were taken by the G.N.W.T. to improve the model that had been initially implanted by Health & Welfare Canada back in the late 1950s.

So there is a core of elements of "The N.W.T. Way" that were brought in initially by Health & Welfare Canada, including those which have been slowly added over the years and there is number six which has been most recently added as a statement of intent. I expect that this description will change every few months as we come to a consensus on how the statement should be better phrased or as to the priority that ought to be attached to these individual elements, taking into account where we are now and what opportunity there is to move forward.

In terms of specific plans to increase the number of aboriginal people in the health care system, there is no comprehensive plan but there are elements of a plan. You have heard one of them in relation to the R.N. program but I think, more importantly, in relation to the access program because the access program can take folks who have less than a high school graduation to the point where they can enter the C.H.R. Program, Ophthalmic Technician, the R.N. program and others. The aim is to overcome the difficulty that many students have had in making the leap not only into a training program but one that takes them far away from home.

CHAIRMAN (Mr. Zoe): As you realize, Dr. Kinloch, it is already five after and we have not concluded with the balance of the chapters. I was hoping that we could get through it today but it does not look like we will. There are other issues in the remaining chapters that our committee wanted to question your department on. I will get back to the department and let them know because we have some other groups appearing before us tomorrow, specifically, Stanton and St. John and our committee will discuss when we are going to call you back. It may be tomorrow to finish off and then call in other government departments, but I do not know what the committee wants to do yet. Since this concludes our agenda for today, we may be calling you tomorrow, after we deal with those other two agencies. So my staff will be in touch with you. We will adjourn until 9:00 a.m. tomorrow morning. Agreed?

SOME HON. MEMBERS: Agreed.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PUBLIC MEETING

PROCEEDINGS

FRIDAY, JANUARY 8, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

FRIDAY, JANUARY 8, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Other Members of the Legislative Assembly In Attendance

Mrs. Jeannie Marie-Jewell

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

Invited Witness

Mr. Michael Martin, Public Services Commission

Department of Health

Dr. David Kinloch, Deputy Minister of Health

Ms. Maureen Morewood-Northrup, Acting Director, Nursing Services

Ms. Stella Van Rensburg, Director of Health Legislation and Policy

Ms. Linda Jackson, Director of Health Insurance Services

Mr. Darrell Bower, Director of Finance and Administration

Mr. Don Olenek, Capital Equipment Officer, Capital Planning and Maintenance

Mr. Barry Lange, Senior Human Resources Planner

Stanton Yellowknife Hospital

Mr. Don Yamkowy, Chairman of the Stanton Yellowknife Hospital Board of Management

Ms. Lynn Olenek, Executive Director

St. John Ambulance

Mr. Brian McCluskey, President of Territorial Council

Mr. Warren St. Germaine, Senior Vice-President of Administration

Mr. Don Irwin, Executive Director

Mr. Max Rispin, Territorial Commissioner

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

JANUARY 8, 1993

Members Present

Mr. Bernhardt, Mr. Dent, Mr. Gargan, Mr. Koe, Mrs. Marie-Jewell, Mr. Ningark, Mr. Whitford, Mr. Zoe

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): Good morning. Yesterday we concluded with the Department of Health, however we did not conclude the whole report with them. We have deferred them because we have made arrangements to hear from two public witnesses this morning. One is the management from the Stanton Yellowknife Hospital, and the other is St. John Ambulance will be appearing before us this morning. After they appear we will continue with the Department of Health to conclude with them. At this time I would like to call upon the representatives from Stanton Yellowknife Hospital to come forward to the witness table to make their presentation. For the record would you kindly introduce yourselves.

Stanton Yellowknife Hospital Opening Remarks

MR. YAMKOWY: Mr. Zoe and Members of the Standing Committee on Public Accounts I am Don Yamkowy, Chairman of the Stanton Yellowknife Hospital Board of Management. I have with me Lynn Olenek, executive director of Stanton Yellowknife Hospital. We wish to thank the committee for extending the invitation for us participate in discussions concerning health delivery in the Northwest Territories. The Stanton Hospital Board of Management is comprised of seven appointed members plus the Chairman. The board of management of Stanton directs the delivery of services to peoples of the western Arctic both in Yellowknife as well as their communities.

Health care in Canada is under a great amount of review, challenge and debate. Future direction of health care nationally and internationally has been debated by all levels of government, agencies, health educators and the public to name a few. Through all of these debates and reviews we must not neglect to consider the needs of the acceptance of our services. We must always ask the question, "What we are doing make any difference to the health of our consumers?"

The Auditor General's report reviews a number of activities of the Department of Health, other departments and health boards. Though we do not live in ideal world we must recognize we have the foundation of a health system many across Canada see as the most viable option for their systems to move towards.

Just this past week in the Globe & Mail an article was written on the uniqueness and success of a pilot project whereas the primary health care model was being applied to rural Newfoundland. The author of the article was reporting the success of this project in delivering health services to the population. The rest of Canada is now finding a structure of health care delivery which we have had in the Northwest Territories for many years. It is not to say that we should sit and neglect any further improvements to our system, we should not lose sight of the goal of our system as we work towards the improvement of it.

The Auditor General's report provides numerous recommendations for possible ways to improve and strengthen our system. In our collective efforts for improvement we should not dismiss the importance of addressing the needs of our consumers in this process. In our comments to the committee this morning we have identified what we feel are the key issues which require attention.

Regarding roles and responsibilities for hospital and health boards, the process of developing M.O.U.s which will provide a clearer understanding of the board's role and responsibilities and those of the Department of Health is a critical activity to move forward on. We see this as a positive step in developing a clearer vision of a health care service organization. Having this sorted out will address many of the areas of confusion which have been identified in this report. The expectations of this process is that it will be a collaborative one. This type of approach will assist in the development of a positive working relationship.

Regarding planning, although there is an OPPLAN process internally within the G.N.W.T. and the Department of Health, health and hospital boards are now entering the process. Stanton Board is nearing the completion of the strategic planning process. This is a process which the board has felt it has the responsibility to drive. This is not an easy process but it is a process which is definitely needed if boards are to manage and impact change on the long-term. What is lacking is an overall plan from the G.N.W.T.

With regard to health care, boards need clearly defined and measurable health outcomes. The recent turnover of Ministers in the Health portfolio had blurred the strategy for health. We sincerely hope our current Minister will be able to weather the storms of the Assembly and have the time to work towards defining these goals.

Regarding information and financial systems, we support the comment in the report which indicates resources between the Department of Health and Finance be pooled and strongly recommend that these come under the direction of the Department of Health. We suggest that the Department of Health work with the boards to develop integrated, standardized, financial and patient information systems which

would meet both the needs of the board and the Department of Health. Without leadership from the Department of Health, especially in the areas of patient information systems, boards will develop stand alone systems which would only meet their needs and which will not result in regional-wide data for long-term planning. This needs to be made a priority and supported with dedicated resources committed to achieving these activities in a timely fashion. Without achievement of these activities we will continue to make decisions without the supporting data and we will be unable to verify the impact of our decisions. By having systems which are structured to provide the data we need we can move away from the detailed control orientated process we are all plagued with and which irritates all of us and utilizes inappropriate amounts of staff time.

Regarding the surplus retention policy, there is need to develop the surplus retention policy which will permit boards to have some flexibility in funding special projects. In the current system we are trying to work towards financial stability but there is no reward in the present system for doing so.

Regarding board appointments, this is an area of concern which our board has experienced. We recognize that this is in part a function of the current process of government as a whole but would like to request if not a change then at least an awareness of the impact of the process. The length of time which it takes for an appointment to proceed through the system is extreme. The length of time creates problems when only a few members remain to carry on the functions of the board. This summer we had a board that was decreased from 15 to four and so the function of the hospital moved to a crawl until we had four more people appointed.

Regarding aboriginal awareness, the Stanton Board of Management has recognized a need for further cultural awareness and sensitivity in both services and programs of the facility. To this end the senior management team is working on a cultural program for the facility. Eighty employees from various departments of our facility, including physicians, attended a cross cultural workshop in December. We are planning to structure a program which will be delivered on an ongoing basis within the next few months. All staff will be required to participate. Also, the board has put forward a proposal to restructure the Stanton Yellowknife Board to better reflect the regions and the people to whom it provides service. The objective is to provide a means for direct input and participation by regions and boards where our consumers come from.

The board is investigating the establishment of a board aboriginal services review committee. The mandate of the board committee would be to examine programs and services we provide at Stanton and through Stanton to ensure that we are sensitive to the issues of the various peoples to whom we are now delivering services. In the last year or so our hospital has changed from a Yellowknife based hospital to a referral hospital for the western Arctic. Our population base is not Yellowknife any more. It is 50 per cent from the communities in the western Arctic and 50 per cent from Yellowknife. So, we have to change also.

In conclusion, we appreciate the opportunity to be here with you today and to express our comments on the report. The short notice of your invitation may be reflected in the completeness of our response. Lynn and I are quite willing to answer any questions that you may have in regard to the areas of the report we did not comment on specifically. Thank you.

CHAIRMAN (Mr. Zoe): Thank you, Mr. Yamkowy. A very well thought out presentation even though you were given short notice. Do Members have any general comments? Mr. Koe.

General Comments

MR. KOE: Thank you. The audit makes reference to "The N.W.T. Way" and there were questions to other witnesses during the week on this. What is your understanding of "The N.W.T. Way" and do you feel that it is a model on which to base new initiatives and development at Stanton?

MR. YAMKOWY: I came on board as a Chairman of Stanton after "The N.W.T. Way" proposal was developed and put forward and I am working on that model. I feel Stanton is committed with "The N.W.T. Way" and we are working on that process. I do not have any criticism for it. I guess I am pragmatic and I look at it and I say, that is the best way that we should provide services to the territories.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: Thank you, Mr. Chairman. Chapter two also makes statements about relations between health boards and the department and I quote from the audit report, "There seems to be a lack of trust in one-way paper flow, poor communication and inappropriate controls by the department. In our view, what should have been help in monitoring has turned into control." Are these statements by the auditors accurate from Stanton's perspective?

MR. YAMKOWY: I would say they are. In the recent past, there has been line by line control on our budget by the department staff. We are bulked in, I guess, as a hospital with all the other health boards and hospital boards but, because of our sophistication and the degree of skills of our chief executive, of our financial people and that, we feel that we have the expertise to do management control, financial control. Some of the policies that have been coming out on line by line budget control takes away that responsibility from what we feel are very highly skilled staff that run a very good facility and run a facility with good managerial control. We are captured in an overall policy that may be there because of some other boards or some other institutions so, yes, we are hindered by some of the detail.

CHAIRMAN (Mr. Zoe): Mr. Koe.

MR. KOE: The auditor also mentions, or talks about, the need to build a partnership between the boards, departments and stakeholders. In your view, what is the best way to achieve this partnership and what steps should be taken to do this?

MR. YAMKOWY: Well, a partnership means that there has to be two people in the decision-making process and two people have to agree with the outcome and that is what we are hoping for. We are hoping for a relationship with the department that is a collaborative one where we can sit down and discuss things so we do not get directives that come down so we are

a part of the decision. I think that is the first step that we have to solidify. It is working towards that now. We have a good relationship with the Department of Health. I think we have the trust.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Koe.

MR. KOE: In terms of the M.O.U. or M.O.A. that is in the process of being developed in the interim report of the Standing Committee on Agencies, Boards and Commissions. We commented on that initiative and I see in your presentation you have commented that you see this as a positive step in clarifying relationships between boards and the departments. I would like to get a feel from you as to what your assessment of this process is and how it is proceeding. Do you feel that the Stanton board is participating as a full and equal partner, as I mentioned yesterday, or is this another top down exercise?

MR. YAMKOWY: Well, I am pleased that the department has come out with the initiative of a Memorandum of Understanding to clarify the rules and the roles between the board and the Department of Health but, when it was presented at the N.W.T. Health Care Association, it was the first we heard about it. So we were not a part of the creation. Nor, up to now, are we a part of the progress of it. The Department of Health is still directing it as a top down operation. They are hiring a consultant or a project manager, I do not know what they are calling it, so from the initial presentation given to us of what the outline of the M.O.U. is going to be, we have not been participating in anything as of yet.

CHAIRMAN (Mr. Zoe): That is very interesting. Any further questions, Mr. Koe? Mr. Gargan.

MR. GARGAN: Thank you, Mr. Chairman. Mr. Chairman, on section 2.7 of the Auditor General's report, it suggests that many of the financial monitoring functions within the hospital and health facilities division and the health insurance division should be consolidated within the finance and administration division of the Department of Health. What implications would this sort of organization have for you? Would it become easier to deal with the board if that were the case?

MR. YAMKOWY: If I can ask our executive director to answer that.

MS. OLENEK: I think what we would see happen out of that process would be just less people to go through. It would consolidate and speed up requests when working through the process and you would have everyone sharing the same information base which is really important in decision-making. So I think it would facilitate that process.

MR. GARGAN: So you support it then?

MS. OLENEK: In the general process of the comment the way the comment is written, I would not say I have a sense as to how, but the concept, yes, we would support.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: Thank you, Mr. Chairman. Mr. Chairman, on section 2.8, the section comments on communications with the boards. Are there areas for improvement and what kind of review, if any, would be useful in addressing the concerns outlined by the Auditor General?

MR. YAMKOWY: Well, we feel that the Memorandum of Understanding is the key issue there. To improve communications between the Department of Health and the boards, we feel the M.O.U. will put down the rules, the perimeters, the understanding and even the process we will be going through when we start to work on the Memorandum of Understanding will clarify our roles then when it finally comes out. We will know what our roles and responsibilities are. I think that is key. That is why we are saying we would really like that to go ahead.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: Mr. Chairman, on chapter 2.11, the Auditor General is very sharply commenting on the lack of resources for board training and development. What are your views on this matter? Can you give us some examples of the sort of training and development needs which presently exist on your board and outline how efficiency and effectiveness could be increased if these needs were met?

MR. YAMKOWY: That is a very key question. Our board is struggling with that now. How do we provide education to the members, because we have just had three or four members appointed to our board and, also, how to do the evaluation to find out whether the board is functioning properly in our own eyes, and the board has had some discussions on this of how we should do it. We have board packages that go out. We try to send our board members on outside conferences but there is really no defined board orientation for members that the Department of Health or the Stanton has. We are trying to develop one and we are wrestling with that right now and we are wrestling with, also, board evaluations of how effective the board is. We have, in fact, as of last week, talked about a two-prong process and the two-prong process would be: one, that we do a self evaluation; and, we would ask a third party to come in and have a look at it to give us advice to say we are functioning properly or here is what we should improve on. So that is an area that, we, Stanton has to improve on and the Department of Health, of course, would like guidelines on it if they could provide some help.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions, Mr. Gargan?

MR. GARGAN: Yesterday, Mr. Chairman, the director of hospitals and health facilities explained to the standing committee that there are differences between boards of governance and boards of management. What is your assessment of this distinction?

MR. YAMKOWY: Are you saying boards of health and boards of...

CHAIRMAN (Mr. Zoe): Board of governance and boards of management.

MR. YAMKOWY: I cannot answer that. I am unfamiliar. I am under a mandate as a board of management and I have the criteria that I follow and the board follows and I do not have the answer of what the difference is.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions, Mr. Gargan?

MR. GARGAN: Yes, Mr. Chairman, just one. One of the things that you said was that political developments have been mentioned, you are the second person that said that it had been mentioned in the Globe & Mail. On page five, I am interested in what you said about hoping that the current Minister will not be able to weather the storm. It is interesting that if things were working out the way in which they would be, I do not see the Ministers as having any problems. It is interesting that you should make that kind of a statement.

MR. YAMKOWY: I have only been the board Chairman for about a year and a half, I have had various Ministers but not for very long. It is like a child and parent situation where you are looking for guidance and leadership from the elder and when the players keep on changing there is a pause where you are waiting to see if there is a change in the strategy of health or if there is a redirection. We have had a lot of players. I am not criticizing how the appointments or how the Ministers are chosen, I am just saying that we have had different faces for a period of time and that has blurred the vision.

CHAIRMAN (Mr. Zoe): To follow-up on what my colleague is saying the operation itself of the Department of Health and all the operations should not be affected by what happens at the political level. The overall operations of the Department of Health and the boards should not be affected dramatically. We should be able to switch the Minister everyday and that should not affect the operation of the department or the boards. I think that is what my colleague is alluding to. By the changes occurring at the political level Stanton is suggesting that it appears to be causing problems at the senior level within the Department of Health. This is the way I read your statement.

MR. YAMKOWY: Also during that period we have had a change in the senior bureaucrats in the sense that we had a change in the deputy minister. We are going through a process of the strategic plan. We are going through a process right now of a functional review. The hospital is changing from a Yellowknife based hospital to a regional referral centre and we are out there looking for answers. We are asking what is the hospital going to become? What are we going to be when we grow up? Are we going to be a full fledged regional hospital? Are we going to be a teaching hospital? Are we going to have all the specialists? Are we will on the right track? That is all that I was trying to say with that statement.

CHAIRMAN (Mr. Zoe): Before I go to Mr. Bernhardt, my colleague from the Kitikmeot, can I please backtrack on the comments my colleague, Mr. Koe made with regard to "The N.W.T. Way". Do you understand what "The N.W.T. Way" is? Do you have a single document that describes what "The N.W.T. Way" is? Do you know what it is or do you know where it came from? Ms. Olenek.

MS. OLENEK: What we are making our comments based on are some draft documents that all boards were asked to critique at one of the senior management meetings. We were given draft documents of the proposed "The N.W.T. Way", which were tabled at some point in the Assembly. If you are asking for our understanding, we have sat and discussed it to try and understand what that means to us and we have provided feedback. I think the basic tenet of it is another term which is used and that is primary health care delivery which is the service being delivered as close to the individual by the right people for that service, who have the right skills, in the right place and with the right resources. It requires a community driven focus. Very much it is driven by the needs of the individual from the community as a whole and they have a very key role in the decision-making process about decisions. I think those would be the basic tenets that our board and our staff at the senior level have grasped from that document. Those would be our foundations. How far that goes and how other people may view that, I think everybody is still grappling with. Does that answer your question?

CHAIRMAN (Mr. Zoe): Thank you. To follow-up on the comments made by my colleague, Mr. Koe, earlier with regard to the M.O.U. or M.O.A., on page four of your statement it appears that Stanton does not have an M.O.A. or M.O.U. with the Department of Health. You do not have one yet right, is that correct?

MR. YAMKOWY: We fall under the Commissioner's Agreement. Yes.

CHAIRMAN (Mr. Zoe): Lynn has indicated that at the Health Care Association's meeting that this was the first time you had heard of the major elements of the M.O.U. There were 15 elements within the address that the Minister made during the Health Care Association meeting. Are you satisfied or are you happy with what is in those 15 components, or should there be additional things included?

MR. YAMKOWY: That was my answer, Mr. Chairman. That is the first time that we were presented with the M.O.U., when Mr. Patterson, the then Minister, made his presentation at the Health Care Association in September. The 15 points which were presented, or the major elements, were part of his presentation, we took these as a starting point. We took that from that point we would be a part, we being all the boards, of drawing it up and developing the memorandum of understanding. I did not take from his presentation that this was it and that these were the only 15 points. I took it as a first draft document and that we were all going to work together. The Department of Health was going to hire a consultant, a facilitator and we, all of the boards and the Department of Health, would develop an M.O.U. that we could live with. So, we did not take it any further than the 15 points because we have said that this is a good starting document and we would then be working with the Department of Health to add to it, delete, or change.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments? Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. The Auditor General comments that targeting and planning for affirmative action hiring has been inadequate throughout the health system. What are you going to do about it?

I know of a well qualified person who applied and yet that native person and one under the gender equality, she never got the position that she applied for. These are things that I am concerned about with regard to affirmative action for our native people. If they are qualified, why are they not given the

positions at the hospital. Our records show that you have the least amount of aboriginals at the hospital yet you cater to them. The majority of your patients are native people.

CHAIRMAN (Mr. Zoe): Thank you. Ms. Olenek.

MS. OLENEK: I cannot comment on the specific situation, and I am not aware of which one you are referring to. I would like to point out that our personnel director is considered a priority one, I believe. She is a native, aboriginal woman and she holds the Hay Plan position in our facility as the manager and director of our personnel division for the hospital. As well, several other departments report to her. She is a member of the senior management team.

We have affirmative action statistics that show that 11.4 per cent of our employees fall under the affirmative action policy of the G.N.W.T. Seven of our 43 management positions are held by affirmative action individuals, classed under the affirmative action, and of those seven, four of them are at a senior management level. So we feel we have made some steps in the senior management aspect of employing and supporting that policy.

Part of our other problem in the process is that a very great majority of our positions at the facility are of a technical nature that there is no training here in the territories for. A lot of our N.W.T. people, whether they are aboriginal people are very poorly represented in these occupations even when people go out for education. We are not well represented in those training schools or in those training programs, so that creates a problem for recruitment into those positions. We strongly support any initiative that would further assist and help people stay in school or return back to school to get the education that is needed to hold those jobs in that particular sense.

MR. BERNHARDT: The commitment seems there but I think it is just like Mickey Mouse. You could strongly support it but is the commitment there and the guarantee for trained technical native people in senior management and middle management? We have to have that guarantee. You could have all the commitment you want in the world but if the jobs are not there for this qualified native person, for me, as a government, we are not living up to our obligation. We have to put our people in key areas where we think we have a responsibility to.

MS. OLENEK: I would like to say that, yes, the commitment is there. We do not do training. The hospital or the board does not have a responsibility for training. We can only employ people. If they are trained, they are employed.

CHAIRMAN (Mr. Zoe): Just to follow-up on my colleague's statements. My colleague is trying to say that within the whole health system, it appears we are not doing a good job. Now, in the Auditor's report, the Auditor pointed out that the boards are doing better than the Department of Health itself. Now, it is stated under the managing people section, under section two, that boards have actually done better.

Now, my question to you would be what type of advice can you give the Department of Health in order to increase native employment, particularly in middle and senior management? As you indicated just now, Ms. Olenek, you have got four out of the seven in management positions. Obviously, your board is doing better than the Department of Health, as stated by the Auditor General. Obviously, you are doing a good job in that area. What kind of advice could you be giving to our committee, through us, to the Department of Health?

MS. OLENEK: I do not know what we did. This is a board policy that is strongly supported by the board and that I am answerable to the board on. We have a strong commitment that that be something we incorporate in our management process. We asked the Department of Personnel to work with us when we sought to replace our person in the personnel department and we seconded an individual, so we worked very closely with the Department of Personnel. We have very good working relationships developed with the Department of Personnel to assist us, so it has been a collaborative effort with the board giving that very firm, strong commitment and direction to the senior management team. We are building those relationships with other departments and making the whole issue an awareness throughout the organization that the persons we provide the service to, and I think Mr. Yamkowy has made that throughout his presentation, we always have to remember who we are providing our services to. That has to be part of all of our decisions, how we deliver the service and who is hired into the process. We have to make that a key part of our decision-making process that the consumer, the customer and the individual that we provide the service to, has to come first. We have to have that as a very, very basic tenet and I have to commend the board on maintaining that visual component and that commitment. We have tried to work those components through in our organization and the board has been a leader in that role.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. Going back to the chairman's presentation on aboriginal awareness. Can I have the name of who is giving out this orientation on the cultural program for your facility? Who is that individual?

MS. OLENEK: The program will be under the direction of our personnel department and our manager of our personnel department is Melody McLeod. She is a native, aboriginal individual and the program is under her responsibility. We have not hired a particular individual to do any of the delivery yet but it is under her review.

MR. BERNHARDT: I know the lady but she is a Dene. How about getting one of ours from the east? It is two different cultures you are dealing with.

MR. YAMKOWY: We have close contact with the other boards including the Kitikmeot board that deals with health and the Mackenzie or the Inuvik board. We are asking, and visiting all the time, saying what can we do to improve? We have had meetings with Pat Lyall, the Chair of the Kitikmeot board. What more do we have to do? We do recognize that it is not just one of the cultures that we serve here. We serve a lot of the aboriginal cultures and we are really aware. The board is made up of a lot of long-term residents of the north who want to stay in the north. They are not here on terms and they are driving changes and we are not happy with what we have got so far.

We want to continue to make changes, so we are asking the question, what more do we have to do? In the interpreters, we are looking at that and we are trying to get the aboriginal members on our board to be very, very honest with us so we can make the change. Fifty per cent of the people who go through that hospital now are aboriginal people. And I know I am not happy when I walk in the front door and the first person that day you hit is a non-aboriginal person. That has to change too, all the way. We have to look at how we deliver services and how services are perceived by our customers.

CHAIRMAN (Mr. Zoe): Thank you. Anything further, Mr. Bernhardt?

MR. BERNHARDT: Yes, Mr. Chairman. How long is your orientation for your staff on cross-cultural awareness.

CHAIRMAN (Mr. Zoe): Ms. Olenek.

MS. OLENEK: Everybody in the facility gets one day of orientation but what we hope to do, with devising a specific program for cross-cultural, is that it becomes ongoing, that there is education all the time happening so that it is not just one day. One day is not going to teach and bring that sensitivity and awareness. We want to make sure that we have programs offered consistently so that we keep bringing it back to our staff, making that a highlight. We went out and asked other groups in the City of Yellowknife and the other boards to identify to the resource people of the various cultures, not just the Dene culture, but of the various cultures, who could assist us in being teachers, who could come and work with one group of individuals about their aboriginal group or their cultural views. So we have been asking for resource people to be identified to assist us in this. It is not just one person. We want a group of people that can be the resource to the hospital, that we can call on. We have also restructured our interpreter process and we have an individual who is designated now for that program. That person has done an awful lot in the last eight to ten weeks gaining awareness of the various different individuals whom we serve, and having dialects identified appropriately and drawing much heavier on the interpreter skills of the language bureau. That person has also brought more people into the facility to assist with the interpreting to improve that service. We see that department having changed and having become much more sensitive to the needs of the individuals. Already we are starting to get a response back from some of the communities with concerns, specifically Spence, Pelly and Gjoa. We are now employing an individual that does speak that dialect and also sign language in that area. We are starting to use our resources and get a sense of who is out there. We are certainly using the language bureau much more than we did before.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. As I have mentioned yesterday the key thing that I get out of the Auditor General's report is that the Department of Health does not seem to have an overall plan. I know the Standing Committee on Finance, of which I am a Member, said this over more than a year ago while we were reviewing the capital budget for the first time. Although the department has presented "The N.W.T. Way" as being a plan it does not satisfy me as being that because it presents some goals and objectives which may be admirable but it does not set out a method for achieving those goals and objectives, and it does not set out a timetable.

I would like to hear from the Stanton Board if their assessment is similar to that of the Standing Committee on Finance and the Auditor General that the department does not appear to have an overall plan.

CHAIRMAN (Mr. Zoe): Don.

MR. YAMKOWY: The board has felt in the last year since we have been moving on our strategic plan and our functional review that we were probably the main instrument in the Department of Health's plan. We were driving it because when we started to develop our mission statement and looked for assistance where the Department of Health thought that Stanton should be in the next five years, it did not seem to be clear and we were developing our strategic plan. At times the board felt that it may have been, and why we are doing ours is that maybe it could have been the Department of Health's strategic plan that we were working on, because we are the largest institution. I would have to agree with the Member that I do not think the Department of Health has a very clear definite plan.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: You mentioned earlier that you felt a lack of leadership from the department and you have just indicated that this was felt when you were going into your strategic plan. What other areas has this lack of leadership impacted on the Stanton Board?

CHAIRMAN (Mr. Zoe): Mr. Yamkowy.

MR. YAMKOWY: The board, as they started to move on the strategic plan, developing a mission statement of where we are going to be in five years, lacked some direction on whether or not we were going to become a teaching hospital, a full referral hospital, what type of specialists we need, and tried to grasp to the Department of Health saying what do you see in five years for this institution. We then started to gather the information and started to try to find out if there is a plan for a master information system, a master financial system. Boards use different systems of reporting, different computer systems or manual systems, and for data gathering and we had some difficulty to find out if there was leadership shown on an information system. We could not find that either. I think that is another area. There is no direction of where that should be taken, or it has not been projected to us. I cannot speak for the department. It just has not been projected to us.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: One of the other things that the Auditor General's report talked about is that this lack of leadership or planning could have implications for boards, in that they may find themselves in similar situations. Do you think that the Stanton Board has overcome that difficulty? Do you think that your planning process is as far ahead as it could possibly be, or do you think you have been somewhat stymied? Has it rubbed off on you, the planning to plan mode? Do you spend more time talking about what your plans should be rather than actually getting to work and accomplishing the plans? It seems to be

pretty clear from the Auditor General's report that they feel that this maybe something that rubs off on the boards.

CHAIRMAN (Mr. Zoe): Don.

MR. YAMKOWY: I do not see that because our board is made up of a lot of business people, community people, people that are driven. What you find is that if you do not have clear direction you will make your own path. We are proceeding on our strategic plan and we are proceeding on a functional review. They are not completed yet so we do not know whether they will be rejected or not. We feel that the Department of Health has been monitoring our progress. The lack of any sign that says change direction means an approval. I do not know if I can agree that it has really hindered us because we are proceeding with our admission statement with some assumptions. If we find out that we are wrong then I can answer that question better.

CHAIRMAN (Mr. Zoe) Mr. Dent.

MR. DENT: It reminds me of one of Mr. Todd's favourite sayings and that is "Keep doing what you are doing until somebody says stop." However, I guess that does mean that the board could in some point in time find that they have been wasting a lot of time if a change in direction should come about.

Since Mr. Yamkowy mentioned financial systems, I would like to ask a question in that area. I was interested in the way in which you put it, Mr. Yamkowy, and that was in terms of the leadership. We know that there are several different accounting systems used, whether it is M.H.O. or H.B.I.S., and I think for the most part there is a concern that perhaps decisions about what unified system, most people now agree that a unified system would be better in terms of gathering information which could be useful in the future, but it seems that you are almost recommending a top down approach in terms of getting the leadership from the department. Would you not prefer to have an approach where the users says this is the information we are gathering, this is why we are gathering it, and try and justify which system to the department to have some input.

MR. YAMKOWY: There are various boards that funnel their information in through the Department of Health's system. Why I would suggest a top down approach is because we should be on the same system as all the health boards, and we should be on the same system as the Department of Health, and we should have compatible equipment. We should have the same knowledge base and the same training, and we should be able to transfer people from the Department of Health to other areas to understand the system. The information then comes out in a correct form. I am indicating that the direction has to be top down to say that this is the system that all of us will use, we are all happy with and this is a system that will give us what we want. Now with everybody using various systems, even down to the terminal equipment, different hospitals that have different terminal equipment will not talk to each other. Stanton Yellowknife is not on the electronic mail system to the Department of Health yet. We should be able to have an information system that gathers financial information, but also communicates with the various boards on the electronic highway. I am saying that something like that takes commitment in finances, and the desire to go with one common system.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Would you not have some concern that perhaps what system might be arbitrarily imposed from the top down might not work because it would be too complex? In other words, in a small board or a small facility, perhaps the people are going to have expertise available to them to use a package like ACCPAC but you start making them have to use the M.H.O. system, they may be totally lost. They may never get the codings right and cause more of a problem in the long-run. So I guess the question is, should there not be something at least from the Trustees' Association, the Health Care Association or from the boards a meeting of the minds as to what complexity of a system is required. I agree that everybody should be on the same system but I think the concern is that you are liable to have something imposed which may make sense to a computer whiz in the Department of Health but may not make sense at the nursing station.

MR. YAMKOWY: I agree with your comments and I guess going back to an earlier comment of yours, we have hired an information officer and his new mandate is to start driving this with the Department of Health. We are trying to become a lead agent, a change agent, in this because there has not been any movement in the last year so we are trying to move it from our end. We hope the whole process is going to be a process that we all work together. It is not going to be a big financial system that a nursing station cannot access because we need the information from the nursing station also. It will not be a system that a small board cannot access. We are hoping the information person we have hired, who is now starting to work with the Department of Health, will be one of the change agents and will start to drive from bottom up until the spark is there. I hope that answers you.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions? Mr. Yamkowy, you indicated -- I am not sure if you indicated or not -- the electronic mail, are you saying that Stanton is on a different system than Health and other boards?

MR. YAMKOWY: Yes. We have our own system, computer system, word processing system, and we are not connected as yet with the main government E-Mail System. I feel, as the chairman, that all hospitals should be connected on the electronic highway for the interchange of information, the interchange of financial information and we are working towards that. If everybody buys a different system, it is going to be hard to link them all together. That is why I am saying the top down situation, is what the hospitals will get, because money, the finances, are controlled by the G.N.W.T. so they have the desire to say let us not waste any money. This is the standard they are going to put in.

CHAIRMAN (Mr. Zoe): My understanding of the electronic mail, I know Inuvik got it, other boards have it, electronic mail and I understand it is not that expensive so I am just wondering why Stanton did not get on that same system as the others and it is not that expensive. It is not hard to get, it is called H.P. Desk I think.

MR. YAMKOWY: I will ask Lynn to answer that. She has got some history on that.

MS. OLENEK: I think this is what Mr. Yamkowy was talking about when he was answering Mr. Dent's question about leadership. Decisions were made before both of our times on purchasing of equipment. There was no standard agreement or direction agreed upon with the boards and the Department of Health as to what kind of equipment would be purchased and what would be the outcomes of purchasing that equipment. By having common equipment, what would we be able to be working towards and this is what Mr. Yamkowy is trying to say with the leadership idea. For lack of having that, boards went ahead and purchased what they needed for their own needs and that is what happened at Stanton. Again, this is history. That was before our time. We do not have compatible systems in that particular sense and that is basically what we are fearful will continue to happen. We will continue to get incompatible systems and you have put a lot of money, the G.N.W.T.'s money into those purchases, and it is not the process. Leadership and agreement, we have to work to have that agreement. Okay, this is the type of equipment we will all use so down the road we can share mail, we can share information. That is what that leadership has been lacking and now we know it because we have run into the problems and now we are working to try and correct the problems. That is the leadership issue that Mr. Yamkowy was addressing and the cost of the actual hook-up is not the issue. It is the fact of connecting equipment that is not compatible at this point in time.

CHAIRMAN (Mr. Zoe): I agree with you. It is because of the lack of leadership within the Department of Health. Again, it goes back to planning. The theme that is coming out of the A.G.'s report is that there is no overall plan at all within the Department of Health, and I understand better now after your explanation, that it goes back to planning again. Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I was going to make a comment on the item on the bottom of page five but I figure it might be inappropriate. I am just going to say though that I hope you are going to do more than just hope, that you provide good information to the Minister and the Minister will be able to answer questions. With that little shot, I guess I will move on.

There have been problems between boards and the top, a lack of communication, and you quite correctly state that but I remind you that it is a two-way street, the wait for things to happen before they happen. The question I would be concerned with follows on with what Charles was dealing with, your comments on the bottom of page six where you talk about endless amount of details being asked by the department. You use the word "plagued" by control requests for detailed information and you also stated that it takes up an inappropriate amount of staff time. Do you have an idea of how much time this takes up in terms of staff time and other resources? Time is money. You know we have got somebody working on that and it costs money. Do you have any idea how much money we would have lost on this?

CHAIRMAN (Mr. Zoe): Ms. Olenek.

MS. OLENEK: I cannot say days, or hours, or that. I will use this as an example. You go through a budget planning process and you have your background supporting documents and then you end up doing it, piece by piece, throughout the year. You end up recycling your arguments or your documents because it needs to appear for a different committee or a different process, in that particular sense. It has improved and I would like to say that. We have managed to make some strides I think and like you said, it is a two-way street, with Stanton and the officials of the Department of Health working towards trying to build a sense of trust so that we do not have to detail everything, that when we say this is what we have done with the dollars, there is a trust. That has certainly assisted us in deleting some of that time. I cannot give you repetitive kinds of hours and that but I do know justifying, for example, collective agreement increases has taken a lot of time over the last year. When you think that X amount of dollars increase, you multiply it by your staffing budget, why would we have to do it all over again?

Part of it is because we are working with manual systems and then inputting them as, again, we do not have the capability of exchanging that information by computer links. That also ties to that particular process and I am not sure what the other boards would be able to answer in that particular sense. A lot of back-up, a lot of documentation preparation when you have said it before in that particular sense. I would like to stress that we have managed to work towards decreasing some of that by developing time and developing trust. It certainly takes a two way street to do this so that everybody is clear. We do not have any parameters and we do not have any specific agreements from a system-wide approach as to how financial information should appear. We are working and there have been in the last year changes occurring with the Department of Health so that we know a time schedule when reports are due and we know the formats for the reports. We have worked to these agreements. These were not there before which required duplication of efforts. I cannot give you dollars and time but it certainly has decreased although it is still there.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions? Mr. Whitford.

MR. WHITFORD: There seems to be a suggestion that we are not speaking the same languages, computer wise, system wise or people wise. In order to not ask a second question the person has to understand the first answer. Maybe whomever is asking the question is really not understanding what is being said. You have suggested perhaps that compatible systems might go a long ways to doing this but does the board not have enough autonomy to go ahead and do this or does one sort of depend on advice or clear direction from the department to be able to adapt a system. Surely the hospital's long experience would know what kind of systems would work best and then match them up. With reference to computers and the electronic age we live in, we have a whole department that does things like that, why can this not have been done already. Stanton has been operating for a while and the systems are not that secret. We have a communications expert on the board. Do you have the authority to do these things on your own, in order to correct some of these things?

CHAIRMAN (Mr. Zoe): Ms. Olenek.

MS. OLENEK: No, I would have to say no we do not as a board. Part of that you have to reflect is not strictly the Department of Health. It is requirements of how funding is flowing to meet the Financial Administration Act, the Financial Management Board's directors. We cannot just isolate the Department of Health when we talk about information systems and financial systems. We have to look at the other acts that have a specific requirement as to how reporting occurs in that particular sense. We have to be able to report to the Department of Health on certain parameters that are set down in a number of other acts in that particular scenario when we present. The best example I would use is that we run a fairly hefty budget at that facility and the budget is compiled on a line by line basis. Anyone of you gentlemen and ladies around the table would know when you are dealing with that, that has to occur at some point in the facilities, and yes you must have appropriate checks and balances to ensure money is being spent and handled appropriately and correctly with the acts that govern. When you start preparing a budget at that level to submit and then go through it line by line, you spend a lot of time in that particular sense. Part of that again though and I have to stress comes back to developing a trusting relationship. There is a lot of concern if you move money from one line to another. Part of that is a reflection of the other acts that are in place. It is to try and develop a sense of trust of what level of detail is needed so that the Department of Health can answer their questions to their Financial Management Board and to the Assembly, but at the same time allow the board flexibility to make some internal decision-making processes. How much detail do people need? I think we are trying to establish that level of comfort and that level of trust. I think that is what a lot of us are working towards. How much detail does the Department of Health need to carry their arguments forward for the Financial Management Board, for example, for them to in their budget planning process be comfortable with the numbers that are being granted. It is not just us and the Department of Health, there are other departments. No, we do not have a great deal of autonomy or authority to make some of those decisions.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: I would like to be able to get a list of the board members, their names and where they are from and if there are any vacancies.

MR. YAMKOWY: We will provide you with the list this afternoon.

CHAIRMAN (Mr. Zoe): Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Thank you, Mr. Chairman. I would like to ask a few questions. First of all I would like to ask in regard to the Stanton Board, Mr. Yamkowy had indicated that they have a 15 member board complement. What is the current number of board members?

MR. YAMKOWY: In the last weeks we have worked towards an agreement with the G.N.W.T. where we now have six members on the board. The six members are all from Yellowknife, with one from Rae-Edzo and one that represents Dettah. We have suggested through the various standing committees and presentations to the government that a better representation would be a match to our customers. Our customers are 50 per cent from Yellowknife and 50 per cent from the communities. We would like a board structure based on that. We have made some suggestions. One of the suggestions was to appoint the chairmen of the boards that use our services, which are Kitikmeot, Fort Smith and Hay River, and make them automatic on our board. I guess that has been debated and the answer that we got back was a structure close to that. The structure is that it would be a 12 person board, six would be from Yellowknife and six would be from the regions. We will be working with the department on how the regions will be selected. The regions will now be in categories of South Mackenzie, Central Arctic and Inuvialuit. I do not have the letter with me because it only came in within the last week. We think we have an arrangement now that will deal with 50 per cent from Yellowknife and 50 per cent from the communities that will capture the areas that we now serve. We also have an opportunity to work with the department of how these people will be selected. Not that we will be doing the selection but we have been asked to comment and work towards how the process could work. We are quite pleased now that we have a structure we can work on. We are up to six members. When you run an institution as large as ours with a budget in excess of $20 million there is a lot of committee work, financial work and monitoring that goes on, so you really need the board members to attend the committees and add the guidance to set the direction for the hospital.

CHAIRMAN (Mr. Zoe): While we are on the subject of boards, can we get something from you in writing with regard to this new structure that you make reference to?

MR. YAMKOWY: Yes, I can give you a copy of the letter we have received. I do not think it is confidential.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: With respect to the boards, there is currently a process being developed for the way appointments are being made and in the past, there has been no process.

MR. YAMKOWY: I was not aware of the process. The process was we, at Stanton, had a nomination committee. We would submit names to the ministry of people we thought had the skills and would represent the interest groups and that would provide guidance to Station. We would submit this to the ministry. The process that the department or the ministry went through or the government went through is not one that we were privy to.

CHAIRMAN (Mr. Zoe): Mrs. Jewell.

MRS. MARIE-JEWELL: Further to that, Mr. Chairman, I would like to ask what is the normal time frame for an individual to be appointed once your Stanton board recommended individuals to the minister's office?

MR. YAMKOWY: The appointments were two and three years.

MRS. MARIE-JEWELL: No the time that it took to be appointed.

MR. YAMKOWY: That is a very difficult question because we have submitted names to complete our board to 15 which have not been filled yet. We have submitted names that went into

a void. So there is no time limit that we are aware of, whether it is five minutes or five years. I do not know. There was no guideline given. We would just submit a list of people that we thought had the skills and we would wait and write letters.

MRS. MARIE-JEWELL: I guess what I am trying to find out is, once you submitted those names, did you submit them once every year and, further to that, if you did submit them once a year, did you get a response six months later, three months later. What was the time frame to appoint board members.

MR. YAMKOWY: The names were submitted when there was a vacancy and a pool of a few names were submitted saying, these were the candidates selected by the nomination committee of Stanton that we feel could fill the vacancy and they were submitted to the department. So it was not once a year. It was when a vacancy came up. It is a very difficult question because there are some names that have sat there with no response for periods of up to six months. We had a board mandate of 15 members and we are only at six now, so we have been submitting names. Here are some people that could fill the vacancies. There were some there that were frozen. Some board seats for the regions were frozen because of some discussions on how that representation would be covered. I am referring to the Mackenzie health board coverage and Kitikmeot. We were in a critical situation in the summer because we were very, very short.

MRS. MARIE-JEWELL: Under your hospital regulations or guidelines, what constitutes a quorum on your board?

MR. YAMKOWY: A majority of one. So if we had three appointed members. It is a simple majority. If we had three appointed members and two were, that would be a quorum.

MRS. MARIE-JEWELL: That is interesting. So you have never really had a 15 member board at any point in time?

MR. YAMKOWY: Not during my tenure. I cannot tell you.

MRS. MARIE-JEWELL: I just wanted to get more information on that, Mr. Chairman. Further to that, I wanted to ask in regards to the area of training. I believe chapter four of the Auditor's report, indicated a lack of training for the nurses, that there were more training dollars for the doctors. Can I ask you, in your assessment, do you feel that type of statement towards lack of training for nurses in comparison to doctors is accurate?

MR. YAMKOWY: I would like to refer that to the executive director.

MS. OLENEK: I am trying to think of how to answer that. Physicians in our facility, the majority are private practice physicians, so they are not employees of the board. Their training is their own responsibility. The board supports some of their training by use of facilities or we may jointly sponsor activities in that particular sense. We do have some physicians that work on a contract basis but they are very specific positions and there are some dollars designated for those positions. If you are asking me to respond from our facility's point of view with our physicians, and you must keep in mind that use the Stanton Yellowknife Hospital are private practitioners, I may not be the best person to comment on that. Commenting in general, for our staff, which are nurses in our facility, I think that we have managed to protect the dollars for training and I am using the term protect because we have all gone through budgets where we have had to consolidate them down, always looking where we are spending the resources and your first indication often times is to cut the training dollars. Our board and our senior management have certainly fought and made that a commitment, that this is important if we are going to keep people.

If we are going to keep staff and we are going to work at reducing our turnover, it is very, very critical that those dollars be there, be protected and be supported and that support is there. Often times, when you are looking at saving money, that is the first thing that you might look to do. That would be the only way that I feel I could comment on that, back to that particular sense of the support, when you are committees and you are looking at how dollars are spent that training dollars are really important to keep, because that helps us keep the people that we are investing money into. That is how we address the training.

For our facility, I think we are fairly comfortable in that but, again, I cannot comment on the general system in that particular sense. For us, again, the majority of our physicians are in business in their own private clinic and their training is largely their own responsibility. We do not have a great deal of dollars dedicated to that.

MRS. MARIE-JEWELL: Does the Stanton board retain a lot of salary positions as opposed to contract positions? I guess what I would like to know is, how many salaried positions do you have on staff, as opposed to private physicians utilizing the hospital?

MS. OLENEK: We have between 10, I think it is 12, full time, we call them contract positions, and those are our specialists that work for the facility. The rest of the physicians that work through the Stanton Hospital are private practice physicians from the clinics in town. We may, on occasion, for some of our visiting services, arrange for that individual from Edmonton perhaps to come to do a clinic three times a year. We basically just make the arrangements and provide the space. We do not pay their salary. They are paid through the Medicare Plan. In the City of Yellowknife, full-time family practitioners, we have between 18 to 20 and there are some that come to the clinics to cover for maternity leaves and vacations so those numbers will fluctuate depending on what the various clinics around town are doing in that particular sense. So you are in that neighbourhood of between 18 to 25 family practitioners, full-time. There are some that also work part-time.

MRS. MARIE-JEWELL: You do not have any salaried doctors?

MS. OLENEK: We have no salaried family physicians. Our contract physicians are part salary and part fee for service, at this point in time.

MRS. MARIE-JEWELL: Mr. Chairman, I guess the comment that I wanted to make is in regards to the utilization of the hospital. The report has indicated, a 38 per cent utilization of the Stanton Hospital and an average of 40 per cent over the

territories. Have you found the utilization rate of the hospital over the past year has increased in comparison to the Auditor's report? Also, have you developed other options or planned to look at ways of increasing that utilization rate?

MR. YAMKOWY: The last information that I read on the occupancy rate showed an increase, one of the few hospitals in the Northwest Territories that has increased in the last three years. The occupancy rate is going up compared to others. Since the hospital was conceived and built we have found a change in how we handle patients. The out-patients have really increased. People are not staying as long for operations or surgery in the hospital. They are in and out of the clinic a lot faster. Because of that the hospital was built at 135 beds and we are now down to 99 beds. We have done some renovations to increase the out-patient facilities of the hospital. We have closed down one operating theatre because we do not need it because of the out-patient facility. We are going through that change all the time. We are modifying and changing. We are going through a functional review process right now saying what do we need for the next two, three, four or five years. How should the hospital change because techniques are changing? The utilization of the hospital is being examined and looked at all the time so that we can get that number up and also if we have vacant wards, operating theatres are shut down during Christmas periods and we try to utilize the hospital as best as we can.

CHAIRMAN (Mr. Zoe): Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Mr. Chairman, I make this comment because on other committees we have heard a significant concern of the amount of dollars that are being used and flown south to rehabilitate many workers' compensation cases. I have wondered whether there has been any effort on the hospitals part to meet with the Workers' Compensation Board to consider looking at a rehabilitation area of the hospital to meet the needs and thus avoiding workers' compensation cases going south for rehabilitation.

CHAIRMAN (Mr. Zoe): Mr. Yamkowy.

MR. YAMKOWY: Mr. Chairman, that is one of the mandates that we are looking at in the functional review. We are looking at the huge amount of dollars that Workers' Compensation pays out of the territories. If we can repatriate some of that to our hospital then we can add to the services and to the specialists. This is one of the items that the functional review is looking at. We are looking at that and we are looking at the possibility of St. John Ambulance putting their facilities in our hospital. We are looking at all of these things so that we can use that facility. It is a great facility. It cost the residents of the Northwest Territories, I should not say the residents of the Northwest Territories, but the residents of Canada a lot of money. We want to utilize it to the maximum. The functional review is looking at all of that to see what we can do and what we can repatriate that is going across the border. Workers' Compensation is one and that was one that was given to the functional review committee to look at.

CHAIRMAN (Mr. Zoe): Thank you.

MRS. MARIE-JEWELL: Further to my comments, Mr. Chairman, I would like to go back to the Auditor General's report, in chapter six it stated that there were concerns and problems controlling assets within the Department of Health, not specifically boards or hospitals. Do you find this an area that is difficult to address? What are your comments in respect to controllable assets?

CHAIRMAN (Mr. Zoe): Lynn.

MS. OLENEK: We have our own system to manage our assets. The board manages them on behalf of the G.N.W.T. We are comfortable that our asset control mechanisms are appropriate and they meet our insurance companies criteria for insurable policy. We do not have a problem.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Thank you, Mr. Chairman. That was all of my comments, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I would like to make a comment on board appointments. I do not know whether or not Stanton is aware or if any board is aware where the bottleneck is. There is Cabinet direction that says no appointments unless Cabinet approves. The Minister may wish to appoint but has to get Cabinet approval. For a point of clarification or information some of the things are not entirely the Ministers fault or even the fault of the department. Cabinet has given direction that there will be no appointments to vacancies unless they get full approval of it.

CHAIRMAN (Mr. Zoe): Thank you for your comment Mr. Whitford. I have one question before I let the witnesses go. With regard to capital assets, last year the Standing Committee on Public Accounts made a government-wide recommendation pertaining to capital assets. Again, the Auditor General, when he took a look at the Department of Health, picked this same item up. You indicated earlier on that you have your own system in place and that you manage your own assets. My understanding from the Department of Health yesterday was that they are in a process of developing a new mechanism to control their assets because all the things that the boards have belong to the government. Is Stanton involved in that process as they are trying to set up this new system? Are they communicating with you? Are you involved in what they are trying to set up for the tracking of all capital assets? Lynn.

MS. OLENEK: Yes. In early December they had sent out some information and ask us to provide them with some feedback as to what processes we presently employ. They have involved us in the initial part on the data collection of what the system would have to have, so that we are not duplicating the input of the information. Yes, we have been involved. The only caution that we have said on that particular process is that you have to have a financial system as well that is compatible. We would like to see that occur perhaps first, in our minds, that is where the importance may lie. I know that other committees have made the suggestions about capital assets on whole for the department but you need to have your financial system tied into that. Yes, we have been involved.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions for Stanton? If not, I would like to thank the Stanton management team who are with us today, Mr. Yamkowy and Ms. Olenek for appearing before us. Thank you very much. We will call on our next witnesses, the St. John Ambulance. Before I do that the committee would like to break for five minutes.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): Our next public witness is the St. John Ambulance people. I believe we have here from St. John Ambulance, Brian McCluskey. Mr. McCluskey, can you introduce the people that you have here with you for the record and proceed with your presentation.

St. John Ambulance Introductory Remarks

MR. MCCLUSKEY: Thank you very much, Mr. Chairman, honourable Members, ladies and gentlemen. Let me first introduce those here today representing St. John Ambulance. My name is Brian McCluskey. I am President of the territorial council for St. John Ambulance. To my left is Warren St. Germaine who is our Senior Vice-President, Administration. Next to me, on the right, is Mr. Don Irwin, our Executive Director and to his right, is Mr. Max Rispin, Territorial Commissioner for our various brigade and cadet corps.

St. John Ambulance appreciates your invitation to appear before you today. Within our allotted time, it is our intention to provide you with a little background information about St. John Ambulance organization, as well as commenting on seven aspects of the department operation as requested in your letter.

The mission of St. John Ambulance in Canada is to improve the health, safety and quality of life for Canadians through the provision of education and skill training programs in first aid and health care and through related community services by the brigade and to support the operation of St. John Ophthalmic Hospital in Jerusalem.

Internationally, the Most Venerable Order of the Hospital of St. John of Jerusalem provides first aid, health care training and community services throughout the British Commonwealth and into many of the countries in Western Europe. The current organizational distribution reflects its roots, the establishment of a hospital for Christian pilgrims in Jerusalem by the Benedictine monks in the 11th century. This founding group was known as the Brothers of the Hospital of St. John.

The charitable organization has been functioning in various forms since then, making it the oldest charity in the world. Today, the hospital in Jerusalem treats in excess of 50,000 patients annually for the eye diseases and injuries that are so prevalent in the Middle East. Mobile clinics travel into the West Bank and the Gaza Strip to provide diagnostic care services for those denied access to the City of Jerusalem. The passport for admission to the hospital was, is and always will be the need for eye care. Considerations of religion or politics are firmly excluded. An average of 20 practical nurses are trained each year at the facility, plus eye surgeons who bring their new found skills back to their home countries. St. John Canada funds, through a number of corporate donations from southern companies, one doctor and one nurse position annually at the hospital.

Nationally, St. John Ambulance's influence and prominence in the field of health care training and community care services is extensive. On an annual basis, the organization trains 470,000 Canadians in first aid and health care throughout a network of 9,200 certified instructors. There are approximately 11,000 uniformed brigade members providing skilled first aid care at public gatherings and disaster sites, all on a volunteer basis. Supporting them in program development are another 12,000 non-uniformed volunteers. There are approximately 300 full-time staff providing business services to this organization through our national office in Ottawa and in the provincial and territorial councils. As a quick aside, Mr. St. Germaine, myself and Mr. Rispin are volunteers and Mr. Irwin is our staff member.

In the Northwest Territories, we have about 150 non-staff instructors. This cadre of people trained a total of 5,530 people in 1992. The majority of the persons taking a course took our standard first aid and C.P.R., or cardio-pulmonary resuscitation programs. Others participate in our baby sitter, child care, family health and in professional courses such as, basic trauma life support program. As you can see, this means that St. John was involved in some way with one person in 10 who live in the Northwest Territories. Further, our national office has done some research which demonstrates that those persons who participate in a training program are less likely to be injured either at home or on the job as a result of increased attention to safety and health issues.

Our 100 cadet and brigade members across the territory put in just under 8,000 volunteer hours last year. These people provided service at 44 sports, recreational events and special gatherings such as, the Circumpolar Conference in Inuvik, Black Bear Jamboree in Norman Wells, Denendeh Conference in Rae and the Canadian Injury Prevention Association's heroes presentations last fall here in Yellowknife.

In addition to the volunteer work, St. John's provides contract services in three communities. These include: ground ambulance/hospital security/handivan transport services in Inuvik; ground ambulance services in Rae-Edzo; and, handivan services in Yellowknife

Also, we provide air medevac contract service for the western Arctic on a round-the-clock basis. We employ five qualified nurses who have been specially trained in patient care in aircraft operating environments. The Air Medevac team utilizes aircraft charter by the territorial government and this service is paid for through the Department of Health.

The territorial council draws on extensive knowledge and experience with the national and international St. John Ambulance resources to fulfil its mission here of improving the quality of life for northerners through education and skill development in health care. We know that the efforts made in health care education produces significant savings in future year health care costs. Experience has demonstrated repeatedly that people trained in first aid and health care have fewer accidents and generally lead a healthier life style. In short, we are convinced that those persons who participate in one or more of our training programs enjoy a better quality of

life because they are more able to make an informed choice about the many factors that impact on their lives. I should add that a lot of the training programs that we have developed here in Canada have gained international reputation and have been exported to other countries. Our health care, family care and baby sitter courses have been exported to Britain.

Recently, some of the courses were sent to South Africa and we have just concluded an agreement with Cuba who have a fairly advanced and progressive health care program. They are very interested in some of our programs and are taking them down there. We are giving these at most cost to them. This is the national office I am talking about, I am not talking about the territorial council. We are giving these courses in return for them translating them into Spanish. These Spanish courses will then come back to our national office in Ottawa and are being sent down to a new St. John Ambulance Council which is being set up the first in the United States in Houston, Texas and will be used for oil and petrochemical workers down in that area and also for fire fighters. So the courses that we do have are recognized internationally.

I regret having to take so much of our allotted time to share with you some of the basic assumptions under which St. John operates but I believe it is necessary to help put the following comments on the report in perspective.

We support the concept that health care services which are reasonably close to the customers are more likely to be sensitive and responsive to the wishes of the people they are intended to serve. Like the department, we, at St. John have struggled with the concept of how best to empower our cadet and brigade units in various communities. In spite of the difficulties, we continue to believe that this is the path to follow. Like the department we have had difficulty identifying qualified aboriginal employees. We believe that our commitment and our efforts are worthwhile in the long run. We have had some success. For example, four of the five persons hired for ground ambulance service operated in Rae-Edzo are aboriginal. Three of the four have been employees for more than a year. All four have acquired their instructor status with St. John Ambulance. The two younger members appear to have developed a nucleus for a cadet corps and within this younger group we sense the development of a sense of pride in their accomplishments.

While I acknowledge that Fort Rae is our most notable success to date, there are every indications that a similar pattern is occurring in other communities. For example, one of our instructors in Pelly Bay has assisted us in translating a good deal of the teaching material into Inuktitut to facilitate our work in the eastern Arctic. We are convinced that it is possible to foster such local initiates while, at the same time, working within the guidelines established both by our national headquarters in Ottawa and by the territorial office here in Yellowknife. We would encourage the department to continue its efforts to define the roles and responsibilities of its coordination function with the service delivery roles of the various boards. We believe that the short- term pains in sorting this out will be well worth the gains made in the long run.

Planning for the future is difficult in a world that is changing rapidly. We all want a better quality of life. As I indicated in my opening remarks we, at St. John's, are convinced that one of the component parts of achieving this objective is the acquisition of knowledge. For this reason, we have developed health courses aimed at assisting people in dealing with the family and child health care and how to care for the elderly and the infirm, as well as to deal with life's emergencies. We know that emphasis on preventive measures including health care training improves the quality and safety of one's life-style resulting in a lower demand on the health care system in future years due to such things as poor health conditions and injuries. We are disappointed that the department decided to change, rather drastically in our opinion, its training priorities in 1991. Prior to that year the department was prepared to fund all training for aboriginals, youth and their leaders. This practice of funding aboriginal training was terminated for what we understand was financial reasons. We believe that the focus should be on the youth, for if we as a community can instill healthy living values in this group, we all will benefit.

At the same time day to day problems remain. We had a recent request to train five lay dispensers working at various communities around Fort Simpson to become health care instructors in their communities. To date the resources have not been identified. It would appear to us, at St. John, that the emphasis on increasing local training skills should be a priority as these individuals could be an excellent resource for the community health personnel attached to the various health care centres in the local communities.

Regarding managing people, St. John Ambulance in the territories is interested in expanding its role by providing more of the professional training for health care professionals. Over the last two years a faculty has been established to teach the basic trauma life support sequence. To date a total of 150 nurses and emergency medical technicians have participated. Consideration is being given to expanding this role to include the paediatric, neo-natal, and advance life support programs. These are costly programs right now that all of the participants have to go south to receive their training. St. John Ambulance can provide such training in the territories thus keeping the funds in the north and increasing the north's capabilities to handle our own health training requirements. The support of the department is imperative if the north is to succeed in this initiative.

Regarding human resources, I do not expect that you will disagree with me if I were to suggest that our human resources are our most valued and our most expensive item when we consider our respective budgets. Again, we are of the opinion that we need to target our youth if we are to realize the improvements towards a more healthy standard of living. Such programs are not cheap. For example, for a volunteer, the brigade members first year of service, we are talking about a volunteer not a staff member, we provide training in emergency and first aid cardio-pulmonary resuscitation and if the person wishes, training as a provider of advanced first aid. Add to this a uniform and the cost to St. John Ambulance is over $800 per person per year. For this outlay however, we obtain the services of an individual who is prepared to contribute on a volunteer basis a minimum of 60 hours per year in providing public health services. I think this is a significant impact if you apply this back into the community level.

While we encourage all our cadet and brigade members to consider careers in health we would be particularly pleased if

that person were of aboriginal origin. In our opinion the St. John Ambulance brigade program is providing a community-based educational opportunity, and a nurturing environment in which an individual can develop self-esteem, pride of accomplishment, training and health care skills leading to a possible career in the health care field. This can be done from within the local community with cadets providing local training and at the same time health care services to their community. While they are developing their own individual life skills they are also contributing to the benefit of the community as a whole.

St. John Ambulance's experience and organization, working with the Department of Health's community-based programs, can provide a career opportunity at the local level for our youth. At the same time these programs provide a way of improving the quality of life from within the community. We do not all start off as doctors. As of now we have several instructors and ambulance attendants of aboriginal origin. Perhaps one of them will be encouraged enough to continue on to become a medical technician, a nurse or a doctor. St. John Ambulance can provide an opportunity.

Regarding capital costs, the issue of capital assets is of interest to us at St. John. We believe that it is absolutely necessary that the department develop some system of dealing with this issue in its contractual relationships. We have operated the air medevac contract now for eight years. Provision is made in the contract for the replacement of consumable medical items but not for other capital equipment. We have held fund raisers and we have utilized the nursing staff in training with their honorariums going to the purchase of capital items to name but two ways that we have addressed our funding problems. The department has made some capital equipment available following a critical incident and only recently an agreement has been reached on replacing some items, such as the original patient sleeping bags in which people are transported.

In one ground ambulance contract, provision was made for such basic capital equipment as an ambulance. In the other contract there is no mention made of the vehicles to be utilized. You have to recognize that this says a good deal about our own abilities to negotiate a reasonable contract. Perhaps it might best be left by our suggesting that as these contracts come up for renewal, the capital cost issue for replacement is one that we will want to incorporate into those contracts. This is a vital issue when you consider that an item such as an ambulance probably will not survive beyond three to four years here in the north because of the harsh climate and the road conditions which we have up here. In replacing an ambulance every four years you are talking about a turn around of $50,000 to $60,000 by the time you get a fully equipped kit. This is a significant amount of money for a charitable organization such as ourselves.

Regarding financial issues, St. John Ambulance has had a training contract with the department for the 20 years that we have been established here in the territories. The size and the purpose of this contract has changed somewhat since the initial agreement was made. These changes have been made on occasion with little or no input from us and sometimes well after the start of the fiscal year on current year issues. This makes planning difficult. St. John Ambulance is a non-profit service agency dedicated to the improvement of the quality of life through education and community service. We do not have cash reserves so we lack the ability to absorb financial shocks caused by the lack of long-term planning, the lack of adequate notice on program changes, delays on decisions regarding program issues and administrative procedures, and by late payment of invoices. Greater effort is required on both our parts to rectify this situation.

The financial issues with respect to the health care matters are complex indeed. We are surprised that the Auditor did not examine the air medevac transport given the amount of money involved in this aspect of health care. We are pleased to advise that the department has responded positively to our recent concerns that standards be developed and implemented on air medevac air transport. We were running into some situations where we had air charter companies chartering aircraft to us that we felt were operating under limits, not safe air practice certainly. Other cases were where the insides of the aircraft was just not suitable for carrying patients, maybe the door was not wide enough so that we could get a stretcher in, things of this nature.

We are concerned about ambulance cost for non-native persons residing in the north. Our outstanding bills to date over the last six years amount to about $30,000 of uncollected fees. This is a large sum for a non-profit agency with no cash reserves. That is two thirds of the cost of an ambulance. Again, the department has agreed to address our concerns in this regard.

In summary, we at St. John Ambulance are convinced of the value of health care and safety training. We believe that training will lead to a better quality of life for all who participate and lessen the future demands on the health care system. We can demonstrate that training reduces significantly the time lost from jobs as a result of accidents and poor health. We recommend to you that the department set preventative education and local health care programs as a high priority in its long range plans. St. John Ambulance encourages joint initiatives with both the department and the various boards to take advantage of our training resources to bring life-style improvements to local communities in a cost- effective manner. We are prepared to encourage and support the department and the boards in their efforts to develop constructive working relationships. Thank you. All of us are of course prepared to respond to any questions you might have in spite of the fact that I have done most of the talking.

CHAIRMAN (Mr. Zoe): Thank you. I like the presentation that you have made this morning, Mr. McCluskey. When you make reference to the outstanding bills, is your contract with the boards or with the department?

MR. MCCLUSKEY: This is a mixture of the two. In some cases we have our contracts, in Inuvik for example, the contract is with the boards. Down here in the Mackenzie, it is the Mackenzie Health Board.

CHAIRMAN (Mr. Zoe): Is it generally both the department and the board that you are having problems with then in terms of late payment?

MR. IRWIN: Mr. Chairman, it is a combination of both. The payment from the health boards, and the one we have been

having the most difficult with has been Inuvik over the last, well, to be quite blunt, part of the dilemma for us occurs with the non-native person who is carried by that vehicle and submitting the bill for a claim. The billing, of course, for native folk goes through with a minimum of difficulty and then it is simply a matter of speeding up the turn around time to try and meet that 20 day time frame that we would like to achieve.

CHAIRMAN (Mr. Zoe:) Okay, any general comments or questions from members? Mr. Whitford.

MR. WHITFORD: Thank you. I just had a couple of short ones. I appreciate, Mr. Chairman, the concise and thorough nature of the presentation, it does speak well for St. John Ambulance. It shows dedication that they have to their role. I just wanted to comment on, they are not numbered, human resources. I was very appreciative of the comment that was made towards the end of that paragraph, that we do not all start off as doctors. As of now we have several of our instructors and ambulance attendants who are of aboriginal origin. Perhaps, one of them will be encouraged enough to continue. I know of a couple of people personally that have taken courses there and I consider have gone on to other things related so, you are quite correct. Yesterday, I mentioned to the Department of Health that we have got to focus our attention not just always on the little seeds but sometimes the saplings and more mature persons as well. It is certainly a good start for those young people that I know of and other persons I do know of that have gone on. So I appreciate that comment very much.

CHAIRMAN (Mr. Zoe): Thank you.

MR. MCCLUSKEY: Mr. Chairman, can I add to that please? I think we all realize that education is probably one of the biggest problems that we have in the north and it is very difficult to get people sufficiently trained so that they will be skilled to be employed in jobs either in the north or in the south. This came home time and time again at the Prospects North Conference last year in Edmonton. St. John Ambulance sees a tremendous opportunity here. We do not see us doing this by ourselves. We see this as a joint initiative between the Department of Education, the Department of Health and ourselves. When I speak of a nurturing environment, I am talking about bringing somebody in as a cadet into the brigade, if they have any interest, any inclination at all to helping out their fellow man, and going into the health care system. We can provide them with a start in the health education field.

The brigade service can carry a person through from nine to ten years of age through until they are 50 or 60 or whatever. They can always be tied into one aspect or another. We see joint venturing programs with community health programs in the communities themselves where we can bring people along and bring them into perhaps a modified candy-striper program. Maybe they can be an assistant of some sort in the community health or in the public health station in the smaller communities and this being complementary to the training that they are receiving in St. John Ambulance.

This can continue as they develop through their adolescence and teenage years so that by the time they do finish high school, if they are really interested in a program in the health care field, then the Department of Education certainly has bursaries and scholarships that can take them further. They can become the medical technicians, the nurses and the doctors to come back to the north and back to the their home communities where they would like to be. This is basically what we see, a nurturing environment where we can bring somebody along, not by ourselves, by working jointly with the various government departments.

CHAIRMAN (Mr. Zoe): Any further general comments or questions from Members? Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. A good part of the Auditor General's report seems to deal, to me, anyways with the lack of overall planning in the Department of Health. The department has what they call "The N.W.T. Way" as their stated goals and objectives. I am just wondering does the St. John Ambulance have a clear understanding of what "The N.W.T. Way" is and where St. John Ambulance fits in that. Are you satisfied with your relationship with the department in that aspect?

MR. MCCLUSKEY: Personally, I have not read "The N.W.T. Way" so I cannot comment on that.

MR. ST. GERMAINE: There is a document stating what "The N.W.T. Way" is and the Department of Health is responsible for developing that policy with the boards and implementing it. There has been no dialogue with groups such as ourselves as to how we could fit in. If we have to change our method of delivery or our programming, there is no reason we cannot do that but unless we are part of the process of defining how "The N.W.T. Way" is going to be implemented it is going to be very difficult for us to adapt. I guess my fear is that at some point in time this is what the department is going to be doing and how they are going to deliver health care and we are on the outside sort of looking in and not able to adjust in time. As Brian mentioned, we have not got the financial resources to wait six months to adjust. That would put us out of business. So I think we have to be very much involved with that process as it goes on.

CHAIRMAN (Mr. Zoe): Thank you, Mr. St. Germaine. Mr. Dent.

MR. DENT: So basically, there is at present almost no dialogue between the department and St. John Ambulance.

CHAIRMAN (Mr. Zoe): Mr. McCluskey or Mr. St. Germaine.

MR. MCCLUSKEY: No, there is plenty of dialogue between ourselves and the Department of Health, the majority through the executive director and through to the director levels into the Department of Health. Right now, of course, they are in a state of flux and that has been part of our problem. Perhaps they are trying to sort out just exactly how they are going to fit their programs into "The N.W.T. Way". I am speculating here when I say that.

For ourselves, in terms of long range planning, probably one of the most urgent things we are pushing with the department is that we have to know long range with them just where we stand in terms of our contracts. It takes time for us to build up a skilled staff of instructors. It takes time for us to bring in

equipment. On the ambulance contracts, for example, we would like to have five year contracts. If we have a five year contract, we can lease an ambulance cost-effectively for four years. If you only lease an ambulance for one year, then you are going to pay through the nose and nobody is going to win on a situation of that nature so we do like and are favouring long term commitments. At this point, they cannot give long term commitments because they do not know just exactly where their priorities and programs are.

CHAIRMAN (Mr. Zoe): I think my colleague, Mr. Dent, is actually saying, in terms of dialogue between the department and your group, in terms of planning for the future, that there is none. There is no dialogue between your group and the Department of Health. Although you do have a lot of dialogue, it seems like it is in a crisis situation, on the day to day operations and in terms of long-term planning and getting your input into their overall plan. I do not think that dialogue is happening from listening to Mr. St. Germaine and to you and to your statement that you made this morning. Am I correct?

MR. ST. GERMAINE: Yes, I think you have interpreted that correctly, yes. It is the long-term planning dialogue and our anticipation or input is what is absent. Because of the extent of the contracts, we do talk a lot about contracts and we make our pitch to tie into a long-term commitment but it is always, well, we are still thinking about how we are going to do this so we want a two year contract or whatever. So you are right.

CHAIRMAN (Mr. Zoe): Have you any further comments? Mrs. Jewell.

MRS. MARIE-JEWELL: Thank you, Mr. Chairman. What is the time frame for your contracts with the Department of Health?

MR. IRWIN: They vary, Mrs. Jewell. At this point our medevac contract for the western Arctic will expire on March 31 of this year. Our ground ambulance service in Inuvik and the ground ambulance service in Rae-Edzo will expire March 31, 1993 our ground ambulance service in Inuvik and the ground ambulance service in Rae-Edzo will expire on March 31, 1994. We have been given every indication to believe by the deputy minister of Health that the air medevac contract will be renewed. We requested, as Mr. McCluskey has suggested, for five years. We were told that we should be thinking for a shorter period of time that than.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: Maybe I did not ask clearly but what were the length of the contracts? Were they two year contracts?

MR. MCCLUSKEY: The length of the air medevac contract was three years and the two ground ambulances were for three years also.

MR. ST. GERMAINE: I was involved heavily with these. The air medevac was a three year contract. The Inuvik contract is a three year contract. The Rae-Edzo contract was for three years but it was renegotiated last fiscal year and it is now a two year contract.

CHAIRMAN (Mr. Zoe): Thank you Mr. St. Germaine. We are recording all of the proceedings so once the chair recognizes you, if you pass on further additional comments by another member of your team I would appreciate if you can indicate who will be making the additional comments. This is for the record in order for our transcribers to be aware of who is speaking. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: What has been the Department of Health's excuse for not extending these contracts from two years to five years. What has prevented them from giving a five year commitment?

CHAIRMAN (Mr. Zoe): Mr. McCluskey.

MR. MCCLUSKEY: I believe, Mr. Chairman, that the reason they do not want to go long-term at this point is that they are in a state of flux themselves in defining their own roles and responsibilities in relation to the boards. Until their own priorities and programs are sorted out then they would like to keep the terms of the contracts that we do have on an interim basis. They are classifying them as interim contracts and keep these short term.

CHAIRMAN (Mr. Zoe): Thank you. Mrs. Marie-Jewell.

MRS. MARIE-JEWELL: St. John Ambulance has provided the service for a number of years and there are some essential services that without question we continue to take, for example water and sewer, electricity, etc. It seems to me that just because there was a change of Ministers that there would be a reluctance at the bureaucracy level to want to request that these services be provided in the future. We know that as a result of the Auditor General's report the department is in a state of chaos. This department was in a state of chaos long before the change of Ministers came about in the past year. I cannot see, from my viewpoint, why the department is so reluctant, this is an essential service which will only enhance the service to the public of the Northwest Territories. I find this reluctance of concern regarding an extension of contracts or to be able to sit down and plan accordingly. This is somewhat not surprising but disappointing. It does nothing but add to the chaotic situation that they are in. It is interesting to note that there is a reluctance to look at a lengthy term as opposed to a two year to a four year term where you can do some long-term planning. I believe that this has been one of the areas that has been pointed out to us legislators the fact that the lack of planning and how it affects so many other organizations has such a ripple effect, detrimental to the delivery of health services to the people of the north. Thank you. There is no questions, Mr. Chairman, just some comments as a result of our findings.

CHAIRMAN (Mr. Zoe): Thank you. I agree. Are there any comments from the remarks that were have heard from Mrs. Marie-Jewell?

MR. IRWIN: I will just add to that to explain to the Members that part of the reason we are in contracts is complementary to our mandate but it also provides some financial support so that we can support our brigade functions, which is what Mr.McCluskey was referring to earlier with the cadets and nurturing a system where people may work with the health care system. If our contacts do not provide enough financial reward

to our organization then other areas of the organization suffer, it is not just the contract itself that hurts. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I get a feeling from what I have been hearing it is suggested that you are not being treated like a partner in the whole scheme of health. I was wondering if you feel this, that your organization is not fully involved in the initiatives for human resource development and that you are not being treated as a partner in terms of territorial-wide strategy for the services that you are delivering. Is this a correct assumption or feeling?

CHAIRMAN (Mr. Zoe): Mr. McCluskey.

MR. MCCLUSKEY: Mr. Chairman, I guess you could say that it varies from contract to contract. In some cases it is not a fifty-fifty partnership. We do have to work hard to keep some of the contracts going. We have had contracts in the past where we have had to carry burdens of a significant financial impact which has really hurt St. John Ambulance and put us on the point of closing our doors. We are still struggling right now to try and get out from under a significant debt which is hampering us in the work that we are doing. When we do have items as such as not being able to collect on ambulance fees and when you build up such as the $30,000 in past fees that we have not been able to collect, or another example has been on renewal of a training contract, this was delayed for three or four months. The department kept telling us that the contract would be renewed. This went on for three or four months and we had staff that we had to continue to pay but they said that we could not train anybody for the time being. We had to absorb those salary costs for a three to four month period. It was a significant amount of money and has really set us back. It is basically an administrative delay within the department. If they had been able to tell us that they were not going to renew the contract or that they did not see that they were going to do something within a six month period, then we could have laid-off the instructors and saved ourselves those wage costs. We do not take any dividends out of St. John Ambulance. The money that we get in goes right back to the communities. We have no cash reserves, no building fund, not anything. As a result when we get into situations like this then this is a debt that we have to absorb and it hampers everything else along the lines. It varies from contract to contract. In some it is a fifty-fifty partnership in others I would not say that it is fifty-fifty, we are doing more than our share to keep the contracts going.

CHAIRMAN (Mr. Zoe): Mr. McCluskey, maybe I will put it in another way. What I think my colleague was saying is that as a stakeholder in the health field, overall we sense that St. John Ambulance is not treated as a partner in the health field. Your involvement with boards and with the Department of Health appears that they are not keeping you as much involved as they should be and do you agree with our assessment. From the statements that you have made and from what you have been saying to us it appears that the working relationship is not there. They are not keeping you as much involved as you should be, is that the correct assessment? Would you agree that is the way things are?

MR. MCCLUSKEY: Mr. Chairman, in general terms, yes, I agree.

CHAIRMAN (Mr. Zoe): Does that clarify it better, Mr. Whitford.

MR. WHITFORD: Yes.

CHAIRMAN (Mr. Zoe): Any further general comments or questions for our witnesses? Mr. Gargan.

MR. GARGAN: Just one and that is, when you made your presentation, you focused a lot on the local level. I am glad that a lot is being done by St. John Ambulance with that. One of the areas in the presentation that was made by the department was that we do not have enough prevention or response to emergencies type of initiates by the department. A lot of the criticism is based on the fact that the administration of health and the delivery of health could be more effective and efficient. One of the statements that was made by the Deputy Minister yesterday is that the Northwest Territories has one of the best health systems in the world. I am just wondering, with your international experience, what do you make of that statement?

MR. MCCLUSKEY: Mr. Chairman, Brian McCluskey. That is a real mine field that one. I have not seen any statistics which would give me an opportunity to compare our systems with others so I really cannot comment knowledgably on that.

CHAIRMAN (Mr. Zoe): Thank you, Mr. Chairman. Just one final comment. With regard to your grass roots experience, what is your opinion with regard to emergencies and that? I mentioned yesterday that we need more paramedic type of programs, emergency response kind of programs, as opposed to maybe the administrative role of the department. We need to look in those areas and I think that maybe with your background in those areas, have you ever discussed this with the department at all? When an emergency occurs, it is more than just a medevac issue you know. It sometimes means life and death right there and then. This is an area in which I have had a lot of problems with the department because, in most cases, it is a two or four hour medevac flight and it is a critical part that is not really being addressed at the local level. We do not have that kind of expertise to deal with it there and then. I just wonder if you might want to comment on that since I have not been satisfied with any kind of response that was made by the department in this regard.

CHAIRMAN (Mr. Zoe:) Any brief comments, Mr. McCluskey.

MR. MCCLUSKEY: Thank you, Mr. Chairman. I think maybe we are looking at two issues here. Number one, I will take the first one in the context of medevac. In some discussions with the deputy minister last month on the overall problems in terms of training of personnel to adequately handle a situation where somebody has been serious injured or is very ill out in the communities showed that for delivery of that patient to a regional hospital or to the south, 70 per cent of the treatment that is done for that patient to arrive at the final place of care is going to be done on the ground. The other 30 per cent is in the air medevac itself. That is really not an issue at this point that St. John Ambulance is getting into other than the fact that we are offering our services to provide advanced training

programs for the community health nurses if that is the direction that the department wants to go.

The second point is in terms of what I had brought out in the paper and this is to try and prevent those injuries and the serious illness from occurring in the first place through proper education. Really, it is preventive health issues. It is two different issues there. So, with St. John Ambulance looking at the preventive health care on the educational side, on the longer range and the short range we are able to provide advanced training courses, if the department wishes, for the people in the health care stations in the communities.

CHAIRMAN (Mr. Zoe): Mr. Ningark, we have five minutes allotted, five minutes remaining in the allotted time.

MR. NINGARK: In Mr. Brian McCluskey's opening comments, under managing people, he stated "providing more of the training for health care professionals." Now we have C.H.R.s in most of the communities in the territories and their contribution to health care is as important as the other health care professionals, like the doctors and the nurses. In fact, they are the essential link between the doctors and the public. Now, Mr. Chairman, I am wondering if St. John Ambulance has provided training for the C.H.R.s? Thank you.

MR. MCCLUSKEY: Thank you, Mr. Chairman. Brian McCluskey. Subject to correction here from the staff, I am not aware of any training that we have given to the community health workers or community service workers at this point. Our initiatives in the future are that we would certainly like to get involved in that as part of this nurturing environment for the cadets coming along. We would like to involve them. If a community only has one community health worker, I think there are enough families out there and enough of a work load that one person alone cannot handle. If they have an assistant to help them along, then that is excellent. That is where we would like to be involved.

CHAIRMAN (Mr. Zoe): Mr. Irwin, do you have additional comments to make?

MR. IRWIN: If I might, Mr. Chairman. We just completed a training program with nine of the community health representatives so, Mr. President, I am sorry. We see this as a very vital role and I think as we have tried to indicate in our presentation, we would like to enhance the role of the community health representatives, the lay dispensers. We see the training for these people as absolutely essential for the delivery of health care services throughout the territories. As Mr. McCluskey has already suggested, we have a faculty for this basic trauma life support course. It is taught as part of the A.N.S.I.P. program. It is made available to nursing staff in the hospitals. We are prepared, as an organization, to examine the financial reality or feasibility of getting involved in the neo-natal, the paediatric and the advanced lay support people. This is the training that would be right there in the community at the health centres which is the point of entry for most of us, in the north, into the health care system.

CHAIRMAN (Mr. Zoe): Thank you. I would like to thank the St. John Ambulance group for making their presentation to our committee this morning. We are very appreciative. We wanted your involvement and you did come forward so our committee would like to thank you for making your presentation to us this morning. Mahsi. With this the committee will adjourn now and reconvene at 1:30 p.m. with the Department of Health.

---LUNCH BREAK

CHAIRMAN (Mr. Zoe): I would like to call this meeting to order. We will continue with the Department of Health to conclude with the Auditor General's report. Yesterday when we concluded with the Department of Health we were on chapter four, the managing of people section. Are there any further comments or questions pertaining to chapter four?

Dr. Kinloch, in regard to this particular section, each year when we do our budget line by line there is an objective that is set out in the S.C.O.F. estimates which the department would like to carry out for that particular year. With regard to human resources, those objectives that you have set out, have they all been completed or worked on as stated in the S.C.O.F. document?

DR. KINLOCH: Mr. Chairman, the document sets out those areas which have been identified by the department for that particular year. It is the intention when that document is prepared that the department will pursue those objectives. Occasionally events intervene, priorities change and they are not all pursued completely. Normally there is some progress in each of those areas set out in the document and we report annually on progress in those areas. We will be doing so in the S.C.O.F. again this year.

CHAIRMAN (Mr. Zoe): For my own and the committee's curiosity, through the research department, I pulled out the last four years of our main estimates. In 1989-90 one of the objectives for this particular section was to develop an orientation and training program for staff on health insurance services. There was another one to develop, in conjunction with the regional health boards, an affirmative action strategy. That was in 1989-90. Where is that work? How far have we gone on that particular work? Mr. Lange.

MR. LANGE: Thank you, Mr. Chairman. In 1989-90 that was one of the stated objectives to work with the boards on affirmative action. There was not a lot of progress made towards that. A lot of this has to do with the overall government's strategy and plans about affirmative action. They have been somewhat not concrete over the last number of years. That is not to say that we should not be doing our own thing but we also work in conjunction with the Department of Personnel's issues for overall government objectives.

CHAIRMAN (Mr. Zoe): I understand that. In this particular year that was one of your objectives that you set out to do. You were asking for money to do these objectives. There is another one which says that to design and introduce, in consultation with the regional health boards, a process for human resource planning. I do not know if you developed this process for human resource planning. This was another objective that you stated in 1989-90.

MR. LANGE: We do not have overall written firm plans in place. We had been working on various projects and specific activities, such as the C.H.R. program. We do not have an actual hard copy of the overall plan at this point in time.

CHAIRMAN (Mr. Zoe): I could go on and on. In the current year, 1992-93, another objective pertaining to your section was to implement a strategy for attracting northerners into health care careers. Again, another one is to assist in the design of northern registered nurses education program. I know that this one has been worked on for the last number of years. In this area what strategy are you talking about implementing? It says to implement a strategy for attracting northerners into health care careers. Do we have a strategy?

MR. LANGE: Thank you, Mr. Chairman, a lot of the activities we do are project related. I guess one of the things that I was alluding to yesterday, which I think people are aware of, is our health careers brochure. That was one of the more concrete things that we did. I think that has been positively accepted by quite a few people. That is one of the ways in which we have been attempting to influence health careers for the younger generation. One of the more positive concrete things we do is the C.H.R. program, which has been very successful. A lot of specific projects are working towards our overall strategy.

CHAIRMAN (Mr. Zoe): On your overall strategy that you are referencing to, can we get a copy of that? The one you just alluded to.

DR. KINLOCH: Yes.

CHAIRMAN (Mr. Zoe): Would you agree that, within the last four years, the objectives that were set by the human resource section have not been met or have not been met completely? Would you agree that the objectives which have been set every year have not been met?

MR. LANGE: No, I would not agree that our objectives have not been met, Mr. Chairman. I will, however, agree that they have not been met 100 per cent. I think there are a lot of activities that we have done towards all the stated goals that we say we are trying to achieve.

CHAIRMAN (Mr. Zoe): In your view what percentage of your objectives have been met?

MR. LANGE: For the type of work we do, Mr. Chairman, we cannot measure at the end of a certain period of time that we have produced ten widgets. A lot of the things we are doing are policy type of developments, ongoing activities such as trying to maintain the C.H.R., producing some things that are concrete. A lot of the things that we do produce are not concrete such as you can hold them up and show people. I think we are making progress towards all our stated activities. They may not be 100 per cent complete but I think we work towards all of our goals that we say we are attempting to achieve.

CHAIRMAN (Mr. Zoe): Would you not agree as the Auditor General's report indicates that we have no mechanism in place to do these measurements, to measure success. We set up objectives and we try to reach that end result. How can we measure that if you have nothing in place to do this. How do you measure your success?

MR. LANGE: In our case if we can show, that over a long period of time, we have a gradual increase in the number of aboriginal people in health careers, that will be a direct measure of our success.

DR. KINLOCH: Mr. Chairman, if I can comment also.

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: I think it is also important to recognize that we are not working alone in this exercise. We are working in collaboration with the Department of Education and with Arctic College and others. The success in attracting aboriginal people in to health careers is dependent on the success of the Department of Education preparing students for entry into those programs. We are faced, as you know, with the bad situation of a 68 per cent drop-out rate in secondary schools in the Northwest Territories which is well over twice the average of any southern province. If we cannot do anything about that, then the efforts to propel people into health careers is going to be seriously handicapped. In addition to that, we are pursuing lines that were described to you yesterday by Maureen in terms of setting up an access program that will draw people who have not successfully complete high school to upgrade their skills to the point where they can enter a number of the careers that are set out in this document. For that reason, it is difficult to assess the success or otherwise of the work of the division because they share either the glory or the blame with other units and other departments.

CHAIRMAN (Mr. Zoe): I understand that. Dr. Kinloch, you are using the rationale again that your problems are because of the education system with 65 per cent failure but our statistics show that the number of graduates have been on the increase for the last number of years. So how can you use that as an argument for saying that is part of the reason why we have not attracted as many people into the health career area?

DR. KINLOCH: Mr. Chairman, I was not making that argument. I was just saying it is a consideration. We need the educational system to produce more graduates, and not just more graduates at the general academic level with a general high school diploma, because that frequently does not prepare you for entry. You need a matriculation diploma.

CHAIRMAN (Mr. Zoe): Getting back to my objectives again. It is my understanding that any objectives that any department sets are supposed to be measurable. Now, your department is saying, well, some of the objectives we have set for ourselves are not measurable. That is what I am hearing from you.

MR. LANGE: Mr. Chairman, maybe I can respond to that. Our objectives are measurable, more meaningful on the long-term rather than on a short-term period and, I say, it is probably not something that is measurable over the course of one year when you are trying to promote the entry of people in the health careers.

CHAIRMAN (Mr. Zoe): Well, do we not have a system called management for results system in place to do that?

MR. LANGE: Again, some of the objectives we are trying to achieve are not achievable in the short-term. They are more achievable in a long-term process.

CHAIRMAN (Mr. Zoe): I will get to you, Ernie. One more quick one, if I could. If the objectives are long-term, and I mentioned some of those objectives that were set, should they not be measurable by now in your terms? You are saying, well, some of them are long-term. I went back as far as 1989-90 and some of those must be measurable by now, would you not say?

MR. LANGE: Well, I guess we measure them every year but the progress would be slow. The definitive objectives also in the main estimates, your are right, are supposed to be completed in one year. As you say, in 1989-90, we were to have worked with the boards to develop an affirmative action strategy. That was not done. No, that was not achieved in that year. I think that is what you are trying to say, the definitive objectives are to be achieved in that year. You are right. We did not achieve all our objectives. I think we made progress towards achieving part of them I guess.

CHAIRMAN (Mr. Zoe): Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. Dr. Kinloch, I think just by listening to you say we have to get our people to go from general education to advanced education. We have to stop saying that. We have to start saying, along with your department and all the government and the parents and say, stay in school, do not drop out, rather than what we are trying to do now. We are trying to make good products with drop-outs and putting them in only selected areas and I think that is really wrong. After all, your department is about the most sophisticated and the most technical field when it comes to dealing with humans. The terminology, everything is so complicated for us to understand. You are setting the criteria for entry too low. You are not setting your standards high enough so that we can tell our people to go into it.

I really disagree when you say, well, some of them drop out of school but in order to gain something you have got to sacrifice your pleasures for a few years. This is where I do not understand this government. It is telling our people, okay, drop out of school, go on the welfare system for awhile and then, after you have finished having fun, go back to school. That is not true. We cannot go on like this. We are not getting our money's worth when we say go into general education. I think it has to start at the community level with the teachers and the parents saying there are two kinds of grade 12, advanced and matriculation. We have to get that otherwise we are just living on dreams. We do not have visions but we only dream and I think that is wrong in society.

CHAIRMAN (Mr. Zoe:) Thank you. Any comments, Dr. Kinloch?

DR. KINLOCH: Yes, Mr. Chairman. I think Mr. Bernhardt may have misunderstood me. I was not suggesting that preferentially we would look to people who had dropped out of school and required upgrading, but I do not think we should ignore those people either. We certainly support every effort to have children stay in school, to have their parents value education, to have communities value education, to have society value education such that, over time, we are going to have a large cadre of well qualified people who can manager this system, direct providers of care and teachers of others and the sooner the better.

CHAIRMAN (Mr. Zoe): Before I go to the Member, I would like to get back to the accountability objectives. Can I ask, Mr. Martin, whether the Department of Health is describing an appropriate use for definitive objectives within the management for results system? Are they avoiding accountability by bringing forth objectives that cannot be measured? Can I get you to comment on that, Mr. Martin.

MR. MARTIN: From my personal experience, I would think that an objective, for it to be useful, would be able to tell you what is going to be achieved within a specific time frame. In other words, it is like a plan of action. I would be concerned in putting down your objective, you have specific goals that you propose to achieve within a specific time frame that are, indeed, measurable and, if that criteria is met in putting down a specific objective, then that is a useful objective that you can then look back on and see whether or not you did, indeed, achieve what you set out to achieve. Thank you, Mr. Chairman. Does that answer your question?

CHAIRMAN (Mr. Zoe:) Not really. Let me try to put it another way, if I could. Now, the objectives that they are setting, they do that each year. My question to you is, are they avoiding accountability by bringing forward objectives that cannot be measured? If they cannot be measured, then why bring them forward?

MR. MARTIN: I think you just answered the question, Mr. Chairman.

CHAIRMAN (Mr. Zoe:) So, in my view, the objectives that have been set for the last number of years, the majority of them are not measurable. Even Mr. Lange attested to that, so I would have concerns about how the objectives are written and how achievable they are. We have to be able to see, they have to be measurable. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I agree entirely and I would also agree that many of the objectives that have been set in the past by the department have not been well framed in terms of the ability to describe progress and to measure it quantitatively. We have begun a process to bring objectives more into alignment with what is considered to be an objective. That is something that Michael has described. In addition to that we have described and set out for ourselves some of the characteristics of the indicators that we would use for measuring the results. Briefly those are that the indicator must be valid. It must measure what it purports to measure and that is not as easy as it sounds. The characteristic must be objective, reproducible when measured by somebody else. It has to be sensitive in reflecting actual change and it has to be specific, ie. responding only to the subject that you are studying rather than something else. We recognize that there are very few indicators that comply with all of these easily and that they have to be tempered, nonetheless it is our aim in 1994-95, to submit a whole new set of objectives that meet these criteria.

CHAIRMAN (Mr. Zoe): Thank you. Do you have any comments, Mr. Martin?

MR. MARTIN: A quick comment, Mr. Chairman. To be fair to the department during our audit the weaknesses of the M.F.R.S. system was recognized by all parties concerned and

they were aware of the kind of work that needed to be done to those objectives to make them more measurable. The problem was recognized. It is not one that can be solved overnight. As Dr. Kinloch has stated work is proceeding to ensure that objectives can be made more measurable. That is not an easy task in some cases. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Are there any general comments on chapter four, managing people? Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I wanted to go back to the whole thing of education getting more northerners involved in health services. Yesterday in talking with the Deputy Minister of Health and Social Services of the Yukon she suggested that the problem was not just the number of graduates you are getting but, as you have alluded to, the number of graduates who are coming through the system with math and science. There is a real problem when you get somebody who has to spend two or three years upgrading before they can even start training to get into the field. It is very tough. I think this brings us back to something that Mr. Gargan was bringing up earlier and that is, is there some way to start getting people into the system so that they get hooked on working in the health field, and then over time upgrade, whether it is from C.H.R. to nursing assistant to registered nurses, etc. Has the department worked with the Department of Education to see whether or not there might be a way to set up a program which takes into account the problems that we have with getting qualified graduates in the north. What is happening with this?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I will ask Maureen to respond to that.

MS. MOREWOOD-NORTHROP: I think that going back to the proposal for the nursing diploma program that we were talking about yesterday, Mr. Dent, when we were talking about an access into the nursing diploma program, we were not just looking at an access into that program but an access into a health career within the system. We may be looking at people accessing that to go into C.H.R. training, medical interpreter training, nursing assistant program, to move on into another area, and then on into the nursing diploma program. People could then have some experience in the health field as a C.N.A. or a C.H.R. and then go back into the access program and take some more courses in order to move into the nursing diploma program. That is just specifically to the nursing diploma program, I recognize that. There are exit points that they can take at the access to exit into a C.N.A. program or I think even Arctic College want to combine the social worker diploma program as well. They are looking at a whole health career program. The nursing diploma program is the actual end product with credits going on to get a degree in nursing. I think that Arctic College may be looking at some of the health careers to combine with the sciences.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: It sounds like you have a start on the way. What I am hoping to hear is that you are going to actively work with Arctic College to try and develop a continual program which will provide better access to get northerners into the system and to stay in the system. That obviously has to be one of the long-term solutions to part of the problem.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: Mr. Chairman, I have a comment in regard to the whole question of efficiency, effectiveness and economy. Two years ago the health budget was about $170 million, and it has since gone up to $250 million if you include the deficit, the $80 or $90 million which still has to be repaid by the federal government. Mr. Chairman, this is one measurement that I could use as an example that the Department of Health has done a substantial amount of expenditure and the increase is not five per cent. It tells me that we do have a situation in which the cancer rate is going up, alcohol problems are rising and suicide rates are increasing. There are a lot of problems within the communities which are not being addressed. We seemed to be incurring more and more costs and we are not living within our means. I would like to see the Department of Health taking the lead role in that area to ensure that since next year we are going to have another deficit, or maybe not I am not too sure, the department should be able to say that we are spending way beyond our means and we do not have that kind of dollars any more. We should be looking at that. I keep hearing responses that leave me in limbo because they say that if we had trained C.H.R.s that would be a measurement of success. What does that mean? Everybody graduates. Even though you poke a person in the behind with a needle, is that a success? You are telling me success stories that really do not mean anything because it is still wide open. We are in a situation now where it cannot be tolerated any longer. We are taking this so lightly. You are responding so lightly, life goes on. It is the communities who are going to take the brunt of it. It is easy for the department to sit up here in Yellowknife and say all those things but we are not doing anything for the communities. St. John Ambulance was here and they have a lot of good initiatives at the local level. We should be doing the same thing but we are trying to measure things. Start doing some measurements out there. Start increasing the health of the people out there. The administrative part is good but that is not where we should be concentrating on.

CHAIRMAN (Mr. Zoe): Thank you. Any comments, Dr. Kinloch.

DR. KINLOCH: Yes, Mr. Chairman. At the risk of being repetitive the department does place a great deal of importance on health promotion and disease prevention and protection of the public. These are not emphasized in the report and that is why we are not talking about them as much as we should be. The bulk of our efforts in the communities are in the health promotion and disease prevention areas. They are not as visible. They are not as easy to measure. They, nonetheless, remain the first order of effort if we are going to improve the health status of the population.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I guess we have kind of moved away from it a bit but I just wanted to come back again to make a couple of suggestions to the department. If nothing else, they could give it some very serious thought and that comes in the way of encouraging more aboriginal peoples to participate in the Department of Health's activities,

be it administration, in the medical field or the community area in some way. Is to take the suggestion and step back a few years in time and, as I referred to yesterday do a little head hunting, and I think you are quite successful in some areas and that might be a step in the right direction. You are going to have to have someone to start things off and maybe design a program with the cooperation of Arctic College, or the Department of Education, or Personnel, based on what the Northern Careers Program was doing. I think that had a lot of merit then and it may have fallen on some tough times since. It will attract people to do things that you want to do further down the road but they have to have some inspiration somewhere. I think it would be money well spent if the department did head hunt and find some high flyers and specifically train them for some area. You know, make a job target three of fours years down the road so they go in there with full vigour to train that person to take my job so to speak because they know they are going to move on to something else anyway.

I know that it has worked well in other areas and I just want to say maybe at this time we dust it off and look at it. I realize there are shortcomings in the educational area, and I know that is probably the feeder for other professions along the way. They have to get this basic background. Now we should not short change the potential of people and say, well, simply because you are from the north you do not have to do all the things and we will give you something easier. Not that at all.

It is just that there are some times you might have to take a person and give them that on-the-job training experience. It will attract other people to get in step further on down the road because they know what effort is. You have to be careful who you pick, too, because there is a lot of work too. Let us do that. We should introduce that. I am not sure what areas they can be introduced into right now, Dr. Kinloch, but there is a way of examining where the turnover is and where some of the key areas would be that you can do that.

I know you will not get a surgeon in there right off the bat but you are going to get an administrator. You are going to get a human resource officer. You are going to get many functions within headquarters that can be done through that method. It is kind of like seeding the department with people who will set an example. In the medical field too. I do not know all of the jobs but surely there are ways of doing it using that method. I would like to encourage the department to visit that and I certainly would be, and I am certain this committee would be, available to help that along the way. It is an old idea that needs to be revisited. Education will do its part but maybe we have to take it a step further.

CHAIRMAN (Mr. Zoe): I agree with what my colleague is saying and there are programs available to supplement exactly what my colleague is saying, for instance, in-service training program. Now I do not know if the department is utilizing that particular program, particularly at headquarters. I know the other departments are. That is why it is there but I do not think your department has gone out, acquired and taken advantage of that particular program that our own government is offering. So I do not know if your department even considered getting into the in-service training program and attach it to a various position within the Department of Health. There is an avenue there that could be utilized and I am not too sure if the department is utilizing it or not. Dr. Kinloch would you like to comment on what my colleague and I are saying?

DR. KINLOCH: Yes, I am happy to hear those comments. We will certainly pursue them. We are, in fact, intending to take advantage of the in-service training program. There are eight allocated positions for headquarters each year and we are intending to take advantage of that program. I have also suggested to the Department of Personnel that, in addition, there should be the creation of additional positions within health so that we can proceed a little more rapidly along this path. The eight positions are spread pretty thinly across a fair number of departments and that is going to take a long time.

CHAIRMAN (Mr. Zoe): Are there any other comments on chapter four. If not, I would like to go on. Agreed?

SOME HON. MEMBERS: Agreed.

CHAIRMAN (Mr. Zoe): Dr. Kinloch, have you any additional comments that you would like to make other than the ones that have been recorded in the report?

DR. KINLOCH: Mr. Chairman, I would like to introduce Darrell Bower, Director of Finance and Administration and Linda Jackson, Director of Health Insurance join me at the table, if I may. Mr. Bower will make some short introductory remarks.

CHAIRMAN (Mr. Zoe): Thank you.

MR. BOWER: Thank you, Mr. Chairman. On chapter five, the department recognizes the need for information to support planning to monitor results against plans. It is agreed that the health information system or H.I.S. System as it is referred to and the community health information systems, C.H.M.I.S., do not now fully meet that need. However, the two systems do provide useful data and they do provide a useful resource for comparative purposes against data from other sources.

The report notes that H.I.S. functions mainly as a billing system. In trust, that is what it is and it works quite well in that capacity. Currently, the Department of Health is looking at the health profiles of various areas which was mentioned earlier to you yesterday, not only at what exists in the way of services but what exists as data to provide the profiles. One component of this effort is to arrive at a determination of the data required to monitor and evaluate and plan. This will provide the department the basis for evaluating its systems needs. It is likely that a proposal for an overall system change will not be brought forward until 1994.

Throughout 1993, the majority of system time and resources will be going into the decentralizing of the existing insurance plans to Inuvik and Rankin Inlet. The time frame for the system to be on the ground is November of 1993. There will be benefits to the effort going into the decentralization of the existing insurance plan. C.H.M.I.S., as a system, will be integrated with the H.I.S. system. Needs of users will be looked at closely and incorporated where possible. Encounters, under various insurance programs, will be linked. The resulting system will have been designed with the flexibility of making further changes.

In the meantime, an important area to be worked on is the determination of board data needs. The effort and cost to collect all data would be prohibitive. However, the determination of the basic data for planning and monitoring would assist in department system re-designs. This combined with health profiles should form a core list of requirements. Interim steps, however, will be taken to provide various data from existing sources based on board requirements. The Auditor General's report recommends that the department improve its ability to have only current eligible residents registered in the health system. The department is examining methods being explored by other provinces but these are in the test phase only and are expensive to undertake. The N.W.T. has one of the most mobile populations in Canada making the task difficult.

The G.N.W.T. is party to a provincial/territorial reciprocal billing agreement which addresses payment for insured services obtained in other jurisdictions in Canada by N.W.T. residents. This ensures portability of eligibility for health care in any locality in Canada. It has eliminated the difficulty that used to exist for a resident in obtaining needed services while they were in the south.

The aspect of research has been commented on in the Auditor General's report. Exception is taken to the statement that the department has no research resources of its own and research data are poorly managed. True the department has no fixed laboratory research resources. However, it undertakes various research efforts into various issues and quite often with existing staff. The department has been actively involved with and has liaised on a regular basis with the Science Institute of the Northwest Territories.

The department recognizes that information sharing within the department and between the department and health boards could be improved. However, there is a great deal of sharing already. In fact there are daily exchanges at all levels that are a form of sharing. Reference is made to the information held by hospitals and health facilities. This information is shared and is referenced on a regular basis.

In reference to the policy and legislation division I would like to note that the division has been extremely busy over the last few years updating existing policies, legislation and working on new policies. The amount of effort required on each on of those activities is extensive.

With regard to references made to the T.H.I.S. Act and its regulations, the department will be establishing a Memorandum of Understanding, which Mr. McClelland noted to you yesterday, over the next few months in conjunction with health boards. Once this has been established it will serve as a catalyst for needed changes to the T.H.I.S. Act and regulations. As indicated in the management response the functionality and mandate of the legislation and policy division will be determined in overall review of the department's functions and roles.

The department recognizes that the assortment of financial systems and charts of account is not in the best interest of the health system overall. To this end the Department of Health and the boards have been determining needs and clarifying the process that would lead to a common system. This process is tentatively scheduled to end in the summer of 1993.

In regards to a common chart of accounts, this is being addressed and will be presented to the directors of finance for the boards and the department in the spring of 1993. Mr. Chairman, that concludes my opening comments.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: In the Auditor General's report it was observed that the Department of Health has not been able to take full advantage of the range of health research projects that have been completed in the territories. You did mention that you liaise quite a lot with the Science Institute. Research is the Science Institute's responsibility. Is this relationship still what was intended? Is it serving the needs that you may find necessary, not having the resources yourselves?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, yes. The relationship with the Science Institute has been fruitful. Some of the deficiencies in obtaining information about completed projects has not been a result of a lack of liaison with Science Institute but rather a lack of fulfilment of reporting requirements by some researchers. We have not always received, in a timely manner, the output of projects that have been licensed under the Scientist Act. The department reviews health related research proposals that are to be considered for a scientific research licence and is free to comment on those and to contact the proposer if there are questions which need to be addressed.

I think that the relationship is one that should continue. I think it is important that there should be a screening of proposed research in the territories because the implications are not always clear to the proposers particularly if they have no northern experience. I think the arrangement whereby health acts as a general filter for such proposals is a good one.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions? Mr. Whitford.

MR. WHITFORD: I have a document titled "Health Research North of 60 Workshop". On page 17 there are a list of criteria. It stresses community involvement, research evaluation and investigation to help northerners to see how well they are doing. It does stress an awful lot of community involvement. Is this still...

DR. KINLOCH: Yes, Mr. Chairman. It is and the Science Institute is the vehicle through which this community consultation is obtained. The proposals are reviewed by the Science Institute through a panel and then into the region or community depending on the nature of the project. Some of them are clearly local and some regional and some territorial-wide in their implications. The appropriate area for consultation is determined by the Science Institute.

CHAIRMAN (Mr. Zoe): Are there any questions or comments on chapter five, information management? Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I know that the Stanton Board told us today that they were quite interested in seeing a

system set up which would be consistent. For instance, using the same chart of accounts and the same sort of accounting system, so I am pleased to hear Mr. Bower say that they are going to be presenting a chart of accounts this spring. My concern, and it was one shared by the board, is that perhaps the department might be imposing a system rather than using a consultative process to arrive at a system which would suit all the potential users. If you make your chart of accounts so complex that somebody in a nursing station cannot use them, then you cannot access their files as easily as might otherwise be the case. You increase the chances for mistakes to take place and that makes your information less useful. My question is that when you say you are going to present this chart of accounts in the spring to the financial officers of the boards, are you planning to present a "fait accompli" or are you in fact engaging in a consultative process right now to ensure that what is going to come about and be proposed is one that is going to be bought into by the majority of the boards?

CHAIRMAN (Mr. Zoe): Mr. Bower.

MR. BOWER: Thank you, Mr. Chairman. I could have elaborated a little bit more earlier. There is a directors of finance group of the boards and the Department of Health that meet. They have been meeting on a regular basis. There is a working group established underneath of that looking at this issue in itself. That is primarily made up of directors of finance from the boards. They have been a major focus in it. It is not something that will be brought down from the Department of Health. It is a collaborative effort. It has to come out of that with a consensus of the group before it is presented to the directors of finance for the health boards. It will be nothing that we are going to impose on them. It has to be a working solution that they are going to be able to live with afterwards.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Not a question, just a comment. I know from my experience with financial systems in the business world, my comment would be that simple is always best and I would hope that you keep it really simple, no more complex than we need for a population of 57,000 so that we get meaningful data back. I think the more complex the system gets, the greater the chance for errors and that makes your data less useful.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Bower.

MR. BOWER: Mr. Chairman, I can only echo that comment. One of the first things that we determined as a requirement was to keep it simple.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I just want to go back to the question of research. Regarding what you mentioned about the department carrying out its own work in the research area, one of the key people would be the epidemiologist position. What is the status of that PY? There was a vacancy there for the longest time. It is filled?

DR. KINLOCH: It is filled.

MR. WHITFORD: It had been vacant for a long time. Could you tell me how long that job had been vacant?

DR. KINLOCH: Mr. Chairman, this story is interesting because the individual who filled the job was a physician epidemiologist who came to Yellowknife for the Canadian Public Health Association meeting here in July and liked it. He applied for the job and came back so we are very pleased.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Could you tell me how long this position had been vacant? Not necessarily right now, but later.

CHAIRMAN (Mr. Zoe): Thank you.

DR. KINLOCH: It was quite a few months.

CHAIRMAN (Mr. Zoe): Chapter five, information management. Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. Dr. Kinloch, under policy and legislation it says, "the department's policy and legislation division reports directly to the deputy minister in a staff report role. The policy and legislation making process reacts to changing needs. No new departmental policies have been established in five years." None of the policies in place deal with current medical and health issues in the Northwest Territories. Why is that? Why has there not been any new policies? For instance, regarding abortions and other related matters that deal with the overall operation of health in the territories. Why has there not been anything new?

DR. KINLOCH: Mr. Chairman, I have asked Stella Van Rensburg, Director of that unit to join us. I would ask her to comment briefly on the nature of the work load of the division and the policy and legislative activities that have occupied her time recently.

CHAIRMAN (Mr. Zoe): Thank you.

MS. VAN RENSBURG: Mr. Chairman, since 1983 the grants and contributions policy underwent extensive revision in August 1991. The medical travel policy underwent extensive revision in June 1992. The extended health benefits policy was amended and approved by Cabinet in January 1991. The department is currently working with various government departments on the G.N.W.T. smoke-free workplace policy and on amendments. We have been very preoccupied amending the current health policies. Mr. Chairman.

DR. KINLOCH: Mr. Chairman, there is also enormous work load in relation to the preparation of legislation. Even relatively minor amendments frequently take a great deal of work as the most recent amendment to the Health Insurance Act. There are major acts under review, the Mental Health Act, the Public Health Act is about to begin and the Medical Profession Act. These are major tasks. Some of the policy work is to be undertaken in collaboration with other divisions. Perhaps the one of particular interest is the policy changes to medical travel. The policy has been instrumental in gaining considerable control over the medical travel budget. We, as a consequence, are achieving some considerable cost avoidance. I should note that this particular policy was viewed by central agencies as a model for how such policies should be prepared and presented and has been recommended to other departments for their use.

CHAIRMAN (Mr. Zoe): Any further questions? Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. According to the Comprehensive Audit of the Department of Health under section five, information sharing between boards and the department, there seems to be a lack of information sharing between the boards and the department. If the information is received at all, it is usually late. There is very important information required by the boards within the system such as utilization reports, medevac, strategic plans and community disease profiles and so on. Mr. Chairman, what is the Department of Health doing in order to correct the situation? What has been the problem in the past when the boards have not been receiving the important information?

CHAIRMAN (Mr. Zoe): Thank you.

DR. KINLOCH: Mr. Chairman, there are a number of efforts under way to attempt to improve the flow of information. One of them is to avoid the need for moving information back and forth by using common data sources. One of them referred to here is H.M.R.I. which stands for Hospital Medical Record Institute. These relate to hospital discharges. They are electronically processed in a central location nationally. They are available to us on compact disk or on computer tape. In effect, a board and the department can access the same information without the need of exchanging it back and forth. One of the difficulties to date in making use of that information is that some of the hospitals in the system have been slow in completing their hospital discharges and therefore the data available to us have been many months out of date.

Second, is the revitalization of the C.H.M.I.S. that is the community data system that Mr. Bower referred to. This is a system that we inherited from Health & Welfare Canada. It was developed in 1986 or 1987. It was developed in a manner rather more cumbersome than was required. They did not keep it simple and as a result there have been some difficulties extracting data from the system. We hope that these problems will be resolved in the restructuring of the system.

In addition to that, we should recognize that boards independently make use of data they accumulate themselves and there is sharing at that level of not just raw data but of analyzed data, something that permits analysis and action. We encourage boards to do that. It is, nonetheless, necessary to pool that information on a territory-wide basis if we are going to use is it for territory-wide strategic planning. We are encouraging all of these efforts and expect that the new systems that are being developed will help in the process.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions? Mr. Ningark.

MR. NINGARK: Yes, thank you, Mr. Chairman. According to the report, under the same section, the board also complained about the poor quality of information they receive which they feel are often redundant and not useful or unreliable. I wonder if the department is going to somehow endeavour to correct the situation? Thank you.

CHAIRMAN (Mr. Gargan): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, yes, we are.

CHAIRMAN (Mr. Gargan): Okay, can we go on to chapter six, capital assets. Are there any opening comments?

DR. KINLOCH: I would like to introduce Mr. Don Olenek who will make the introductory remarks on capital.

Introductory Remarks On Capital

MR. OLENEK: Thank you, Dr. Kinloch. Thank you, Mr. Chairman. I would like to acknowledge the Auditor General's report on chapter six. I look upon that as being a positive piece of information for the department to work from. The Auditor General's comments on chapter six were very to the point and the brevity sometimes makes it, I guess I find it, a little confusing. I would like to clarify for the Members two points which I feel are very important.

During the period of 1986-87 and 1991-92, the department's capital program activity was in the range of $63 million in the Northwest Territories. These expenditures were broken down into approximately $56 million for fixed assets. These are the items that fall under buildings and works. These are the health centres that we construct, the renovations we make and safety code upgrades throughout the territories. Another $4.8 million was expended for the purchase of the x-ray machines, the stretchers, the E.C.G. recorders and microscopes that we put into the health centres. An additional $2.14 million was provided in the way of contribution funding. These are the areas that we provide funding for including the personal care facility in Fort Smith and the boarding home in Ndilo.

The department does not purchase assets on behalf of the health boards. We provide the funding to the boards and they make the decisions on which assets they need to replace or to enhance their programs.

At the time of transfer in 1981, neither the Department of Health or the Department of Public Works had an historical database of health facilities from which to plan and develop capital estimates for capital projects. D.P.W. did their best to provide costing estimates assuming construction practices similar to public buildings like schools, recreation centres and administrative complexes. Both departments have since learned that the construction and supply of equipment for health centres are more complex and specialized, resulting in increased project costs.

The Departments of Health and the Department of Government Services and Public Works, are currently reviewing the capital projects process manual and anticipate completion of this process by September, 1993. Revision of the capital standards and criteria for health facilities will be undertaken as a parallel project. The department has a post-occupancy evaluation process for health centres. The P.O.E.s which they are referred to are scheduled anywhere from 12 to 24 months after a facility has been constructed and/or renovated.

All health facilities which are maintained or operated by Government Services and D.P.W. are operated in accordance with an approved maintenance management system. The Stanton Yellowknife Hospital and the H.H. Williams Memorial Hospital have their own maintenance staff and also maintain their facilities under approved maintenance management systems.

Development of specific operating policies is an ongoing, collaborative responsibility of the boards, Government Services, D.P.W., and the Department of Health. Maintenance of general equipment in health facilities is also addressed under the maintenance management system of Government Services and D.P.W.

Bio-medical equipment is the specific responsibility of the boards. Each board is responsible for the maintenance of the necessary contracts with suppliers and/or service companies to provide for the inspection, testing and maintenance of bio-medical equipment. Routine preventive maintenance is to be performed in accordance with regulatory requirements and to the manufacturer's specifications. Thank you.

CHAIRMAN (Mr. Zoe): Could I ask the A.G.'s office to comment on the remarks that were made? Do you have any comments? None? General comments or questions from the committee. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I understand that the department has been working on a capital asset tracking system or C.A.T.S., and that this a four phase program which was introduced to help boards in October, and is scheduled for introduction over the course of the next year and a half or so. I am quite pleased because I have been harping on plans, goals and methods of achieving this and I see this one has a timetable, it has goals and it has exactly how you plan to get there. I almost loathe to go into this next part but it seemed that Stanton was not totally aware of the fact that they might have to change their system. We questioned them this morning about capital assets and they seemed to think that their system was perfectly good. They had heard that the department was looking at a capital asset tracking system, and they did not seem to be aware that they might have to fit into the program along the way. Was this system presented to the finance officers in October and just as something that was done, how much of a collaborative process was involved? Were the people who are actually going to have to use this system involved in helping to design it?

CHAIRMAN (Mr. Zoe): Mr. Olenek.

MR. OLENEK: Thank you, Mr. Chairman. The tracking of assets is over the last year and a half more than just counting numbers of pieces of equipment. As we looked at asset tracking, we found that from the insurance perspective we could not provide a very good accounting of the value of an asset at a given time in its life. When you start measuring an asset's value, you start talking depreciation. As I have learned, depreciation is not a regular word that is commonly used within the government's financial structure. It is a bit of a new concept for government as a whole.

The second aspect is the life of an asset itself. Again, that is not a common format that the government works with, recognizing that an asset does have a life and it has be replaced at some point. The challenge is to get everybody on the same plane, thinking in terms of depreciation, in terms of assigning a life to an asset and to devolve a plan. I guess before you can present something to someone else you have to understand it fully yourself and that has been a major learning step for our department. What are all the things that we want to bring forward to the boards.

In October we made a presentation of where we want to go with the asset tracking and how we would like to get there. We have prepared a questionnaire for the boards and presented what we feel are things that would be very valuable in an asset tracking system. This presented them with ideas of how we feel it would work for them and we have also invited feedback to tell us the things that we have missed and what they want to be able to do with it. They have responded in that manner to us, giving us the information we need to go back and tell them this is what you are telling us and this is the direction you want us to go with this package.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I am happy to hear that you feel that there has been some feedback and, again, as I pointed out, the Stanton representatives who were here today did not seem to be aware that there had been that sort of feedback. I guess what I am saying is that it is tough for me to get a comfort level when that sort of thing happens.

There is another I think important group in your own department that needed to be consulted. How much input did you get from the finance section of the department, what would work in terms of an inventory tracking system? Were they consulted in the process along the way too?

MR: OLENEK: Are you referring to the government's Department of Finance or our own finance people? I have been working with the department's computer and system people that come under the finance division. They have been assisting me in the development of what we would like in a system and how it would integrate with the future plans of the information handling.

ACTING CHAIRMAN (Mr. Gargan): Thank you. Mr. Dent.

MR. DENT: Again, I almost hate to ask the question as I have been harping on plans with time objectives. I notice that in your objectives for 1989-90 you wanted to develop a standardized asset inventory program for health facilities and implement that in the first phase. I am really happy to see a timetable on the project of getting a controllable asset tracking system. One thing that surprises me a bit is that the timetable is such that the training and orientation sessions are scheduled for May of this year. It would seem to me that the people who would be most involved in this in May are pretty actively involved with closing off the books from the previous year. It would just seem to be a strange time to try and get them involved in a project that is going to be fairly intensive and have a fairly steep learning curve for people who have not had to worry about this sort of thing in the past, when they are also going to be involved in trying to wind up the books from the previous years so that the government can get ready for the audit. Was that considered when the timetable was set?

ACTING CHAIRMAN (Mr. Gargan): Thank you. Mr. Olenek.

MR. OLENEK: I cannot honestly answer that. If I recall correctly we have actually pushed it back later than what it was from the first time we were looking at a schedule. The original schedule was much more compressed than what the current one is.

ACTING CHAIRMAN (Mr. Gargan): Are there any further comments or questions? Mr. Dent.

MR. DENT: I do not really have a question but I would like to finish off on this. As I said I am impressed with this system, the goals and the way of getting a timetable. It would be my suggestion to the department that when you are doing these make sure that you set your timetables in a realistic manner so that you can achieve them. You are going to be under all sorts of pressure from M.L.A.s to get there fast. You will have to recognize that this is one of the pressures you will live with. Make sure that you are giving yourself enough room so that you are not setting yourselves up to fail.

ACTING CHAIRMAN (Mr. Gargan): Thank you. Mr. Olenek.

MR. OLENEK: Thank you. I will take that advice and consider it very seriously.

ACTING CHAIRMAN (Mr. Gargan): Thank you. Are there any general comments on capital assets? Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. According to the Auditor General's report there is an indication that the boards prepare their inventory and send it to the department. It is my understanding, Mr. Chairman, that there are no guidelines in place for inventory control. No standards have been set up to keep the controls. I am wondering what the department is going to do to make sure that the inventory of assets are controlled and that there is a standard set up to meet the control. What is the department going to do in this area? Thank you.

ACTING CHAIRMAN (Mr. Gargan): Thank you. Mr. Olenek.

MR. OLENEK: Thank you. The accountability of assets, as the Auditor General has pointed out, is not only a problem unique to the Department of Health but the government as a whole. The government has not been very successful in achieving that goal. Regarding the asset tracking system, it is our goal to provide the tools to the boards that will allow them to have their own records from which they will manage, input and maintain that database at all times. This will permit them to have an accounting at all time of the assets within their responsibilities.

There is one other item that we are looking at in our research of asset tracking and it we are going to call it the concept of bar coding of assets. The bar coding technology has come a long way in the last ten years. We have received information that other health jurisdictions have bar coded their assets to ease the process of doing validation on a yearly basis of all assets. This information can then be uploaded into a computer and quick verification can be done on assets. This is something we are taking a very serious examination of and if it proves it to be a viable option well supported by the boards we will certainly work to achieve that goal. I feel it will be a very valuable tool for the boards when it comes to the manpower exercise of accounting assets.

ACTING CHAIRMAN (Mr. Gargan): Thank you. If there are no other questions on chapter six, I would just to remind Members that our committee made recommendations pertaining to capital assets government-wide during our last report. The Auditor General picked this up while doing the Comprehensive Audit on the department. Are there any further questions? If not, I would like a break and then we will continue on to the other chapters. We will take a five minute break.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): I call the committee to order. We are still dealing with the Department of Health. We just concluded chapter six. Before we move on to chapter seven, I would like to ask one more question of the department with regard to chapter five. For the record, Dr. Kinloch, we are recording all of our proceedings, could you reintroduce your staff?

DR. KINLOCH: Mr. Chairman, with me are Darrell Bower, Director of Finance and Administration; Linda Jackson, Director of Health Insurance Division; and, Stella Van Rensburg, Director of Policy and Legislation.

CHAIRMAN (Mr. Zoe): Thank you. When I asked my colleague, Mr. Gargan, to chair the meeting for me, he moved on to chapter six. My question is in regard to the H.B.I.S. system. In the Auditor's report, it seems like there are a lot of problems with this system. My understanding from talking to Stanton is that they are not too happy with that system. I do not know the history of how this evolved, but this new system that we are trying to put in place seems like it is being imposed on the boards. All of the computers are not compatible and this appears to be a big mess. When you put this new system in place to standardize all boards, did you get feedback from the boards saying "the system you are imposing on us is not suitable. We see problems with it." Have they communicated with you in terms of the H.B.I.S.? It appears to be a big problem.

MR. BOWER: The process that we are going through right now is not to impose a system on the boards, but to determine our needs and find a system that meets all of our needs. To go back to your point, have the boards ever voiced any concerns to me regarding H.B.I.S., yes, they have voiced quite a few concerns to me. Most of them of a negative sort. Certainly, we have systems and charts of accounts. We are trying to come up with one system because we are a relatively small organization in the north. We need one system that is simple to use that meets our needs using one chart of accounts. That is what our goal is as a working group to the directors of finance for the boards.

CHAIRMAN (Mr. Zoe): We know this problem exists. What exactly is the department going to do to resolve it? I know that Stanton does not use the H.B.I.S. The M.H.O. is what I think they are using. From my understanding, they are not happy with it, it is too complicated and it is not compatible. So all of the information that gets to the department has to be translated into our own system that we have in place. On top of that I know we spent a lot of money developing the H.B.I.S. because there are three people in the Department of Finance helping you to develop all of this. Last year our Standing Committee on Finance recommended that this little section of three PYs be deleted because we did not think they were warranted. What is the department going to do in this whole area of information systems, particularly to the boards? You have not really said how you are going to resolve this issue.

MR. BOWER: Mr. Chairman, that is what the working groups of the directors of finance for the health boards have taken on as their task. We have looked at the needs that we have determined and we have developed a process that we would like to go through. What that process will do is take the needs and do vendor selections, identification and then an evaluation of systems all aimed towards coming up with a system that meets the needs of the boards. The timetable for that is we are looking at the draft process in the middle of January. Our hope is to be able to select the system by this summer. If we select the system, it will have to be a staggered approach to implementing the system because it is a large task to do. We will be approaching the boards from that aspect.

One other point you made, Mr. Chairman, you mentioned the team that is residing in Finance. They do serve a very useful purpose. We have the H.B.I.S. system now and they do support it. If we moved away from H.B.I.S. or M.H.O. whichever system the group selects, we would still see this group as a resource to supporting the system that goes into the boards. We do have a turnover at the board level, resources are thin out there and they do need the backup that this team would provide. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): You are going to do that with each individual board, or are you going to bring all of them together at once and try to come up with one system? For instance, are you going to deal with Stanton and try to work out a system for them, and then go to the Mackenzie Regional Health Board, the Fort Smith Health Board and the Hay River Hospital Board? Is it going to be separate or together to try and figure out the best information system?

MR. BOWER: Mr. Chairman, the approach right now is to do it all together. That is why we have representatives from the Mackenzie, Inuvik and Stanton on the working group. The other members from the Kitikmeot, Baffin, Rankin Inlet, Hay River and Fort Smith will be reviewing what the working group puts together and that will be done at the next directors of finance meeting. The ideal is to come up with one common solution so that we can support one another across the territories instead of having isolated solutions that when something goes wrong we are forced into an emergency situation to resurrect it.

CHAIRMAN (Mr. Zoe): Mahsi Cho. That is what I wanted to hear. On to chapter seven, members agree?

SOME HON. MEMBERS: Agreed.

---Agreed

CHAIRMAN (Mr. Zoe): We will go to medical travel, chapter seven. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, Mr. Bower will make a short introductory statement on the financial issues section.

MR. BOWER: Thank you, Mr. Chairman. A major focus of this section is the ability of the Department of Health to forecast expenditures and subsequent supplementary appropriations. The major area of funding changes, over the time period noted, have been that of hospital and health boards and the insurance programs of medical travel, medicare and N.W.T. hospitals. Increases to hospital and health facilities reflect collective agreement increases, inflationary increases to other O & M and basic increases to budgets to reflect service level of delivery. Another factor resulting from the time of transfer in 1988, was that board budgets were based on the model for the Baffin. Unfortunately, this model was not fully seasoned and in retrospect was deficient. This caused deficiencies in other boards that had to be addressed later on. The insurance programs have had difficulties. One is the delay in recovery cost data, and the other is the inflationary and utilization changes. All three insurance programs received cost data late. In the case of out of N.W.T. hospitals, it usually takes four to five months to get 70 to 85 per cent of the expenditures for any given month. In other words, it lags behind a great deal before we receive the billings.

These timing delays cause difficulty because of the timing cycles for the operational plans and the main estimates. Often projections of expenditure increases are not known until the fall for a given year. By this time, both the operational plan and the main estimate exercise for the following year have been completed and do not reflect the change. The other change has been inflation and utilization and during the period reported on there were major price increases in all three insurance programs. Utilization changes did occur, but they were not significant as compared to inflation. As a further point to that we saw major efforts by the provinces to recover costs and they all bumped their per diems significantly anywhere from 10 to 20 per cent year over year. That really hurt us badly.

The department recognizes that it has to strengthen its monitoring of expenditures and its ability to forecast the same. To this end, the department has been doing the following to improve management space of information for planning and forecasting:

- we have been studying work load factors;
- we have been developing community profiles to determine health needs;
- reviewing expenditure issues such as travel, drugs and overtime;
- negotiating per diems and salary contracts with physicians to provide predictable costs;
- strengthening and monitoring of medical travel utilization;

On this particular one the department is in the process for recruiting staff that had been approved for the function.

- reviewing southern hospital utilization and repatriating services where practical, and
- putting in place the resource to discuss patient care in southern jurisdictions to allow for the provision of practical, efficient and effective care at the most appropriate location.

A proposal for the development of management data for the insurance programs has been delayed due to changes in staff and the prioritizing of the decentralization of the health insurance services division. This will be pursued as soon as feasible. With regard to a forecasting model, the department is using the best of the methods provided by the provincial jurisdictions some five years ago when I canvassed them and

I took the methods that they provided and selected the best one.

Health and the F.M.B.S. are now in the process of requesting updates from the provinces on the models that they currently utilize. We are requesting not only from the provinces' Health departments, but also from their treasury board counterparts.

The allocation of resources between east and west is basically as it was at the initiation of the transfer process. Stabilization of programs has been the focus. In addition to the percentages noted in the report, if hospitals and their staffing are removed, the ration of nurses serving community residents is similar per region across the whole N.W.T. The location of hospitals and doctors is an historical fact which will not be substantially altered until political direction is received on the structure that the health care system is to take, for example, "The N.W.T. Way" that we have been talking about.

With medical travel, the department has taken numerous steps over the past few years to control expenditures. The medical travel policy was revised and made public. A place of nearest treatment directive was developed and released that directed patients to the nearest location that their condition could be treated, versus flying everyone to a southern location.

Funding and person years have been approved to create a control and monitoring point for medical travel. It is this group that will liaise with patients, care providers and referral groups. Another function of this group will be to look at the information flow and data capture surrounding medical travel and to make recommendations for improvement. The department recognizes the lack of detail in coding and the difficulty in linking travel to service. These points will be identified and will be addressed as much as possible in the revision to the computing system as the result of decentralization. The level of detail in ICD9 coding can be quite detailed as suggested in the report and quite often the travel forms are at a general level. The difficulty is that when travel is authorized, the specific reason may not be known and only that the person needs treatment. Another difficulty is the amount of time and effort required to train an already overloaded field staff that turns over on a frequent basis. The question here is, "What is the cost for the data and are there other alternatives?"

The department recognizes that it needs better data and is examining alternatives. A correction to the section on escort travel is that it is approved on a regular basis where justified. With regard to the two medical travel programs offered by Health and Personnel, discussions have been held and will continue to be held to ensure programs are working towards the same goal of proper treatment at reasonable and appropriate costs. It should be noted that medical travel is authorized by many non-G.N.W.T. sources. This travel also affects the costs of the G.N.W.T. when patients receive insured service through a hospital or by a doctor. Some means have to be found to expand the cooperation of Personnel and Health into these other areas.

The D.I.A.N.D. receivable has major implications to the G.N.W.T. as noted by the Auditor General. A legal claim has been filed in the Court of Canada to pursue the matter. As the matter is before the court, the department is in a position that it should refrain from making further comments pending resolution of the court case. The federal government will be filing a statement of defence to our claim in January 12, 1993. Mr. Chairman, that concludes my opening comments.

CHAIRMAN (Mr. Zoe): Thank you. Any general comments or questions? Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. I was wondering if Mr. Bower could provide us with some more specific examples of how the Baffin model was deficient as he said in his opening presentation?

CHAIRMAN (Mr. Zoe): Mr. Bower.

MR. BOWER: Mr. Chairman, I am not fully aware of all the details, but the specific ones that I am aware of include overtime not being calculated properly, some of the allowances were not calculated properly, the cost of drug, supplies etc. were deficient and the difficulty was that the Baffin transfer happened the year before the full transfer happened. We did up the model and time did not allow us to go back and say "is that a sufficient model or not." We moved on to the next major transfer and we continued with the model. It was only in retrospect that we found that it was not fully working for us.

CHAIRMAN (Mr. Zoe): Mr. Dent.

MR. DENT: You indicated that one of the big problems with presenting accurate budgets was the considerable lag time between the expense and the recording of the same. Did you then say that this was going to be almost impossible to address this year because of decentralization? How and when are you planning to address this part of the problem?

CHAIRMAN (Mr. Zoe): Mr. Bower.

MR. BOWER: Mr. Chairman, we have a lag time problem in three areas. Two other areas as well, but those budget amounts are lower. The major area we have difficulty with is medical travel, N.W.T. hospital costs where we send our patients down south and medicare. What we are attempting to do is go through the decentralization aspect and look at all of our systems to identify what we can do now so that we can pick some of these costs up earlier. We are not doing anything until decentralization is complete because we have a problem that does require a resolution.

The other steps that we are going to have to make is how can we identify that we have a commitment at the point of incurring the service. Medical travel, we think, has a solution to that which we will be putting in place. We generate the travel form itself so we can estimate the cost. What we are trying to look at, this is only one possible solution, is can we develop what may be an additional cost related to each travel that takes place. Another thing that we might be doing and I might defer to my colleague from health insurance, is contact the provinces to see if somehow we can get earlier notification of what costs might be. We have pressured them in the past, and quite frankly our pressure does not amount to much to somebody that is spending $2 billion and they are recovering a few million from ourselves. We are going to be talking to them. We have a body that has been approved that will liaise with the hospitals and jurisdictions.

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: As Mr. Bower has suggested, the problem that we have does not seem apparent to the provinces because out of province billings represent such a small proportion of the total. Whereas for us it is a major difficulty. I expect, at the upcoming meeting, the Ministers of Health to make an appeal to Ministers to assist the territories in getting access to information on a more timely basis because for us it is a major problem. I think with that additional boost we may be able to get more timely reporting.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Dent.

MR. DENT: Thank you, Mr. Chairman. Is decentralization going to hinder further the timeliness of information flow?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: The decentralization policy is now being pursued with the aim to improve the operation of the system. To us it is not reasonable to decentralize a system which is not operating optimally. We would see improved reporting forecasting ability of managing to be a part of the preparation for decentralization.

CHAIRMAN (Mr. Zoe): Are you saying decentralization, in your view, is not a good thing in terms of what that section does? Or is it better to move the system out?

DR. KINLOCH: I am saying neither, Mr. Chairman. I am suggesting that there is a policy to decentralize and in carrying out that policy, we are going to send out to those decentralized units, systems which operate, systems which are reliable, systems which provide information and which can be managed. We believe that is a necessary prerequisite to a successful decentralization.

CHAIRMAN (Mr. Zoe): Mr. Dent.

MR. DENT: A very political answer. I really did not expect much different. I would point out that it would appear that a lot of important information measures are going to be slowed down or put on hold because of the decentralization initiative. It is obvious that decentralization is going to have a negative impact on the department achieving some of the improvements that the Auditor General points out.

On page 43 of the report there are three recommendations regarding strong suggestions from the Auditor General that there is room for improvement for providing costing information and support for budgets. The management response was that the department will review existing operations in respect to the recommendations being made. The department has now had some time and I was wondering if we could get some specific responses as to these three recommendations and whether or not the department can be more specific about how they are going to react to these three recommendations please?

CHAIRMAN (Mr. Zoe): Thank you.

MR. BOWER: Mr. Chairman, of the three items, the first one being a better method of developing budgets and reporting expenditures against them. If you follow the documentation, it was based on not providing enough documentation to support the budget and we are going to be trying to develop, through the next call that we go through, much detailed information to support the budget submission that goes forward to the F.M.B.

The accountability for reporting and corrective action related back to the variance reporting. I think the comment was that we do not take seriously the variance reporting, I would suggest that we take it very seriously. As the report also notes, we have been making annual pilgrimages back to the pot. We take very serious notice of the variance reports and we monitor throughout the year where we are going and we update our projections throughout the year. Certainly there is room for improvement, we acknowledge that and we are going to be working towards that.

Monitor and analyze the cost of supporting budget requests, my comments to the first two follow through to this. We do need to provide more detail and we can. We can sit down with the Financial Management Board Secretariat staff to determine what they need and also with our own people to determine what they need to manage their activities.

DR. KINLOCH: Mr. Chairman, I think that the message, which may not have been fully received by boards initially about the seriousness of the financial situation that we were facing and of the need to bring some better control mechanisms to our budgeting, is now very clear to everybody. I suspect that in itself, will improve the ability of the department to deal with budgetary matters. However, in addition to that, there is a developing collegiality between finance officers and their departmental counterparts in dealing with what are essentially common problems and where it is in the best interest of all that they should be managed carefully. In addition to that, there is a new ability of the department to provide on-site assistance to boards who are having difficulty with budgetary matters. We believe that the combination of these should be very helpful to the process.

CHAIRMAN (Mr. Zoe): Thank you. Any further general comments or questions on chapter seven? Mr. Gargan.

MR. GARGAN: D.I.A.N.D. used to produce a booklet that profiles every community, the population and the demographics.

DR. KINLOCH: Mr. Chairman, we are familiar with some of the standard reports that were produced by medical services branch but we are not aware that they were used for the allocation of budgets. They were reporting on health statistics and other community profile data and, yes, we have all of that information and have expanded it. In itself, that has not been particularly helpful to the budget allocations. Initially, the budget is on a region by region basis and so the sub-level is done by the regions. If there is some other report we are not referring to, I would be happy to look further at it.

CHAIRMAN (Mr. Zoe): Any further comments? Mr. Ningark.

MR. NINGARK: Thank you, Mr. Chairman. Mr. Chairman, in chapter seven of the Comprehensive Audit of the Department of Health, it seems to suggest that the medical travel is not being properly monitored by the managers of the department, thereby leaving it almost subject to being manipulated by the

G.N.W.T. employees who travel under the system. For instance, there are two examples here on the Auditor's report where employees travel to the medical centres outside of the N.W.T. but not to the nearest medical facility. Mr. Chairman, I want to know how closely the Department of Health is monitoring the medical travel by the residents of the N.W.T.? How closely do you monitor the policy in the system?

CHAIRMAN (Mr. Zoe:) Thank you. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I think it is important to restate the distinction between medical travel and travel benefit. Medical travel is managed by the Department of Health and refers to the movement of patients through our system, wherever, within the territories or outside. The travel benefit is a benefit of employment by G.N.W.T. and it is managed by the Department of Personnel.

The Department of Personnel has adopted essentially the same policy as Health for managing its medical travel. However, it lacks the capability to question referrals which are made outside of the N.W.T. For that reason, we are now in the process of consolidating the management of all medical travel in the Department of Health. Initially, there will be a period when the Department of Health will provide consultation to Personnel in the management of this program but the ultimate aim is that the management will be consolidated in Health so there will be one travel policy applying to medical travel and travel benefits. We expect to achieve substantial cost avoidance in the process.

CHAIRMAN (Mr. Zoe): Thank you. I understand that you are working on it now, what is your timetable? A timetable is always of great concern to us.

DR. KINLOCH: We expect the consultation to begin within the next month or so, and perhaps by the end of the fiscal year a consolidation could be achieved.

CHAIRMAN (Mr. Zoe): Any further comments or questions, Mr. Ningark.

MR. NINGARK: No, thank you, Mr. Chairman.

DR. KINLOCH: Mr. Chairman, Ms. Jackson reminds me that consultation has begun.

CHAIRMAN (Mr. Zoe): Just one question in relation to health insurance services again where we get money back. If I am correct, every individual in the territories get these health cards. We changed the process. We used to get a renewal every year. What mechanism or what process do we have, for instance, if I move say to any province, I am eligible to use our plan in the other province up to a maximum of three months. On the other hand, that is how much time is required from the province to accept me. The thing that I think is that there is a loophole in our system by having this two year renewal. Our plan is free do not forget, it is paid by the government. If you go to another jurisdiction it is not all free, you have to pay a certain fee, a user fee, I think they call them premiums. Now, say for instance, a person moved to B.C. and these renewal cards are sent out how you catch this individual? They forward their card, although I know that they are not supposed to be sent out of territories but some people do send them forward to wherever their friends are living and they receive it, sign their name to it and send them back. How do we catch those type of people?

DR. KINLOCH: Mr. Chairman, I will ask Ms. Jackson to explain the situation to you and the options we have for dealing with this.

MS. JACKSON: Thank you, Mr. Chairman. I would just like to first say that we agree with the Auditor General's statements that this is a considerable problem. It is a considerable problem in all jurisdictions as well as in the Northwest Territories. It is a very expensive process to routinely survey all the population to make sure that they are still meeting the residency requirements in the territories in order to be covered. When we first get notification that somebody may be using our health care card outside the system, we are looking at a way to verify whether or not we have sent that person out on medical travel. We can then follow up and do a spot check on those individuals that are receiving services outside.

With the redesign of the health information system, we will be capturing more useful management information on medical travel and the medical travel commitment up front. We will be able to send individual renewal requests to those individuals and we will rule out those people that we know we have sent out for specific treatment, but those that have just appeared on our list and we are not aware that they are outside, and they may be legitimately out visiting and that is fine, but we will ask them to reconfirm.

CHAIRMAN (Mr. Zoe): It will not necessarily only be people that we send out, for instance, I could be travelling down south and if I get ill, I just go the clinic or to the hospital and I use my card. It is paid for by our government. That is what I am saying. Maybe another suggestion could be, if they are within the number of acts that we have, maybe we can put something in law saying that it is against the law to abuse health care, because it is a two year renewal, and give some kind of penalty. It is difficult unless you know of certain people, but a lot of people in our system do not know if this person is still residing here and would not know that Joe Blow has already moved, after he renewed his registration six months into the year, and during the year he has been visiting hospitals down there. It could be assumed that he is travelling or something. It would be very difficult for our staff to pick that up, because it could be seen as somebody travelling in B.C. and he just happened to get sick and the bill comes up here and we pay for it. You indicated that you are working on the process, but I am not sure how effective that is going to be. In some areas we are losing a lot of money, especially when people move out of here, because from what I hear there are people abusing our system because it is free. We pay for all of their bills.

MS. JACKSON: Thank you, Mr. Chairman. Your comments about situations where people are travelling outside of the territories and using their health cards to obtain services are accurate. People who are temporarily out of the territories are still covered by our health plan and will continue to legitimately use that. Where our concern is, is where someone has changed their residence past the three month waiting period and have failed to notify us. A number of provinces are working on these issues and we are going to try and copy some of their initiatives. One of the initiatives that we are

evaluating right now is the ability to link a tracking of our residents to other information systems. For example, one of the first things they must do when they change their residence is register their car and apply for a new driver's licence. Some of the provinces are experimenting with tying in that information so that the health care system would be made aware of the new car registration.

Some of the provinces are taking a much more aggressive stance in terms of locating the individual who has used the card and no longer has residence to seek reimbursement from that individual. You are quite correct, it is against the law for that to happen. It is a very complicated and expensive undertaking because the only information you have about that individual is the fact that they have been in another province. You have a wide space to look for them in. We are watching what the other provinces are doing very closely to see what rate of success they have.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions on chapter seven? Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. You said it is a three month waiting period before the expiry of your health care card, what about native students who attend a post-secondary institution? Do they have the same kind of situation, they have three months and then an Alberta card? Is it different?

CHAIRMAN (Mr. Zoe): Thank you. Ms. Jackson.

MS. JACKSON: Thank you. No, it is different for students. Students are not considered to have changed residency when they go to school. Their residency is still where their home is.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: Mr. Chairman, I noticed that you are signalling us to call it a day, but I just have one question with regard to Dr. Kinloch's presentation. It is also echoed by St. John's Ambulance. There was an article that was in the Globe & Mail and I took a look at it, but it does not say anything about the Northwest Territories except that it talks about the primary health care and the role that the nurses have taken. It talks about the community participation and to be more self-reliant. It says because of the high cost of health delivery, we must focus more on our nurses to play a broader role, but they did not mention anything about the Northwest Territories. It sounded as though Dr. Kinloch was saying that we are getting the credit for that article, but it does not say anything.

DR. KINLOCH: Mr Chairman, my point was we do not get any credit.

---Laughter

We developed this system and no one acknowledges it. I think anyone reading that article without knowing where it came from would suspect that it was talking about the Northwest Territories' arrangement. It also reinforced another point I made, that until we ran into our current financial troubles, people were not thinking along those lines outside of the Northwest Territories. They were content to continue on as they had for the past 20 or 30 years.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: Mr. Chairman, I guess there was a declaration in 1978 and I thought that it was as a result of that, that the Newfoundland initiative came into being. It is sponsored by the World Health Organization.

CHAIRMAN (Mr. Zoe): One more. Mr. Bernhardt.

MR. BERNHARDT: Thank you, Mr. Chairman. Dr. Kinloch, is it possible for the government to issue everyone in the territories a plastic health care card? The paper ones do not even last one month, and sometimes you lose them right away and you have to wait to get a replacement. I pack mine in my wallet, but you could use it to blow your nose now.

---Laughter

CHAIRMAN (Mr. Zoe): Any comment? Our colleague here from Yellowknife pursued in the Legislature to have our licences changed to plastic. I think you are alluding to something more solid so that it does not wear out? Ms. Jackson.

MS. JACKSON: It is certainly possible to do that, but there is a considerable cost involved in doing it. The paper format is quite a bit cheaper just because the material is cheaper. It is also less expensive to produce because it can be produce a directly online through the computer system. That reduces our cost of production and our turn around time for the applicant. We will certainly take your remarks into consideration and continue to evaluate doing that.

CHAIRMAN (Mr. Zoe): Mr. Bernhardt.

MR. BERNHARDT: I used to go to the Charles Camsell Hospital and as soon as I walked in, they issued me their own nice plastic card. I do not see why the hospital cannot do that.

CHAIRMAN (Mr. Zoe): You are making reference to the hospital in Edmonton. Do you think it is that costly to laminate? It is already there, all you have to do is put plastic on top of it. They have the machines at motor vehicles.

MS. JACKSON: We will look into the cost of doing that. I would suspect that we would have to have our own laminating facilities because we send the cards out in large numbers. To make it feasible we would have to have our own arrangements. We will price it.

CHAIRMAN (Mr. Zoe): Mr. Dent.

MR. DENT: If people had to show up every two years to get their picture on one, it would cut down on the claims and it would not be justified.

CHAIRMAN (Mr. Zoe): Are we finished with chapter seven then? Do you have any comments on chapter eight, Dr. Kinloch?

DR. KINLOCH: Mr. Chairman, we discussed the system earlier in the afternoon.

CHAIRMAN (Mr. Zoe): Any questions or comments from Members? I think we did deal with it during general comments the first day and right through. Mr. Martin, do you have any comments pertaining to this?

MR. MARTIN: I have no additional comments.

CHAIRMAN (Mr. Zoe): That concludes our hearing on the Auditor General's Comprehensive Audit on the Department of Health. I would like to thank Dr. Kinloch and his staff for appearing before us for the last three days. Thank you very much. We will be making a report to the Legislature in the winter session. In our second phase, as I indicated the first day, we will be travelling to Rankin Inlet and Inuvik. We will be back in Yellowknife to do our final round, putting together our draft report and tabling it in the House. Once again, thank you for appearing before us.

DR. KINLOCH: Mr. Chairman, we have appreciated the opportunity to spend so much time with the committee over the past few days. From our stand point, it has been very interesting and I believe helpful. We look forward to pursuing the conversation. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Meeting is adjourned, moved by Charles. Do you move to adjourn?

SOME HON. MEMBERS: Agreed.

---Agreed

CHAIRMAN (Mr. Zoe): Adjourned until January 25, 1993.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PROCEEDINGS

PUBLIC HEARINGS

RANKIN INLET, NORTHWEST TERRITORIES

MONDAY, JANUARY 25, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

RANKIN INLET, NORTHWEST TERRITORIES

MONDAY, JANUARY 25, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

The Honourable John Todd, M.L.A. Keewatin Central

Keewatin Regional Health Board

Ms. Bette Palfrey, Chairperson

Dr. Bruce Peterkin, Chief Executive Officer

Mr. Chris O'Neill, Director of Finance and Administration

STANDING COMMITTEE ON PUBLIC ACCOUNTS

RANKIN INLET, NORTHWEST TERRITORIES

JANUARY 25, 1993

Members Present

Mr. Arngna'naaq, Mr. Gargan, Mr. Pudlat, Mr. Whitford, Mr. Zoe

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): Ladies and gentlemen, I would like to call this public meeting of the Standing Committee on Public Accounts to order. It is always good to be back in Rankin Inlet. As M.L.A.s from other regions of the territories, we always look forward to the opportunity to experience the hospitality and the friendly welcome for which the Keewatin people have developed a well deserved reputation. Also, it is a very real pleasure to be visiting the home community of a colleague, the Honourable John Todd.

I will be making some brief comments to tell you a little about our committee's mandate and our purpose for travelling to Rankin Inlet today. First, I would like to ask my colleagues on the Standing Committee on Public Accounts to introduce themselves and indicate the constituency they represent.

MR. ARNGNA'NAAQ: I am Silas Arngna'naaq. I represent Kivallivik, with the communities of Baker Lake and Arviat.

MR. PUDLAT: I am Kenoayoak Pudlat. I represent Baffin South.

MR. GARGAN: I am Sam Gargan. I represent the Deh Cho region.

MR. WHITFORD: I am Tony Whitford. I represent the constituency of Yellowknife South.

CHAIRMAN (Mr. Zoe): Thank you. We have with us members of our staff from the Legislative Assembly, who are helping us with organization, translation and recording of these hearings and with background research on matters raised in the report. As Chairman, I would like to take a few moments to tell you a little about our standing committee and the role that it plays in the workings of the Legislative Assembly.

You probably already know that the Standing Committee on Public Accounts is one of five committees that the Legislative Assembly has established under the authority of the Legislative Assembly and Executive Council Act. The other ones are the Standing Committee on Finance, Standing Committee on Legislation, Standing Committee on Agencies, Boards and Commissions and the Standing Committee on Rules, Procedures and Privileges, which I also chair. My colleague, Mr. Arngna'naaq, chairs the Standing Committee on Legislation, which I just referred to. Each standing committee has its own mandate and areas of responsibility. These are established in the first session following each territorial election by a full motion of the Legislative Assembly.

Like other Legislatures across Canada, and most countries that use a parliamentary system of government, the Legislative Assembly has established a Public Accounts Committee and has given it the responsibility to monitor the way the government spends public money. Each year, our Standing Committee on Public Accounts reviews the performance of the Government of the Northwest Territories to ensure that money is spent according to the way the budget was passed and according to the statutory requirements for financial administration. We are also concerned with making sure that the programs and services being delivered to the people of the territories are being provided at the highest level of quality possible, given the amount of funding that is available.

Often, we summarize the role by saying that the role of the Standing Committee on Public Accounts is to ensure that the Government of the Northwest Territories is operating efficiently, effectively and economically. We want to make sure we are getting value for money. The usual process for doing this involves the committee reviewing an annual report, which is presented by the Auditor General. The Auditor General's office has the responsibility to examine government organization and expenditures. It has a team of accountants and administrative specialists who are able to examine the accounts and procedures used by each government department. Together, they try to identify areas where government administration and operation can be improved so that the people of the Northwest Territories can receive better services. They describe these areas in the Auditor General's annual report.

When the Auditor General completes his annual report, it is then transmitted to the Legislative Assembly and referred to our Standing Committee on Public Accounts review. The review usually involves public hearings and results in the standing committee making a series of recommendations to the Legislative Assembly.

In addition, to our annual activities in reviewing the Auditor General's report, the Standing Committee on Public Accounts also serves another important function. When the Legislative Assembly has concerns or questions about the operation of a particular department, it can pass a motion requesting the Auditor General to carry out an in-depth, comprehensive audit of that department. The comprehensive audit focuses on a wide range of issues. It looks at the whether or not the government department is operating efficiently and providing good service to the people it is supposed to help.

When the Auditor General finishes the comprehensive audit, his officials prepare a final report. It is then up to our Standing Committee on Public Accounts to review it. That brings me to the reason why we are here today. Before the last election, the 11th Assembly's the Standing Committee on Finance expressed some concern about the way the territorial Department of Health was running. The Standing Committee on Finance introduced a motion requesting the Auditor General to undertake a comprehensive audit of the Department of Health. This review was carried out by the Auditor General's office in late 1991 and early 1992. The report was received by the Speaker of the Legislative Assembly in October and was referred to our Standing Committee on Public Accounts for a public review. The report deals with a wide range of issues including comments on several aspects of the departmental administrations. These are:

1. the organizational structure of the Department of Health;
2. planning for the future;
3. managing people;
4. managing information;
5. capital assets;
6. financial issues; and,
7. management, reporting and accountability.

Each of these areas has been examined by the Auditor General and a series of recommendations have been made. Our job as a standing committee is to review the Auditor General's findings and tell the Assembly whether or not it should implement the Auditor General's recommendations. In doing this, it is important to have the views of a wide range of individuals and organizations that are involved in the administration of our health system. We often refer to these as stakeholders. For that reason, the standing committee has scheduled a series of public hearings aimed at finding out what stakeholders think of the Auditor General's report.

The first set of public hearings were held in Yellowknife at the beginning of the month, January 6 to 8. At that time, we heard witnesses representing the Office of the Auditor General, the Department of Health, the Board of Management for Stanton Yellowknife Hospital and the St. John Ambulance people. We are continuing our public review this week with public hearings here, in Rankin Inlet, and then we will be moving on to Inuvik later on this week. While we are here, we hope to hear from our colleague, the Honourable John Todd, M.L.A. for Keewatin and the Baffin Regional Health Board, Keewatin Regional Health Board and the Kiguti Dental Clinic and anyone else who may be interested in commenting on the comprehensive audit.

On Wednesday and Thursday, we will be travelling to Inuvik to hear from stakeholder groups about the Auditor General's report. On Friday and Saturday, we will be back in Yellowknife to finish hearings from various groups and individuals who have registered to appear as witnesses.

I think that the process of public hearing is a very important one. This is the way we will be able to find out what the people who are most affected really think. After we finish our public hearings, the standing committee will prepare a report for the Legislative Assembly and bring that forward when the House is sitting in February of this year.

With those comments, I would now like to proceed with the hearing from witnesses who wish to appear before our standing committee here. I will be asking our first witness who registered with us, to come forward. If there is anyone here who would like to make comments about the Department of Health and the Auditor General's report, please tell our clerk, who is sitting at the back, Rhoda Perkison, and you can register. I will be asking all witnesses to make opening remarks which should not exceed 15 to 20 minutes in length. I would ask witnesses to please stay within that initial time frame because I am sure that the Members of the standing committee will have many comments and questions about your presentation. I want to ensure that we have time for sufficient discussion.

I would now like to call our first witness, the Hon. John Todd, M.L.A. for Keewatin Central to come to witness at the table. Just before Mr. Todd starts, I would like to acknowledge the special and rather forceful input that Mr. Todd had into the process when we were planning for these hearings. I know that I received several strongly worded letters insisting that the standing committee make sure it travels to Rankin Inlet to hear views from the Keewatin region. Of course, our committee Members were very happy to accommodate our colleague. We are happy, as well, to recognize our colleague as our first witness tonight. Welcome to the public hearing, Mr. Todd. You can proceed with your opening statement. Just before you do, for the public, we do have copies of the Comprehensive Audit on the table if you want to take a copy. It is also translated into Inuktitut. Mr. Todd.

HON. JOHN TODD: Thank you, Mr. Chairman. My comments tonight will be brief, direct and to the point. I would like to welcome the Members of the Standing Committee on Public Accounts to Rankin Inlet. I have no doubt, and I certainly hope, that the presentations that you hear over the next two days will help those Members, not familiar with the Keewatin region, to better insight into the way health care services are delivered or, perhaps, not delivered in this region. I understand that the committee is specifically concerned with the Auditor General's comprehensive audit of the Department of Health. However, Members will appreciate that health care delivery issues are so closely intertwined that the specific concerns of this region will be raised during this round of your public hearings.

To begin, Mr. Chairman, I have three specific issues that I would like to raise with the committee. The first is the role of the board within the health care system. The second is the delivery of dental health care in the Keewatin region, which we have all heard about over the last months, and third, the impending decentralization of health insurance services. Mr. Chairman, we are very fortunate, and I say this in all sincerity, in this region to have a highly capable health board that fully understands the health care issues of this region. Much has been done by this board over the past several years to improve the delivery of health care and respond to the concerns of Keewatin people. This has been done despite the fact that there has been no clear or concise delineation of responsibilities between the Keewatin Regional Board of Health and the Department of Health.

Chapter two of the Auditor General's report clearly examines some of the problem areas between boards and the

Department of Health. It has long been my observation that much of the difficulty in this relationship has been the uncompromising position of the department. The Department of Health has continually attempted to retain authority at the centre. Boards of health were established to be the primary vehicle for the delivery of health care services within the regions. To do this, they must have the necessary authority to make decisions on health care within their regions. As long as the Department of Health insists on maintaining such a level of control, this, in my opinion, will not be possible.

As Members of the committee may be aware, the Keewatin Regional Health Board has been very aggressive in trying to provide the types of health care services that the people of this region need and expect. Why should we expect any less service than someone who is sitting in Yellowknife?

This brings me to the second issue that I would like to raise with the committee. The provision, and I am using it as an example, of dental care services in the Keewatin region. This is referred to in section 2.8 of the Auditor General's report. For many years, the University of Manitoba was contracted to provide dental care in the Northwest Territories. This arrangement, although satisfactory in the past, provided little benefit for the people in the Keewatin outside of the dental care provided. There was no net economic benefit to people in Keewatin. When the dental services contract with the University of Manitoba expired on March 31 of last year, the Keewatin Regional Board of Health negotiated a new five year deal with a Northwest Territories dental consortium. This contract has resulted in much benefit to this region. A new state-of-the-art dental clinic was built in Rankin Inlet, which provides outstanding dental care to all the residents in Keewatin. If you do get an opportunity, I would like you to take a look at the Kiguti Dental Clinic, of which Bernadette Makpah is the President.

This new initiative, which had the support of the health board and the region, in one short exercise, created eight jobs in the Keewatin, one in Rankin Inlet, three aboriginal jobs within Rankin Inlet, seven dental therapists in the communities, new housing facilities owned and operated by aboriginal people and a new dental clinic owned and operated by aboriginal people. Prior to that, we were paying $1.4 million to the University of Manitoba and most of our taxes to the Government of Manitoba. All of you know my passion for talking about the economic impact of initiatives in the north. I would like to talk, and will talk later, more about the economic impact of this contract. In my view, in a debate that is taking place with respect to dental care facilities, this issue has been overlooked. With this contractual agreement, it has meant a reduction of $1.4 million annually that was previously lost to the south. It has created eight new positions in the Keewatin and this service is being delivered for a similar price than that which was charged by the University of Manitoba.

The Kiguti dental service contract is a prime example for all of us about how programs for northern and aboriginal people can be better delivered by northern and aboriginal people. The Auditor General makes reference in his report to a lack of communication between the department and the board. When this contract was negotiated, I encouraged the board to act in that manner because of little or no faith in the department's ability to look beyond the status quo. I understand that both the regional board of health and the Kiguti dental services will be making a presentation later on tonight. As the M.L.A. for this region, my point is that, for the first time, the Keewatin region is being provided with first-class dental care at a reasonable cost. This, combined with the real economic benefits that flow to the Keewatin region from this contract, is an example of how northern and aboriginal people can take control of programs that affect them.

Finally, Mr. Chairman, I would like to speak about decentralization of health insurance services. As you know, this government has begun to decentralize this section of the department, despite, in my opinion, departmental resistance. This section of the department will be decentralized to Inuvik and Rankin Inlet. Next year, this will mean 12 new positions to be decentralized in Rankin Inlet for Keewatin. I understand that, during the recent public hearings held by the committee, this issue was raised in relation to section 2.7 of the Auditor General's report.

I would like to give the Members an update of what the Keewatin region has done to begin planning for the decentralization of these positions. The Department of Public Works and Government Services is currently negotiating with regional aboriginal development corporations to build the necessary housing and office space for this program. These assets will be completed some time in the fall and will be owned by a regional consortium. Recognizing that all of the people currently working in this section of health services will not transfer to Rankin Inlet, for whatever reason, Arctic College has developed a training plan to train northern and aboriginal people to fill any vacant positions. In my view, this is an important first step in the decentralization of government programs and services. It also takes into account the impending division of the Northwest Territories by shifting some of the responsibility for delivery of this service to Nunavut

Mr. Chairman, this responsibility of health care must be in the hands of the stakeholders, not a status quo, centralized bureaucracy that is reluctant to accept change. I ask you all to stress that in your final report. Thank you.

CHAIRMAN (Mr. Zoe): Thank you, Mr. Todd. Are there any questions or comments from Members? Mr. Todd, as you noted in the report, the Auditor General has not made specific comments pertaining to the decentralizing of the health component. A suggestion was made by the Auditor General that all the financial administration sections of the Department of Health should be consolidated. He did not say to move it Can I get your views on that?

HON. JOHN TODD: Definitely. I think there were two points of view. One point of view is that we know there has to be an orderly transfer of responsibility to the Nunavut government All I see is that this is a small part working towards that. You know my views on centralization, Mr. Zoe. The other point of view is, if you put all the power in the centre, and it is further away from the problem, then the solution to the problem created by those who are directly involved. It is easy to say, "Well, it is going to save us money if we centralize it. We will run things better."

We have an extremely adversarial position between the Department of Health and the health boards. The Department

of Health does not even know who we are out here. When was the last time we saw anyone come here? They only come when there is a political crisis. They do not come on a regular basis to determine what is happening. They make decisions with respect to dental care and eyeglasses without any understanding of what is going on in Whale Cove, Coral Harbour, Lake Harbour, or wherever. I am not going to support and will not support any kind of strong redirection of centralizing any kind of authority, least of all, a financial one. You have to put the responsibility closer to where the issues are. To me, I am a strong regionalist. I have made no bones about it. I make no apologies for it. You have to put the authority and responsibility closer to where the problems are. I see that being done through our regional health boards.

By the way, reading the Auditor's Report, the last thing I would want to do is give these people more financial authority. They cannot even run what they have.

CHAIRMAN (Mr. Zoe): Let me rephrase my question. I understand what you are trying to say. That is not the point I was trying to make. The Auditor General suggested that many of the financial monitoring functions within the hospitals and health facilities division and also the health insurance division should be consolidated within the finance division of the Department of Health. What implications would this consolidation have for you?

HON. JOHN TODD: I do not know. Who knows? Until we try it, I do not know. All I know is that it is not working right now.

CHAIRMAN (Mr. Zoe): As you know, within these various divisions, they have their own finance and administration sections. The Auditor General is saying that we should consolidate them into one division.

HON. JOHN TODD: If they consolidate them in Rankin Inlet, I do not have a problem with it.

CHAIRMAN (Mr. Zoe): Even though we transfer the health insurance services to Rankin Inlet, the authority will still be at the centre.

HON. JOHN TODD: That is the whole crux of my argument here. I have said it before and I will say it again, you have to put the financial responsibility into the hands of those who are directly related to delivering the service to the stakeholders. It cannot be sitting in the centre. I argued this before, as Mr. Whitford knows. I believe that we have confident, responsible boards that are reflective of the politics of the day. You have to put the administration in place and give them the authority to go with it.

CHAIRMAN (Mr. Zoe): Are there any further questions or comments from Members? Mr. Gargan.

MR. GARGAN: This is in regard to decentralization. One of the things that John mentioned is trying to get away from the status quo. Could you enlighten me by what you mean by that? There are certain standards that you have to maintain. I do not know the situation in the east as much as I do in the west. In the west, for example, we have nursing staff at the nursing station. Many times, the staff take the role of interpreters and technicians. They operate an x-ray machine and everything else that they possibly can. You are not going to grab the janitor and tell him to take an x-ray of this individual, but we do have double standards. I am wondering what you really meant when you said that we have to get away from the status quo. Are you saying that we should possibly do it on a real loose basis so that we allow cost-effectiveness to move over? We are not going to have a radiologist or translator in every community, but ...

HON. JOHN TODD: I agree. We all work within financial limitations. We know we are spending $200 million a year on health care. It is going through the roof when we are sitting with an emergency, a legal battle right now which, a year ago, was $35 million and is now $90 million. We have to find a way to do things better. I realize you cannot be all things to all people, but in this region, for example, I asked the Department of Health, and fought like hell this last year, to do a simple evaluation of a cost that we are currently paying for health care in Manitoba. You would think I asked for the moon. You would think I was committing heresy or something because these professional elitists are saying, "The status quo is spending $6 million a year in the province of Manitoba." I am saying, "Look, let us do an impact assessment to determine if we should put some in the Keewatin. Do we go fill Mr. Whitford's white elephant in Yellowknife, which is 51 per cent occupied, according to Mr. Yamkowy, chairman of the health board? Do we move to Iqaluit? I do not know. Fort Smith, Inuvik and Fort Simpson are all being flattened with a level of health you had because you have this monster sitting in Yellowknife and this desire to fill a $40 million white elephant that is only 51 per cent occupied according to Mr. Yamkowy last week. That is not acceptable to me. I would hope that it is not going to be acceptable to you. We have to find other ways and means of doing it. I think that is all I am asking people to do, think a little more creatively. The dental clinic is a clear example of the repatriation of territorial dollars from Manitoba into the Northwest Territories. That is all I am trying to say.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: You mentioned decentralization and putting the dollars where the services are being provided from a regional perspective. What is your formula in regard to that? Do you have a formula in place with regard to how that should be done? I am interested in doing it in a fair and equitable way. That is the only way to do it. Do you have other visions that I am not aware?

HON. JOHN TODD: We agreed, Sam, that we believe in decentralization. The current decentralization was not an instrument of me. I had no influence over that. Everybody knows that. That was a decision made by the Cabinet in terms of whether it was going to Baker Lake, Fort Simpson, or wherever. The principle of decentralization, we agree with. To me, you have to look at what the net benefits are with respect to decentralization. What is the cost? If there is an additional cost, what is the economic impact within that community? What is the cost of the job? I believe that government should be an instrument of economic activity. Therefore, if it means that we can shift some dollars, and there may be a premium to be paid for it, but it creates some jobs and economic balance, then that is where I am coming from.

Let me give you an example of this hospital. I am getting mad as I sit here because I have been at this thing for a year, not at you people, but just the thought of something behind me, those people in Yellowknife. You know what happened to the Keewatin region with respect to that $2 million. They tried to whip it out of there, even though it was in there to do the impact assessment on health care in this region. That indicated to me that they did not give a damn. They just took it out. "Well, we do not need that." I do not know whether it was a political decision by Mr. Patterson, but it must have been in conjunction with the department, in my opinion. Everybody denies it. I said it publicly and I am saying it again. They have never demonstrated to me, at the senior level, any commitment to looking beyond the status quo. That is all I am trying to say.

All we asked for in this region was to do an evaluation, for our people, my kids, of Silas' kids and everybody else's kids, what it was costing to run dental care from Manitoba and could it be redirected and repatriated. Heaven forbid that we should nudge this thing called Stanton. That is why I am still angry after the year and I am still cynical. I intend to continue to be until I see a clear commitment from the bureaucracy because they are the ones who make it work, no matter how well-intentioned previous Ministers and current Ministers are.

MR. GARGAN: You are still part of that bureaucracy.

HON. JOHN TODD: That is right. You have to try and make it work, but you give 20 reasons why you should not do something and one reason why you should. I know that you cannot have the level of service in Yellowknife in every community, but we did think a little creatively and we did bring some economic development and a quality service with respect to dental care into the Keewatin. Baffin has it with their $40 million hospital. Yellowknife has it. We should be looking at the Keewatin and other regions. I am here to talk about my region as an M.L.A. and I want this government to look, in a fair way, at repatriating health care as we are currently doling out "x" million dollars to Manitoba into the Northwest Territories. If it happens to be Keewatin, I will be very happy about it, but if it means we have to go to Yellowknife, I would be less happy but I would live with that. It just does not make any sense to me to continue to support a medical facility which is using G.N.W.T. dollars of which we are getting no impact on. We certainly get good health care, do not misunderstand me, but it is costing us a great deal of money.

CHAIRMAN (Mr. Zoe): Are there any other comments? Mr. Whitford.

MR. WHITFORD: The gospel according to Mr. Todd. That is your favourite line in the Legislature. I am not going to criticize you. What I am saying is that the Keewatin Regional Health Board is to be applauded for attracting back and establishing dental care in the Keewatin. Let us not go on all evening crapping on Yellowknife. Yellowknife did exactly the same thing that you are doing here. We are repatriating services that, otherwise, would have gone out of the Northwest Territories. What Yellowknife is trying to do is to put back into the territories exactly what you are trying to do with the Keewatin. We have a difference of opinion on some of the things that you were saying, but I am not going to go into that. I just want to say that, if all the health boards worked as effectively as yours, we would have no problem, but the fact is that they do not. As a government, we have to do something about that so that they can deliver the services in the communities that the people want at the cost. You have not had that in operation for that long a period of time. I was curious to know if there were any figures already on the similarity. You said "delivering a service at a similar price for dental care" once your clinic was established. Do not get me wrong, I think that is a great idea to take out of the provinces what we were putting in there. More of that needs to be done. What do you mean by "similar cocst"?

CHAIRMAN (Mr. Zoe): Mr. Todd.

HON. JOHN TODD: I do not know the details of the concept. My understanding is that there is a bit of a dispute right now in terms of some of the things that are being paid for health care. It is part of a larger picture, in my opinion. It is the off-loading of aboriginal health care and the department's inability to be able to take federal government to task on it. There is some confusion about whether or not we are delivering this health and dental care for the price in which we were doing it through the University of Manitoba. Kiguti and the health board will address that more than I can because I do not know the details of the contract.

Mr. Whitford, you have to determine what the net benefits are accrued to it. If I said to you, for example, that you think I am crapping on Yellowknife, that is fair enough. People crap on the Keewatin all the time. That is just life in politics, correct? I said to the M.L.A.s in Yellowknife six months ago, "You people should be looking at repatriation and rehabilitation of the W.C.B., that rehabilitation centre, and tie it into the Stanton Hospital." I talked to Mr. Yamkowy last week and nothing has been done. It is not my issue. I did not get elected in Yellowknife. That is the responsibility of Mr. Dent and Mr. Lewis. You get out there and hustle like I am hustling for the Keewatin. That is my job. You can repatriate, in my opinion, the rehabilitation services that we are currently using for the Workers' Compensation Board in Alberta. I think you can take a look at repatriating that into the Stanton Hospital and receiving greater utilization of the Stanton Hospital than you are currently receiving. It is no different than the initiative with the dental clinic. All you can do is give advice. Whether or not people take it, that is another thing.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? If not, Mr. Todd, this is just to follow-up on the decentralization issue. I was not clear if you were indicating that you are quite satisfied with just the decentralizing of that health insurance services from the central government to the regions. They are splitting that function, one to Inuvik and one to Rankin Inlet. Are you saying that you are satisfied with that function being here in Rankin Inlet? Were you suggesting that that particular responsibility be transferred to the local boards? I was not sure if you were saying, "For now, I will live with just that transfer component of it because it will eventually tie into the Nunavut territory." Were you saying, "Maybe it could go a little further than that?"

HON. JOHN TODD: I would like to see health boards have more autonomy. I do not know how we would work that through. Maybe Mr. Whitford is right. There are some health boards at this level and some health boards at that level. It

reminds of, for some of us who have been around a while, the old days, in 1971, we said, "We are going to let aboriginal people run settlement councils." D.P.W. and all the bureaucracies in Yellowknife said, "That will never work. It will fall apart. They will never be able to run it." Municipal governments are running it today. It is the same with health boards. If you do not try, how do you know? If you are not prepared to make a lousy mistake, how are we ever going to move forward on it? You need to give more authority to the regional organizations. You have to put the solution to the problems closer to where the problems are. There is a cost associated with decentralization, and you have to, in your own mind, evaluate if that cost is worth it. It is no different, in my opinion, as it has been done by many of you and all of us paying a premium to a northern business over a southern one because he is going to train and employee northerners. That is the way I view it.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? Mr. Whitford.

MR. WHITFORD: You have outlined some of the economic benefits of decentralization of the health insurance services component of the department. It sounds as though it will have some very specific benefits to the Keewatin, specifically, of course, to Rankin Inlet. How would decentralization improve the quality of service provided to all of the people of the Northwest Territories? How do you balance that against what the Auditor General suggests, that greater efficiency and quality of performance by the health insurance services would be improved through consolidation rather than decentralization?

HON. JOHN TODD: I do not want to be at odds with the Auditor General, but he comes by once a year, makes a report and we are here forever. In my mind, I do not want to oversimplify it, but I think we have to try it and see if it works. I am in an awkward position because there are economic benefits going to Rankin Inlet, so I am obviously viewed as being suspect. I think if we are moving toward an orderly transfer of the division of the territories, there is going to be some requirement for some of those services to be delivered by a Nunavut government. If we wait until 1998-99, we will never be ready. Let us just roll it in now nice and gentle, see if it works, work out the bugs as we move along, as there will be, and hopefully will come about by being able to deliver the service in a more responsive manner. Only time will tell that, Tony.

Right now, if we sit back and wait until the Nunavut Implementation Commission is in place and that and the next thing is in place, where are we going to be if 1997, 1998, 1999 rolls around? I see this as very much experimental, personally speaking. I cannot quantify to you how successful it will be. In my simple way of thinking, as I frequently say, if you put it closer to the problems, I think it is going to be easier to solve this and find the solutions.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? Mr. Todd, you know that the Auditor General's report comments that the Department of Health is stuck in a pattern of "planning to plan." It sounds as though the Health planning has been an issue in this constituency of Keewatin Central. Can you comment on this from a political perspective?

HON. JOHN TODD: Let me step back a little bit. My understanding is that the department has now recognized that there is a desperate need to get some planning underway. I am talking about my former life as chairman of the Standing Committee on Finance. In fact, there are now significant dollars being allocated and approved to create these need studies and to evaluate the kind of health care that we are currently doing. I think that crosses right across the territories. There were huge dollars in there for planning. To me, it is no different than building a house. You need a blueprint to determine how you are going to build it. The cost of health care is not just a territorial issue, it is a Canadian issue which is skyrocketing.

As a government, we are currently are in an enormous dispute with the federal government about the off-loading component of what was paid for before, which they do not want to pay for now. Again, we are no different than Ontario or any of the other provinces. We need to be able to put together, if you want a plan of action, one, to deal with the fiscal end of it and, two, to deal with the delivery end of it. Are we, in fact, delivering services as well as we should be? How are we going to find that out? We will find that out by going out there and asking people. You have to be realistic, as Mr. Gargan and Mr. Whitford said. You have to go out there and ask and determine if what we are currently doing is actually meeting the needs. The health care conditions of this region, for example, and I am sure Ms. Palfrey will speak to it much more eloquently than I can, are an absolute disaster. It is almost criminal the level of health care our people receive for a variety of reasons. I could spend all night talking about it.

How are you going to make it change? That is why sometimes, if I speak this evening with some frustration, it is because I see things being determined at the centre that have not taken into consideration what is required in the regions and the communities. I am not sure whether or not if it is intentional.

All I know, as a manager, is that whether you are managing people or money, you need the flow coming in and the flow going out. If you look at the Auditor General's report, he talks very clearly about the boards' relationships with the department. I do not want to speak to that. It is fairly blunt and direct in the report. One way or the other, we have to improve that and find the way to get the flow coming in from the regions, re-evaluate what we are doing, etc. Previous people obviously thought it was a centralized system. That was their political jurisdiction. I suspect, if you look into some of the research, that is probably why they have a large, central facility in Yellowknife. I am not taking anything away from that facility. I understand it is one of the best. I am not sure if it is accessible or if the health care is accessible. That is what my expectations are for the people of this region. I cannot walk down the road to a doctor. We have to evaluate what we are doing and we have to recognize that there are some financial limitations, as you have said. We have to look at what we are currently doing to determine if, in fact, that is the right way to do things. I think we proved that in a small way with the dental clinic.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Todd, in chapter two of the Auditor General's report, there is a reference made to "The N.W.T. Way." What

is your understanding of "The N.W.T. Way"?

HON. JOHN TODD: My understanding of "The N.W.T. Way" was to shut down the hospitals in Fort Smith, Fort Simpson and Inuvik and centralize health care within a larger constituency in which to give us less in the communities, not more because we just simply could not afford it. In simple language, that is my interpretation of "The N.W.T. Way." Other constituencies are saying, "When I read it and argued about it in the House, I saw a shrinking of services rather than an expansion of them." It was done, obviously, for the difficult, fiscal position that we are currently in and weathering at the time." That may be a valid argument. I am not debating that. I think you have to look beyond just what we are doing. That came up in Fort Smith. A Member has raised that in the House.

CHAIRMAN (Mr. Zoe): I assume that you looked at it as a model in which no new initiatives or development would take place within a certain area.

HON. JOHN TODD: I do not see any creativity. I do not see someone saying, "How are we maintaining our health care with these poor nurses who are working night and day?" I believe there are many well-intentioned people in the region. I do not see anybody saying, "How can we do it better or different?" Every way you turn, people are talking about the exorbitant cost of travel. What are they going to do? They want to centralize a travel coordinator. The individual who is making the decision in the region knows more about the travel costs and what should be going on than somebody sitting in a central place. Maybe I am just too simple, but that is the big thrust now, a centralized coordinator.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? If not, I would like to thank Mr. Todd for making a presentation to our committee. Thank you very much.

HON. JOHN TODD: All right, Henry. Thank you.

CHAIRMAN (Mr. Zoe): Can I call on our next witness, the Keewatin Regional Health Board representative? I would like to ask the representative of the Keewatin Regional Health Board to provide copies of the presentation to the committee. For the record, could you kindly introduce yourself and your colleague and proceed with your presentation?

Presentation by Keewatin Regional Health Board

MS. PALFREY: Thank you, Mr. Chairman. My name is Bette Palfrey. We have with us several of our board members in the audience tonight as well as Bruce Peterkin, the Chief Executive Officer of the health board. I would like to welcome you to Rankin Inlet, on behalf of our board. Thank you for travelling out here to hear the concerns of the board.

Mr. Chairman, the Keewatin Regional Health Board is encouraged by the report of the Auditor General. This report has brought to the forefront matters that we have recognized for a long time as barriers to efficient management of the N.W.T. health system. Mr. Chairman, my response, unlike Mr. Todd's shortened version, is fairly detailed and lengthy, but our board felt it important to try and cover all the issues that were raised in the report as clearly as we could because we feel it is an important report that was done.

We think the Auditor General's report verified what we, in many regions, already know. The report paints a bleak picture of the way the Department of Health is managed and the attitudes of some of the department staff toward the people who they are hired to serve. There are five main areas of disagreement between some boards and the Department of Health. The first is the issue of authority or mandate. The second is the issue of reporting relationships. The third is an issue of self-government. The fourth, as you referred to, are the principles of "The N.W.T. Way." The fifth issue is one we feel of paternalism. The Department of Health and the regional health boards have had long standing disagreements about our respective roles, and this ongoing dispute has had, and continues to have, a significant impact on both the Department of Health and boards to be effective. Let me explain.

The Department of Health has been mandated to assist N.W.T. residents to attain, maintain or regain their highest achievable level of health. The department attempts to fulfil this mandate by providing or supporting programs and services designed to encourage individuals and communities to accept responsibility for their health by protecting the health of the public and by ensuring access to needed preventative, therapeutic and rehabilitative services and care.

Officials of the Department of Health would have you believe that the T.H.I.S. Act gives the department legislative authority to deal and to manage with health services here in the N.W.T. We have a copy of the T.H.I.S. Act and it does not even mention the Department of Health. What it does state clearly in section 13 are powers and duties of boards. They are before you: "That boards shall manage, control and operate health facility or facilities for which they are responsible and may, subject to part nine of the Financial Administration Act, exercise any powers that are necessary and incidental to the duties under paragraph eight." In our health board trustee manual, which is developed by the Department of Health, it outlines health boards' mandates as the following: "The boards have exclusive and sole responsibility for making operative policies for issuing policy directives, administrative procedures and functions, retaining accountants and consultants, negotiating and administering contracts," and among several other areas that are outlined in the health board manual.

First, I would like to deal with the issue of the reporting structure. The Department of Health officials have stated, and I quote in their presentation, "The boards have the responsibility to manage, through day to day work of C.E.O.s." Health officials say that C.E.O.s are accountable to boards and boards are accountable to the Department of Health. The Minister of Health is accountable to the Legislative Assembly. The departmental officials are wrong. Health board trustees are appointed by the Minister of Health. We discuss all important matters with the Minister of Health. The Auditor General's report clearly points out the need for role clarification. We would concur with those findings.

Unfortunately, the Auditor General's report suggests that the Department of Health has lost sight of the differences between encouraging individuals in communities to accept responsibility for health and controlling them. We agree. The Department of

Health is expected to guide health care in the north and ensure that residents in the N.W.T. obtain their highest achievable level of health status. The staff at the Department of Health must facilitate open, honest and effective communication with the people of the N.W.T. and health boards in order to ensure effective development of health care programs in the regions.

The need for the Department of Health to have a decentralized philosophy for the development, implementation and evaluation of health programming to the regions is essential if they are to learn how to deal effectively with regional boards. We believe that the Department of Health must manage the N.W.T. health care system with the interests of all N.W.T. residents at heart. We feel that the department is an important stakeholder in the health care system. If properly run, they can do a great deal to improve the status of the residents. We believe that a well managed department would solicit from boards their opinions and factor those opinions into decisions that they make prior to decision-making, not afterward. A knowledgeable Department of Health should be able to provide support and consultation on important initiatives that are undertaken by various health boards.

The Auditor General's report identified that the Department of Health has been poorly managed. A poorly managed department will create and foster tension in working relationships. It will hinder the people of the N.W.T. from achieving the appropriate health status by creating obstacles for health boards and hinder the regions and aboriginal people from taking charge. The Department of Health has been defensive with the overall thrust and tone of the Auditor General's report. They would have you believe that there are unique challenges faced by them that hinder their ability to respectively manage their department. They will also, no doubt, endeavour to make you believe that they have established special programs and services to deal with the various issues as outlined in the Auditor General's report.

The Auditor General's report also provided us with several comments and recommendations. The Legislative Assembly and its various standing committees should act on the recommendations of the Auditor General's report. Please do not leave it up to the Department of Health to facilitate the changes necessary. They may have tried to convince you that they have the situation at hand and that many of the recommendations can be dealt with through measures already in place or being implemented. We feel they need a guiding hand to ensure that the recommendations are implemented. The Minister of Health must play an important part in the direction for change, as outlined in the report.

The Department of Health has not been very good at managing the health system to date. The Auditor General's report presents us with an analysis of how they have done to date. The Auditor General's report card of the Department of Health gives them a failing grade. The question of the will of the department to facilitate the necessary changes is there.

The Auditor General's report also brought into question the ability of the department to manage health promotion, protection of the public and prevention of disease. The Department of Health will try and convince you that the problems experienced in the N.W.T. are common throughout Canada. We do not agree. Many of the problems in the N.W.T. are worse than those in the rest of Canada and some problems we have are unique to the N.W.T.

The Department of Health has endeavoured to put the argument to health boards that the allocation of scarce resources is causing the tension between the health care partners, the department and the boards. Yet, we see many examples where boards on one hand are told to cut back due to the scarcity of dollars, and, on the other, numerous consultants within the Department of Health are hired during these supposedly meagre times.

Within the Auditor General's report, the Auditor stated they encountered an attitude within the department that shows a lack of respect for board members. The report outlined that board trustees were not viewed by the Department of Health as capable. This outwardly patronizing view of board trustee capabilities can be seen as an excuse for doing little for helping board trustees improve. The report notes that the suspicion will continue, that the Department of Health wants to keep board trustees ineffective so that the department can continue to control the overall administration staff. This perpetuates the myth that boards cannot do what they are supposed to do and the department is, therefore, justified in maintaining controls. It is a catch 22 situation. They do nothing. They do not help boards develop. Therefore, they do not have to give any more control to boards.

We feel the issue of this paternalist manner with which the Department of Health staff deals with our trustees and staff is of concern to us. Paternalism presents itself in unusual ways. As an example, when the board gave direction to our executive director regarding a strategy relating to the use of a multi-use health care facility, the Department of Health presented concerns that indeed this issue was being driven by the executive director of the board, who is also defining the board's agenda and priorities. The Department of Health did not believe that our board trustees were capable of developing an opinion or a strategy on this important issue. When it became apparent that the executive director was doing the bidding of the board and that the board was responding to stated needs in the community, officials at the Department of Health then declared that our board lacked leadership. The Department of Health claimed the board did whatever the communities wanted even if it was wrong. Essentially, these individuals did not want to recognize good planning ideas and strategies coming from aboriginal trustees, especially if these ideas differed from those of the Department of Health.

The relationship between boards and the Department of Health will only improve if there is an attitude change in the way with which the Department of Health deals with health boards in the regions. Senior departmental managers, in their paternalistic attitude toward health boards, openly indicate that they do not plan to delegate more control to regions because they want to retain control at the Department of Health headquarters. The Auditor General's report outlined this as well.

We believe that, to some extent, the senior managers of the Department of Health have endeavoured to systematically negate the intent of setting up health boards through an undermining process which was intended to erode the credibility of boards, trustees and senior board managers. The issue has been well documented in the Auditor General's

report.

Lastly, in our opening comments, the report clearly identified the need for a clarification of roles, responsibilities, et cetera. between the Department of Health and health boards. We would recommend that sorting out the boards' roles and the role of the Department of Health is paramount if the health system is to be truly sensitive to health issues at local and regional levels. Mr. Chairman, this concludes our opening remarks. If there are questions, we would like to respond before proceeding with the rest of our presentation.

CHAIRMAN (Mr. Zoe): Mahsi. Thank you. Are there any comments or questions from the committee? Mr. Gargan.

MR. GARGAN: With regard to page four, you referred to section 13. Under section 13, it says to manage, operate and control health care facilities. Where does that section refers to the control of health delivery?

MS. PALFREY: The point we were attempting to make, Mr. Gargan, was that we understand, in the presentations made previously by the Department of Health, they indicated that they have been given some type of authority through the T.H.I.S. Act. We have read the T.H.I.S. Act. There is no authority delegated at all to the Department of Health. The authority has been delegated under section 13 to boards of management, of which our regional board is one. That section indicates that we shall manage, control and operate the health facility or facilities for which we are responsible, which is the operation of the regional health delivery system for this region of the N.W.T.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: Under that section, it does not refer to the overall delivery. I thought the T.H.I.S. was dissolved as a board. All right, the Act is still in existence.

CHAIRMAN (Mr. Zoe): Are there any other questions or comments from the committee? Mr. Whitford.

MR. WHITFORD: The biggest concern of the Keewatin board is the relationship between the Minister of the department and the board. It seems to be almost adversarial. I have heard this before. What works in the Keewatin may not necessarily work somewhere else. Are you suggesting that the boards receive more autonomy? Are we looking at a partnership? Are we looking for more autonomous boards to do what they think is right?

CHAIRMAN (Mr. Zoe): What steps should be taken in order to achieve this?

MS. PALFREY: My experience, in the past, is that, if you issue a challenge and set goals and clear definitive objectives for people to reach, they will rise to the challenge. Currently, there is nothing to encourage boards to rise to the challenge. Some boards are operated under the direct mentorship or control of the department so they have a much different operating mandate than boards which operate under a different set of criteria. We think there has to be some equality developed. There also has to be some clear direction. Later on in my presentation I would like to go through the Auditor General's report, to deal with that clearly as we can to try and explain our position a little better. That is a key issue in terms of the development of boards across the N.W.T. and with respect to how self-government will evolve across the N.W.T. as we enter that era of aboriginal self-determination.

CHAIRMAN (Mr. Zoe): Are there any further questions or comments, Mr. Whitford? If not, I would like to add a question in regard to the relationship of the boards of the central agency. On December 10, the Standing Committee on Agencies, Boards and Commissions submitted an interim report to the Legislative Assembly, where they commented on the initiative which is underway to establish M.O.U.s that would clarify the relationship between boards and the department. What is your assessment of how this process is proceeding? Do you feel that this is a solution that is being imposed or one which you are fully an equal partner? They identified 15 elements within the M.O.U. that can be considered. Do you feel that these major elements are sufficient? Do you think it should be enhanced?

MS. PALFREY: Mr. Chairman, in December, our board as well as chairpersons of other boards appeared before that Standing Committee on Agencies, Boards and Commissions to make a presentation. At that time, we indicated clearly that we felt the memorandums of understanding were not the "be all and end all" to answering or solving this problem. We felt that it had to be a multi-pronged approach. It is something that the Legislative Assembly, at some point in time, should be looking at and providing some guidelines for the departments or for other agencies that may be looking at devolving more authority to boards.

Under appendix one, there is a letter that I have written to Adrian Wright, who is, I believe, the Chairman of the N.W.T. Health Care Association, with respect to concerns that I have about the way the memorandums of understanding are being developed. We were told that we would be consulted in the process. However, we were consulted after the terms of reference were developed and after the department had decided to send proposal calls to three consultants. To me, that is not consultation. That is after the fact token consultation. That is not the type of role that we advocate. If we are going to be consulted and part of the process, then we are part of the process from developing the terms of reference to deciding how the contracts will be awarded and ultimately to guiding the consultants through the process. In this instance, we do not feel that it was the true consultation process.

CHAIRMAN (Mr. Zoe): Does the Keewatin Regional Health Board have an M.O.U. with the Department of Health?

MS. PALFREY: No.

CHAIRMAN (Mr. Zoe): Not yet? Are there any further questions or comments from the committee? Mr. Gargan.

MR. GARGAN: I have one observation, Mr. Chairman. You do not have much love for the Department of Health. How effective is the Keewatin Regional Health Board with regard to providing leadership and direction to the region and with regard to the delivery of health care as opposed to the problems you are having with them? There seems to be no

dialogue between yourself and the department. You have put a great deal of your presentation on yourself and you are comparing yourself with the department. With regard to the delivery as opposed to your fighting with the department, how much of that are you doing?

MS. PALFREY: As I go through the presentation, it may be a little clearer as to actually what we are doing. Currently, we have been mandated by the Keewatin Inuit Association and, to a certain extent, through their representation on T.F.N. to provide technical advice to the region on any matters dealing with health care. We have also been requested by the Keewatin Inuit Association to represent them in any dealings or concerns with the federal government with respect to aboriginal health care in the region. That, in itself, speaks for the faith that some of the other organizations within the region have with the Keewatin Regional Health Board and our ability to deal with health issues for the people of this region.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: What is your feeling with regard to the 1988 transfer policy? Do you really feel that the territorial government should be taking on that responsibility now or should it go back to the federal government and eventually devolve the funding and control just to the regions?

MS. PALFREY: We deal with that to some extent in the rest of the presentation. Within the binders, you will see a presentation that we did on a position paper from the Keewatin Regional Health Board with our position on the non-insured services and aboriginal health care. One of the recommendations of that position paper is that aboriginal organizations have to be involved in the negotiation and the solution of the problems that are currently being encountered with the federal government. Ultimately, it should not be some white civil servant sitting in Yellowknife who ultimately decides the future of your children and your grandchildren. As aboriginal residents of the N.W.T., what will be left for them when the health care system is handed over?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: It sounds to me like the Auditor General's report suggests that the Department of Health has been making plans to make plans, that it should come up with an overall plan which will decentralize many of the services that are provided from the centre. You are making plans that will take place in the Keewatin region, and the department is not responding. If they are, then they are responding negatively. What is necessary for the department to become responsive? I do not know if you have any kind of ideas as to how to build a relationship, not necessarily with the health board here in the Keewatin region, but with the other regions?

MS. PALFREY: I think one of the recommendations that we made to the Standing Committee on Agencies, Boards and Commissions was to look at part of the solution as being legislated direction for the department to look at how they are going to be delivering services in the future. That means a certain degree of direction will have to come from Members as elected representatives. We have community representatives on our board. The community representatives bring us the wish of those communities. However, if we cannot translate that wish and take it to the head and have them listen to the wish, then we are not accomplishing anything. That is part of the frustration right now. The boards were created to allow residents across the territories to have input into the system, but it is only working from the bottom up. It is stopping in the middle. The top is not listening to what the little people are saying. That is why some of the direction will have to come from Members such as yourselves who are accountable to the people who elect you.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments? Mr. Pudlat.

MR. PUDLAT: I know that the Department of Health is not willing to give the health boards as much authority as they want. Is it just the department, or also the Minister? Possibly you are not having proper contact with the Minister of Health. Are you working with him properly? Is there a misunderstanding between your group and the Minister of Health? Are you solving any problems between the health group and the Minister of Health?

CHAIRMAN (Mr. Zoe): Ms. Palfrey.

MS. PALFREY: Thank you, Mr. Pudlat. Our board has had good relationships with the previous Ministers of Health. However, what we have found in the past is that sometimes the department does not fairly represent the regional positions to the Minister, mainly because they do not understand them. The department has placed itself in the position of being the ultimate authority in terms of the development of regional issues. Given that we deal directly with the Minister of Health on important issues, we do not feel that we are accountable to the Department of Health. We are accountable to the Minister who appoints each member on our board to their board position during their term of time on the board. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I just wanted to get a sense about what you felt of the appointment of K.R.H.B. members by the Minister rather than be selected by the communities. Is that something that should be a structural change? Do you get a sense of that from the communities, whether or not they should be selected by the communities?

MS. PALFREY: Apparently, as it stands now, the Minister requests three names from the communities. Those three names are vetted by the Minister and a name is selected by the Minister as to who they wish to appoint. The origination of the three names come from the hamlet involved. For instance, if it is Baker Lake, they would request that three names with resumes come from the Hamlet of Baker Lake to the Minister who will ultimately make a selection and appointment. That is the process.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: There is quite a difference of opinion between the relationships and relationships of boards and department and/or the Minister. It must be very frustrating for the board, five Ministers in two years. Have you met with the Minister yet? Everything is clearly outlined in your

documentation. I trust that she has a copy of this.

CHAIRMAN (Mr. Zoe): Ms. Palfrey.

MS. PALFREY: She will not get a copy until after the presentation tonight. We will be making a copy available for her. She is very aware of our concerns with the department. We met a week and a half ago in Rankin Inlet with the Minister.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: We should have a better relationship having a Minister from a smaller community as to one opposed to a more centralized one.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Ms. Palfrey, I wanted to ask you a question. During our public hearing in Yellowknife during the first week of January, Mr. Nelson McClelland, the department's Director of Health Facilities, made some comments pertaining to a management letter from an auditor who did an audit on the Keewatin Regional Health Board. I will read it to you. From the transcript, he indicated that, I will quote it. "Mr. Chairman, here is the indication from one of the management letters that we received from auditors in this respect. As you know, each hospital and health board has to have an annual audit. It provides a financial information statement and it also provides a management letter. I will read you an extract from some of these letters and it will give you, certainly, our accountant friend, Mr. Koe, will appreciate some of the problems that are here. One of the audit letters says, and I quote, 'the accounting system controls and procedures were not implemented. As a result, financial statements produced are materially inaccurate. Senior management of boards do not formally meet to review the monthly financial statements. Billings are three months in arrears. Bank reconciliations were not properly completed. Manual pay cheques were issued but not recorded. At one point, over $100,000 in unrecorded cheques existed. Responsible managers did not receive regular monthly financial statements. Fixed assets listings were not maintained.' Mr. Chairman, the list goes on and on and I raise them simply to emphasize the magnitude of the work and degree of frustrations that these have caused both the board and the Department of Health." This letter, after we got a copy of it, was about the Keewatin Regional Health Board several years ago. Is it still a true description of how your board operates today? Was it fair for the department to use this documentation this way?

MS. PALFREY: Are you aware of the date on the letter?

CHAIRMAN (Mr. Zoe): I believe it was about four years ago.

MS. PALFREY: Then I think it is extremely unfair of the department to reflect that as being indicative of the accounting procedures of this region's stature. I am surprised that, if it is four years old, he would be raising it at a meeting. Also, to me, if it was an instance of something being current, I would say that the department would be at fault because we know nothing of it. We are not perfect in any sense of the imagination, but, at the same time, I would suggest that if there were major problems, we would be aware of them.

Four years ago, the health board did not do these types of functions itself. These were handled by the Department of Finance. These could have been comments that were made by the G.N.W.T. auditor with respect to areas that were done by the Department of Finance. It was not the regional health board per se. Now that the accounting has been brought back to the region, we hope that there has been a significant improvement. We have already identified that we are unable to meet some of the requirements being asked for by the Department of Health. When the positions were given back to us, that had been formally done by the Department of Finance, two of those positions were taken from this region and pulled into headquarters. Now, we are unable to meet some of the financial pressure that they are putting on us to provide reports because we do not have enough bodies to do it.

CHAIRMAN (Mr. Zoe): Thank you. That is what I wanted to hear. I wanted to have your comments on record pertaining to what the director had to say in that regard. I just wanted to get your comments on record. Are there any further comments or questions from the committee?

MS. PALFREY: I would like to continue on with several other items in the report because I feel that some of the things that we have yet to cover are significant. I will try and be as brief as I can. I think that some of the specifics that were raised in the Auditor General's report are items we would like to have the opportunity to comment on.

CHAIRMAN (Mr. Zoe): Ms. Palfrey, I took a look at your presentation. I think we still have about 53 pages to go.

MS. PALFREY: No. I am sorry. It is not as bad as it looks.

CHAIRMAN (Mr. Zoe): Including your recommendations...

MS. PALFREY: I will not be going through most of the recommendations. We will leave that with you because we think it is very self-explanatory. We have taken the response the department has made, which was rather open-ended and vague, and specified what we think are more realistic areas that could be addressed in the recommendations. We have closed them in a bit by saying that agreed is not necessarily a good response, possibly by stating three or four things that could be done rather than stating agreed.

CHAIRMAN (Mr. Zoe): How do you want to deal with this? Do you just want to go through them quickly?

MS. PALFREY: I can be brief. I will attempt to be brief, Mr. Chairman.

CHAIRMAN (Mr. Zoe): We would appreciate it. Fire away.

MS. PALFREY: Since you travelled all this way, we really feel that it important that you get a true reflection of the feelings of this board. We were the only board, I might add, which was singled out by name in the Auditor General's report, and, if indeed Mr. McClelland has indicated that we were at fault financially through his presentation to you, even though it does not state our name in the report, I would be dismayed.

CHAIRMAN (Mr. Zoe): Proceed, then, Ms. Palfrey.

MS. PALFREY: Thank you for your indulgence. As you are aware, in 1988, the G.N.W.T. took over delivery of health care and decided on a new approach to organizing the health care system that is a central government complemented by local and regional health boards.

The boards and the department still remain confused about their roles and there is great distrust. According to the Auditor General's report, the department still questions the competency of boards but has done nothing to train or develop them. There is still a great deal of discord between the parties, but nobody is doing anything to correct the problem. The Legislative Assembly has not really helped because it has not indicated clearly to all parties whether it wants a centralized or decentralized control. The Strength at Two Levels report suggested a decentralized approach and the T.H.I.S. Act delegates the responsibility to manage, operate and control health facilities to boards, but it really is not specific on what is included and what is excluded. The Auditor General's report states the Department of Health is standing in the way of transfer because many of the department's officers disagree with such a strategy. In addition, it states the department's style is far too controlling to be effective, not communicative enough to reduce misunderstandings and too paternalistic and patronizing to be credible.

Officials of the department have presented you with many reasons why health boards should not be autonomous. We do not believe that is the issue. We believe that the Department of Health should be less controlling and health boards should have more freedom to fulfil their mandate. As I indicated earlier, I think if you provide freedom, people will rise to the challenge. We have endeavoured to carry out responsibilities outlined in the T.H.I.S. Act. However, as was presented to you in the presentation to the Standing Committee on Agencies, Boards and Commissions, the single biggest stumbling block to meeting the health care needs of the regions has been the Department of Health. When management decisions are made by our board of management, the Department of Health, in their patronizing style, has scrutinized our decision-making and have attempted to overrule our decisions and directions to our staff. They are of in the opinion that the board reports to them when, in fact, we feel we are directly accountable to the Minister of Health. They have little respect, if any, for the decision-making process that occurs within the health boards, and we believe that there has been a movement within the Department of Health bureaucracy to have health boards eliminated as mechanisms for delivery of health services in the regions through undermining and casting doubt as to our abilities.

Some officials in the Department of Health would have you believe that they have not been able to concentrate their efforts for four years on developing a strategic plan for the future of the department with the appropriate infrastructure to support the system because of boards, as we have engaged them in four years of debate over alleged infringements of autonomy. In our estimation, the Department of Health will continue to use smoke and mirrors to blame boards for the state of confusion they are in and the mismanagement that has been identified by the Auditor General. We cannot understand why action has not been taken by the Legislative Assembly in dealing with the findings of this report. We are thankful that you are here before us today.

If this report had been completed on a private sector corporation, we would, no doubt, have seen numerous resignations and dismissals of senior executives for their failure to manage the company's affairs properly. To date, nothing has happened to senior officials who have been responsible for the management of the Department of Health. They should, and must, be held accountable.

To tell this committee that you cannot really understand the Auditor General's report, "it is so difficult to understand," I find that appalling. The Department of Health would have you believe that memorandums of understanding will help sort out the various roles and responsibilities between health boards and the department. We caution that a multi-pronged approach is required to resolve the issue.

We acknowledge that we are bound by government policies, regulations, statutes and budget allocations. Accountability is an important part of the administration of authority entrusted to us. We have prepared a discussion paper on the role of health boards in the N.W.T. We are accountable to our residents, our communities, our organizations, our politicians and to our Minister. The need for the Legislative Assembly to provide the appropriate response to clarify this role of the Minister of Health, the Department of Health and the health boards is long overdue, four years overdue. The Legislative Assembly should give health boards the clear mandate for the responsibility for delivering health care to the regions and the people they serve. Boards must be accountable to the Minister of Health.

With the onset of the development of Nunavut, the Department of Health will indeed be forced to assist the aboriginal people to realize their dream of autonomy in the delivery of health services to Nunavut. For Inuit of the Keewatin, health care has become a self-government issue. People here see boards as a beginning to self-government. The Department of Health does not include any input from aboriginal organizations in the N.W.T. with respect to development of key health and services or guiding principles. They do not consult. We do. All but one member of the Keewatin Regional Health Board is aboriginal. Our members represent the Keewatin communities and aboriginal organizations.

The Auditor General's report states that, even though four years have passed since the transfer of health care, the department has no strategic plan outlining what it expects health care to be and how it attempts to get there. In addition, the report outlined that the Department of Health has neither asked the opinions of boards, even though some of them may have a useful perspective on health care issues, nor have they developed a mechanism to gather opinions. The department is firmly anchored in a one-year budgeting process. They do not think about long-term issues. They are worried about getting this year finished. How much did they have to go to F.M.B. for? How much money are they short? The lack of planning shows itself in the placement of health care professionals in the north. Even though the system was designed to be decentralized and have nurses provide medical support, 200 of the 360 nurses are in urban centres, and physicians provide primary care in Yellowknife, Inuvik, Hay River, Iqaluit and Fort Smith. The department admits that the system of health care they help set up and support is inequitable. The western Arctic has 62 per cent of the population, 5 out of 6 hospitals, 86 per cent of the doctors and

70 per cent of the nurses.

The department has been operating the delivery of health services in a vacuum. They have no strategic plan in place that gives them direction for delivery of health care. If they had a strategic plan in place, they would have been able to anticipate the various environmental factors and the internal and external ones that impact on their ability to achieve their mandate. The strategic planning process would enable the department to plan for the delivery of health services in a pro-active manner rather than reacting all the time while working cooperatively with those who are affected by the decisions they make. The strategic planning process would also enable those who are affected by the decisions of the department to have more influence on the decision-making process.

Please do not let the Department of Health convince you that they do not have any control over the destiny of the health care system in the north. They do and they should. The reason they are unable to accomplish their objectives are as follows: they do not have good strategies; they are poorly thought out; they react heavily to crises; they fail to consult with people; and, they have no planning. An example of this can be seen in the way in which the department has attempted to imprint "The N.W.T. Way" of health delivery that you have spoken about before. They have developed a new and improved version of "The N.W.T. Way" that still has to be sanctioned by the people of the Northwest Territories. There has been no consultation process put in place to gather input from the people, especially in the regions. Aboriginal organizations, stakeholders in the system and consumers have not been consulted about this new system. To this end, we believe that the model for delivery of health care services in the N.W.T. should be called "The Department of Health Way." If the Department of Health has their way, there will be an inequity of service to aboriginal communities. The Keewatin Regional Health Board will not support any health care system that provides a different level of care to aboriginal and non-aboriginal people.

The Auditor General has found that the department and boards have not increased aboriginal involvement in health care delivery, although this is a policy objective. Two of three hundred and sixty-five nurses on staff are aboriginal. In addition, most health boards in the regions have a high percentage of aboriginal or Inuit staff, on the average of 40 per cent. The Department of Health has 11 per cent. Overall, the report is critical of the department's management and staff. There is no discussion of cultural sensitivity with new hires. Recruitment ads are bland. There is little assessment of an individual's suitability for the north. Performance appraisals are poorly done, as the report indicates.

The Auditor General's report criticizes the department on the inequity of training budgets. In spite of the primary caregivers in our health system being nurses, doctors, on the average, are given professional development budgets eight to 11 times higher than nurses. Professional development expenditures per nurse are $1,000 to $8,000 versus $8,000 to $10,000 per doctor. Although nurses are the primary caregivers and the chief focus of delivery for the health care system in the territories, there are no programs developed to facilitate training, recruitment and development of aboriginal nurses. Why can we not put a program into place like we have done with T.E.P., to bring aboriginal people into the health care system? We have had four years. The Department has done nothing.

With respect to the management of information, because that was one of the areas that you raised with Mr. Todd, the Auditor General's report was very critical of the department's management of information. The systems do not provide information on important health care issues. They are not structured with health care planning in mind and reports are seldom available in a timely fashion. In addition, the department has put little effort in controlling the quality of information submitted through the health care claims process. As a result, all the information we have is of questionable value

The report was critical of the way reciprocal billings are handled for a number of reasons. Copies of all the interprovincial agreements cannot be found or if the payments were recovered. Agreements do not allow for recovery from promises involved when overpayments are discovered. We currently have a situation going on where we are disputing reciprocal billings with the department, and yet, we are unable to capture the interest. We think there is a significant amount of dollars involved.

We have an ongoing deluge of requests for financial information from the Department of Health. We believe in fiscal responsibility and accountability. We do this by following the generally accepted practices throughout Canada. We have our own internal controls. We have a chartered accountant. We have annual audit statements that are made available to the Minister of Health. To date, we have met all the budgetary criteria set up by the Department of Health. Much pressure is put on us for detailed controls. We feel that the department should be looking for ways to improve its services and support to us rather than, for example, asking us to provide the per unit cost for all the x-ray film utilized within the Keewatin health centres. Too much time is being spent on detail. Too little time is being spent on broad, financial planning.

We have instituted, over the past few years, the use of different accounting systems with the various boards by the Department of Health. We agree that detailed control, processing the information and different accounting systems are all inefficient and they add to the cost. You see in the Auditor General's report how many accounting systems there are in place. The Department of Finance developed the H.B.I.S. system and it is being utilized by health boards. This was developed in the N.W.T. and supported by the Department of Finance. We do not understand, in the recent recommendations by the Department of Health, why they now want to throw out this system and go back to the Manitoba health system. We believe that the Department of Health, in cooperation with the boards, should analyze the available systems, as well as other potential systems, and see which one best suits the overall needs. The Auditor General's report outlines this clearly, and we agree with it wholeheartedly. However, we would take this one step further to include the requirement for the department and the boards to work together to assess and define the specific accounting needs.

The Auditor General's report also indicates that there is a lack of research capability within the department. There is, indeed, an archive process within the department for initiation of

research. The Auditor General's report outlines this as a problem. We have taken, with our partners, the lead to identify the health status of our people throughout Keewatin regional health needs assessment. We have also developed a number of position papers outlining direction and providing input into various systems issues from a regional perspective and papers such as the role of the health boards in the N.W.T. health care system, non-insured services to aboriginal people, report of the medical officer of health, presentations to the standing committee, et cetera. We feel if we are able to do this kind of planning as a regional board, why is the department is unable, with all their resources, consultants and financial resources, to do the same or similar type of initiative?

There is an interdependence between research and strategic planning. The department's lack of a strategic plan, as well as their lack of appropriate research capabilities, should cause us all to question the very strategies they would put forth on health issues. We are of the opinion that, if the Department of Health does not have the capability to pursue the appropriate health strategies aimed at improving the health status of the N.W.T. because of their lack of research, policy and health resources, they do not have the ability to steer health programs toward specific health program needs. They do not have the ability to measure program effectiveness or efficiency.

Since 1988, we have not had a problem managing our financial affairs, I thought. However, we can now see the Department of Health's mismanagement of the budget process causes regions to appear to be out of control. I would like to cite an example of how they put us into this situation constantly, where we are being defensive rather than going about and doing what we should be doing.

At the beginning of the year, we receive a budget allocation that is developed by the Department of Health. They tell us what we are receiving, it does not matter what we ask for. We receive what they give us based on the allocation of the previous year's budget or forecast. In addition, we receive a list of assumptions that are to be used to derive a detailed budget. For the remainder of the year, the Department of Health managers use this budget on a line-by-line item. If, during the year, the Keewatin region has a deficit on one line item of $500 and a surplus on another line item of $500, the Department of Health pulls the excess $500 and suggests that the region fund the deficit from within. I would like to be able to do that at home. After the Department of Health has done this several times, the region's surpluses are all pulled into Yellowknife and the deficits are left in the regions. Eventually, the region is forced to request supplemental funding for the growing deficit costs by the Department of Health. We are not quite sure what happens to all the money that got pulled into Yellowknife.

The next several pages are a list of statistics that I think are self-evident in the north. I would like to, in an effort to save time, go on to financial issues on page 20. One of these problems with the existing budget system is the lack of ownership as I indicated we feel toward the process. The existing systems, with controls on the line-by-line items, do not encourage efficient use of resources. Boards that underspend their budget are not allowed to use any of the excess funds for the support of new initiatives. If we can save, we cannot redirect that money to do new programs or to do anything that may prevent sickness. The surplus is returned to Yellowknife for their distribution or their utilization. In addition, boards fear that the next year's budget will be cut if we save money, if we are good fiscal managers. To make matters worse, the boards that exceeded their budget are simply allowed to increase their budgets the following year to ensure their budgets are met. Boards who are financially responsible risk losing dollars.

The Auditor General places the blame for this squarely on the shoulders of the department. Needs analyses are not done as mechanisms to determine budget requirements. By needs analysis, I mean documentation such as we have done with the health needs assessment in the region to determine where we are going to have to spend money in the future as a basis to determine where we are going to budget our money effectively. They are not used wisely by the system as the mechanisms for determining budgets. There are no rewards in the system for controlling costs. The budgeting process does not include forecasting models. The department lacks quality controls and claim processing and does not manage medical travel. The result is predictable. The regions are left not knowing the cost of medical travel for their regions. The department pays the bills without knowing if the patient actually attended treatment or whether the bill has been paid under another contract. The Department of Health officials would have you believe that the health boards are irresponsible fiscal managers.

The Auditor General's report outlines that there is a need for the Department of Health to put appropriate mechanisms in place to enable them to predict budgetary needs accurately. Because of their inability to predict budgetary needs, the Department of Health is required annually to return to the Legislative Assembly for more supplementary funds. We believe that there is a lack of financial expertise and sophistication within the department to predict trends and costs in enabling them to come up with realistic budget estimates. We concur with the Auditor General's findings that the department needs trend information and prediction models showing the estimated price in use of these provincial facilities. We agree that, without this trend information, it would be difficult to budget appropriately for hospital, medical treatment and medical travel as well as to analyze the use of out-of-territory facilities.

The Auditor General's report notes that the Department of Health has difficulty managing the $20 million they spend on out-of-territory medical treatment exclusive of medical travel. If the Department of Health is having problems managing $20 million, then how do you think they are doing with approximately $188 million?

The Auditor General's report indicates the Department of Health is doing very poorly in its financial management accounting of the territorial health budget. It would appear that insufficient funds were transferred to the G.N.W.T. to deliver health services in these regions. It would appear that, perhaps, the G.N.W.T. negotiators did not negotiate a good deal at the time of transfer. The Auditor General's report notes that federal transfer government officials did not consider the adequacy of resources at the time of transfer. What that means is at the time of transfer the federal government does not care what the territorial government is going to need in the future. You get what was transferred at the time of transfer. It was up to the Department of Health to consider the future. This means long-

term funding. They believe, and they state in the Auditor General's report, that it was up to the negotiating team to either accept or reject the terms and conditions at the time the transfer occurred.

The apparent lack of sufficient funds to deliver health programs is translated into itself the need for the Department of Health to now return annually for supplemental funding. We are concerned to see in the report that the Department of Health started each fiscal year without enough money to deliver its programs, which causes them to go back annually for supplementary funding. The Auditor General's report outlined this practice has been going on for four years. We would concur that this is a disturbing pattern and we must ask ourselves what has been the most significant development that occurred during this four year period?

Approximately four years ago, the Government of Canada transferred the management of hospitals, nursing stations and community health to the G.N.W.T. In summary, because of the Department of Health's inability to negotiate, there was not enough money at transfer. There is not enough money today and there may never be enough money for proper health care in the territories. This has long-term implications on the residents of the north and for the public purse.

As you are all aware, the government has filed a statement of claim in the federal court, which I see has escalated from the $79 million since we drafted the speech to $90 million as it stands today, which the G.N.W.T. claims is owed by Canada for costs that have been incurred for the delivery of aboriginal health care dating back to 1986. We cannot understand why this matter was not dealt with much sooner. The liability was allowed to increase over the past seven years. This is not acceptable. The department, in ostrich-like fashion, chose to respond by ignoring it all. "It is going to go away." All I know is, since last October, when we talked about it, it has gone from $35 million up to $90 million today. It is staggering to think that there is that kind of sword hanging over our heads with respect to the future of health care in the north.

According to the Auditor General's report, the biggest problem with the management of results system and the way the department manages affairs relates to the way it assesses programs and people. For the most part, the department tracks its activities, not results. It tracks programs, not people. Many objectives are not clear, few have specific targets and many have inadequate measurements. The above notes taken from the report are all consistent with comments that many of the Keewatin Regional Health Board and staff have made. The comments made in the report suggest that nothing will change. The fact that planning for the future is absent is no surprise to anyone in this region. People here, who have dealt with the department in the past, have mentioned that the department has the incorrect perspective on many issues.

Mr. Chairman, in conclusion, those are two words I am sure you will be glad to hear, I would like to state that the trustees of the Keewatin Regional Health Board commit to six guiding principles. I would like to share those with you because these principles guide us and bind us in a common mission. They are considered in every decision we make, every contract we sign and every policy we develop. We expect our employees, our staff, our vendors of goods and services, as well as the Department of Health, to commit themselves as well to these principles. In the absence of written policies, we expect them to use these principles to guide them in their dealings with the people of our region.

These principles are, any individual from the Keewatin region has the right to be treated in a culturally appropriate manner. People have the right to be treated with respect, including our board. Services should be provided as close to home as possible by Keewatin people and in Inuktitut. Residents of the Keewatin have a right and a responsibility to participate in their health care. The Keewatin Regional Health Board, the staff and the contractors commit themselves to helping the Keewatin people have healthy life-styles. We believe that healthy life-styles and healthy minds go together. All programs and services will be delivered in a way that economic opportunities and opportunities for training, education and employment for Keewatin people are maximized. That is what we have endeavoured to do in repatriating our service contracts.

We believe that a goal of a health care system is to improve health by assisting people to take greater control of the factors that determine their health. A health care system should be planned in such a creative and innovative way to give the community both empowerment, which is fundamental for health, and build their capacity for solving community problems. Many of the medical problems we manage both here and in the south are not medical, but they are social and spiritual in nature. This philosophy reflects an aboriginal approach to the delivery of health care and it necessitates the continuation of community involvement in that process. The goals of a health care system and the process of providing health care services are mutually supportive. Improving the health of people is achieved through their respectful participation in the decisions, including research, implementation and evaluation of programs. In other words, services are not sufficient in themselves to promote health. We must plan to assist people to take over.

We believe that the two most important factors to promote health in the north are meaningful employment and strengthening the community. Every decision made by the health board, whether it fosters Inuit employment or if it strengthens community capacity, is within the guiding principles. Inherent in this belief is the assumption that health care should enable people to take greater responsibility for the conditions for health, employment, adequate housing, nutrition and a safe environment. We challenge any health care system developed that does not recognize the primacy of the community as our health developments.

The Auditor General's report focuses on the need for the Department of Health to change the way in which they manage the health care system in the territories. We should now begin the process of ensuring that each and every recommendation of the report is implemented. The Department of Health itself requires radical surgery.

Following is a Keewatin Regional Health Board response to all the Auditor General's recommendations as outlined in the report. As I indicated earlier, we feel that it further clarifies and expands on some of the responses that were given by the department. On behalf of our board members, we would like to thank you very much for travelling here to meet with us and

to hear our concerns and congratulate you on your efforts to date. Thank you.

CHAIRMAN (Mr. Zoe): Thank you, Ms. Palfrey. Are there any comments or questions from the committee? I do not want to get into the recommendations that the board has made to us at this time. We still have to digest it. I wanted to ask you a question in relation to the H.B.I.S. versus the Manitoba health M.H.O. system. You indicated that the department was thinking of converting from H.B.I.S. to the Manitoba system. My understanding is that the Department of Health was reviewing this option. Which system does your board use?

MS. PALFREY: We are on H.B.I.S. currently. The payroll is on the Manitoba health system.

CHAIRMAN (Mr. Zoe): I understand the department is having many problems because various boards are not using H.B.I.S. Some are using a different system, such as Stanton Yellowknife Hospital. Stanton's chart of accounts is totally different from yours. You are using the Manitoba system for your chart of accounts, correct?

MS. PALFREY: I think part of the problem is the department is attempting to treat boards and hospitals as two like entities. All the regional boards of health are on H.B.I.S. except for the Baffin. We feel the department should spend time consulting with all the boards to determine what is the best system to be used across the board. It does not make sense to think it is an easy answer to say, "Everybody is going to change on to the hospital system." We are not hospital boards. We are regional boards. We deliver a myriad of services to our residents. We are not the same as a hospital that delivers one set of functions. That is part of the problem. They are attempting to look at the two systems as being one function.

CHAIRMAN (Mr. Zoe): My understanding is that it has been imposed on the board without any consultation. That is where the problem lies. I have heard that also from the Stanton Board of Management that they are trying to impose a number of systems onto various boards. Apparently, there has not been any consultation with the N.W.T. Health Care Association or any other group. That is my understanding. I believe, in the hearings in early January, the department indicated that they were looking at re-evaluating the entire system.

MS. PALFREY: The point that we are making, Mr. Chairman, is that we have been told by the department that there will be this change taking place. That is typical of the consultation process that takes place with boards, rather than going around and asking or communicating with people prior to making a decision, it comes down at a meeting of finance officers or C.E.O.s in Yellowknife that this is the department's decision on where we will be going and, after the fact, they then say that they consulted with us because they talked about it. That is not consultation. Consultation is carried out before you make a decision and it takes into account people's opinions. It is not developed by the opinion of only the central agency.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: I hate to leave the evening with this feeling. I was responsible for the department for a short period of time, four months to be exact. You present things in your presentation that, I am sure, are going to be hot issues with the department. We will wait for that to happen on its own. On page ten, you state that you believe there is a movement within the department to have the boards eliminated as a mechanism for delivering health services. Where do you get this from? Can you identify where this is coming from within the department? Is this from the Minister, D.M., A.D.M.s, from the bottom up or from the top down?

MS. PALFREY: This is from a private conversation with one of your counterpart M.L.A.s who indicated that he had been told that by members of the department.

MR. WHITFORD: This is second-hand now. Third-hand maybe.

MS. PALFREY: No.

MR. WHITFORD: These are not your observations. I am more interested in the other conversation. If this is the case this goes against everything that the boards across the territories are striving to accomplish, if the department has a hidden agenda to get rid of boards. This is contrary to what the people want and to the good delivery of health, they should be pointed out. Did you see this yourself or do you just believe what you heard? It is a very serious statement. It is one that is fundamental to the delivery of health in the territories using the health boards as the principal drivers of health services in the territories. You went on further to say, if this was a private corporation we would fire the works of them. Maybe you do not want to fire them all. In defence of the department from the bottom up, there are many good people there who are working very hard. Somewhere in there, there must be this attitude. Where is this attitude coming from? How should we deal with this? Do we identify them and fire them? Do we work some other way? How can we deal with this? First of all, can we identify where it is coming from? Secondly, how do we deal with it?

MS. PALFREY: First of all, it has been identified by a number of sources. Number one is the Auditor General's report. It clearly speaks about the lack of respect that the department has for the boards. They are concerned that boards are unable to deal with issues, that we do not understand issues and that we are not able to provide or make sound decisions. Secondly, as I indicated before, it has been indicated to M.L.A.s from individuals within the department that they are not particularly supportive of boards. This was during the initial round of consultation to do with the Standing Committee on Agencies, Boards and Commissions. In addition, we have been told by members of the department that we should not get too comfortable because they are reviewing the future of boards right now, we may not be around. You take all these things into consideration, and I have no doubt in my mind that there are certain elements within the department that would like to not have to deal with boards. They see themselves as only having to deal with C.E.O.s in the region. We are almost, for instance, a thorn in their side because we ask difficult questions, we do not necessarily agree with them and we have the best interest of our regions and our communities at heart where they have a differing point of view. Sitting in Yellowknife, it is quite easy not to take into consideration Whale Cove or Repulse Bay because you can go see the eye doctor and buy

eyeglasses every day of the year.

We think that anything that is stated in this report has certainly been verbalized either personally or in discussion with the Department of Health. I do not think most of these things are any secret to them. We stand behind what we have stated here today. We would be prepared to present our case to whomever is necessary. Obviously, this is a public forum. We realize that anything stated here is public. We are prepared to stand behind our statements. Within the Auditor General's report specifically on page 12, it was stated during the interviews that the Auditor General's staff had with the departmental managers, that they do not plan to delegate more control to the regions because they wanted to retain control in headquarters. This, to a large degree, negated the setting of the boards. We are constantly fed with that type of response from the Department of Health.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: Mr. Chairman, I wanted to know where this attitude is coming from that they intend to dispense with boards, do not get too comfortable, et cetera, what you were saying there. Where is this coming from? I always thought that, although they never got along well, there was a certain amount of respect for the boards, their autonomy and their running the health care systems in the regions. I did not think there was an attitude to get rid of the boards. I wonder where this comes from. If boards are going to be around, we need to make sure that this does not happen, that, in fact, the department is not reviewing to eliminate the boards or their authority. Who told you these kinds of things?

MS. PALFREY: We have had conversations with individuals in the Department of Health at several meetings that indicate that there was much discussion being held with respect to the future of boards. As I indicated before, the Auditor General states it very clearly in his report. He also indicates, from discussions within the department, boards and other departments, that they encountered an attitude that showed a lack of respect for board members, that board members are not viewed as capable of understanding the complex issues involved and that there are many inexperienced and patronizing views of members' capabilities. It is an excuse to doing little to help them improve. I do not think it can be any clearer than that. The Auditor General stated it. We have been told that, within our board, it lacks leadership.

Certainly, in the speech that the former Minister made to the N.W.T. Health Care Association, he stated clearly that boards did not act responsibly, and that boards were controlled by the chief executive officers. In the case of our board, that is not the case. Our board directs our chief executive officer to do our bidding, which he does.

CHAIRMAN (Mr. Zoe): Thank you, Ms. Palfrey. This is just to follow-up on my colleague's question. You were told by someone, "Do not get too comfortable." Where did you hear this from, the department staff themselves or just general rumours that are flying around?

MS. PALFREY: I believe it was during discussions that we were having with the Department of Health with respect to long-term planning that we were doing at the time. It would have been about a year ago when we were discussing the Strength at Two Levels report and where that might be taking us in terms of regional government and boards. They indicated to us, because there was an ambiguity within the Strength at Two Levels report, whether it would be municipal or board government, what form it would take, that we really should not get too comfortable because we could be gone tomorrow.

CHAIRMAN (Mr. Zoe): That would fall under the community transfer initiative that the government is talking about, and that is what you are making reference to. Are there any further comments, Mr. Whitford?

MR. WHITFORD: Again, I am curious because this is a fairly major issue if the department's intent is to eliminate boards in the future. We, as a Legislature, must know about this and take steps. If we, 23 Members, believe that the boards serve a useful purpose, we must protect the boards. I was wondering at what level this conversation would have taken place. Is it at a minor level where perhaps it would be less likely to be enacted, or is it at a medium or high level? If it is at a high level, then it is very serious business.

MS. PALFREY: Mr. Whitford, this was at a very senior level at a very senior meeting that we were at. However, I might caution that one of the things that we would hope will come out of the recent series of standing committees is that there will be some clear direction to departments as to what future this Legislature wishes to see with respect to boards. Unless that is clearly spelled out for the departments, we will continue to get this kind of ambiguity that we have now, where they are almost playing games with respect to, "How much do we have to tell the boards?" During the audit process, it was clearly indicated to us that the staff had been told during a visit to Yellowknife that they only tell boards what they feel we should know. That is not a good attitude for the department to take. Do the boards provide a useful function? Are they there for a reason?

If the department truly believed in the function of boards we would not have this back and forth attitude that we have now. We would not have the concern about responsibility, roles, delineation of authority and that type of thing. Until there is some firm direction from the elected representatives to the department, we will continue to have this attitude and, depending on the individual involved, this response.

CHAIRMAN (Mr. Zoe): Mr. Whitford, are there any further comments or questions?

MR. WHITFORD: I do not want to prolong it, Mr. Chairman, but I am sure that the majority of my colleagues will support the role of boards in the territories. We see no immediate plans to lessen their authority and autonomy in the role they perform. This is fundamental to the delivery of health services in the territories. We have four or five boards. It is true they work differently in different areas. There are some that are more vocal, but they are all working to a degree of success in their respective regions. When you ask that you want to be assured that the Legislative Assembly is going to support the role of boards, that is one thing I have never heard while I was with the department or subsequent to this particular

conversation and this attitude. There has been a role that the department and boards play, a very important role, although they do not always work in harmony, I am quite shocked to hear this and read it. It is identifiable. We will have to do something to find out where this is.

MS. PALFREY: Mr. Whitford, if an objective third party, an Auditor General from the federal government, can come in and indicate that this is a concern and is something they feel is prevalent within the department, then I feel that there is cause for concern. We have been discussing this for some time at a board level. We feel somewhat vindicated now to find out that the Auditor General went into the department, spoke to a number of people, came back and reported officially in this document exactly what we have been told.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: I have one concern, Mr. Chairman. In your presentation, you mentioned a $500 surplus and a $500 deficit as an example. As far as the law goes in the Financial Administration Act, I do not think that is allowed. Do you have any specific examples on that?

MS. PALFREY: We are expected to report monthly on a line-by-line object on the status on our budget. The Department of Health frequently comes in at a finance officer level and says, "All right. We will now repatriate this surplus back to headquarters." That is quite common within the system. They also do not compensate for the deficit items within the budget, so surplus ends up going back. However, we are left with the deficit through the normal budgeting process. "Just take it from within your budget," is what we are constantly told. I am not meaning to imply that it is done at the deputy minister level. It is done by the finance officer level with our D.F.O. in the region.

CHAIRMAN (Mr. Zoe): Mr. Gargan.

MR. GARGAN: Perhaps I will dig into this a bit more. I am interested in the process. If the department is doing that, under what authority are they doing that?

MS. PALFREY: I would be pleased if you wished to speak to our director of finance at a regional level and ask him precisely how it happens. I understand the theory behind losing surplus money, but I do not understand the specifics of how they do it.

CHAIRMAN (Mr. Zoe): Ms. Palfrey, did you say your C.E.O. or your director of finance?

MS. PALFREY: Director of finance for the region. Our district finance officer.

CHAIRMAN (Mr. Zoe): Does the committee agree to invite the finance officer for the board?

SOME HON. MEMBERS: Agreed.

---Agreed

CHAIRMAN (Mr. Zoe): Could you introduce yourself, please?

MR. O'NEILL: My name is Chris O'Neill. I am the Director of Finance and Administration for the Keewatin Regional Health Board.

CHAIRMAN (Mr. Zoe): There was a question posed by Mr Gargan pertaining to deficits and surpluses.

MR. O'NEILL: Normally, our budget year starts in December of every year, at which time we receive a letter from the Department of Health giving us our targeted budget for the following year. That comes in as a single line on a spreadsheet that lists all of the health boards and all of the health facilities in the N.W.T. and there is one line that says Keewatin Regional Health Board. The number at the end of it that says, you have $6 or $8 million or whatever. That normally happens before Christmas. This year, for the 1993-94 fiscal year, unfortunately, it is somewhat delayed. We have not received that letter yet, but it is probably in today's mail. Then, shortly either right at Christmas or right after the new year, we receive a budget spreadsheet from the department that gives us a line-by-line listing of all of our lines showing our budget in actual for the previous fiscal year, our approved budget and our projected budget for the current year and a blank column in which we are supposed to put in the numbers for the coming fiscal year. We complete that exercise usually around the end of February or toward the latter end of the fiscal year

Sometime after the new fiscal year starts, we get another letter back from the department saying, no matter what we put in the blank column in our proposed budget, your target is your target. There you go. Throughout the year, at various stages. we receive target adjustments. There are two scheduled target adjustments every year in about July or August and then again around November or December.

In the 1992-93 fiscal year, thus far, we have received four target adjustments and I was just advised last week that somewhere toward the middle of February we will have our fifth target adjustment for the fiscal year. This year, that was unusual because of the transfer of positions from the end and functions from the various departments. There was a fair amount in this fiscal year of shuffling of the deck. When we get one of those target adjustments, at roughly about the same time, that is when we are putting in a year-end projection. I do not have any specific numbers or instances that pop to mind quickly We get the letter that says, "We are going to shuffle the deck a little bit." They take into consideration your last year-end projection. If you have a surplus in there, it will disappear at the same time. Ultimately, we end up with either the same amount of dollars, or in some cases, less dollars, even though they may be saying, "We are giving you more money for these programs," by the time it is all said and done.

The biggest example I can think of in this fiscal year is that we were supposed to have gotten four positions from the Department of Finance for doing financial accounting. We also had, within our shop, two accounting positions. When the dollars came over from the Department of Finance, there was a transfer of budget for those four positions, but then the department came in and said, "Now that you have all of these functions in your own house, we are going to take away these other two positions." In effect, back in April, what looked to us like we were going to have four new positions, in the end. when the actual letter came saying, "Here are the dollars that

you have," we still have the four positions, but we do not have the dollars to fund to them. We cannot go out and fill those other two positions.

Another example is that there was a transfer of funds from our budget for utilities for D.P.W. They took out electricity, fuel, water and sewer. Unfortunately, they also took the dollars out to put the fuel in the vehicles that we have. We have ski-doos, four-wheelers and trucks in the communities to do pick-ups and deliveries, etc. When they transferred the dollars, whether it was by oversight or whatever, it certainly is not significant. We do not burn $1 million of gas in our four-wheelers, but some sort of an error was made and "whoops" there it goes. Now we are going to have to fill those vehicles with fuel and turn around and bill the Department of Public Works and go through the accounting process of being paid for those dollars. With all of the transferring and moving around of dollars and people, I had to develop a spreadsheet so that I could track what was happening with the ledgers. I was told late last week that we are going to have our fifth one come in the middle of February. I do not know what that one is going to be. I will just have to add another column to my spreadsheet.

CHAIRMAN (Mr. Zoe): At year-end, your board gets an audit. Am I correct?

MR. O'NEILL: That is right. After we close our year-end...

CHAIRMAN (Mr. Zoe): My understanding is that if you have any surpluses, it goes back to the department, but if you have a deficit, then you make up from within for next year's budget. That is my understanding.

MR. O'NEILL: Not necessarily so. Right now, we actually have a negative equity in the health board because health boards used to be allowed to make adjustments every year for accrued employee benefits payable. I believe we are carrying approximately $250,000 worth of accrued payables. In the past, we were funded for those in the fiscal year and we were able to build up some reserves. Two years ago, the department came in, by the instruction of the Legislative Assembly, and their first letter said, "You are not allowed to build up too much surplus, so we are going to take it all." I believe it was two per cent or something like that. They fund us every month, so in that particular month, they did not give enough funds. I was not in the Keewatin at that time. I was in the Kitikmeot. Basically, we were getting $300,000 a month to fund ourselves. That month, we got about $60,000 and the rest came out of our reserves. The following month, they came back and said, "Sorry. F.M.B. said you cannot have any of it." They took the rest of it.

The boards had a certain amount of cash flow that they could rely on to cover their ongoing operation so that when money was being transferred in and out of banks and cheques were being written, we had funds to cover things. The situation we are in now is that through the recovery of prior year's surpluses, through the recovery of reserves for accrued liabilities and so forth, we are on a month-to-month basis. When the department comes in with a budget adjustment, a supplementary funding adjustment or a transfer and they say, for instance when they transferred the departments over, the net effect of that was actually we lost $1 million. That was because a large chunk of that was actually funds being transferred from the health board to D.P.W. for utilities. It did not come out in 12 increments, it came out in one shot. We are on a month-to-month basis, and all of a sudden there was a major change in our funding arrangements.

We went into a bank overdraft because we were expecting $500,000 and we only got $300,000 or whatever it was. We are also in the investment pool. According to the rules in the investment pool, we are not allowed to have an overdraft. As soon as the Department of Health made an adjustment to our funding, we went into a bank overdraft. The investment pool people in the Department of Finance are phoning the Department of Health saying, "Those individuals in Rankin Inlet are in overdraft." We then get a phone call from the Department of Health asking why we are in overdraft. It is obvious, because they made an adjustment to our funding.

MS. PALFREY: Mr. Chairman, I think what this can identify is the reason why our board has never ratified a budget that has been presented by the Department of Health to us. It is not our budget. We have no control over it. We do not control cash flow. We do not have any say about it at all. It is done at the whim of the Department of Health. Therefore, on the one hand, we accept responsibility for being good fiscal managers and ensuring that the money is well spent and what is allocated for, but on the other hand, we cannot really accept responsibility for some of these things, and yet the department continually holds us accountable for it saying, "You were in a bank overdraft. You are not good managers. You are in a deficit position." Really, when the ultimate control comes down to it, we are not in control of the situation. It is done between the Department of Finance at a headquarters level.

CHAIRMAN (Mr. Zoe): Mr. Gargan, do you have any further questions?

MR. GARGAN: Even though you operate as a board, you really do not have approval of the finances for last year, payment for this month, and those sorts of things. You do not have control over that. Who takes care of your bank overdraft interest and bank charges?

MS. PALFREY: That comes out of our operating budget.

MR. O'NEILL: We are not funded for interest revenue. There is no provision, in my understanding of the acts, to cover interest charges. If we are running into a cash flow problem, the only thing that we can really do is be quick in getting our invoices out for some of the services that we provide for non-insured services and those sorts of things and hustle on that end of it. Quite frankly, if this were to continue and, ultimately, we were to get into a situation where our cash flow was so poor that we just could not keep up and we were in an overdraft, I do not know how we would fund it. We would have to ask the department and the department would have to ask the F.M.B. for us to have some sort of a provision with the bank for an operating flow.

MS. PALFREY: Ultimately, that is not the desire of our board. We wish to be accountable and responsible for our budget, which means being accountable and responsible not to have it yanked in and out. To me, it sounds like a shell game when we are listening to it, but that is really what it is. We have to watch and see what we have here now, and we have to find

the peanut. At the end of it, sometimes there is no peanut under the three shells we look. I would like to finish Chris' comments by saying that within the packages there is a copy of our last year's audited financial statement. We closed last year off with a $129,000 surplus. We have attempted to be good fiscal managers. Again, we would like to feel more in control of our fiscal responsibilities.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: In the presentation that you made, on page 15, you indicated that the K.R.B. has an ongoing deluge of requests for information from the Department of Health. From those requests, are you able to determine in dollar terms how much you spend in staff time or resources to create that information that the department is asking for?

MS. PALFREY: We feel that there is an inordinate amount of time being spent responding to these requests. If the Department of Health could develop a reporting system that is appropriate across the board, then we feel that they would not be requesting these continual drains on the time of our finance people to respond to line-by-line budget items. We feel that we are responsible for delivering a major program. Ultimately, through the autonomy given to us, we should be held accountable for that. If the department could plan properly, they would be working on developing a system that was meaningful and could provide them with the information they required without constantly having to get our people to stop what they are doing to respond to these continual requests. I do not understand why, when we are dealing with the budget to the level that we have, we are continually being asked to report on a month-by-month level for variances on budget items that are in excess of $300 but under $500.

MR. O'NEILL: On a quarterly basis, we have to report on plus or minus five per cent or $50,000. If we have a budget line, for instance, that is for $2 million, if we have a $50,000 surplus or deficit, in theory, we are supposed to provide detailed analysis of that $50,000. We have some lines that are $1 million up, I believe.

MS. PALFREY: ... and some that are very small.

CHAIRMAN (Mr. Antoine): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: My question was not about how much money is being transferred from this line or that line. Do you have a cost estimate or an idea of how much it is costing the board for the staff? How much staff time is being spent finding that information for the department? Are there an extraordinary amount of resources that you are using to create this information that the department is requesting? In dollar terms, are you able to say, or even an estimate as to what staff time is used for that? Do you have that information?

CHAIRMAN (Mr. Zoe): Put a value on the amount of time that the staff spends on developing all the responses for the Department of Health. What would you estimate?

MR. O'NEILL: I have never done that kind of analysis. It would probably be a very interesting analysis. I would say for myself, I would spend a good ten or 15 per cent of my time doing some sort of paper work, study or response, much of the requests do not come directly to me. They come to Bruce. Bruce then pages me and says, "I have a letter from the deputy minister wanting to know about whatever." That flows downward to my staff. I do not actually pull files and do that sort of thing. My staff does that for me.

CHAIRMAN (Mr. Zoe): It would be interesting if we could put a dollar value on the amount of time the board spends seeking out information for the department.

MR. O'NEILL: I would like to make a quick comment regarding information. One of the problems in the Department of Health is that there are a number of divisions and there is no coordination of the information within the department. We have to respond for requests for information from the capital and facilities planning people, the hospital and health facilities planning people, the dental people, the medical people, et cetera. If you wanted to provide some time savings in there for money savings, they could just coordinate their requests so that we have one group gathering all of the information. Quite often, we will get requests and, a few weeks later, it will be a similar sort of request, but twisted slightly so that we have to look at it again.

CHAIRMAN (Mr. Zoe): There was a good suggestion made by the Auditor General in that respect. Within the various divisions, he suggested that all the finance and administration sections of the divisions should be consolidated into one unit. So, you are basically agreeing with the Auditor General in that respect, that things that are requested goes to different divisions, and they are not being coordinated, like you indicated. Obviously, you are almost in the same conclusion as the Auditor General in terms of making that particular summation, to consolidate all the finance and administration sections of all the divisions. I tried to point that out to Mr. Todd when he appeared before us this evening. It does not only pertain to the H.I.S., but for all the divisions within the Department of Health.

MR. O'NEILL: I do not think Mr. Todd fully understood. He took your term consolidation to mean consolidating from the regions to Yellowknife. I, personally, would not support that myself.

---Laughter

John is going to come to me on Monday.

---Laughter

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? Mr. Gargan.

MR. GARGAN: Education boards, et cetera, were getting quarterly funding, and now they are getting monthly funding. What is your feeling with regard to that? I know the Auditor General is suggesting it, but is that realistic? Should boards be given funding at the beginning of each fiscal year? Another thing is with regard to your finance person. Where are you getting the directions or the requests for this detailed information on budget line items, from the director, the D.M., or who?

MR. O'NEILL: As far as the division is concerned, primarily the hospital and health facilities division, that is Mr. McClelland's shop. They have a financial analyst in that division that we primarily correspond with. Again, as I indicated before, while that is the primary source of where we get requests for information, we also have all the other divisions requesting.

MS. PALFREY: Most of the regional bodies understood the necessity of looking at monthly payments rather than quarterly or twice or year. We understand the rationale of the government wanting to keep the money in their coffers as long as possible. However, on the other side, we also have to look at what limitations that places on the agencies and the groups that you are providing funding for. In our ability to operate, as Chris has indicated, it provides some cash flow difficulties given that, on occasion, we can go into a serious deficit position and actually be in an overdraft position because we only get payments on a monthly basis now. Our board would very much prefer to go on quarterly advances. We think that would be much easier and put us in a less precarious position in terms of cash flow. We would recommend that people look at that again.

CHAIRMAN (Mr. Zoe): Are there any further questions? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: This is just a follow-up on the question asked by Mr. Gargan and the response that you gave. I think that we could make requests to the department saying that this is what we would like to see, but this has become a policy throughout the government. I do not know if it is likely to change even if there were a million different requests from different organizations for this to go back to the way it was. Is there anything that the department could do to improve the situation for the Keewatin Regional Health Board? What is it that could be done which would help the board be able to manage itself? You are giving us these examples of the different problems that you have run into with the department. Is there any one area that they could do that would help improve your situation?

MS. PALFREY: I would say it would be to grant global budgeting to boards. In our position paper, we have developed the roles of boards and agencies and recommended that as something to look at. By global budget, we mean that, if we go into a deficit position, we are aware of that, unless there is some extraordinary cause for it, as we had happen here last year where the E-coli outbreak almost cost a half a million dollars that we had not planned or budgeted for, which would necessitate us coming back and making a request for supplemental funding. Other than that, we would like to have the delegated authority to be responsible for a global budget with the department and have other boards develop budgets that are realistic, so they are not continually trekking back to F.M.B. every year for supplemental funding.

CHAIRMAN (Mr. Zoe): Are there any further questions or comments? Could you explain or describe your understanding of "The N.W.T. Way"?

MS. PALFREY: I think we referred to it earlier on in the presentation. We see "The N.W.T. Way" as "The Department of Health Way." It was developed without consultation in the regions or with the aboriginal and other people to whom health care is intended to provide its services in the Northwest Territories. In any consultation or development that we have done in the region, our first line of development is to go and talk to people who will be involved. We do not develop papers and then say, "Here it is. We are consulting with you now." That is what has happened in that case. We do not advocate anything that would lessen health care delivery to people or allow for different levels of service based on where you live. We feel that is what "The N.W.T. Way" is all about. We have to look at making better utilization of resources, not centralizing more into the centre.

CHAIRMAN (Mr. Zoe): In regard to that, what do you think are the most important elements from your perspective?

MS. PALFREY: Community consultation, wiser utilization of resources and looking at dollars to see how we re-allocate them to make the best use of them as we can are the most important elements. I do not think the instance of what happened here with the dental contract is unique. We certainly intend to look at all of our programs to see how we can make better utilization of the dollars available and provide more services to the community with the money that is there. At the same time, at the bottom of it, keep in mind that we want to provide the best level of service that we can to the people who live in our region. I think that should be the guiding principles that the department has in their philosophy when delivering programs across the territories.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? If not, I would like to thank the representatives of the Keewatin Regional Health Board for presenting a well put together paper. Although we did not get into the recommendations, we will be reviewing them very carefully. If we do need any clarifications or have questions pertaining to the recommendations, we will definitely get back to you before we make our report. For the committee, we have advertised that our public hearings would be from 7:00 p.m. until 10:00 p.m. this evening. We will continue again tomorrow starting at 10:00 a.m. until noon. Apparently, it will not be held in this same room. The supreme court has booked this room tomorrow. We will be moving to the town hall, the hamlet council chambers. The Baffin Regional Health Board and the Dental Clinic, do you mind if we adjourn tonight and continue tomorrow morning rather than continue on this evening? All right? So, you agree with the committee then. We will adjourn. Thank you, again, for appearing before us.

MS. PALFREY: I would like to thank this group for travelling out here. We really appreciate when people travel from Yellowknife to hear regional concerns. I cannot tell you how much we appreciate you taking the time to do that. Thank you very much for coming to Rankin Inlet. I would like to reiterate what Mr. Whitford said before. I think there are some very caring people in the Department of Health. However, we have some problems at a very senior level within that department. We have had excellent cooperation from the Ministers, all of them whom we have been involved with during their tenure as Ministers of the department. I understand how difficult it is to come into a portfolio and only be there for a few months. Our criticism is not with the Ministers and it is not with many of the people within the department. It is with a very few people who we feel need some gentle nudging and encouragement to look at health from a different perspective. Thank you very much.

Thank you, all the other presenters, too, for being so patient with our very lengthy response and presentation here this evening.

CHAIRMAN (Mr. Zoe): Thank you. The committee is adjourned until 10:00 a.m. tomorrow morning.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PROCEEDINGS

PUBLIC HEARINGS

RANKIN INLET, NORTHWEST TERRITORIES

TUESDAY, JANUARY 26, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

RANKIN INLET, NORTHWEST TERRITORIES

TUESDAY, JANUARY 26, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

BAFFIN REGIONAL HEALTH BOARD

Mr. George Eckalook, Chairman

Mr. Trevor Pollitt, Chief Executive Officer

KIGUTI DENTAL CLINIC

Ms. Bernadette Makpah, Member, Board of Directors

STANDING COMMITTEE ON PUBLIC ACCOUNTS

RANKIN INLET, NORTHWEST TERRITORIES

JANUARY 26, 1993

Chairman's Opening Remarks

ACTING CHAIRMAN (Mr. Gargan): Good morning, ladies and gentlemen. My name is Samuel Gargan. I am the M.L.A. for Deh Cho. Before we get started, I would like to introduce the Members who are present at this moment.

MR. PUDLAT: (Translation) My name is Kenoayoak Pudlat. I represent Baffin South for Cape Dorset, Sanikiluaq and Lake Harbour. Thank you, Mr. Chairman.

MR. WHITFORD: My name is Tony Whitford. I am the Member for the constituency of Yellowknife South in Yellowknife.

ACTING CHAIRMAN (Mr. Gargan): The Chairman is in. I will ask him to take over from here.

CHAIRMAN (Mr. Zoe): Good morning. I am a little bit late this morning. I am on Dene time in Rankin. My deputy chair was just introducing the Members to start off the meeting this morning. Let us call the first witness, which is the Baffin Regional Health Board. The representatives can now come up to the witness table. Thank you. Can I ask the Baffin Regional Health Board representatives to introduce yourselves for the record and proceed with your presentation?

Presentation by Baffin Regional Health Board

MR. ECKALOOK: (Translation) My name is George Eckalook from the Baffin Regional Health Board. I am the Chairman, with my Executive Director, Trevor Pollitt. Mr. Chairman, I normally speak in my language because it suits me better. We have a submission written in English. I do not have an Inuktitut copy, but you have the copies. It will probably be faster because I do not read very well in English. I think it will save us some time if Trevor reads the submission. There are some responses that we will probably have to your questions, but in order to save time, we will have the submission read in English. Thank you for letting us be here, Mr. Chairman. I will now hand it over to Trevor to give the presentation in an understandable manner. If you have any questions afterward, we will be ready to respond.

MR. POLLITT: Thank you, Mr. Chairman. My name is Trevor Pollitt, the Chief Executive Officer with the Baffin Regional Health Board. As an introduction, the Baffin Regional Health Board was established in July, 1981, and assumed responsibility for the management of the Baffin Regional Hospital on December 4, 1982. Under phase II of the health transfer, the board assumed responsibility for the health centres and the community health programs in August, 1986. During the final phase of the health transfer, the dental services came under the boards of management in April, 1988.

CHAIRMAN (Mr. Zoe): Trevor, could I ask you to slow down so that the interpreters can keep up with you? Thank you.

MR. POLLITT: During the transition period, 1982-88, the board exercised its mandate with greater freedom. The intent and the spirit of the health transfer agreement was to decentralize programs and services to the regions. The agreement indicated that regional health boards were to be established. The comments in the Auditor General's report are generally fair and accurate. However, generalized statements fail to identify specific regional problems. Blanket statements fail to explain why some of the events happened as they did.

Visualize the situation on April 20, 1988 when the staff of Health and Welfare accepted employment with the G.N.W.T. All the staff who transferred would be on lay-off notice, which meant the one year the Department of Health would not know who was committed to the new organization. This would not be known until the year had elapsed in April, 1989. The audit commenced in late 1991. Is it fair and reasonable to expect a new organization to be developed as one that had not experienced such a major upheaval and resistance to change in some quarters?

The purpose of the three-phase health transfer in the Baffin region was, hopefully, for other regions to benefit from that experience. This was not the case. In chapter seven, under the financial issues, section 7.2, allocation of resources at the time of devolution, this section is one of the keys to our present-day problems for which the government of the day should accept some responsibility. "We discussed program transfers with the federal health transfer officials. They confirmed that federal policy dealings with the devolution of programs to other levels of government does not consider the adequacies of resources in relationship to long-term needs. As a result, when health care programs were transferred to the government, it was up to the negotiating team to either accept or reject the terms and conditions of the transfer."

By contrast, the federal government to Indian band transfer policy requires that a needs assessment be completed as part of the negotiating process. This is to ensure that the receiving band is capable of meeting health needs on the reserve and that it is capable of assessing on a continual basis where the need is being met.

Compounding this section is the ongoing dispute between the G.N.W.T. and D.I.A.N.D. dating back to the final health transfer in 1988 for unpaid claims, which, at that time, was in excess of

$50 million. Unless these major issues are taken into consideration, the Department of Health and the board will continually be under scrutiny. During the last ten years, the Baffin Regional Health Board has enjoyed a good working relationship with the Department of Health. Since 1988, there has been a definite change in how the board is allowed to operate. There has been more centralization, with increasing operational control through the budget. All parties must be aware of the intent of the health transfer, which was to decentralize programs, establish health boards and let the people have a say in the system. The intent was not to clone health and welfare operations, which was more centralized.

When the boards were established, they reported only to the Territorial Hospital Insurance Services Board. The T.H.I.S. Board was dissolved in the summer of 1991 as a cost-saving exercise and to avoid duplication. The functions of the T.H.I.S. Board were transferred to the Minister of Health. Previously, boards had an appeal mechanism, especially since the T.H.I.S. Board was the funding agent. The Baffin Regional Health Board did not agree with the dissolution. It would have preferred the terms of reference to be changed. From this point of view, this was the first step in close control of budgets by the Department of Health. One of the last functions of the T.H.I.S. Board was to appoint the various directors in the Department of Health as inspectors, which gave them authorized control of programs.

The board, as defined in law, is a legal entity distinct from its members or owners. It is an artificial person. It has rights and duties which are not the same as those of members or owners. It can sue be sued. As the power and authority of the board is invested in the trustees, there is a corresponding duty imposed on the trustees to act in favour of the board. Their duty to the board comes before their duty to any other organization or person. The duty to the patient is carried out directly by the board which operates the facility. Action against a hospital is usually only taken by a patient as a result of various wrongful acts which have been committed against him, including negligence, assault and battery, false imprisonment, liable, slander or loss of property.

The major legal question to be answered is did the institution, in any particular case, actually agree or hold itself out as agreeing to provide certain services to the patient. The institution is only responsible for those services which it undertook to provide or which it held itself out to be able to provide. It cannot avoid responsibility by delegating part of this undertaking to someone else. The board has the duty of care to the patient, which is not exercised by other boards. What is not always appreciated is that the hospital corporations are subject to general corporation law contained in the common law apart from the act under which the hospital has incorporated legislation of the territories and the institutional by-laws. This is clearly stated in "Canadian Hospital Law" by Lorne Rozovsky who is an authority on hospital law.

Unless this basic concept is recognized, those failing to understand will not appreciate why a hospital is required to have certain basic staff and equipment to fulfil its obligation to the public. By setting itself up as a hospital, there is a public expectation that the institution is required to meet. The board, acting on behalf of the patient, must ensure that no harm befalls the patient and is obligated to hire competent staff. These ramifications have financial requirements which cannot be ignored.

Organizational Structure

Under the section of the Auditor General's report dealing with organizational structure: When the final health transfer was completed in April, 1988, the Government of the Northwest Territories built on the federal government's foundations. The intent of the health transfer was to establish regional health boards to decentralize the decision-making process to the established boards of management. In the Baffin region, after 1988, there was a noticeable centralization of authority. Contracts previously entered into by the board, and a third party, were gradually taken over into one master contract. The board's input was often solicited too late to impact on the contract to reflect regional differences.

After four years, has the idea of local involvement worked? The Baffin Regional Health Board has completed ten years of operation. One of the most notable aspects of the change is that boards do work. Trustees and the people have a say in changing events, even if progress is not as quick as trustees would like to see.

The players are confused about their roles and responsibilities. The board trustees and management in the Baffin region are not confused about their roles. The confusion arises when the boards want to exercise responsibility in managerial discretion. The boards, in order to meet their legal obligations, are required by law to ensure there is a safe environment to treat patients, which means adequate staff and equipment.

Some boards are more powerful that others and receive more resources than others. All the boards fall under the same legislation. When some exercise a degree of freedom it is through interpretation. The challenges are on shaky ground. In law boards are responsible. Some boards have evolved more through the years and have more experience than others. In the absence of any standards the funding arrangement is basically historical. An independent work devoted to health organizations would definitely highlight the differences. The health system, at the time of the Auditor General's report, did not allow the Department of Health sufficient lead time following the major health transfer to remedy the inherited anomalies.

Where clear standards are identified for any program across the Northwest Territories funding should be allocated to meet the minimal levels set. Adjustments in finances and person years could result and a baseline would be in place. Each board who wished to provide above the minimal standard should find the funds from elsewhere in their budget. For example, if it is agreed that a physician should visit a community, the frequency of visits should be based upon the health status of the community, the size of the community, the location and such criteria that is in keeping with the Minister's objectives, health education and promotion being one. Once the standards are determined, the dollars and length of stay would follow.

Today the Ministers and M.L.A.s are more involved in operational issues. This, in part, is due to the interest taken by the individual to address public concerns brought to their attention. Much of the basic problem between the boards and

the Department of Health is a result of certain interpretations by individuals who have not perceived the role of boards as was the intent of the health transfer agreement. It would be totally unfair to state that the staff of the Department of Health as a whole have not been helpful and are not attempting to continually improve the health care system. It is not always appreciated that there has to be a settling down period after a major transfer, some issues continue unresolved for many years.

Much of the disharmony and jealously stems from the last minute change prior to the health transfer in support services in the new boards. They were lead to believe they would follow the Baffin model, which is responsible for its own finances and personnel functions.

One of the most significant issues concerning health care delivery in the Northwest Territories is the contrast between the perceived, practised and prescribed roles and responsibilities of the department and the boards.

The Baffin Regional Health Board follows the intent of the health transfer agreement which was to be responsible for the management, control and operation of the programs and facilities in the Baffin region. The intent of decentralization is given lip service unless protected by the boards. It is the safeguarding of this erosion that can result in a difference of opinion.

The Auditor General's report is accurate in stating "inappropriate control by the department." The Baffin Regional Health Board recognizes monitoring is desirable and expected. The board is subject to annual audits by the federal, territorial and board auditors. The Baffin Regional Health Board, operating with the Commissioner's Agreement, has exercised a good working relationship with the Department of Health. To control the new boards, in reality, has meant more control is necessary when dealing with the old boards, Stanton, Baffin, Fort Smith and H.H. Williams to make the playing field level.

In recent years, a review of the department policies has led to more control through the budget process. The department controls boards by its power over their budgets. In reality, the budgets are not the boards', but what the department provides the boards to operate with.

The department informed us that the tight controls were set in the early days following transfer when the boards had inadequate financial controls. The Baffin Regional Health Board is being carefully monitored by G.N.W.T. and board auditors each year since 1982.

"Boards have no evaluation process," according to the Auditor's report. It must be recognized that to meet the Canadian Council's Health Facilities Accreditation Standards, it is necessary to meet the evaluation process. This is done through self-evaluation questionnaires, public complaints, trustee attendance and removal of trustees from the board. Three trustees have been removed from the Baffin Regional Health Board, the Minister has revoked their appointment.

Planning for the Future

The Baffin Regional Health Board has been one of the boards requesting the need for planning to have an overall N.W.T. health strategy in place. During the past year a more concerted effort has been made by the Department of Health to meet the board's request. Currently needs assessment studies are under way to determine what is required at the community level. In the absence of an overall N.W.T. strategic health care plan being in place, the Baffin Regional Health Board monitors trends, plans short-term to meet the OPPLAN requirements and has input into the five year capital outlook. The board has been mindful of the Minister's key result areas that have to be met. Once they are identified, the board determines their strategy to meet these goals. This is reflected in the OPPLAN, the board's objectives for each year, the C.E.O.'s objectives and down through the program managers to have the greatest impact at the appropriate level.

There is a need for each program, for example dental services, environmental health et cetera, to publish a document setting goals and objectives that flow from the Minister to ensure what is be accomplished at all levels including the Department of Health and boards reflecting both the N.W.T. and the regions and it should be made known to all parties involved. To determine N.W.T. standards would identify shortfalls in any particular region, person years in budgets. This would reflect any regional anomalies based on need. This would ensure a minimal baseline service is being delivered throughout the Northwest Territories. In conjunction with Management for Results, closer monitoring would reflect the actual status.

Historically, Stanton always had the person years to meet the program needs. This was a result of the board of the day exercising its responsibility to meet the public demands. It is only in recent years through more published information that other regions have been making comparisons. Baffin and Stanton provide additional services apart from the basic community programs that all regions provide.

An accurate database needs to be established of the status of healthiness and illness by community. This does not need to occur annually. Once the health status of the population is determined it would provide an accurate tool to plan future services and to re-allocate funds where necessary. The public, in the Baffin region, always relate back to the annual visit by the touring hospitalship when individuals received an annual physical examination. Even though physicians visit communities more frequently today there is a public perception that certain patients should have been diagnosed earlier, especially cancer patients. Physicians do not support the need for an annual physical examination. In reality it is not an annual physical process that is required, but a database to assist the health status by having each person complete a physical examination.

The hospital and health service centre staff provide treatment services which are more easily measured than the progress made in health education and health promotion which is a long-term strategy. Although in recent years the Minister's key results have placed more emphasis on health promotion and health education, appropriate increases in staffing and funding levels to achieve this goal at the regional level is not a reality.

The Department of Health recognizes that there is a need to have 4.8 full-time nurses to provide relief in the community health centres of the Baffin region. This is to offset sickness, holidays and statutory days. The fact is, the board is only provided with funds for two relief nurses. The difference has to be met from within the budget. The board has asked the Department of Health to recognize all the components that make up the baseline budget. That includes sickness, holidays, statutory days, travel days and winter bonus days. This provision is not appropriately recognized for community nurses, which results in unnecessary supplementary requests.

It is recognized in the hospital, Mr. Chairman, that hospital nurses have holidays and sickness, but there is no provision made in the community budget and they have a greater need. The statement that "there is up to a 70 per cent nursing turnover, in the N.W.T.," needs clarification. In the Baffin region the nursing turnover rate on average is 51 per cent a year. The mix of staff in health centres should be more appropriate to reflect the service demands. The mental health issues and the midwifery demands would indicate there is a need to have a team of health care workers that reflect skills and training that are not always provided by the community health nurses.

Managing People

The Baffin Regional Health Board has always been mindful of the affirmative action strategy of the government. The director of personnel services for the board is required to publish the statistics to meet the affirmative action strategy. The board's staff also works in close cooperation with the regional director and his staff to develop a regional plan to meet established strategies. This involves working closely with other government department and boards, for example, Arctic College, adult education and the divisional board of education. On average, the board has between 34 to 36 per cent aboriginal employees, mainly in the support category. To improve beyond this level, greater emphasis has to be placed on the professional and technical categories. One of the setbacks to training opportunities is that most courses are offered outside of the region.

The department should consider the desirability of eliminating the recruitment function from the human resource management division. The Baffin Regional Health Board would agree that they can meet the human resource recruitment function on a regional basis. Alternatively, the function could be in the headquarters personnel. That is the function that is presently undertaken in the Department of Health.

Seven physicians are employed at the hospital and one is in private practice. The physicians have a base salary plus an incentive bonus. To encourage physicians to undertake aspects of the health policy directives, the N.W.T. fee schedule should be changed. This would encourage physicians to become more involved in health education and promotion.

Performance Standards for Physicians

The Baffin Regional Health Board agrees there should be standards to assess physician's performances. All Baffin Regional Health Board contracts have a termination clause which requests both parties to give appropriate notice of termination. The Department of Health introduced a standard physician contract after the date of some of the longer-term physicians joining the staff. Since the benefits are more generous than the original contract, the board had no difficulty asking the physicians to accept the new terms of the agreement. Unless a reasonable bonus incentive exists, salaried physicians may become less motivated as individuals.

An exit interview in the Baffin region is conducted by the personnel department of the board. Mr. Chairman, these are all in answer to the questions posed in the Auditor General's report.

It must be recognized that opportunities for ongoing education should be available to ensure that health professionals remain current in their speciality. With fiscal restraints in place educational budgets are normally the first to be cut. This is detrimental to staff retention and staff morale.

Inequitable Training Budgets

Physicians only access education leave up to ten days per year to a maximum of $3,200 for course fees, travel and accommodation. If a physician was required to meet a board requirement, this would be duty travel. The rates quoted in the report of $8,000 to $10,000 are not in the Baffin region. The report indicates $400,000 is available for 365 nurses. This statement is misleading since the Advanced Nursing Skills In-service Program, A.N.S.I.P., is not utilized by all categories of nurses in the final total.

Funding was removed by the Department of Health for the Dalhousie Outpost Nursing Program to set up the A.N.S.I.P. program despite the Baffin Regional Health Board and the physician's objection. The two programs are totally different. If greater emphasis is to be placed on the community health nurses under the N.W.T. Way, they need more advance training. This was provided for under the Dalhousie Outpost Nursing Program. Most nurses coming north today have less specialized training to meet their role than in previous years, and have more demands from the public. Although the Baffin Regional Health Board is one of the two boards not under the government human resource system, the delay was due to the lack of computer equipment being available. The board is now a participant.

Managing Information

The Baffin Regional Health Board has held back on the implementation of an appropriate information system for ten years to enable the Department of Health to determine which direction standardization should be introduced. In reality, the appointed resource person could not keep up with the evaluation of all the sites and provide recommendations in a more timely manner.

The Baffin Regional Health Board has been concerned with a master program that was compatible, to avoid obsolescence of hardware at a later date.

The completion of physician's claim cards is by individual physicians. It is in his or her interest to complete correctly as this income affects the individual physician's incentive bonus. The onus is on the physician.

Reciprocal Billings

We feel all residents should have a plastic health card with a photograph. The removal of names from the microfiche every few years creates a great deal of work at the entry point where the patient seeks the services. The Department of Health has obtained, over the years, a comprehensive record of the board's reports. It would be more appropriate if this information was shared between the directors of the Department of Health. The H.M.R.I., hospital management records information, is a national standard data collecting information system which is able to compare disease patterns across Canada. To be more comprehensive, all the health activities should be included. The health centres have a separate information reporting system which is known as the Community Health Management Information System.

In Baffin Regional Health Board, regional health trends are reported in the annual report and a copy of which is sent to the Department of Health each year. They are aware of our trends.

Systems Interaction

The Manitoba Hospital Organization is purposely designed for hospitals across Canada. Since Stanton Yellowknife Hospital is one of the original participants in the Northwest Territories, the Baffin Regional Hospital continued with this standardization following the hospital transfer in 1982. In is unfortunate, when the new boards transferred in 1988, they decided not to continue with the system. A decision has to be made whether the N.W.T. hospitals and boards follow the national system, or we continue with a mixture of different systems across the Northwest Territories. I am adding, Mr. Chairman, that in 1980 or 1981 we did have a systems analyst who was a member of the team who met with the Department of Health and all the boards to try to come up with a standardized reporting system.

Capital Assets

The Baffin Regional Health Board capital equipment is inspected and serviced regularly by a specialist. The equipment assets are stored on a computer printout. This listing provides the item, the manufacturer, the date of purchase, the cost and the date of service. Equipment prior to 1978 is identified as pre-1978, since no information was left by Health and Welfare when they departed the hospital in December, 1982. I think this must be remembered too, that at the time of the transfer, what you inherited was really an empty office and you had to set up your own systems. The same engineer has been servicing the equipment since 1978 and was able to compile the information. This process has yet to be expanded into the health centres. The Department of Health capital planning division has always been helpful and accommodating to the board's requests. A new tracking system is to be established by the department in the near future to include all facilities. It must be recognized that the capital planning division is small in size yet has managed to fast-track capital projects and monitor expenditures in a timely manner. This division should be evaluated to ensure they have adequate person years to perform the expected tasks on an ongoing basis.

Under the health transfer agreement capital funds flow to the G.N.W.T. from the federal government on an annual basis to replace the hospital in the Baffin region. Can the Baffin Region Hospital Board be assured that those funds in excess of $1 million annually are being set aside in reserve fund so that when the time comes to replace or expand the present hospital they will be there?

The Baffin Regional Health Board has an excellent working relationship with the capital planning division.

Financial Issues

There is an inequitable distribution of resources. The west has 62 per cent of the population with five of the six hospitals, 86 per cent of the physicians, who have been identified as driving up the cost of the health service, and 70 per cent of the nurses. This imbalance needs to be recognized and addressed. It is not correct to state that the central region is served out of the Baffin region.

The Baffin Regional Health Board feels the need for frequent supplementary estimates is because the baseline does not reflect reality. As mentioned earlier, there is inadequate provision for community health nurses to be relieved for sickness, statutory holidays et cetera. These are the realities of the collective agreement. An arbitrary vacancy factor of four per cent or over $470,000 was deducted from the budget without any discussion. This, in reality, reflects 14 person years, dependent upon their salary level. This means the board has to decide which 14 positions should remain vacant on April 1 of each year. During appeal, this dollar figure has been reduced to approximately $290,000 in the most recent budget of 1992-93. Mr. Chairman, you can see if you have 14 positions to keep vacant this does impact on your operation. We are running a health system, we are not running a stationery shop. I think people have to realize a health system is a 24 hour service.

At the time of transfer, the Department of Health was a small department and many of the existing divisions did not exist under Health and Welfare. The boards at the date of transfer inherited positions that were frozen and not funded. There had to be a delay when these established positions were funded to enable to programs to be delivered to the public. The health transfer created in the minds of the public the idea that the situation would improve.

The Baffin Regional Health Board has attempted to contain medical travel costs by providing consultant services to the communities. These savings in airfare and boarding home costs that would have been expended if the patients are not flown to Iqaluit are not credited to the board. Ten visits between October, 1991 and October, 1992 resulted in a total saving of $190,719.15 to the government. This side of the equation is not recognized and these funds do not flow to our budget.

The fiscal control of the budget to meet program needs and public expectations has been the main area of difference between the Baffin Regional Health Board and the Department of Health. If there are insufficient funds to meet the established program needs, decisions have to be made as to which programs will no longer be provided. This must be relayed to the public and the government.

Management Reporting and Accountability

Although the management results system is in its infancy as far as board application, the Auditor General's report make no reference to the Canadian Health Facilities Accreditation Survey which is an independent assessment of hospitals, boards and management operation, and measures performance of our hospital against national standards. The Baffin Regional Hospital presently maintains a three year accreditation status which is the highest level prevailing when the assessment completed.

Aspects of board performance are evaluated by the accreditation surveyor process, self-evaluations, public concerns and the removal of trustees who do not take their responsibilities seriously. The N.W.T. board trustee handbook is of limited value until it is translated in the aboriginal language and is updated.

As a matter of urgency, the needs assessment study of each community should be completed across the N.W.T. This would provide useful data to plan for the future and address health issues. Since this project impacts on various government departments, it should be a high priority for the government to see that all departments participate in the collection of this information. If the public could see where the shortfalls were, they would better understand the need to equalize distribution of funds and person years. This would also be a useful tool for the government to plan for the future. Decisions would be made on need to readdress the imbalances across the territories. This will become more important as we move towards the Nunavut government.

In conclusion, Mr. Chairman, the public are having more input into the health service. All their concerns are not being met but they are being noted. We have to recognize the new financial realities of the day and make collective decisions even if they are not popular. Parents and individuals must assume greater responsibility for their own health and their children's health, and not solely rely on the health professionals.

Those involved in the health service and the politicians must present a more positive approach to what is being achieved so that the public confidence in the service will not be undermined. There are many dedicated and hard working personnel involved in the health care system who work in less than ideal conditions, and this must be recognized. The erosion of employee subsidies will contribute to greater staffing problems, especially in the communities.

Mr. Chairman, the board submitted in December other information which I think is in support of this submission. We have not duplicated that but it is in record. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Are there any questions or comments from Members? Kenoayoak.

General Comments

MR. PUDLAT: (translation) I have a question on your submission. There is quite a bit of turnover, 50 per cent or more of a turnover of nurses. Is this a reality? Is it reflecting just the individuals from the Baffin or is it individuals both from Baffin and the south?

MR. ECKALOOK: (translation) It is reflecting the Baffin region. The turnover reflects the Baffin region so it is within our jurisdiction. I think you are referring to the nurses from the communities.

MR. PUDLAT: (translation) I am looking at your employees. Is it reflective of the turnover of your employees or is it a reflection of your physicians or your nurses?

MR. POLLITT: Mr. Chairman, this reflects all the staff actions. You could still have the same people but they could be moving to different communities. You may have one nurse working in Cape Dorset covering the holiday period and that would be considered one action. In reality we try to keep the relief nurses and the experienced nurses in the community. Although it says 51 per cent, it is really 51 per cent of all staffing actions, which does not necessarily say that everyone is turning over. You may still have senior nurses in the community.

As for physicians, we have a very small number. We have about eight physicians. When you see the total, as mentioned in the report, it makes you wonder where they all are and why they are needed for this population. We have eight people to serve a population of 11,000 and we have greater distances to travel than any other region. Yet, especially in the Stanton region, apart from their budget, they have all these physicians in private practice which is not even shown in their budget. So, in reality, you would question why Yellowknife, with a population of 15,000, needs so many more physicians. On average, I think, Mr. Chairman, we are lucky if a physician stays two years. We have one physician who has been there over 16 years, we have another physician who has been there four years and she was with us in the 1960s. We just lost our surgeon and he was with us four years, although he is going to come back later this year and work part-time.

CHAIRMAN (Mr. Zoe): Thank you. Are there any questions or comments from the committee? Mr. Whitford.

MR. WHITFORD: Yesterday we heard many concerns expressed about the Department of Health and its interaction with the boards in the Keewatin. The Baffin Regional Health Board is not an exception here. You were saying that many patients' problems between the board and the Department of Health are the result of certain interpretations by individuals who have not perceived the role of boards as was the intent of the health transfer agreement. It sounds to me that there are certain levels of the Department of Health that are not looking at boards in a positive manner. They seem to be looking at them a little differently. I wonder about the area in which this is coming from. Is this a general trend? Is this the whole department or can you, without naming names, identify divisions of the Department of Health that reflect this? I think this is important to the overall operation of the system of health in the territories if we are going to continue to use boards to do what boards do for the people, rather than just the department. It seems to be causing many problems. Is this the general theme in the whole of the department, or can one identify it to just some specific divisions?

CHAIRMAN (Mr. Zoe): Thank you.

MR. POLLITT: I think, Mr. Chairman, the Strength at Two Levels talks about 800 boards. There is often a public perception of what do all those boards do? You all get lumped in together. I think there is a growing process because boards have to evolve. There is a need for orientation for all government employees to recognize the role of boards, it is not just health boards. Health, because it was previously operated by Health and Welfare, did not have the same relationship as other government departments. It was a new creature. The Stanton board has always operated as more independent, as we would all see a board operating. It only runs into conflict because they are operating as a health board would do down south. They have a degree of autonomy. That is not always appreciated by some of the staff in the Department of Health. I think it has been a slow training process.

I think since this report came out, one particular officer's attitude in the Department of Health has changed considerably. That is why I do not think everybody in the Department of Health has to be condemned. I think it is a mistake for an official in the Department of Health to be a public administrator, such as the Mackenzie Health Services, because that is similar to a conflict of interest. He cannot separate the roles, and he then makes our roles more blurred. I think it has to be recognized. We are not asking for anything that a normal hospital would not have down south, to make decisions. If the government has set up these boards there is no point in criticizing what they do. They should have said what are they going to do before they set them up. If you feel they are not doing anything, somebody has to change their role or clarify. I am quoting from Rozovsky who is the authority on law. Lorne Rozovsky and her husband are both two Dalhousie professors who specialize in hospital law. It may be useful to have them identify the role of trustees.

People do not realize there is an obligation on health boards far greater than any other board in the government, and that is the public accountability for the patient. You are obligated to meet certain common law requirements. This is not appreciated and I identify this in some of the previous reports because it is a very important factor. If you employee a surgeon and he cuts off the wrong leg, it is the board that is held accountable. There are many legal requirements. Boards take their responsibility seriously, and that is all you are asking them to do, you have given them this responsibility, allow them to get on with their job. I think some boards are more evolved than others. I support the Keewatin in so far as saying we are not on an even playing field. Although Keewatin may appear more vocal they have just recently because they are much further behind than some of the richer boards. I think when you are fighting for your own region it is not because I want everything to go from Baffin to Keewatin, but I would rather give something up to have a minimal standard across the territories and that is why I think you have to have standards Instead of giving people more than 100 per cent, let us give the people who have not reached that baseline, let them reach that baseline. So, there is a lot of catching up to do.

I feel, at the time of transfer, more time and research was required, not just by the Department of Health, the financial people were also equally responsible for what went into the transfer agreement. You can see the mess we are in with what has been inherited which was not clarified. Anything that has been mentioned about health -- and I am sure amongst your colleagues you have been saying "Can we not deal with another topic in the Legislative Assembly apart from health?" -- but we are just trying to get a baseline set that reflects reality so we do not have to keep coming back for supplementaries.

This is January, 1993 and we have not received confirmation of that supplementary. We have been operating since last April, so from April to September you have to keep 14 positions empty because you do not know if you are going to have a supplementary until the first outlook, which is in July and not recorded until November. You operate from April until November with a freeze in place. If you just operate with all your positions, you are going to be over budget because, as I said earlier, it was the equivalent of 14 positions that were frozen.

In the health service you cannot apply the same vacancy factor as you do to other government departments. You cannot say to a patient come back tomorrow or be sick next week. You have to deal with reality.

CHAIRMAN (Mr. Zoe): Does anyone have any further comments or questions? Mr. Pudlat.

MR. PUDLAT: (translation) It seems as if the Government of the Northwest Territories has too much control over the health boards, even though the health boards are very capable of carrying out their jurisdiction. Perhaps you may have some recommendations for us on health in your submissions to reflect some of these problems. We could address those recommendations on how we could deal with those health issues.

MR. ECKALOOK: (translation) The health board in Baffin region wants some controls on making decisions on health issues. We have sought support and since day one there have been many improvements made with our relationship with the government. If we could have additional funds for our staff I think we would be very capable of further handling the health service in our jurisdiction. There is always a problem of cutbacks in terms of funds. Native people are now more involved in being on different boards and they are more involved in their responsibilities. I think this is an opportunity to make a submission to you on how we should address these different problems.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? Mr. Gargan.

MR. GARGAN: In your opening statement you indicated the Auditor General's report is generally fairly accurate but that his statement fails to identify specific regional problems. I would think that some of the recommendations that were made by the Auditor General's office do not really reflect the realities in the north. One is in regard to consolidation of departments. It sounds good if it is going to be done in Yellowknife, but we have the Baffin region, the Keewatin, the Kitikmeot, the Deh Cho region, so we have many other regions and the Auditor General's report does not reflect that. It reflects more of a southern reality as opposed to a northern reality. Would that be an accurate assessment of what the Auditor General's report is on?

The other thing is with regard to payments. You mentioned you do not know for sure if the appropriation in the first six months is going to go through because you are holding onto 14 positions. What would you see as the financial arrangements between the regional health boards and the government? Do you see an annual contribution agreement, a quarterly contribution agreement or a monthly contribution agreement? What would be the reality now with regard to the administration of money?

MR. POLLITT: I think, Mr. Chairman, a budget has to be based on reality. You have to take into fact all the collective agreement requirements. You cannot ignore them and think they are going to go away. There has been an agreement between the government and the union and you have to meet those items agreed to, and any other increases which are beyond that control. I think if the budget is based on reality we do not have to keep going back asking for more. At times the supplementaries are not put forward to you or to the F.M.B. We are told many months later we did not put this supplementary forward, so here we are expecting a decision and it has not even gone forward.

In the Baffin, because we used to rely on the sea lift, as far as the cash flow, we used to make arrangements at the beginning of the year in April, to have two months payment so that when the bills came in from the July sea lift, with much higher invoices, we would adjust our cash flow.

Another thing you must be aware of, in the first few years of the board's operation we never received our twelfth month O & M funding for many years. When the Auditor examined this, he came out with over $1.4 million which has never gone through the Baffin books. We did this as a paper exercise because you do not see the positive side, it is always putting forward the negative side. I think you have to balance it. Likewise, I am saying we have saved $190,000 just by changing our mode of delivery. By sending the specialist into the community you save $190,000 by not utilizing airfares. It is saved for the government, it is not saved for us. We want some of that money put into our budget to further expand that program because if we send a specialist with a nurse, we may have to pay the nurse who is doing the specialized work in the community so that the existing community nurses can get on with their work. This is one way you can save money. That is all we are asking to do is to be allowed to use our initiative. There is a surplus fund.

We are audited to death every year. The federal auditors come in every year for health and welfare and non-insured services. Other auditors include the G.N.W.T. auditors and the board auditors. If there is any problem, surely those three different types of auditors could identify them.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments or questions? Mr. Gargan.

MR. GARGAN: I realize some of the incentives you have are with regard to the money operations of your board, but what you are saying is that the Auditor General's office is not reflecting the regional realities. That is what I wanted you to respond to.

MR. POLLITT: Mr. Chairman, maybe I did not answer correctly, but I did state the comments in the Auditor General's report are generally fair and accurate. That is as they reflect to Baffin. Other regions may not see that. If they had identified that Baffin had a problem in this area, you would have more accurate information to go on. You are dealing with eight boards and generalized statements. The same problems do not apply in all the regions and they are not stating why. We are not quite in the position to say why there is an anomaly, unless one has been identified.

They make a sweeping statement that all doctors get $8,000 to $10,000 educational leave. That only applies to a few doctors. I do not know where that applies, but it is certainly not in the eastern Arctic. Why do they not say the region that it applies to? We all get lumped in and we are all painted black. This does not reflect the regional problems. That is all we are saying, it could have been more detailed.

He is making blanket statements, but I think some of the comments, including the one that there is too much control by the department, are true. I think that is a fair comment.

I think you must also remember that when this report was done, I do not think there was enough lead time for a settling down period after the major transfer. They came in too soon. The Auditor General should have done the report before the transfer so we would have had a baseline. If this was done, all of these problems we are having now with finances would have been identified up front. We are going to live with these problems unless someone readdresses them or wipes them off the books.

In reality, in some communities, we have had no staffing increases for nurses in ten years. They are doing a nursing study. However, we think this workload measurement is flawed. You have asked a few questions, but you have not sent someone in to do a work study to see exactly what that nurse does for a month. If someone goes to Pangnirtung for a few hours, that does not reflect a true working monthly cycle of what a nurse has to do. There is no consideration taken for exactly what that person does, in order to make recommendations on how to improve the system. More nurses may not be necessary.

We think you should have an office manager in every health centre who is an Inuk, and that office manager can interact with the public. The nurse can spend her time doing what she was trained to do, nursing. One third of the time in the communities is spent on administration.

Our health system is out of control because the salaries have gone up from what was inherited at the time of transfer. That is what people do not realize and that is where they should be making the comparison. They should compare what we inherited at the time of the transfer and what we have now, and then make some statement on the reason why. Of the costs in a hospital operation, 70 percent of the costs are in salaries. You have very little to play with, but you employ highly specialized staff.

I would like to make a comment, Mr. Chairman, regarding Stanton. Stanton doubled its occupancy and overnight everyone had the expectation that this facility, built for the next

ten or 15 years, would be fully operating after it doubled in size, and this is not realistic. It should have been put in mothballs and said well that wing will not open. They built Stanton without any consideration of the total strategy to the north. Now they are left with it and they are saying "Well, what should we do with it?" Now everyone is having to utilize that. I am not saying that you cannot utilize it for some services.

We have still many needs to be met, Mr. Chairman, especially in the east. These include psychiatric services and long-term care. Community problems have to be addressed. It may be more cost-effective to have home care programs in all of the communities. You would create jobs for the local people. Most of the training is done in Yellowknife, although we have C.H.R.s on the books who should be implementing the Minister's strategy for health promotion and education. We have about six vacancies because we do not want to come to Yellowknife to train the C.H.R.s. This is the reality. Stanton does not reflect reality. That is an exception. You have really got to take that out of the equation. You do not appreciate what a community health nurse does. I think you should go and work in a community. We have staff, Mr. Chairman, who are supposed to serve the Baffin region, and you may see them once a year. Now, if someone is supposed to work in the Baffin region, I would rather see that person taken out of the Department of Health and put into the region they are responsible for to see if I can get some value from them.

We have a vacancy for a nutritionist. The last two nutritionists have done a tour of the Baffin and have left. Now, what we felt would be more appropriate, because of the size of Baffin, would be to combine the nutritionist's position with the health promotion officer so that we would have a second health promotion officer who could strengthen the strategy for health promotion which the Minister is trying to do. However, we are not allowed to do that. The Department of Health says we cannot do it because they do not want us to. Now, that is not meeting our aspirations as a board and it is not being effective. We feel, because of the geographical size of Baffin, we should be allowed, if we wanted, to have that nutritionist do two jobs and call it a senior health promotion officer with a major speciality in nutrition. When she went around to do her nutrition, she would do other health promotional aspects. You would get a better service. This is where I was saying the department should not have their say because their inspectors have all of these programs, and they think they are the final voice.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Gargan.

MR. GARGAN: One final observation, Mr. Chairman, during your statement you mentioned something about the financial control. It is obvious now that the department has used the budget process as a way of controlling the Baffin. It relates to board autonomy. What is you observation right now with regard to that autonomy? It certainly feels, as you said at one time, as if they are trying to bring up the boards 120 per cent. Perhaps they are putting the Baffin down to about 80 percent, comparable with the other boards, as opposed to trying to make the boards move up a bit so that they are comparable to the Baffin health board. Do you feel that is the direction or the hidden agenda that the department is having with trying to put Baffin in its place, if you want to call it that?

MR. POLLITT: I think, Mr. Chairman, we have to acknowledge that all regions are different. We do not want anybody to model on the Baffin and think that is the be all and end all. I think when it was set up no one took any notice of the phasing. The whole intent was to take advantage of that and to set up a central organization. The central organization as a blueprint was not really determined. I feel if someone was to do an evaluation based on the needs of the population and the health status of the population, if you found that in the Keewatin there was a great need for a service, I think Baffin would say level out the playing field. Stanton, which has the largest chunk of the budget, because they have done this for many years, has set a standard. I think if you were to measure the same number of people doing the same job in Baffin hospital and Stanton, you would find that people are different, and that there are different salaries. If your obligation as a manager is to make sure the service, the program, is delivered, you have to find staff. That is where the board would exercise its autonomy at Stanton. Because we need that person, we recognize experience, we are going to put that person at step four instead of step two. Now, we may be controlled, you are not supposed to appoint anyone above step three without further permission, but you see those are some of the things that traditionally went on. I see a board saying, well, their first priority is to the patients to deliver the programs. As long as you recognize you have to live within a budget, we are asking for the budget to be reasonable. You cannot just spend, those days are over. I think everyone realizes that. When you compare what the Baffin trustees spend to deliver their service at their board meetings compared to the divisional board of education, you are comparing apples with oranges. You have two boards trying to deliver regional services.

You cannot always compare one region with another because of the distances. It is like a doctor flying into Inuvik. If he flies into a nearby community, it takes him half the time that it does for someone in the Baffin. So, all we are saying is that the government should ensure that there is a level playing field across the N.W.T. We are planning in ignorance because we do not know what the health status is out there. You have many statistics. There is a great deal of activity, but what does it all mean?

CHAIRMAN (Mr. Zoe): Any further comments or questions from the committee? Before I go to Tony, I want to ask one general question. Yesterday, you heard the government initiatives with regard to decentralizing the health insurance services to Rankin and to Inuvik. Would your board benefit directly from this decentralization of the health insurance services division?

MR. POLLITT: I think, Mr. Chairman, what you are really doing is duplicating the same service. It does not matter if you put it at the North Pole because you are really dealing with figures, transfer of information, a communications system, and if you have got it set up properly, it could be anywhere. It would not have an impact on us. It is just as good as the people operating it. I do not see that we will get a service any less than what is in place now because it is being decentralized. I think it is a financial operation. It is not going to impact on the quality of patient care because primarily what you are doing is paying bills, you are making decisions, and you have a policy in place, which you follow through the medical transfer policy. It is when you have a dispute. I think if I have got a patient

who is sitting at the airport, I have to make a decision. I make that decision and I live with the fallout. By the time I phone for a decision, it may be many hours later and you would then incur greater cost, because the patient is held over in that community. I think if you are paying a manager, such as ourselves, to manage, you have to allow us to make decisions. Sometimes, common sense has to prevail.

CHAIRMAN (Mr. Zoe): Are you suggesting hospital insurance services be decentralized but not broken into two components as is being discussed by the government, half to Inuvik and half to Rankin? Would you prefer seeing that unit being decentralized to one of the communities rather than being split?

MR. POLLITT: I think someone would have to do an analysis of exactly what those 26 people do, or however many you deal with in there. This is a whole new growth industry in the Department of Health. Twenty-six people, in the days of computerization, knowing what the two parts are doing, I cannot see them doing anything different. All you are really doing is reaching for another agenda. You are thinking in terms of east and west, planning for Nunavut, in reality. Now, whether you say the 20 odd people should go to Rankin or the 20 odd people should go to Inuvik, it would not really matter. You are dealing with two agendas. One is decentralization and the other one is planning for the future with Nunavut.

CHAIRMAN (Mr. Zoe): Any further comments or questions from Members? Mr. Whitford.

MR. WHITFORD: Perhaps, Trevor, you are right, there are other agendas. I am intrigued by the first question asked and I still do not have an answer, because we have covered a great deal of ground, but the fact is, we do have boards. These boards are not going to be very successful unless they have the full cooperation of the Department of Health, and many of the Members of the Legislature, to continue their operation. Boards are important to the delivery of health in the territories. If they are not seen as being helpful by the department, and there continues to be road-blocks in the way, the delivery of health to the people is not going to be what it can be. I guess I am interested in finding out where, in the Department of Health, is this attitude persisting, to not recognize the boards and treat them as they should be treated. We need to find this out so there can be some corrections and changes made. If it is a bad attitude, if it is the whole department, then we have got a problem. However, if it is found only in certain levels of it, then I guess we could make some progress in making some changes. I want to get back to that question again, where would this be coming from?

MR. POLLITT: I think, Mr. Chairman, there is a question of interpretation. What do you mean by manage control? It is much easier to operate. When you have the M.O.U.s, the memoranda of understanding, spelled out, I hope there will be some clout behind them, I hope the M.L.A.s will actually vet them or have some say to make them almost law. The M.O.U.s would state what the boards should do, what the staff in the Department of Health should do, and until that is all spelled out, we do not know what each person is supposed to do. The Department of Health's role is primarily setting standards and updating the legislation, and if you got on with those two aspects that would keep them busy for years. Under Nunavut, two of the boards, the wildlife board, the water board, are going to be regulatory boards...

MR. WHITFORD: Mr. Chairman?

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Mr. Chairman, we have been here for an hour and we are going to go on for an hour more, I was wondering if he could be a little more succinct in the answers. I am not interested in other boards. I asked a question and if he is not going to answer, I do not know what we are doing here.

CHAIRMAN (Mr. Zoe): Could you be more specific?

MR. WHITFORD: I asked if there is an attitude, does the Minister have a bad attitude toward the boards? I have heard continuously that the boards are not seen by the department as being what they should be. There is a great deal of confusion in roles, or possibly their roles are not spelled out correctly. From my knowledge of the boards, they have objectives and mandates and they are trying to carry them out, but they are being blocked by the department and this is what they are saying here, that is what was said yesterday. Is it the Minister? Is it the Deputy Minister level? Is it down lower? Is it just some parts of the department? You made a statement here. The board also made a statement yesterday, and I guess at some point in time you have to call a spade a spade.

MR. POLLITT: Mr. Chairman, I am not trying to avoid the question. I was only making that point because of the status of the boards. When you say the board is regulatory, you have authority. If it is called advisory, then people assume you take that advice. In the Department of Health, the financial comptroller controls the finances and controls how we operate. The majority of the people in the Department of Health are well-meaning. They work very hard and they will insist things go through the board. I have no problem with that. I cannot pinpoint an individual who I say is not in support of boards. What I can say is that they have a responsibility, fiscal responsibility, to the financial management board, like any government department, to make sure that money is spent appropriately. All we are saying is that if the budget is sorted out appropriately there would not be all of this fiscal control over us. It is the control, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Any further comments or questions from the members? Mr. Whitford.

MR. WHITFORD: Mr. Chairman, I have another question not to do with this, away from that. You mentioned something about identification, and that all residents should have a plastic health card with a photograph for reciprocal billing. I am missing something here. Why would this be helpful?

MR. POLLITT: This is a piece of information. All of the names are wiped off the microfiche every second year or so. This means each individual has to re-apply every two years, and most of the time they do not re-apply. A more durable plastic card is required, instead of a piece of paper which goes into the back of a pocket and is of no use because many people do not re-apply for their new card. The application may not be sent out in a timely manner, or originally it may not be sent out

in Inuktitut, sending it straight into the bin, not even opened. You just have to go in the post office. We have to have people fill in a new form, which puts the onus back on each health board to do that at the port of entry. All I am saying is from a government point of view, because in the Baffin region most of them are aboriginal people, you could issue a five-year card, as it is a universal service. That is all I was saying.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions from the committee? Mr. Gargan.

MR. GARGAN: Mr. Chairman, going back to your statements with regard to specific regional problems, I have been listening to your response on it and I guess that it is no different than any kind of response from the Department of Health. Even though the general trend in all the regions is to have control, autonomy and self-determination, all of the regions are different, the distances are different. If you go to Yellowknife to make a request of one regional health board, and you want to compare it with the Baffin Regional Health Board or the Stanton Yellowknife Health Board, we keep hearing that the reason for not giving you what you requested, possibly due to the development of that board or money or whatever it is, is the differences between the boards. The general focus should be that the reason why these boards were created in the first place is that they could be autonomous. The Chairman might have a different view on that, but my view is that we created those boards for a purpose and that is to start controlling the delivery of programs for that region. I have not heard you say that. All I have been hearing you say is something similar to what a Deputy Minister would say in Yellowknife. All of the regions are different. You cannot treat all of the regions equally, but in reality, politically, you can.

CHAIRMAN (Mr. Zoe): Mr. Eckalook.

MR. ECKALOOK: (Translation) Regarding the Baffin Regional Health Board, they started in 1980-81. I have been a Member since. The Baffin Regional Health Board has been operating since 1981 and it is our objective to represent our organization. Perhaps, because they are Inuit or native, this is why they are seen as not capable of running a board, and sometimes, when they request more control, there is little response to that. Perhaps, Yellowknife might think that we are too native to run an organization.

CHAIRMAN (Mr. Zoe): Any further comments? Questions? Mr. Pudlat

MR. PUDLAT: (Translation) Mr. Chairman, regarding a comment. I would like some further clarification on funding. I think you want some more detailed information reflecting Baffin and some detailed information on Keewatin, and you want that to be reflected in the Auditor General's report. Am I clear on that, sir?

MR. POLLITT: Mr. Chairman, that is correct. Some of the statements made in the report are too generalized. They should be more specific. You could then see where the problems were and that particular region could give you definite answers. Mr. Chairman, some of the communities, such as Cape Dorset, want to take on responsibility at the community level, and we are meeting with those communities. Social services and Health and these things are under discussion. They are all on the table, and as each community comes forward and wants to take on that responsibility, we are not putting road-blocks in the way. The role of health committees, which are subcommittees of hamlet councils, should empower the people at the community level to have more say. Some of those are developed under different auspices, mainly under M.A.C.A. because they are subcommittees of elected people. There is a perception that health committees are subcommittees of the health board, but in fact, they are not. So, until that is addressed at the community level, you do have a gap in the system. We are aware that there are these gaps. We have not been able to plug them all yet, but we still work on it.

CHAIRMAN (Mr. Zoe): Questions from the committee? Mr. Pudlat.

MR. PUDLAT: (Translation) We are working very hard in Cape Dorset in terms of the community board having more control, but what kind of date are we looking at in terms of transferring some responsibilities to the local board, I cannot say.

CHAIRMAN (Mr. Zoe): Any comment?

MR. POLLITT: I think, Mr. Chairman, we tread very cautiously, as Mr. Todd says, sometimes you have to take a leap of faith and allow people to make limited mistakes, as long as they do not make too many. Unless people are given the opportunity, they will never know whether they are going to be able to develop the programs. We are of the idea that the communities, provided they have the necessary financial support, can quite easily deliver some of these programs at that level. If you look under the Public Health Act, there are many items in there that you can misread. Setting up boards. You can have your own medical health officers if you read that and it is stated in that act. There is nothing stopping from saying I have my own medical health officer. It is there right in the act. We want the people to have just as much say as possible.

CHAIRMAN (Mr. Zoe): Is there any further comments or questions from the committee? If not, I would like to thank the Baffin Regional Health Board representatives for making their presentation to our committee. Thank you very much.

MR. POLLITT: Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): We will call on our next witness. The Kiguti Dental Clinic representative. I believe it is Bernadette Makpah. Could you introduce yourself, for the record?

MS. MAKPAH: My name is Bernadette Makpah, resident of Rankin Inlet. First of all perhaps, I extend my welcome to your visit into Rankin Inlet as a committee. Thank you for coming to hold your public hearings. Elected representatives and citizens, such as myself in the private sector, thank you. If I speak too rapidly please let me know. It is difficult to express myself in Inuktitut because it is a longer way of speaking, and I do not know Inuktitut very well, so I will be reading in English. If I am too fast for the interpreter, by all means, let me know. As a regular public member of my community, Rankin Inlet, it is nice to see a committee such as yours coming to listen and

hear concerned bodies or boards like myself, or business people expressing their concerns in the area of health.

Unfortunately, I probably will not be able to answer many technical questions because I do not sit on a health board. I do not work in the area of health. I do not know much about specific health issues, but I do have an interest and I am a stakeholder in dental care. So, if you do not mind I will proceed.

Mr. Chairman, Members of the committee, my name is Bernadette Makpah. I am a mother of four and a stakeholder in health care, a resident of Rankin Inlet and a Director of Kiguti Dental Services Limited. I appreciate this opportunity to address the Standing Committee on Public Accounts on the subject of health care in the Northwest Territories.

I would like to acknowledge the attendance of two people from Yellowknife. They did not have to do this but I guess they were lucky in coming to this community, Charlene Adam and Susan Durenko from the Adam Dental Clinic in Yellowknife. They are here to help and assist our staff at the dental clinic, either to find another administrative system or set one up. Thank you for coming.

As an Inuk mother, I am concerned for the quality of health care services delivered to aboriginal people. I do not want to speak for all aboriginal people either. I am specifically referring to Inuit people because I am from the Keewatin region and I am an Inuk. There is a lack of planning for the efficient and effective delivery of those services. As a resident of Rankin and the Keewatin region, I am concerned about delivery mechanisms for providing quality health care to the people at the community level. As a stakeholder and a director of Kiguti, I have a personal interest, along with other stakeholders, my co-directors and our professional staff, in the quality of dental health care services provided throughout the region. From the Auditor General's report on the Comprehensive Audit of the Department of Health, which we have all been referring to, and from various newspaper reports, it is apparent that neither the Legislative Assembly nor the Department of Health is clear on the lines of accountability and responsibility for the development and delivery of health care services. Who is accountable and responsible? Department officials say they are waiting for direction from the government, through the Minister responsible for health. Government, and by that I mean the government which is constituted by the Legislative Assembly, expect the bureaucracy to take the initiative.

Mr. Chairman, occasionally initiatives and, perhaps more frequently, inspiration will come from below. However, leadership comes from the top. The Legislative Assembly is abrogating its responsibility to the people of the Northwest Territories in failing to provide direction to departmental officials for the development of a health care system which meets the needs of those people. The people who elected the Members of the Legislative Assembly to provide leadership on their behalf.

The G.N.W.T. accepted responsibility for the delivery of health care services from Canada in 1988. It introduced a two-tiered system for delivery. The Department of Health was to be the central agency and regional boards were to be the delivery mechanism at the community level. This two-tiered system has been supported by the Strength at Two Levels report. The lines of accountability are clear, or should be clear. The government is accountable to the people of the Northwest Territories for the delivery of quality health care. The Department of Health is accountable to the government through the Minister of Health for the development of a quality health care system. The regional boards are accountable to the Legislative Assembly, again through the Minister, for the delivery of quality health care at the community level. What has not been clearly delineated are the responsibilities of the parties.

The government should be responsible for providing direction to the department in the development of a strategic health care plan and for approving the plan. The department should be responsible for developing the strategic plan, monitoring its implementation and providing support to the boards in the delivery of components affecting the regions. The boards should be responsible for the delivery of health care services at the community level. Mr. Chairman, these responsibilities cannot be undertaken independently by each of the parties. The government, the department and the boards should be responsible for communicating with each other and, more importantly, with the fourth party. That fourth party, Mr. Chairman, is the client. The residents of the Northwest Territories should be, must be, consulted in the provision of health care services. After all we are the intended beneficiaries of a good health care system.

With the accountability and responsibilities defined, the broad organizational structure for the delivery of health care services should be quite clear. The Minister reports to the Legislative Assembly, the department and boards report to the Minister. Functional relationships between the department and boards should be delineated for the development, implementation and monitoring of the strategic plan. The department should also recognize it should provide assistance to the boards in meeting their day-to-day responsibilities established through legislation, regulation, policy or the strategic plan. From what I have been hearing the last couple of days, the department is still planning to plan such regulation or policies or a strategic plan.

The boards should recognize the department's role in providing functional direction and support. It should be made quite clear there is no line reporting relationship between the departments and the boards. The preceding organizational structure ensures that the intended beneficiaries of the health care system participate in a meaningful way in the decisions which affect them.

My third point is with regard to the delivery of dental health care in the Keewatin region. The Auditor General refers to the contract between the Keewatin Regional Health Board and Kiguti Dental Services Limited. The contract has also been the subject of several media reports. The Auditor General's report does not disclose all of the information. We are unsure whether this is the result of editing by his office or the failure of the Department of Health to provide all of the information. The department was aware and involved in the discussions for the provision of dental health care services. We cannot comment on the extent of that involvement, since it was between the department and the board. However, the Minister of the day did advise the Keewatin Regional Health Board that if a dentist could be persuaded to live in Rankin Inlet, the board could

proceed with a contract. We do not believe the department was unaware of this communication. Under the original contract signed between the board and Kiguti, dental services were to be provided on a fee for service basis and there was financial consideration for the logistical support required in providing the services. This contract would have resulted in a reduction of direct cost to the government of slightly over $400,000 a year on a fee for service basis. Subsequent to the signing of this contract, the contract was amended at the department's request. The new contract was to be exactly the same as that provided to the University of Manitoba for so many years. Kiguti concurred and signed the amended contract in April, 1992, six months prior to the release of the Auditor General's report.

Mr. Chairman, the contract for the provision of dental health care by the University of Manitoba was quite satisfactory for years. Why is it no longer satisfactory when Inuit people are the major participants in the provision of the services? Aboriginal people represent approximately 85 percent of the Keewatin region. The socio-economic benefits derived from the contract by residents of the territories, the region and the communities were minimal when the contract was held by the University of Manitoba.

Kiguti has created eight new jobs in Rankin Inlet, a correction to John's little speech last night, and seven other jobs in the communities in our region. We are proud of that and rightly so. That includes professional staff right down to the assistants and clerical. It has also expanded the role of Inuit in the provision of dental health care, raised the wages and benefits paid to employees, put in place a modern dental facility to serve the community and we believe improved the quality of health care at the community level. If you have any time later, I could take you on a little tour to our dental clinic. Just advise me.

The provision of dental health care, dental health to school children is done through the dental therapist located in the schools. The volume is such in Rankin Inlet that sufficient care could not be devoted to each child and most recently, Kiguti, in collaboration with the Community Education Council and the board, has entered into an arrangement where a second dental therapist has been provided in Rankin Inlet. This dental therapist provides care to the high school students using the facilities of Tesar Dental Clinic, down in our facility here. The Kiguti board has members from Baker Lake and Rankin Inlet. By the end of March a member will be added from up there. Over the next several years, we expect to add board members from each of the other communities. Plans are under way to equip each of the communities with the required equipment to improve the efficiency of service delivery. Having equipment in a community will eliminate the inefficiencies associated with packing, shipping, unpacking, and within the next year, we plan to establish a clinic in at least one community and another one will follow in the next year.

Kiguti has also proposed to provide orthodontic services in the region. We estimate the savings to the government will be in excess of $250,000 and the board is awaiting a decision from the department. We also would like to perform oral surgery in Rankin Inlet, while a definitive study on the cost savings to the government has not yet been done, we believe that the savings would also be significant. By the way, most of these studies are done independently by a private management company. Savings from performing orthodontic and oral surgery in Rankin Inlet would accrue not only in the area of health care but also in personal cost to the public and private sectors. Important replacement of the services as with the dental health care, as with the dental health care contract, provides a major economic benefit to the territories, this region, in addition to cost savings.

Kiguti is a privately-owned company. The shareholders are Doctors Adam and Mackie of Yellowknife, Dr. Pastori of Iqaluit and Tapiriit Developments Limited. Tapiriit is a wholly Inuit-owned company. In order to demonstrate their commitment to improving the quality of dental health care throughout the region, the shareholders have signed an agreement whereby any surplus revenues accruing to the company will be reinvested in dental health care. We are not in business to make a profit but to provide a service.

With your patience, I would offer short comments on one other issue from the Auditor General's report. It is understandable that many of the professional positions involved in the delivery of health care services require advanced levels of education, experience and training. However, many of the technical and administrative positions do not require the standards set out in job or position descriptions. Descriptions are written to raise the pay levels rather than reflect realities of the duties themselves.

Position descriptions for technical and administrative health care personnel should be reviewed. Where they are found to unnecessarily create systematic barriers for aboriginal people, they should be revised.

I think there are some interesting comments that the Auditor General made in regard to the Department of Health's affirmative action initiatives or lack of them.

In conclusion, the Auditor General has identified some serious concerns respecting the delivery of health care in the Northwest Territories. While he has been careful not to suggest the quality of health care has been affected, one cannot help but believe it has been. It takes a considerable leap of faith to believe that the lack of adequate planning and the constant bureaucratic bickering has not denigrated the quality of health care.

Mr. Chairman, we look to you and your colleagues of the Legislative Assembly to provide the leadership necessary to ensure quality health care for all the residents of the Northwest Territories. Qujannamiik.

CHAIRMAN (Mr. Zoe): Are there any general comments from committee Members? In your submission you have indicated that the department and boards must start communicating more efficiently with the public. This was also stated in section 2.9 of the Auditor General's report. Could I ask if you have any practical suggestions as how this could be achieved?

MS. MAKPAH: Are you referring to practical suggestions as far as communicating with the public?

CHAIRMAN (Mr. Zoe): Yes.

MS. MAKPAH: We have been hearing several suggestions or just facts about Department of Health officials or civil servants that have all this control in the central agency in Yellowknife. As an Inuk person, I feel that central bureaucy, the monster in Yellowknife, really does not listen to the concerns of "the client", and that is the people. The people should be most important as far as the whole health system is concerned.

One of the suggestions yesterday, I do not remember whether it was John or Betty, in business, for instance, I can relate to the Kiguti Board. Our policy with the Kiguti Board, and our philosophy, is to provide quality dental health care within our region. We want dentists who are sensitized and who have an interest commitment and loyalty to providing top quality dental health care within our region for our people. If they do not perform, if they are not personally suitable to the cultural needs or just for good quality dental service within our region, then we will turn around and fire them if we find too many people from the communities complaining that they are not happy with their new dentures or whatever. Maybe there needs to be a major overhaul and review of the department's management. We could then come down to the regions and have one person, this is just a suggestion and get a consultant, I am sure there is surplus money to pay a consultant, to go into each region and listen to the views and concerns of the client. Every region is different as Trevor, and everyone else, has been saying. Maybe that is one way to communicate with the public.

If you are going to keep your management or the management is going to stay as it is in Yellowknife, maybe they should visit the different regions more often and talk to people like Bruce and Trevor and the health boards.

CHAIRMAN (Mr. Zoe): Just to continue in that area. In your presentation, in relation to the client, what role should the board play, in your view, with regard to communicating with the client? Do you think they are being effective now with regard to communicating with the client or the general public? Are they serving their purpose?

MS. MAKPAH: Again, I have to go back to the specific example of Kiguti. I think our regional health board was very successful in completely listening to the region's concerns and desires for better quality health care when we negotiated this contract with the Department of Health to get away from the University of Manitoba.

Right now, I do not know what mechanisms exists. I have an idea, that each hamlet council has a representative. A board is only as good as its content. If the member from Chesterfield Inlet is listening and comes back advocating the concerns of that community to the regional board then, yes, I think they hear. I think there is a good aggressive and caring board in our region. The ministerial appointments are referred by hamlet councils.

CHAIRMAN (Mr. Zoe): In your speech you indicated that the department and the boards should be responsible for communicating with each other and, more importantly, the client or the general public. In your view, are you suggesting that the board is not consulting with the general public? From reading this it suggests there has to be more improvement in this whole area between the board and the general public that they serve. Are you suggesting that the board or even the Department of Health should have workshops, those types of things, so that the public would have more input into the board and also into the Department of Health?

MS. MAKPAH: This is how I see it. If you look at an organizational chart for your corporate structure the client is at the bottom, that is number one. Then there is the community subcommittees, then the regional health board, then the department, the Minister and whatever. I do not know how it works in between there. What I am suggesting there, Mr. Chairman, is I am more than happy with the regional health board's ability and sensitive nature in listening to its clients, the general public in the Keewatin region. I do not know about the other boards. However, what I am suggesting is our regional health board has been involved in this Kiguti issue since last year, and I am aware of the difficulties that were placed by the department as far as proceeding with the operation of the dental clinic itself. That was all I was interested in, opening up the dental clinic, providing better dental care, hiring staff, working and providing jobs for our community. Our regional health board, as far as I am concerned, is listening to the region. However, the department is not. I am not suggesting that, I am stating it.

CHAIRMAN (Mr. Zoe): All right. Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I do not have the presenter's comments from yesterday, but the comments referred to dental services that are now being provided here in the territories by a consortium of northern people with a great deal of aboriginal content, is a good thing and I congratulate it. I have been to the clinic and you should be commended for the initiatives you have taken.

However, the Auditor General's report in section 2.18 refers to the process that took place over a period of time to the eventual establishment of Kiguti. I am puzzled, they said they were making money and were going to make money, but did not state exactly how successful they were. It may be a little early yet because it has only been going for less than one year. In section 2.8, after talking about the history of it where it was taken over from the University of Manitoba after the contract expired, the Auditor General goes on to explain a fairly complicated process of billings where the medical services branch of Health and Welfare Canada has to reimburse the territorial government for costs, and where certain fees are not paid. In turn, what it says is, "it would have been reasonable to involve the department in this contract negotiation particularly as it understands the needs of M.S.B. and has an umbrella responsibility for the whole of the G.N.W.T./M.S.B. relationships. The department believes that the board may not have understood all the cost ramifications of this new contract." How accurate is the Auditor General in this statement?

MS. MAKPAH: We are only spending as much as the University of Manitoba spent. Our initial proposal, the department, through the regional health board, I cannot speak for them, was based on a fee for service basis, where the doctor pulls out a tooth and charges whoever it is $25 for that tooth.

We went through a round of discussions and meetings where Dr. Lewis came into Rankin. I went out and reviewed clause by clause the contract with the Kiguti Board, the professional, groups and the regional health board and Dr. Lewis and his bureaucrats from Yellowknife. However, we ironed out clause by clause, reviewed the contract clause by clause, agreed, gave up, concurred and said fine we will take the per diem. I do not really understand what their problem was but I know there was a great deal of resistance to make this whole contract go forward.

This is not accurate.

MR. WHITFORD: The Auditor General's report is not accurate.

MS. MAKPAH: No. I think it is unfair. The Auditor General's report is so general in referring to problems in different areas of health, and then specifically it mentions us. I guess we are good examples because there was a lot of controversy. People were nervous that the regional health board went ahead and exercised their right, as far as I am concerned, authority, autonomy, whatever you want to call it, to choose a system and dare to not renew the University of Manitoba's contract and take it back to the region.

This is not accurate at all. We were going to save the territorial government $400,000, but Dr. Lewis and those people did not like it, for whatever reason, so we concurred and said fine, we will take the $1.4 million and provide a service.

MR. WHITFORD: What would have prompted this? This contract expired on March 31, 1992, less than one year. What promoted this? What came first the chicken or the egg? There was an incident that occurred between the Manitoba university, dentists and this community. That had nothing to do with it, did it?

MS. MAKPAH: No, it did not, but it certainly helped in lobbying — well, we did not have to lobby. It certainly helped in regular individuals coming out and publicly supporting the concept of a dental clinic based in Rankin where we can hire five more local people, build five more houses and raise the salaries of the dental assistants in each community. We are paying our dental assistants more money. We have two residential and one float dentist in Rankin Inlet.

MR. WHITFORD: Personally speaking, I am all in favour of repatriating any services that we obtain from the south in order to stem the flow from money to the south and do it locally which is what appears to be happening. I am not criticizing, it would be unfair if I did because it is such a short time between the time of the establishment of this business. I believe that the concept is good, especially when you involve northern dentists. There is a certain responsibility that the Government of the Northwest Territories has in dealing with Health and Welfare Canada. It remains to be seen if this will violate any agreements that we have had with medical services. I just wanted to ask you, and get it on record, with regard to what the Auditor General had to say in his report.

MS. MAKPAH: As I said, I did not think is was very fair for him to specifically identify or indicate our group from a private point of view. I do not think I would have been making a presentation today if this did not rile me up. I think there are many positive items, including good economic impacts. I want to see the money staying in the north, flowing in the communities, with more jobs and more houses. I think if you give us the control within our own community to manage our own people to provide our own people a type of service, we are going to do the best. As John was saying last night, take the services close to where the problems are so it will be easier to provide a solution. I think that is the initiative we took and we are doing it.

We are going to open up two more dental clinics in the other communities in the Keewatin region. This is our own initiative, the government has not given us that creative idea. That is where the surplus money is going to go, to new equipment and new jobs.

CHAIRMAN (Mr. Zoe): I do not think Mr. Whitford was questioning your specific group. I think what he is saying is there was a lack of effective partnership between the board and the Department of Health because the Department of Health has certain responsibilities. What he is saying is that the Department of Health should have been involved in these negotiations because they are the ones who are responsible. They have to bill the feds to get reimbursement for Inuit and Dene health benefits. The Auditor is saying it seems there have been some problems because they are not working together and he used that specific example. I do not think the Auditor General is saying anything about your particular group, but I think he is referring to the board and the central agency because they are the ones who are responsible. They have an umbrella responsibility in terms of dental care, but the board went on their own with no consultation with the central agency. That is my understanding. There was a breakdown in communication, a misunderstanding, and the Auditor General also said there is possible monetary loss by having this particular contract.

MS. MAKPAH: May I respond to that? That is a very strong statement that the Auditor General is making regarding a breakdown of communication. I do not think there was any breakdown of communication. I will vouch for the Keewatin Regional Health Board and my own group that there was more than adequate communication. In fact, I think it was usually from our end forced on the department. The board, as a group, ended up inviting Dr. Lewis and they were informed more than adequately, they were consulted more than adequately. This is the department's accusation that they were not consulted. I think there may be some written information dating back to those days when they were trying to deal with those negotiations for this contract to become a reality. I cannot really speak for the board, but I know as far as my involvement the department was consulted on a regular basis because we know how the payment system works. How else could we negotiate a contract? So, the department was more than involved.

CHAIRMAN (Mr. Zoe): I think what the Auditor General is saying is that because the central agency was not involved, not with your group but with the board, particularly with the board, the department believes that the board may not have understood all the cost ramifications of the new contract because they do not know how the billing is done between the territorial and federal governments. What the Auditor General is saying, and the department is also saying to the Auditor

General, how could the board negotiate this type of contract when they do not know how we do our billings to the federal government, how we get certain things reimbursed? If the board does not know how the billings are done between the territorial government and the federal government to get reimbursed for Inuit and Dene dental care, how is the board going to negotiate a contract for the best? That is what the Auditor General is saying.

MS. MAKPAH: I cannot answer those specific questions because I do not sit on the board.

CHAIRMAN (Mr. Zoe): I think that was what Mr. Whitford was trying to get at.

MS. MAKPAH: All right. Any clerk can learn how to do that billing. However, I want to emphasize that there were no additional costs incurred by coming up with this contract. My group could not have helped but be involved because we were going to take over the services that the University of Manitoba was providing. What is the difference in the payment method or billing method as far as I am concerned regardless of whether the health board knew, I cannot speak for them, but I am sure with their C.E.O. he must have known. Their finance director must have an idea. I do not know those answers, Tony, but what is the difference between funnelling the money, the payments, to the University of Manitoba, or missing Winnipeg and coming to Rankin Inlet? There must not be a huge difference in the administration of that.

CHAIRMAN (Mr. Zoe): I think that particular question should have been more appropriately posed to the Keewatin Regional Health Board.

MR. WHITFORD: It was only to point out this part in here, Mr. Chairman. It may work out well, but the Auditor General pointed this out. Although the costs may be the same between here and the territorial government, the problem may lie not there, but between the territorial government and the federal government and how they get their money back.

MS. MAKPAH: I also know if you want to use common sense, Tony, from the business point of view, I know for a fact that there were no additional costs incurred as a result of this contract. In fact, we proposed a savings of over $400,000 but they struck it down, Dr. Lewis and his group in Yellowknife, and said no, we want the per diem thing, the same as what the university had. Our contract is exactly the same as what the university had.

CHAIRMAN (Mr. Zoe): In other words your group is happy.

MS. MAKPAH: We are happy. I just wanted to clarify these inconsistencies in this report.

CHAIRMAN (Mr. Zoe): I would like to continue on. Are there any further comments? Mr. Gargan.

MR. GARGAN: With regard to the Auditor General's report, was your organization consulted in what was done in any way, shape or form? The consultation was done with the government with regard to the response that is in there, as opposed to your organization being consulted to respond?

MS. MAKPAH: If I understand your question correctly, was the Kiguti Board, or the private stakeholders in this contract, consulted? No. I do not think we were. I cannot speak for the Keewatin Regional Health Board.

CHAIRMAN (Mr. Zoe): Mr. Gargan, any further comments?

MR. GARGAN: It should be noted because I think it is important. If the Auditor General is going to be giving a report to the Assembly and he is only telling one side of the story I think we should know the other side of the story.

You have been using the term of hiring people quite loosely. There was an individual practising up here who had A.I.D.S., Carmichael I think his name was. Because you are a private health services agency, how stringent are you with regard to the hiring process? If you are going to maintain not only good dental hygiene and personal hygiene in general, you have to make sure you have to hire the right people for the job. I wonder what are the protection mechanisms that are in place right now for your private company to hire people, dental therapists, dental assistants or dentists, and to ensure that they are in the best of health.

MS. MAKPAH: From the little I know about dentistry itself, all the requirements under the Dental Profession Act are being practised on a daily basis in our dental clinic.

I have a liaison person. Dr. Adams is a partner, and he is one of the individuals who hires the dentists. I cannot because I have no knowledge in dentistry, but I can sit on the selection board and perhaps evaluate the personal suitability of that dentist to Rankin or Baker Lake as to our culture. That is my role. I am involved in hiring clerks, steno assistants and receptionists. They all have to go through a training period with the dentists. I do not know what they do specifically, but all precautions are taken. The professionals are hired by the dentists. They all have to wear gloves and masks, and have to sterilize their equipment every day.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments or questions from the committee? If not, I would like to thank you for making your presentation on behalf of the Kiguti Dental Clinic. Mahsi cho.

Does anyone else from the general public want to make a presentation? If we do not have any further presentations from the general public, then we will adjourn until 7:00 p.m. tomorrow in Inuvik. The meeting is adjourned.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PROCEEDINGS

PUBLIC HEARINGS

INUVIK, NORTHWEST TERRITORIES

WEDNESDAY, JANUARY 27, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

INUVIK, NORTHWEST TERRITORIES

WEDNESDAY, JANUARY 27, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

Kitikmeot Regional Health Boards

Ms. Jean Morrison, Executive Director

Mr. John Naksagak, Vice President

Inuvik Medical Clinic

Dr. Ingrid DeKock, Physician

Mr. Eddie Lavoie, Manager

STANDING COMMITTEE ON PUBLIC ACCOUNTS

INUVIK, NORTHWEST TERRITORIES

JANUARY 27, 1993

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): I would like to call the Standing Committee on Public Accounts meeting to order. My name is Henry Zoe and I am the M.L.A. for North Slave and Chairman of the Standing Committee on Public Accounts. We are very pleased to be in Inuvik. I know that the people of this region are interested in the delivery and administration of health services and for many years the Inuvik Regional Hospital has played an important role in the life of this community.

I will be making some brief comments to tell you a bit about our committee's mandate and the purpose for our travel to Inuvik today. Before I begin I would like to ask my colleagues to introduce themselves and indicate which constituency they represent.

MR. ARNGNA'NAAQ: My name is Silas Arngna'naaq and I represent the communities of Baker Lake and Arviat in the Kivallivik riding.

MR. WHITFORD: My name is Tony Whitford and represent the constituency of Yellowknife South. It is nice to be back in Inuvik.

MR. PUDLAT: (Translation) My name is Kenoayoak Pudlat and I represent Baffin South, the communities of Lake Harbour, Cape Dorset and Sanikiluaq.

MR. PUDLUK: My name is Ludy Pudluk and I represent the High Arctic.

CHAIRMAN (Mr. Zoe): Thank you. The rest of our staff from the Legislative Assembly are the sound people, translators, our researcher and our clerk, Rhoda Perkison. I would like to take a few moments to talk about the standing committee and the work we have been doing on the review of the report of the Auditor General on the Department of Health. The Standing Committee on Public Accounts has been established during the 12th Assembly and was given the responsibility to monitor the way government spends public funds. It is interesting to note that we are not the only jurisdiction in which this occurs. In each Canadian province, the Yukon and in most countries which use the parliamentary system of government, public accounts committees have been established to ensure that governments are acting in an accountable fashion.

In the Northwest Territories, the Standing Committee on Public Accounts uses two approaches to make this happen. Firstly, it reviews the annual report of the Auditor General to ensure that the Government of the Northwest Territories' departments have been spending money according to the way the budget is passed, and they also have to abide by the statutory requirements for the financial administration. Secondly, it can take on a specific review to examine whether the structure and the operation of a particular department is conducive to good management. That is what our purpose is here today and tomorrow.

The standing committee has been asked by the Legislative Assembly to conduct a public review on the report which the Auditor General has completed on a Comprehensive Audit of the Department of Health. We are holding hearings in Inuvik today and tomorrow, and are collecting information from key stakeholders in the health system. We will hear from representatives of the Kitikmeot Regional Health Board who have travelled to Inuvik from Cambridge Bay. I believe we will also hear from representatives from the Inuvik Medical Clinic. Tomorrow, at 9:30 a.m., we will be asking representatives from the Inuvik Regional Health Board and also from the Inuvialuit Regional Corporation to appear as witnesses. If there is anyone from the public who would like to make a presentation please register with Rhoda Perkison, our committee clerk.

The Auditor General's report touches on a number of issues. There are eight chapters within the report. I will not get into the specifics at this time. We have copies of the Comprehensive Audit available. I am sure that I speak for all of our Members of the standing committee when I say that we consider the input from the witnesses to be very important. Too often, recommendations and decisions which are important to communities throughout the Northwest Territories are made in Yellowknife without any significant attempt to get input from others. This winter the Legislative Assembly is making a concerted effort to ask opinions of the people throughout the Northwest Territories about a range of issues that are currently being considered. That is why it has been so important for us to come and meet with you in your own region to discuss the Auditor General's findings regarding the Department of Health.

The Auditor General, in his opening comments points out that "at present health is the single most expensive program in the Northwest Territories and that annual costs of $200 million consume approximately 16 per cent of our entire territorial government budget". Those are big dollars. More importantly the services and programs we are funding have an impact on the daily lives of the people throughout the Northwest Territories. This is why the public review of the Auditor General's report is one which we consider to be very important. It is critical to ensure that the department is running effectively, efficiently, and economically.

In our earlier hearings, this month, we have heard the opinions of the Deputy Auditor General of Canada, the officials who manage the Department of Health, the Board of Management of Stanton Yellowknife Hospital, St. John Ambulance, the regional health boards from the Baffin and Keewatin, the Kiguti Dental Clinic in Rankin Inlet and also one of our fellow colleagues, the M.L.A. for Rankin Inlet, Mr. John Todd. We are looking forward to continuing the review process this evening and tomorrow. We are primarily interested in finding out what people outside of Yellowknife think of the Auditor General's report. After we complete our public hearings our committee will be making a report to the Legislative Assembly. This report will be discussed in the Legislature and if it is accepted a number of our recommendations will be adopted.

I will call our first witnesses, the Kitikmeot Regional Health Board representatives to make their presentation. If the witnesses will please introduce themselves and the organization which they represent.

MS. MORRISON: I am Jean Morrison and I am the Executive Director of the Kitikmeot Regional Health Board.

MR. MAKSAGAK: I am John Maksagak from Cambridge Bay. I am the Vice President of the Kitikmeot Regional Health Board.

Presentation by Kitikmeot Regional Health Board

MS. MORRISON: We thought that I would do the initial presentation and Mr. Maksagak is going to add comments as we go along. In reviewing the Auditor General's report the board has found most of the recommendations and information to be consistent with what they have found since transfer over the last four years. There are a few items in the report which we would not support. There are two areas where we have somewhat differing opinions than what the report outlines. As for the other recommendations which are in the report, we see a number of them that actually stem from two or three main issues, even though they come out in four, five or six different recommendations.

When we were in Yellowknife this morning we met with Pat Lyall who is the Chairperson of the health board. One of the items Mr. Lyall wanted us to bring up, which has been an issue with this health board over the last year and one half to two years is how relationships between health boards and the Department of Health are not generally good relationships and are sometimes confrontational and uncooperative. From the Kitikmeot's point of view, we have not found that to be as much of an issue. Certainly we do not agree on everything that happens on all of the decisions which are made, but we have found a cooperative spirit with the department. We have found that we are able to present our points and work to a common resolution that we are both satisfied with in the end. We would say that in terms of the report, we are not as strong on the point of how difficult it is to work with the department as perhaps some others have found in the past.

Throughout the report we see that it talks a lot about control issues, who controls what, who makes what decisions and has what authority. We believe very much that this has been a problem. There is a lot of confusion that stems from varied and opposing perceptions regarding who has what authority. When trying to get down to the grassroots of who has what authority, we find it very difficult to find it in writing or on paper who the authority belongs to. Given that, this is possibly why we do not place blame on people. It is more a matter of time and direction from a health system which has recently been transferred. The board believes that the development of the M.O.U., which is now being developed, will solve that problem. We expect that the M.O.U. will be very explicit. The health system traditionally has been led by very autocratic leaders. That is most of the examples which health workers and people have had to follow. We believe that it will take a lot of training and education to assist health care professionals and administrators to learn to be less autocratic and more sharing in decision-making.

When the M.O.U. is being developed, the board believes the position for the department should be as a supportive entity. An entity who is there to ensure that we do follow and understand government policies and directions clearly and that they provide us with planning, support and expertise which we require. It would not make sense for each board to have this manpower available. We would also like to see the development of standardized territorial policies which legally protect boards given the fact that we use a service delivery mechanism which is very different than the rest of Canada.

From my perspective, coming from a health background when we look at the fact that nurses are performing a number of medical functions and are dispensing and prescribing narcotics, which goes against federal legislation, the only way as a territory that we can be protected is if we have strong standard policies, so that if any one of us are called to task, the policies have been made on very sound reasoning and we are all following the same policies. I think as we look at midwifery in isolated communities this is the same kind of issue. We have to be very consistent in what we say are acceptable risks for a population which is living far from secondary and tertiary care centres.

Our third point is looking at the need for rationalization of fund distribution. To do this we have to have very sound information systems. This came out strongly in the Auditor General's report. We need to look at population indicators, health status indicators, health conditions and the different distances which are travelled within boards. This makes a great difference to the budgets within each board. We strongly support the development and integration of a better information system which is easily accessible. Right now, when we try to look at how much money we are getting, and are we getting an equal distribution of money, all we can do is divide the money that we have received in a given year by what other regions have received. In doing that, we come out with a figure where we have about $400 less per capita in terms of budget dollars than other regions who provide similar services to us. For example, services without a hospital or without long-term care facilities. If that is the only indicator you have to look at, certainly it does not look like an equitable distribution. If you do not know for sure if there are other factors involved, that means that other regions need $400 more per person and it makes you sit back and feel somewhat resentful wondering who distributes the money.

The fifth point, which we strongly support, is the employment equity policies in the hiring and training of aboriginal people. In our last OPPLAN submission, and again this year, we will be

asking for increased person years to increase our support staff so that we can redistribute some of the workload. We would like to move back into that, but in order to do this we will need training dollars. There must be a greater emphasis on training within boards.

In the report, the Auditor General mentioned that the health careers promotion officer position could be deleted. From our board's perspective, and we have a very slim administrative staff, if we did not have that position in Yellowknife doing a major portion of the nurse recruitment review and summarizing, we would be in a real bind in trying to get staff at this point. We do not have the resources to put the time into the job which is done by that person. I know there are some other boards which use this position extensively, but for us, this is a key role to changing a lot of the ideas of who can deliver different types of health care, how to recruit and how to develop training systems for health people within the Northwest Territories.

Those were the main concerns which we wanted to point out. John may have something he would like to add.

MR. MAKSAGAK: I think Jean has covered most of the things we wanted to. I would like to add that when you go out to recruit nurses, it would be nice if one of the board Members was able to go with the recruiter. This would allow us to hire the person that we want. This is very important. People ask us why many of the nurses came to our community. It is not right for people to say this. If we, as a board, can play a part in the recruitment process, we would probably get better nurses in the north to work with our people. Quite a few years ago, when I was with Education, we went out to recruit some teachers. This enabled us to get the type of teachers that we wanted. I think this is a very important step.

CHAIRMAN (Mr. Zoe): Thank you. I have a general question. In section two of the Auditor General's report, there is reference made to "The N.W.T. Way". Can I get your perspective of what "The N.W.T. Way" is? Do you know what it is?

MS. MORRISON: That is interesting because over the last year our board has been discussing a stronger emphasis on health promotion and developing a health care team which would take more direction from the local level. For example, meet with hamlet councils, and provide and deliver services the way the hamlet council wants it delivered.

From my perspective, and because we have already started in this direction, "The N.W.T. Way" is very much following along those lines. To health professionals, it is taking what they call around the world, "primary health care" and applying the primary health care model in the Northwest Territories. We are operating with great distances and with people who want to be involved in making decisions about what happens in their communities. This is what "The N.W.T. Way" is to me, taking all of the philosophy which goes with basic health care and trying to implement that in the Northwest Territories.

CHAIRMAN (Mr. Zoe): You look at this particular model as a base which you can implement new initiatives and build on it for your particular region. Is that what you are saying?

MS. MORRISON: Yes.

CHAIRMAN (Mr. Zoe): This is what your understanding of "The N.W.T. Way" is.

MS. MORRISON: Yes. That is my understanding. I think the basis of "The N.W.T. Way" is that we provide services in the most cost efficient way, given the way in which the community wants the services provided and what services they want and need.

CHAIRMAN (Mr. Zoe): I have another question pertaining to "The N.W.T. Way". Have you received any documentation from the Department of Health pertaining to "The N.W.T. Way"?

MS. MORRISON: Only draft documentation which was presented in June 1991. The documentation probably did not come out in 1991. The first I time I heard about it was at a meeting in 1991. Some time last winter we received basic guiding principles of what "The N.W.T. Way" would encompass.

CHAIRMAN (Mr. Zoe): I wanted to find out if there was any input from the region in developing "The N.W.T. Way"? Did your region have any input in developing "The N.W.T. Way"?

MS. MORRISON: Not prior to receiving that documentation. After we received the documentation, we went over it at the board level and reviewed it. We made some comments on the first information which came out. We have not received anything new since that time.

CHAIRMAN (Mr. Zoe): Do any committee Members have any questions or comments? I have one more. You mentioned the M.O.U. in your presentation. It is my understanding that the Department of Health made a presentation to the N.W.T. Health Care Association. There were 15 points outlined to be included in the M.O.U.s which are supposed to be developed between various boards. Did you have any input in developing these 15 principles? Did you comment on what was presented to your board?

MS. MORRISON: We did comment on what came out in the package of information. Our understanding was that the document was prepared by taking information from various other reports which had been completed. We did not have direct input into what went into it.

CHAIRMAN (Mr. Zoe): Do you feel that the 15 major elements are adequate?

MS. MORRISON: No, I think in some ways they leave out some key points. In some respects it is not going to be specific enough if we just look at the 15 key elements which were outlined. From the board's perspective, we would want to see the M.O.U. developed by a third party or someone more removed from the situation. I think it would be very hard to develop it internally between the department and the boards as it now stands.

CHAIRMAN (Mr. Zoe): Does the Kitikmeot Regional Health Board have anything in place pertaining to M.O.U.s between the Department of Health and your region?

MS. MORRISON: No, we do not have the Commissioner's Agreement. We had an agreement in 1988 with various service departments. We did not have another agreement or, I have

not seen another agreement, that we have with the Department of Health about who provides what services or control.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. In your presentation you talk about the relationship between the board and the department. The Auditor General's report says that some relationships work well and some do not. There is quite a variation. Boards are important. They get the message to the department regarding what level of service should be delivered in the region. It is refreshing to hear the degree with which your board seems to work with the department. However, the Auditor General's report comments on the need for board evaluation, because some boards work well and others do not. I am not sure whether or not there is a process in place to evaluate the performance of the boards. I wondered how, if at all, this should be carried out. What does your board do to evaluate the board's performance and operation?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: Currently we do not have a mechanism in place for evaluating our board's performance. Given that we do not have an agreement with the department on who has what explicit authority, it is difficult to evaluate the board's performance. On item by item we do not know until it comes up how far things can go. The board supports this, once we know exactly how much accountability we have as a board.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. It is true that there has to be an agreement between the departments and boards as to what their roles are. Performance standards for these boards, as you pointed out, should be the same across the territories with minor variations to take in regional concerns. Would there be benefit from a standardization of board evaluation and protocol to be used across the territories?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: I think Mr. Maksagak may want to comment on this. From an administrator's point of view, I believe there would be. I think it would give people a lot more direction and desire to take responsibility and control if we knew we were going to be evaluated on what we are doing and how we are doing it. We would need some training. Our board has had very little training in terms of how they should be making people accountable, myself included. It is a very difficult process at present.

CHAIRMAN (Mr. Zoe): John.

MR. MAKSAGAK: I think when we joined the board, we did not know exactly what we were supposed to be doing or what authority we had. That is one thing we would like to know. As a board, we sometimes do not know what to do because we have never been trained to be members or a board. I think that if there was some training, we would gladly take it. It would give us more perspective on authority. We should have training across the territories.

CHAIRMAN (Mr. Zoe): Thank you. The Department of Health has a trustee manual which they put out. Has this ever been given to your board for its members?

MS. MORRISON: Originally, when they were appointed to the board, they were given manuals. John.

MR. MAKSAGAK: I do not think we ever received any manuals.

CHAIRMAN (Mr. Zoe): I think it is called a trustee handbook.

MS. MORRISON: Yes. There are two volumes of the trustee handbook.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: Thank you. I would like to go back to the discussion regarding evaluation. All of the boards have meetings from time to time. I understand that they have an annual meeting. Do all of the boards get together from time to time?

MR. MAKSAGAK: I do not think that we have ever had all of the boards from the region together to meet. We have never done this.

MS. MORRISON: There was a call at one time. I have been with the board since 1990 and there was a request for board chairpersons to get together, but that has not happened.

MR. WHITFORD: I was curious. That would have been an excellent place for all of the boards to get together and discuss these concerns without the department present.

MS. MORRISON: I think the only time one of our board members has been to a meeting was an orientation which our new chairperson went to last year.

CHAIRMAN (Mr. Zoe): Are there any other comments? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. You have indicated that with respect to the M.O.U., you would prefer to see a third party create a draft. I do not understand. Am I correct in saying this is what you would like to see?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: Yes. To me it would be by a third party who would develop the draft in consultation with the departments and the boards. I believe it should also go to the Legislative Assembly or the Special Committee on Health and Social Services to decide if this is the kind of relationship they want to see between the department and the boards. I think this is the bigger issue, what the representatives of the people believe the relationship and the authority should be, versus what the boards and the department believe it should be.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I am finding this different from the responses which I have heard from the Keewatin and the Baffin

regions. They seem to be taking a much more aggressive route and are saying that we should come together.

Do you receive any requests for financial information from the department, either from their reports or your reports?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: We receive requests from various divisions within the department, but not just related to financial information. We receive requests for information regarding statistics on immunization, clients seen or how many clients with various conditions. We receive a vast array of requests for information. This information is not easy to collect. We do not have systems in place to collect this information. Our systems are all manual systems. We are very careful about what information we decide to collect because it is too cumbersome given the systems we have.

CHAIRMAN (Mr. Zoe): Silas.

MR. ARNGNA'NAAQ: Do you have any idea how much time or dollars would be used in trying to answer questions which are asked by the department?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: I know that one exercise, where we were gathering information on immunization, we calculated we used one month of person time to gather this information which was required in five days. That year, we did three of those exercises within the health centres. This was information which had to be gathered at the health centre level. In terms of within regional office, at any given time, we are preparing some information to go to Yellowknife.

CHAIRMAN (Mr. Zoe): I would like to follow-up on Silas's question. Are you not using the H.B.I.S. system in the Kitikmeot?

MS. MORRISON: We are using the H.B.I.S. financial system. We down load the financial information onto Lotus so that we can manipulate it more easily on personal computers. That gives the dollar information related to our expenditures and budget on a group basis. However, if someone wants specific information about how much it costs us to provide a specific program or wants a report with a different format, it is all done manually.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Pudluk.

MR. PUDLUK: Thank you, Mr. Chairman. The Auditor General's report talks about board members and that not very many of them have previous experience. He touches on the board members and the lack of resources for board training and development. What are your views in this area of membership training?

MS. MORRISON: Do we have training for people who are coming on the boards?

CHAIRMAN (Mr. Zoe): I think what my colleague is saying is that the Auditor General made some comments pertaining to board training and development, and the lack of resources for this particular area. What are your views on this matter? He comments that there seems to be a lack of resources for board training and development.

MS. MORRISON: We have no specific resources allocated to board training and development. The only money which has been spent on this, is the money to send the new chairperson to Yellowknife last year. Yellowknife reimbursed us because we do not have the money. Probably internally we could do more work with the handbook and do a regular training program based on that at board meetings. However, this has not been a practice to date. We do not have funds or much time dedicated to board training.

CHAIRMAN (Mr. Zoe): What type of training or development needs exist within your board? If there were to be resources allocated, how could you improve what the board is doing? Ms. Morrison.

MS. MORRISON: From an administrator's point of view, I think it would make it much easier for the board to evaluate and know what questions to ask me because they do not have a health care background in terms of what kinds of programs we should be delivering, how we should be evaluating our programs or needs. Currently our board does not have the background to do this. They can only rely on me in terms of what I am telling them, and hope that we are providing the quality of service that we should be. They have had no training or background on quality assurance or what kinds of audits should be done and what those audits would tell us. Even in terms of reading some of the financial statements, they are very cumbersome and detailed.

CHAIRMAN (Mr. Zoe): I would like to ask John a specific question with regard to board training. What do you see as the type of training the board requires?

MR. MAKSAGAK: Thank you. I think we are talking about training of the board members. You cannot train a board member without financing. We need money to train them. There are times when we ask the director what certain things are and what they do. The words are so long we have no way of understanding what it is we are reading. If we are going to be trained, we must be trained like any other trainee. The board need to know the financial aspect. Sometimes the board members do not even understand the agenda. We have to be trained.

CHAIRMAN (Mr. Zoe): Thank you. Am I correct in saying that through this board training, you would want to get trained with regard to the roles and responsibility of a board member as a trustee and also be able to read financial statements and medical terminology? To be able to have this type of workshop by the Department of Health so the board members are well aware of certain programs within the Department of Health, and also what role the executive directors are suppose to play. Is that the type of training you are suggesting?

MR. MAKSAGAK: I think we are talking about training in finances and all these other things. Some of the board members have never been to school and some training, or a workshop, would be good for their understanding of what they need to do. Sometimes I do not understand the terminology

of medical terms. I think that would make us want to be a board member a little more. Sometimes because of misunderstandings, we get frustrated and quit.

CHAIRMAN (Mr. Zoe): Earlier on, John, I asked Ms. Morrison her perspective of "The N.W.T. Way". Does the board know what this model is? Do you know, John, as the chairman? It is quite complicated and we are hearing that from a lot of other boards.

MR. MAKSAGAK: It is complicated.

CHAIRMAN (Mr. Zoe): Nobody really knows what "The N.W.T. Way" is. Are there any further questions or comments from the committee? Silas.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. Somewhere in the middle of your presentation you indicated that there should be more data or that there is uneven data coming in. Is that what I understood you to say? There is information going to one board that is different from what is going to another board from the Department of Health?

MS. MORRISON: I do not think we get different information. There is not a way of gathering good information and distributing it to us. I think sometimes one board gets information that another board does not get as an oversight. Maybe when one board has a question that would be pertinent to all boards that information does not necessarily go out to all boards. We then end up going through the same things again, when we come up with the same problem.

MR. ARNGNA'NAAQ: You were saying you have a manual system of keeping track of things, so you do not have any computers in your head office?

MS. MORRISON: In head office we have some computers. Our secretaries are just getting computers. In terms of keeping statistical information from the information sent in from the health centres, it has all been manually tabulated in the past. It is only if we can get some adequate training on the computers that we will be setting up some computerized information systems. The information would still come in from the health centres. It would still be, at this point, collected manually in the health centres. Where it is already collected once and sent to Yellowknife they would be collecting again to send to us so we could set up a database. We really hate to have that duplication of information gathering and distribution.

MR. ARNGNA'NAAQ: Are the computers you have at your office compatible with those that they use in Yellowknife?

MS. MORRISON: We have ensured that all the computers we have bought are compatible with what is in Yellowknife. The programs we have been buying are the basic programs, the same as what is now used in Yellowknife.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. Do you find that the systems you are using now are adequate for the kinds of information they are looking for? Would you work with another system if it was going to be better, or do you know of another system that would be better than the system you are using now?

MS. MORRISON: I do not know specifically of another system that would be better, but I am sure there has to be a system that would be easier and better than what we are using now. There are ways to link with Yellowknife for information movement and generation. If we could do one set of data input, it would be a much better information system.

The only computer information we gather now is the financial information. To get into the H.B.I.S. financial information on a computer, unless you are doing it every day it is not an easy system to remember how to use.

CHAIRMAN (Mr. Zoe): I will follow-up on your question. You are quite comfortable with the H.B.I.S.?

MS. MORRISON: I am used to H.B.I.S. When I need to find something out, I ask someone to help me get into it and find the information I need, but it is more cumbersome than I would like to see.

CHAIRMAN (Mr. Zoe): I would like to backtrack on my question. When the regional board was considering implementing a system, did the Department of Health consult to see what system you people wanted, or was it driven from the Department of Health that you have to have this particular type of system?

MS. MORRISON: From what I understand, the H.B.I.S. system was actually driven from the Department of Finance. Once it was developed then the Department of Health supported and encouraged us to go on H.B.I.S. In Cambridge, it was the Department of Finance who strongly supported our using H.B.I.S. because they felt they could support it and answer our questions more easily as it was the clone of F.I.S. and easy for them to understand.

CHAIRMAN (Mr. Zoe): I am quite surprised because there are other boards that use different systems. For instance, Stanton Yellowknife Hospital uses the M.H.O. system, the Manitoba Hospital Organization system. I believe the Baffin does too. They have not switched over. There are a lot of problems in the system. There are a lot of systems that are not compatible. I think the Auditor General's comments on that were that they should try to standardize, but with everybody's input to see which system is the best.

Earlier on in your statement, Ms. Morrison, you touched on the issue of relationship between the board and the Department of Health. You indicated that generally they are in good cooperative spirit. You also commented that the people in the Department of Health were autocratic people. Could you explain that because I do not quite understand what you meant by that? Give me some examples.

MS. MORRISON: I did not mean that just the people in the Department of Health were autocratic. I think through the health system, we have many autocratic people because in health care there is an attitude where people think they know what is best for other people. I think we see that in the department and even within the boards. I think that is an attitude that has to change all the way around. With the

department, I believe they have more control and authority than what we, as a board, think they should have. Is it maybe somewhat because they are autocratic? I do not necessarily see them as an empire, but I do think they believe they know better than we do.

CHAIRMAN (Mr. Zoe): If I understood you, Ms. Morrison, you are saying in any type of health system there appears to be those people in place. You are suggesting that it happens in our own system here in the north. Am I correct that it happens in every system, so obviously it must be happening in ours, too?

MS. MORRISON: Yes, from my experience I believe we have it here.

CHAIRMAN (Mr. Zoe): That is quite interesting. Could I get you to elaborate a little more in that area, the attitude? Give me some examples if you could.

MS. MORRISON: Within the board the kind of examples we see are, for example, at the local level they decide on what clinic times we will have and who we will see at what time. In health centres, the people who are working there are quite controlling and say "you must come to the health centre for certain services between this time and between this time." Yes, it is done somewhat in the name of efficiency, but they do not see that as a way of being controlling and controlling people. Maybe we should be going out to the community and finding how people want the services delivered and when.

I suppose some of it is because there is not a standard funding base, but once the department has given the board money to spend, it is up to the board how to spend it. Monthly or quarterly, when we are sending in reports and we say "this position has not been filled" and they say "no, we do not have that money because we are using it to do something we have needed to do for the last three years." When you have to do those explanations month by month and week by week, you spend a lot of time and energy on them. They see that as accountability. I see that as control. Once they have decided how much money the board should have, then the board has to decide how that money can best be used. There are things that do not have to be done every year, but at some point you have to spend money on them and I do not expect the board should have to answer all those specific kinds of questions. I think that is the board's accountability. The department sees that as accountability, to me it is control and it is saying that the board does not have the ability to make those rational decisions or they will not make the right decisions.

CHAIRMAN (Mr. Zoe): Ms. Morrison, are you suggesting that the boards should have more autonomy? Do you think through this M.O.U. that you will accomplish your 15 major elements that are outlined?

MS. MORRISON: Looking at the 15 major elements that are there, I am not sure that is what will be accomplished. Yes, I believe the board should have more autonomy, and then there is a specific way for being accountable for that autonomy.

CHAIRMAN (Mr. Zoe): Mr. Pudlat.

MR. PUDLAT: (translation) I will be speaking in Inuktitut. I think I may have misunderstood, in the report there is a section that describes health boards and their perceived lack of proper operation. I think you are saying that you do not have enough powers and responsibilities. This was reflected as the trend. I may have misunderstood on that part. Did I understand you correctly when you said many people think that health boards are not able to operate properly? What is your thinking on that? Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: I remember that point from the report where it talked about people indicating that boards did not have the ability or the background to have control or responsibility. I was saying that they should have more power and responsibility. I think it is patronizing to assume that someone cannot make appropriate decisions for themselves, so sometimes the right decisions are not made or we have to go back and do it twice. I think we gain a lot more and learn a lot more from that, than always having somebody give us all the direction and tell us step by step how we should operate and the direction we should go in. Otherwise, we are never going to grow and we are never going to learn how to take those responsibilities and make those hard decisions, even if there are problems on the way.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. As you are aware, the government is decentralizing some of the services and the Department of Health is decentralizing part of its operations to the regions. I wonder if your board is going to benefit from decentralizing the health insurance division currently operated out of Yellowknife. Will you be benefitting at all by this move?

MS. MORRISON: No, it will not be any benefit to our board that I can see. One of the decentralized positions, the health promotion officer position is coming to the Kitikmeot board. I do not know what impact the decentralization of the insurance board would have for us because I do not know how they are going to split between the two centres. It will change where we send information. It will mean the need to reorient ourselves as to whom to contact when we have questions.

MR. WHITFORD: Do you think your board would ever be in a position to take over direct responsibility for the H.I.S. payments?

MS. MORRISON: Do you mean decentralizing in a manner that our region would look after making those payments?

MR. WHITFORD: Yes, transferring the responsibility to the board.

MS. MORRISON: In our region those payments are very small. We have, in terms of insurance systems, we only have one medical clinic and one other physician who services our region, then the people who would go out of territory and out of region. I do not see what the benefit would be of decentralizing to the board level because I think given the amount of work it would generate, it would take a lot of people

to learn a service that can probably more efficiently be done on a larger scale.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments or questions? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Further to the question that Mr. Whitford just asked, I would like to know is there any part of the department that would be beneficial to the board in your region if it was decentralized?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: There are many services that would be nice to have at the board level. However, I am not sure of the economic or efficiency benefit of doing it at our level given the size of the board. Certainly the health promotion officer position coming out has been very useful. Possibly some information system decentralization would be useful to us because we have no one that acts in that general capacity.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. Going back into the health insurance services division, in the Auditor's report they mention the hospitals and health facilities division, the health insurance services and the financial administration division being consolidated. What implications would putting those together have on your board?

CHAIRMAN (Mr. Zoe): Ms. Morrison.

MS. MORRISON: I believe it would be easier because currently we end up calling two or three places. We will receive requests for information from different places where that group was consolidated. It would make good sense because they could more easily access one another's information. It would be a more comprehensive group to work and deal with.

In terms of the last question, we have not really looked at decentralization of specific services, other than program delivery type services. How those would be a benefit to the board, that is not something the board has discussed or thought about at this point.

CHAIRMAN (Mr. Zoe): Are there any further comments? If I could, I will ask Mr. Maksagak a question pertaining to power of the boards. Yesterday, in Rankin Inlet during our public hearings, the chairman of the Baffin Regional Health Board, Mr. Eckalook, indicated that he had the impression that the Department of Health did not want to give boards more power. He felt that because their board members were aboriginal. Do you agree with his statement?

MR. MAKSAGAK: I think I agree with him because Mr. Pudlat was asking a question about how much power or how many things we are supposed to have. From the Yellowknife point of view, when they appointed us for the board they told us we have power to do things and power to control, but I think most of us never understood how much power we had. Sometimes they take away the power that we should have. They said we have power to do this and to do that. I agree with what you just said.

CHAIRMAN (Mr. Zoe): All right. Could I get you to comment a little more on the whole issue of board autonomy. What other powers would your board like to have? I understand that the board does not really know where it stands at the moment. Are there specific areas that you would like to see the board have? Which areas would you like to have more power? Would it be in recruiting or in human resources?

MR. MAKSAGAK: To have more power is something we have to talk about together. When we agree to have more power, then maybe we can do more things. Right now we do not really know where we sit with what we have. When they say something, can the health administration follow it up? I think you are asking us things that we really do not know right at the moment. We need to get all the regions together and then maybe we would know more about how much power we have.

CHAIRMAN (Mr. Zoe): All right. Ms. Morrison, can I ask you another question pertaining to funding. You indicated you would like to see more equitable distribution of funding. Can you elaborate a little more? How do you see that? It appears that the funding process that is now in place seems to be inadequate from the comments you have made. How can we improve that, in your view? What would you like to see?

MS. MORRISON: I would like to see more standards in place that lay out the funding. I know it is difficult to do, because boards provide different kinds of services, because some have hospitals and some do not. I think there has to be standards laid out that allow you to include that. If we look at things such as how much does it cost to provide services in a region that has a lot of conditions? We can look at health conditions that cost a lot to care for. We would have to look at what the health status is and say "this region has 30 people who have kidney disorders and that is going to cost "x" dollars per year." Each region needs to make a certain number of supervisory visits by different personnel to health centres, and given the distances and travel costs in that region, that will cost this much. There should be a standard for education and training. You have this many of this group of workers and this many of this group and it is expected that they will receive a certain level of training and that the dollars are laid out based on those standards. It is now laid out, as the report says, based on historical spending. Because it is very difficult to get information that is really solid that proves that a given board needs more money, it is hard to get better base funding right now than what a board already has. The base is not equitable at this point, it is not established on common needs or standards from region to region. I think the whole thing would have to be readjusted.

CHAIRMAN (Mr. Zoe): I understand what you are saying. You are standardizing various programs and services you are funded for. Other boards have indicated there is a possibility of getting block funding. Would you see that as a suggestion from your board?

MS. MORRISON: Sure, if it is was per capita block funding we would be better off because we have the lowest per capital funding currently. From our perspective, either those other boards would end up with a lot less money or we would end up with a lot more, so I would not have a problem with that. I do not know, given the population of the Northwest Territories if that is an equitable means. Because the population is relatively small, you could have one area that had a very

serious health condition that was very costly, and would it be fair to block fund that small area the same as another area that just by chance does not have that same health problem? I would be concerned, given the small population, that block funding truly would do the job, but I think it would be more equitable than what we have now.

CHAIRMAN (Mr. Zoe): I guess block funding could be based on programs, rather than per capita. It was other boards I made that suggestion to.

MS. MORRISON: I would have to see how it is laid out. I think even block funding by program, if you have very different distances and population sizes...

CHAIRMAN (Mr. Zoe): Yes, that would have to be taken into consideration, but with block funding, if you get into deficit, then you have to live within your means. Then with the following year's block funding, you would have to eat up your deficit. Right now, I believe, if there are any surpluses by the boards, they are automatically taken back by the Department of Health.

MS. MORRISON: If it was equitable block funding, financially we could not end up worse off because we have the lowest funding right now.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? If not, I would like to thank the representatives from the Kitikmeot Regional Health Board for appearing before us. Thank you very much.

MR. MAKSAGAK: Before you quit maybe I could ask a question?

CHAIRMAN (Mr. Zoe): Sure.

MR. MAKSAGAK: Nunavut is coming. We need training now. How can the Health put in more training, with Nunavut coming into place? I am asking because it will take ten years or so, but ten years is not very far. Even 15 years is not very far. I am concerned about how much training our native people can get.

CHAIRMAN (Mr. Zoe): I am from the west, so I will let my eastern colleagues comment first before I say anything. Silas, Ludy or Kenoayoak? Silas, can you comment on the training needs for the creation of Nunavut from your understanding as to how or what is suppose to be happening in the Department of Health?

MR. ARNGNA'NAAQ: I think that all regions are asking the same question, where can we find funding for further training? I know T.F.N. is coming out with some training funds. That, I think, comes from their T.F.N. agreement. Other than to say that we, as a territorial government, would be able to find funding for further training, I do not know. Being only one Member of 24, I do not know how to respond.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Pudlat.

MR. PUDLAT: (translation) Thank you, Mr. Chairman. I have a brief comment to try and answer this. Yes, Nunavut is coming and the training that is suppose to be in place we have been talking about in the Legislative Assembly. Also T.F.N. has been discussing it. I cannot say exactly what we are going to say, but I agree that we will have to train the aboriginal people so that the aboriginal people can govern themselves, especially what we have been discussing tonight. I cannot say exactly what is in place. However, we will have to start planning that. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): I think that particular question, in my view, is quite important. I think they have to be raised at the earliest time as you are doing now. The Legislature has a special committee set up to deal with health and social services. That particular question should be posed and commented on to that committee, so that issue could be commented on in their report. I think your question should also be directed from the board to the Government Leader, and it should be copied to Mr. Kakfwi so his department is also aware. The T.F.N. people have the Nunavut Implementation Commission. I think that particular group would be considering those types of issues you are raising now. I believe it would be part of their mandate to take a look at what is required for Nunavut. If you board has strong concerns in that whole area, those are the people to write to and raise your concerns with; the Government Leader; Mr. Kakfwi; our Special Committee on Health and Social Services; and, also the Nunavut Implementation Commission. I do not know if that is set up or not yet, but I think they are in the process of setting it up.

MR. MAKSAGAK: Thank you. We will write to them in our next meeting and see what answers we can get. Thank you very much.

CHAIRMAN (Mr. Zoe): Thank you. Thank you for appearing before us. We will take a short break and then we will reconvene.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): For the record, could you kindly introduce yourself?

Presentation by Inuvik Medical Clinic

MR. LAVOIE: Mr. Chairman, and fellow Members of the standing committee. This is Dr. DeKock and she has been with us at the clinic for three years. My name is Eddie Lavoie. I am the manager of the medical clinic. On behalf of Dr. Fellows, I would like to apologize that he was unable to be here. He is the owner of the medical clinic, but he expressed his wishes to me and, hopefully I will be able to do justice to him. I will initiate the presentation and Dr. DeKock will answer all your questions.

It is, of course, a lot easier to criticize the health care system than to devise a better one. The Inuvik Medical Clinic desires and is committed to enabling the Inuvik Regional Health Board and the Department of Health in realizing its goals and objectives.

The Inuvik Medical Clinic has always endorsed and supported the five principles of medicare as expressed in the Canada Health Act, which are: comprehensiveness; universality; portability; accessibility; and, public administration. There is

nothing in the Canada Health Act which appears to prohibit contracting out any health care services to private industry. To date, the Government of the Northwest Territories has not confirmed the five principles of medicare by enacting them in legislation. We believe that it is important that the Government of the N.W.T. take the first step to make these principles an integral part of N.W.T. law.

By talking and listening to people within this region, we have arrived at a set of simple guidelines which along with the five principles of medicare, we believe are necessary for a vibrant health care system in this region in the N.W.T.

1. The public first. Public servants must always put the public's interest ahead of their own.

2. Home sweet home. Medically necessary services must be provided in or as near to the patient's place of residence as is consistent with quality and cost-effective health care. For example, more of the medical services needed by the residents of Inuvik should be provided in Inuvik and few in Yellowknife. More of the medical services needed by the people of Fort McPherson and Tuktoyaktuk should be provided in Fort McPherson and Tuktoyaktuk and fewer in Inuvik.

3. A time for change. The focus of the health care system must be on providing those services which improve health outcomes. These outcomes must be defined, measurable, subject to analysis and able to be independently evaluated. Services which cannot be shown to improve health, should not be funded by the health care system.

4. Self-determination. Decisions should be made as close to the community level as possible. Local people must be allowed to shape the local system of health care delivery. Government should be prepared to fund coordinators and to encourage the creation of health boards. If it attempts to force local citizens to participate in schemes designed by Yellowknife, then health delivery programs will be failures.

5. The wall. Administrative walls within the ministry of health, health care institutions, private clinics and educational institutions must be broken down in favour of an integrated health care system.

At this time, I would like to address the specific references made to the Inuvik Medical Clinic in section 3.4 of the report. I quote verbatim, "In the absence of a master health care plan, policies may be working at cross purposes. For example, since transfer, doctor cutbacks in the Inuvik Regional Hospital has lead to the Inuvik Medical Clinic picking up the slack with a complement of five doctors. They work out of the clinic on a fee-for-service basis and are doing some work that could be carried by nurse practitioners in the region. The costs supporting the clinic are significantly higher than nurse practitioners. The department noted no observable health benefit from the Inuvik situation.

Also, the department was concerned about damage to the delivery system where the expectation of the population is based on high cost doctor services, when nurse practitioner services would suffice."

Our concerns are that the department noted no observable health benefit from the Inuvik situation. It is the Inuvik Medical Clinic's position that this is a flagrant misrepresentation of the Inuvik Medical Clinic and the people within this region. This can be verified simply by talking to people within this community and region. Before the clinic came into existence, the hospital recruited approximately 360 physicians in a ten year period. In the six years since the Inuvik Medical Clinic has been in operation, there have been approximately 25 physicians hired. This would include locums replacing physicians who are on vacation and/or seek to continue their education.

The concept of the clinic was given birth because of a continual complaint. The need to focus on family medicine. The high turnover of physicians at the hospital interfered with the consistent treatment of patients. My wife had six different physicians in a nine month pregnancy. Yellowknife has always had the family practice clinics. They do not understand the frustration the people within this region experience due to a lack of medical continuity. These two examples also heighten the problem of medical records and their lack of consistency, not to mention the danger of legal liability. We believe that the focus on family practice is essential and that the Inuvik Medical Clinic is the result of pragmatic concerns within this region. As we stated at the Native Health Round Table Conference, when you are in need of health services, you need to be respected and you need to be treated with dignity.

The department was concerned about damage to the delivery system where the expectation of the population is based on higher cost doctor services when nurse practitioners services would suffice. We do not believe that damage was inflicted on the delivery system within this region. However, we do confirm the need for the development of an articulated vision and a clear direction for the health system in the N.W.T. The problem with the above stated as expressed by the audit report, is the belief that there is unlimited billings. Private practice has allowed the north to be competitive and to attract quality physicians. Although fee for service monies have increased for doctors, the money spent on keeping them have decreased. For example, the Department of Health was responsible for transportation, hospitals hired physicians from England and Newfoundland and found them housing, the cost of recruitment, advertising, government benefit packages and removal packages. The above examples are now financed by the Inuvik Medical Clinic.

Let us not forget that the Inuvik Medical Clinic and health transfer opened at the same time. By having quality physicians we have aided the Inuvik Regional Health Board and the Department of Health in saving considerable costs on medevacs and transportation. How can anyone in sincerity point a finger and say that one department has been more responsible for cost savings than another?

We recognize the burden on the health care system. One key point in creatively working to eliminate the burden is to pick logical boundaries rather than imposed viewpoints from Yellowknife as to what the boundaries should be. The logical solution is not to replace physicians with nurse practitioners,

but to have them work together. It is not a question of either/ or but the ability to transcend pragmatic self-interest and to enhance system integration, coordination and to ensure data compatibility by establishing common boundaries for health related activities. Specifically, we see the clinic providing physicians who will act in a more consultant role. To a great degree this is already in effect within the communities. Nurses are the prime care givers and offer patients adequate and at times exceptional care. However, we must not lose sight of the fact that physicians are still legally liable for the patients. Though the nurse would be responsible to examine and treat the patients under the guidance of physicians, the physician may not have direct access to the patient, but they are still legally responsible for that patient.

The cost for physician services would be considerably less, but still exist. This model has been implemented to some degree in the communities within this region. If this model is implemented in Inuvik the total number of doctors in Inuvik could decrease. It is important not to lose sight of optimal medical care and the need for nurse practitioners to have continued training. Unfortunately, there are only two schools in Canada that train nurse practitioners.

In summary, I firmly believe that there is enough evidence that a marriage between what is perceived to be two opposing systems would provide medical services at a lower cost. We are fully aware that change is difficult and that we will all need our passports to reality stamped on a regular basis. This requires physicians to broaden their perceptions about nurses and vice versa. Physicians enjoy both personal and professional freedom, but do not shy away from hard work. Financial reward in planning is the result of their schooling in self-discipline. Physicians are often hesitant and frightened about the implications of being an employee. If the ministry of health should decide to shift away from fee for service towards salaried physicians, then they should encourage funding for community-based clinics with employee salaried physicians that may have direct links with either specialists on contract to community-based health centres.

Many others within this region have continually expressed concern regarding the quality, mandate and the management of the delivery of medical programs. Unless we settle on a decentralized model for the health system in the N.W.T. we will not be able to address the particulars of health at a cost savings but will also lose sight of the broader picture which includes lifestyle, both personal and social and the housing problems we face in the N.W.T. Private industry is a constant reminder that only by cutting the strings of government dependency can we empower the system to move beyond expensive band-aids.

On behalf of Dr. Fellows and all of the physicians at the clinic we are committed to working with the Inuvik Regional Health Board, hospital, nursing stations and the people within this region in rediscovering appropriate levels of resources to ensure solutions to the problems which exist are the present requirements. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Are there any comments or questions from committee Members? You made reference to salaried doctors in your statement. Can you elaborate with regard to salaried doctors versus fee-for-services?

MR. LAVOIE: Yes. I did mention fee-for-service physicians in a couple of different areas. The comment I made was that the cost had gone up in one area, but had decreased in another. I also made reference at the end with regard to private industry in relationship to physicians becoming salaried. If that was a possibility in the future, then what should happen is that clinics who hire salaried physicians, if this is the direction the N.W.T. takes, should be supported and sponsored in bringing this about.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: In the Auditor General's report there was a reference to "The N.W.T. Way". Have you heard of this? Do you have an understanding of "The N.W.T. Way" for the delivery of health?

MR. LAVOIE: In all honesty I have never seen the report. After the first speaker I asked someone exactly what it was. I have heard rumours about it. Presently we live in a society where we are looking at the Strength at Two Levels and decentralization and that the health system would possibility fit in there somewhere, removing itself to some degree from physicians being the prime care giver to nurse practitioners. This is a grey area which has not been defined. This is all that I know about it. I have never seen the document.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: I was intrigued with some of your more broader initial statements about bringing the medical service to the people, instead of the people going to the service. I have been to both. If we had all the money in the world we probably could do precisely that. I wondered to what degree do we level this out at? Instead of going to Yellowknife we will go to Inuvik, that is just creating another Yellowknife. Then you went on to say that instead of going to Inuvik we will deliver the service into McPherson, then the people in Arctic Red River say they do not want it there, and the people in Snare say they do not want to go to Yellowknife. Where do you draw the line?

MR. LAVOIE: In all honesty, from a management perspective, and Dr. DeKock would have to answer that from a medical perspective, the line for empowerment is a fine line. In all honesty, I do not know where that is. I do know we live in a time when all people want to be empowered and all communities want to be empowered. The way to define that is, obviously you cannot duplicate costs and you cannot in fact make one centralized over the other, but at the same time people realize there is a certain reality. I think that basically all people are willing to change. When I look specifically with regard to people, I know where the health programs affect them directly, such as the patients and the doctors. How do you get people to see each other as partners working together instead of saying that they want it in Inuvik or in Yellowknife? When people see themselves as partners there is at least a greater tendency to work together and perhaps have a little more creativity on how that happens. I think it would be foolish for me to think that I, myself, in Inuvik would be able to define that because in reality all I know is that like all people we want to be empowered, we know that change is there and we know to some degree we have to wrestle with that.

CHAIRMAN (Mr. Zoe): Dr. DeKock.

DR. DEKOCK: I think from a practical point of view we have that to a large extent. We are giving as much medical services in the smaller communities as are practically possible. There are some things which have to be done in a larger centre. There are some things we cannot do here and that is done in Yellowknife at the moment. I personally think from a practical point of view, that the system works reasonably well at the moment.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: I am intrigued with this particular concept. As I have stated earlier, I have been in both places. I am sure that many people in the north have been there also. Getting services to the north is a milestone. We have achieved that in the last 15 years. We have had to go to southern parts of Canada to obtain services which we are now bringing north and establishing them in various centres. As physicians I am sure that you need a certain number of cases to be able to work proficiently. I hate to use the example of a mechanic, but if you have never worked on a certain type of car for years, you lose touch. I am sure that this is the same with physicians. We have finally recruited an orthopaedic surgeon. The orthopaedic surgeon says that we need to do so many operations of a certain type in order to keep proficient. If you do not have those then we cannot have that service here. We are bringing services north but we cannot have an orthopaedic surgeon in every community. We put them where we can make the most use of them. Perhaps Inuvik can specialize in one type of service and get really good at it, and rather than sending patients to Edmonton we would be able to send them to Inuvik. Would something like this be practical in our system today?

DR. DEKOCK: For example if we were to put a neurologist in Inuvik, we do not have one in the Northwest Territories at the moment, this would mean there would be a lot of travel for all of the other communities. Probably more than what we have at the moment. It would involve a lot of travel and transportation costs to get people to Inuvik. Rather, if we had someone for example in Yellowknife, it would be more central for all of the communities to reach. I really think that the system we have at the moment works very well. We have specialists in Yellowknife. For us it seems to work well. We do a lot of general things in Inuvik and we have enough cases to keep up with. None of us are specialized and we have to send those people out. I think the system at the moment with Yellowknife being the specialist centre seems to work quite well.

MR. LAVOIE: To confirm what Dr. DeKock is saying, at least from a management perspective, I think that one of the problems and not only in the N.W.T. but also in the rest of Canada is that no province has taken the five principles of medicare and said, "Do we really believe in these and emphasize all five equally?" The reason I state this is because I think to some degree they are like a compass. We all get off track. It does not matter if you have a strong centralized system in Yellowknife or have a strong decentralized system in all of the communities, at some point they will get top heavy as well. They act like a compass and a reminder for all of us in which direction we are going and are we putting too much emphasis on one over the other? I do believe that from a management perspective, at least the five principles confirm and support the medical perspective that it is not an either or I have a tendency to avoid the either/or.

CHAIRMAN (Mr. Zoe): Are there any further comments? My understanding of the Auditor General's report, and in particular to the section which makes reference to the medical clinic in Inuvik, the Auditor is saying that the Department of Health does not have a master plan. There is no plan in place. There is no model. The understanding of the witnesses who have appeared before us is varied. It also appears that the boards do not know what it is. It is my understanding of this report that since we do not know where the Department of Health is going and there is no master plan in place, when we asked the Department of Health to explain it, they emphasized that "The N.W.T. Way" is going to put the nurse practitioners as front line health deliverers.

You have made comments that they should not be the front line workers, but rather that they should be working in conjunction with the private medical clinics and the doctors. I think the Auditor General, when looking at our system, was also looking at other jurisdictions when he made those observations. I know that other jurisdictions are having a lot of problems in terms of the health care systems they have in place. Their costs are skyrocketing. More and more they are looking at our system because the nurse practitioners are the ones who are going to be the front line health care givers. The thing which intrigues me is that although the department is telling us this, many ordinary people on the street do not know what the N.W.T. model is.

You indicated that you had just heard of "The N.W.T. Way" this evening and that you do not know what it is. I did not either I had heard about it, but until we had various witnesses appearing before us, it all varies between regions. Everybody has a different interpretation as to what it is. I do not think that any of the committee Members exactly know what "The N.W.T. Way" is. My understanding from that is that the nurse practitioners are supposed to be the front line health care givers. That is because the department has also been monitoring the other systems. We see across the country that health care costs, especially in doctor's fees, are high and other jurisdictions are starting to inquire into our system. Many of our own people do not know what our system is. We are having problems in this area.

I am trying to understand what you are saying. How can you make these two work together? Dr. DeKock.

DR. DEKOCK: In the smaller communities we do have nurse practitioners in place and they do the major portion of the work. The physicians go in and consult on cases that they cannot deal with. They can phone, and if it is an emergency, we will medevac them out. I am not sure exactly how they are seen in places like Inuvik with a population of 3,000. Do they want to kick out the five physicians and put in five nurse practitioners and have a physician from Yellowknife come up every two weeks, and then medevac the rest of the people? Medevac costs are quite frightening. I am not sure in the end that it is not going to be more cost effective to have some physicians in place, perhaps decrease the numbers, to bring in some nurse practitioners. I cannot see that you can, for a

place the size of Inuvik, take out all of the physicians, and run it from Yellowknife.

CHAIRMAN (Mr. Zoe): Where would you find that balance? My colleague, Mr. Whitford, was trying to ask about where the balance is?

DR. DEKOCK: There are many things which we see that I do not think a nurse would be comfortable with. She would want to phone a doctor and consult. She would also like the doctor to see a number of the patients also. There are some things which we get called out for, which is expensive, but could be handled by a nurse practitioner. In general, I do not think you can cut out all of the physicians. You might be able to decrease the numbers, but for Inuvik which has to cover all of the settlements around, you do need some doctors in place.

CHAIRMAN (Mr. Zoe): I would like to get back to the Auditor General's comments. He indicated that some of the things which the clinics are doing could be done by the nurse practitioners. The costs associated with doctors versus nurse practitioners is lower. Do you agree with part of that statement which the Auditor General made?

DR. DEKOCK: Yes, I do. However, I do not think they are looking at the other side of the coin. What about those patients that they cannot see, are not happy to see, or are not sure what to do? What is going to happen to those patients? They are going to have to be medevaced to Yellowknife or Edmonton. I think in the end that is going to be a very large cost which has not been looked at. It is very easy to say, "Take out the doctors and put in nurses because they are cheaper." However, I do not think the complications from this have been looked at.

CHAIRMAN (Mr. Zoe): I am not too sure if this is what he is trying to say. I am trying to read between the lines. I think he is trying to indicate to us that the cost for fee services is high. In my view, I think this is the point he is trying to make. I am not too sure if the committee Members are trying to read between the lines or not. It appears that the costs for doctor services is getting quite high. He is implying that those costs should be revisited and seriously looked at. He does not say this directly, but indirectly. This is my interpretation of what he is trying to say.

MR. LAVOIE: As someone who works with physicians, the only thing that I can say in regard to this is that again, it is not a question of either/or. I think that this is a valid concern and it is a concern which should be brought up and looked at. I think where the problem is, at least from our side, is that to some degree it is suggested that somehow the physicians are the pirates taking away the bounty from the ship. In reality, all they are saying is that fine you have a concern, but involve us in the process. If you are concerned about costs, we have shown in other areas that we can be just as cost efficient, effective or thoughtful as you. So, let us get together on the process. We are not the enemy. To some degree the suggestion that also comes up is that instead of developing a process where the two groups work together to define these boundaries, what has happened is it is an imposed boundary put upon us saying these are my waters and you had better not cross them. From working with physicians, I know there is a willingness to change and to look at the issue. I think this has to be respected.

CHAIRMAN (Mr. Zoe): Are there any further comments from the committee? Mr. Arngna'naaq.

DR. DEKOCK: Before moving on, some mention should be made of negotiations in place at the moment between the Medical Association in Yellowknife and the Department of Health about fee-for-service. I have a feeling that comment has also got something to do with this. There has been a lot of back and forth and there has been no consensus on it so far. We are an isolated group who are still fee-for-service and I think we are a bit of a thorn in the side. We have not come to any clear conclusions there yet.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I was trying to write down some of the points you were making during your presentation. One of the areas I was not able to keep up with was titled "Time for Change." Can you recap that section of your presentation for me?

MR. LAVOIE: The focus of the health care system must be on providing those services which improve health outcomes. These outcomes must be defined, measurable, subject to analysis, and able to be independently evaluated. Services which cannot be shown to improve health should not be funded by the health care system.

MR. ARNGNA'NAAQ: Is this a recommendation you have made to the Department of Health or is this something which you believe?

MR. LAVOIE: This is the perspective I think the clinic works out of. They basically believe that this is what keeps the vitality going with regard to bringing physicians here and also that what we hear within the region as to what people want. We asked, "What are the boundaries and who says where they are?" In a sense, what we were saying is that in this time for change, let us define and measure these boundaries together and not the either/or situation.

MR. ARNGNA'NAAQ: Mr. Chairman, has the department asked for your direction or input in this area?

MR. LAVOIE: Not to the clinic personally, no. I know that, in fairness to the health board, often there has been questions and there is some form of relationship which I think is fairly positive. With regard to Yellowknife, the only time I think there was, was with regard to communities and the fee-for-service. When the deputy minister came up this was the only time that I know of personally.

CHAIRMAN (Mr. Zoe): Other than that there was no consultation between the department and the private clinics especially here in Inuvik?

MR. LAVOIE: No.

CHAIRMAN (Mr. Zoe): I am quite surprised. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: The management response as far as the Auditor General is concerned, says that "the department, as part of its ongoing operations, will continue to monitor the provisions of professional services." What kind of monitoring model would be appropriate for the G.N.W.T. as far as private practitioners are concerned? Is there a level where their monitoring would go too far or is it close enough as far as you are concerned?

MR. LAVOIE: I can only voice what I believe my employer thinks and hopefully I do justice to that, as well as the people who work with us. We go back to one of the principles of medicare, public administrations. We believe that public administration does not just mean private enterprise or industry, but also means that government has a right to be involved and, in this instance, to give it some form of direction. We try to respect both points to the best of our ability. I think if we were to take the Inuvik situation which has begun, for example, in the communities themselves, the physicians receive a per diem. There is no fee-for-service whatsoever in the communities. In Inuvik there is a fee-for-service. I personally feel that this was an extremely creative approach in the sense of having both together. It is not an either/or situation. I think there are many other situations probably where things like this could be worked out. I think the people in the communities are more or less happy with the service they are receiving. It is also new ground which has to be broken with regard to the relationship between physicians and the nurse practitioners. Where do they want to be in five years? Where does the health board want this whole approach to be? At least it has begun. I think that this is a good model of showing how the two can work together.

CHAIRMAN (Mr. Zoe): Are there any other comments or questions? Mr. Whitford.

MR. WHITFORD: I have a question with regard to decentralization. Health insurance services are going to be decentralized to two regions, Inuvik and Keewatin. This should take place soon. That section looks after the payment of doctor bills. Are there any direct benefits that you see by having the division decentralized to Inuvik? Would this be better? Is this going to improve the service for doctor billings?

MR. LAVOIE: I personally have a bias. I like the decentralized system. But, I do not think that we will directly benefit from it. I think the only way in which we will benefit from it is instead of walking to the post office and mailing our billing cards, perhaps we can now walk across the street and give it to the clerk. This is probably the only way in which we will benefit. I do believe that the decentralized model is a good model. This is a sign of it coming into play and it has to happen in other areas as well.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: This goes back to your initial statement. I have heard it about three times, but I keep missing it. It is with regard to the improvement of health services to the territories and if we cannot improve it, we should not continue. What exactly do you mean by this?

MR. LAVOIE: Is that when I refer to the outcomes must be defined?

MR. WHITFORD: No.

MR. LAVOIE: Services which cannot be shown to improve health should not be funded by the health care system.

MR. WHITFORD: Can you give me an example of this?

AN HON. MEMBER: Smokers.

MR. WHITFORD: Smokers should pay their own medical health bills.

MR. LAVOIE: I was not taking it in that broad of a context.

---Laughter

MR. WHITFORD: I would like an example of what you meant by your comments.

MR. LAVOIE: I come from management bias and I am saying that instead of everybody saying this is what I feel and this is what think, and this is what I would personally like, I am saying that there must be some way to define and measure what is good for the system and what is not. Without that sort of definition and measurement, what will happen is that the majority will win, or the one who pulls the hardest regardless of what system is put in place. I cannot give you a specific in regard to which one perhaps should be removed. I do believe that something can be defined so that in fact that it can be looked at as to whether it is empowering the system or not.

DR. DEKOCK: Something which is not in place at the moment but was done before was that people were routinely given a chest X-ray for tuberculosis. It has been shown that this is not worth it and it has been stopped. At the moment, we are not looking at these types of things. We need a little prod now and again to start looking to see what is necessary and if there are things which we can throw out.

MR. LAVOIE: I did hear of one the other day, somebody was saying that there were five physicians for the delivery of a baby. This is a good example, do you need five physicians? That is probably quite easy to measure. I had not thought of it until now.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments or questions? Ludy.

MR. PUDLUK: I have a short question. The Auditor General said that the government needs to set performance standards to evaluate how well doctors are doing their job. Can you comment on that? What sort of standards should be developed?

CHAIRMAN (Mr. Zoe): My colleague is asking with regard to performance standards. I believe that we do not have any performance standards within the Department of Health for doctors. What type of standards would you recommend that they develop?

DR. DEKOCK: Traditionally doctors are evaluated by their peers. I think this is probably the best way to go about it. I think most doctors would have a problem being evaluated by

a non-professional or a non-doctor. I cannot see what you can base that on.

CHAIRMAN (Mr. Zoe): I understand what you are saying, in terms of the conduct of their membership and code of ethics. I think the Auditor General is trying to say that the government, the employer, and the doctors are either salaried or fee-for-services, they are our employees and we should have some sort of monitoring process in place. At the moment, we do not have one, a standard performance for doctors.

DR. DEKOCK: I think this is one of the problems with salaried doctors, you take away part of the motivation or incentive. At the moment, with the fee-for-service, you work hard and you get your money. With a salaried position the government would like to see whether or not you are doing your work. I am not sure how they can do that. I have no idea.

CHAIRMAN (Mr. Zoe): If I am correct, do they not have certain standards set for nurses? I think the Department of Health has a certain monitoring process for nurses. I think they are looking for something similar to this for doctors, either salaried or fee-for-service. These performance standards have not been developed yet.

DR. DEKOCK: I do not know how one will do it. Are you going to monitor to see how many patients a doctor sees in a day, or how many appendices you take out in a year and if that is enough, or if that is too much. I do not know.

CHAIRMAN (Mr. Zoe): If I am paying for a service I would like to know if they are doing this. A hypothetical situation is how would I know as your employer? You give me the bill and you expect me to pay you, do I have to take your word for it? What is being suggested is that there has to be a process in place where we can measure the performance of doctors, either salaried or fee-for-service. That component of it is not there right now. This is what the Auditor General is saying.

DR. DEKOCK: If you look at doctors in other places who are salaried and work in hospitals, there is nothing like this in place. You work, you have a certain amount of things to do and you do them. I do not think that this is a general thing. There is always so much work that you cannot do anything but perform.

CHAIRMAN (Mr. Zoe): In my view, the suggestion being made is a good one. I think this process has to be developed.

DR. DEKOCK: I am not sure that you will ever be able to.

CHAIRMAN (Mr. Zoe): I am not sure about other jurisdictions but the suggestion which is being made is a good one. If I was the employer, I would like to know what I am paying for and I would like to have a process in place so that I can evaluate. Standards have to be set to evaluate certain people.

DR. DEKOCK: I think there are two things which could be looked into. First of all, one could start by going and looking at other hospitals where doctors are paid a salary each year to see if they do have something in place and how they feel about it. Up until now, doctors have never been monitored like that. I am not sure that it will go down all that well. The second thing would be that the patients would be the ideal ones to give you feedback.

CHAIRMAN (Mr. Zoe): Can you elaborate?

DR. DEKOCK: Perhaps something like patient surveys to see what the patients feel about doctor's services. Did they get enough attention, care and time?

MR. LAVOIE: With regard to what Dr. DeKock was saying and from a management perspective, not from the medical side, I do think there is some common ground in a sense that both physicians and management would be concerned about liability. How do we eliminate risks so that both the physician as well as the hospital are not held accountable from a liable perspective. Probably within that context with putting it in a broader perspective, that in one sense you would have peers evaluating peers, but on the other hand, you could have a discussion type of relationship between management and physicians with regard to how we do, to eliminate this risk management, both for the hospital and for yourself as a physician. Probably some kind of appraisal or standard could be developed from that perspective.

CHAIRMAN (Mr. Zoe): The Auditor General indicated that the department needs a contract with standard performance criteria to assess the effectiveness of work practices, utilizing health care costs, achieving a more economical and efficient use of resources and demand tools to assess and reward good performance. He is indicating that this process has to be incorporated into the contracts and also incorporated with our salaried doctors that we have. I think we have one or two. I think this is the point he is trying to make and that it has to be done in conjunction and consultation with the boards.

MR. LAVOIE: To some degree this is done already in the Inuvik region. When we hire a physician, the physician not only signs a contract with the Inuvik Medical Clinic, but also signs a contract for what we call "quality assurance." I am not saying that this does not have to be defined more and re-evaluated. At least what it does, is heighten the awareness of the physician who is coming that there is an appraisal with regard to what is required to receive privileges at the hospital. Obviously, we will find the pros and cons of it and be able to see where it is working and where it is not working. I think it has been implemented and the physician is being evaluated, not just by peers, but by the employer, by the hospital or the board as to whether or not they are meeting certain objectives.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from committee Members? If there are no further comments, I would like to thank the Inuvik Medical Clinic for appearing before us. We appreciate your comments and your presentation this evening. Thank you very much.

We will hear from the Inuvik Health Board and the I.R.C., Inuvialuit Regional Corporation, tomorrow morning. With that, I adjourn until 9:30 a.m. tomorrow morning.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PROCEEDINGS

PUBLIC HEARINGS

INUVIK, NORTHWEST TERRITORIES

THURSDAY, JANUARY 28, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

INUVIK, NORTHWEST TERRITORIES

THURSDAY, JANUARY 28, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. Fred Koe

Committee Members

Mr. Silas Arngna'naaq
Mr. Ernie Bernhardt
Mr. Sam Gargan
Mr. John Ningark
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

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Ms. Rhoda Perkison, Committee Clerk
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Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

Inuvik Regional Health Board

Ms. Dale Hanson, Chairperson, Board of Management

Ms. Wendy MacDonald, Acting Chief Executive Officer

Mrs. Raj Downe, Director, Finance and Administration

Inuvialuit Regional Corporation

Mr. Roger Gruben, Chairperson

Ms. Gloria Allen, I.R.C. Representative on Inuvik Regional Health Board

STANDING COMMITTEE ON PUBLIC ACCOUNTS

INUVIK, NORTHWEST TERRITORIES

JANUARY 28, 1993

Members Present

Mr. Arngna'naaq, Mr. Whitford, Mr. Zoe

Chairman's Opening Comments

CHAIRMAN (Mr. Zoe): I would like to call the Standing Committee on Public Accounts to order. We are reconvening our meeting, a continuation from yesterday. We are dealing with the report of the Auditor General, a comprehensive audit of the Department of Health. Our first witness appearing this morning is the Inuvik Regional Health Board representative. Could I ask the representatives to come up to the witness table and introduce themselves for the record.

Presentation by Inuvik Regional Health Board

MS. HANSON: Good morning gentlemen, and ladies and gentlemen of the public. I am Dale Hanson. I am chairperson of the Inuvik Regional Health Board. With me I have our chief executive officer, Wendy MacDonald.

First of all I would like to thank the standing committee Members for allowing us this opportunity to speak to you in regard to the audit of the Department of Health.

We, as the providers of health care, understand and realize that 16 per cent of your overall budget is spent on the health care of the people of the Northwest Territories. We thank you very much for your care, concern and understanding that the care and quality of care of the people of the Northwest Territories has to be one of the foremost items for government to deal with.

The audit itself, we believe, has thoroughly assessed the Department of Health. Basically, with one minor exception, we agree with the report and recommendations.

I will be addressing six major points in my presentation. Then Members, please feel free to ask as many questions as you feel you need to.

At the time of transfer, health care was turned over to the Northwest Territories. Really what has happened is we have a system in its infancy. We were given a job to do. We immediately took that job and ran with it. Unfortunately what has happened, I believe, is that we were all so busy doing that we were not busy thinking. Now is the time to sit back and reflect, and to find out where we should go from here.

The hospitals and the boards were left with an enormous task, as was the government, as was the department. I suppose it is analogous to a child. The boards and the departments are in their infancy. I believe that over the last four years what has happened is that we have been able to get past the being fed and diapered stage, and are now at the "terrible two" stage. What we are doing is fighting and kicking for our independence. Every time someone tells us we cannot do that, we say "yes, we can" and "yes, we are going to." I think where the problems arise in that is that not only are the boards in that stage of the "terrible twos", but so is the department. Therefore, we have two two-year-olds fighting, kicking and wanting the same things and not knowing how to get it. I believe we need the strong, firm, gentle and caring hand of an adult to lead us and to show us that we can each get our own way, but we have to do it in a sensible fashion.

That leads me to point one of the Auditor General's report. That being that, I believe sirs, it is your responsibility as the Government of the Northwest Territories, to provide us with a health care model. That model must be a priority of this Legislature. Right now, every board across the territories and the department is functioning as an entity unto itself and there is no set model that we are following. You have made reference to your remarks last night to "The N.W.T. Way", which I am sure you will ask me about later. That is one model, but it is only one model. What we have to do in consultation with the people of the territories is to decide which model we want to follow. We have to make that decision and we have to make it soon.

The idea of having a health care model leads us into the second point. I believe one of the major faults we have is that there is no plan. Therefore, what is happening again is because we are all in our infancy we are all trying to develop our own plan. What happens is that Inuvik Regional Health Board, for example, goes about doing its planning, but our plan does not necessarily fit into the department's plan, and it does not fit into Stanton's plan, and it does not fit into the Keewatin's plan. So, consequently, once again, what we have is discord.

Unfortunately, not like the Members of the Kitikmeot, I cannot say that we have experienced a smooth working relationship with the Department of Health. We have not. Kicking and screaming seems to be what both of us do well. I am not proud of that fact but I think things have improved over the last while, but I really believe it is part of the growing process.

When we have a plan, I believe that all boards then can make decisions based on what the people of their region want and need, and it can be fed into the way the department oversees things because accountability has to be there. That will, in turn, feed into the model of health care that yourselves are purporting to the Legislature. It is very important, we believe, that the plan be done and it be done immediately. I believe that this particular report is probably the start. What I hope happens out of this report is that your recommendations go

back to the Department of Health, that we are given specific time frames when these recommendations must be implemented and that this report is not simply put on the shelf. I also think that at this particular time one of the things that has also happened is that we have had many different types of evaluations, reports, reviews or whatever you want to call them. I think that is fine. I think a time for self-reflection is very important, but I think it is time now that we stop criticizing. It is time that we work together in a constructive manner and took these management reports, put them together and let us find where it is we are going.

That brings me to point three which is the M.O.U. I cannot tell you how good I felt at the last standing committee that I addressed when I believed the M.O.U. was going to come to be. I think once we have very clearly delineated roles and responsibilities for the government, for the department and for the boards, then we can all get about the business of providing quality health care for the citizens of the Northwest Territories. We are not going to spend our time, energies or our money duplicating services and fighting with each other.

This particular memorandum of understanding, however, is not going to be a simple task. It is going to be a very difficult task. It is going to be a fairly lengthy task and it is going to be an expensive task. I really believe that it is time that monies were spent in this kind of venture. It is very important that now for four years we have all been operating with our own ideas of what is right. It is going to take us a short time, hopefully not four years, to sort out what really is right.

Once again, leading me back to the plan, the role, the model. Every point that I think the Auditor General has come up with is valid, but it all leads back to the one thing. Until we know what the model of health care is that we want in the Northwest Territories, and until there is a plan in place to make sure that happens, we are all going to be going in many directions and wasting a lot of time, energy and money.

The Department of Health -- I will admit to you that I am one of the people who feel the Department of Health stands in our way many times -- has many competent and caring people who work in it. I truly believe that part of our problem is, once again, that their time and energies have never been focused on how to help boards. Right now, once again, I go back to my analogy, they are struggling with wanting their piece of power as we are struggling with wanting our piece of power. Therefore, that focus has to be clearly outlined and some change of thinking and philosophy has to go on at the departmental level. We need the department, I would never say we do not. We need them to be consultative, we need them to be our helping hand and support, we need them to be there when we need them, we need them to be there also to be our form of accountability because like it or not everyone is accountable to you, sirs.

In the development of an M.O.U. it is very important that the boards are able to have a great amount of input. At the present time, I know that the Northwest Territories Health Care Association has been given a mandate to find a consultant to begin the process of the M.O.U. I think that is fine. We need someone from the outside who is not embroiled in the discussion and the debate to look at this logically, and try to pull together some semblance of order. In that process, I would sincerely hope that what happens is that that consultant spends a great deal of time with the boards because every one of the boards in the Northwest Territories has different needs, different wants and different desires. I think somehow we have to be able to address that, as well as coming out with a very clear line of role delineation.

One of the other areas that the Auditor's report addresses is physicians. Once again, I go right back to what kind of model of health care do we want in the Northwest Territories? Do the physicians have the southern model that we have now, or do we go to a different kind of model where I am not saying we will ever do without physicians? Of course we will not, but will they play a different role in the health care system? Right now, I believe, that what we have done is transported a southern model into the Northwest Territories as far as physicians are concerned. Unfortunately, we have done it now for a number of years and it is going to be very difficult to change because in our communities, if there is a doctor in the community everyone wants to see the doctor and they have that right. When I start to talk about physicians, and I will in a moment, once again coming back to the model to the role, we as a board, you as a government, are going to have to do a great amount of educating of the citizens of the Northwest Territories once we have decided on that role so they understand what it is that they are not getting second class care because they see a nurse practitioner, for example. I think we have a great selling job to do.

As a health board we have a contract with the Inuvik Medical Clinic. I will reiterate Mr. Lavoie's statements from last night and say until such time as we had that contract we went through doctors like there was no tomorrow. Since we have had that contract we have had some consistency with the numbers of physicians who have not only been here at the hospital and in the town of Inuvik, but also consistency of the physicians travelling out to the communities so that one physician sees a community or goes to the same community for their entire length of time here. The people in the communities really appreciate that. They get to know the physician and the physician gets to know them, which is equally important. Therefore, they are feeling more comfortable with that system. So, consistency is an important thing when we start talking about physicians.

There are a couple of areas that we need to address. As lay people, yourselves and myself, not being medical people, we suffer from the doctor/God syndrome. In other words, if the doctor tells me this is it, this is it. He or she must know. We have to educate our people to ask questions. We have to educate our people that they too are infallible, and the only way we can do that is to ensure that our physicians are made accountable. When a physician tells you that you have something and that you need this, you simply accept it. Because that physician is nice to you and kind to you, you accept that what they have done or said is probably the very best thing that could happen. However, if there was a peer review of physicians possibly what has happened is that another physician might say to that physician, it may have been better to do this or that or whatever. We do not know that, we are lay people. They have the education and the expertise to know.

One of the problems the health boards have is that we have

the responsibility to credential these people. I have to say to you I think that is a very difficult task. As a lay person, I have no idea whether they are capable of doing what they tell me they are capable of doing. We have to rely on the physicians ourselves and our C.E.O. to tell us if that is right. I feel that is a very inadequate service, because when you work closely with someone you are not about to tell them "I do not think you have the skills to do that too readily." Especially when you have professionals like physicians who have a professional etiquette they must follow.

Therefore, I see an opportunity here for the Northwest Territories to develop their own college of physicians and surgeons. That particular college would do several things. First of all, the health boards could use it to credential. In other words, we would ask them to come and visit our hospitals in our communities and first of all tell us what kinds of functions should be going on in our facility. Then we would send them to see our physicians, and we would say you as professionals tell us what you believe these people can do. Then, as a health board we would feel a whole lot better about saying yes, go ahead and do it in our facility.

This same particular college could look after making sure there was some accountability for physicians. They could ensure that, for example, peer reviews were done. They could ensure that audits were done on physicians' charts. They could ensure that physicians were following through with the requirements of quality assurance and accreditation. That way, we have a group of peers reviewing their peers. We would not have many lay people trying to tell a physician how to do their job, which is what it is seen as now and it does not work.

I also believe that this college of physicians and surgeons would allow us the external affiliations with our sister provinces, the territories and the southern universities.

We, at Inuvik Regional Health Board, at the moment enjoy a teaching relationship with both McGill University and a specialist relationship with the University of Alberta, relationships that we would very much like to carry on. I believe that the quality of the young doctors we get coming here is good, and I think that the experience that they gain by coming to a place such as Inuvik and its surrounding communities to practise is invaluable, but it is expensive. It is something that is not built into our budgets, yet it is a very valuable resource. We can attract physicians to the territories if we have given them the opportunity to be here and to see what we are all about and to show them that we are not a group of peoples who live in the dark ages. Therefore, I think we do have more response from our medical clinics down south.

Quality assurance is a very important aspect of any health board. It is very difficult for the health board to ensure quality of service with the physicians. They are very busy people. The debate is on now whether or not physicians should be salaried or whether they should be fee-for-service. I see benefits to both. I have a real concern that it has to be something that is negotiated, once again, going back to what model of health care do we want and how do we feel into that, what is the plan? In that way we are not left out on a limb to fend for ourselves. To enter into considerable argument with the department in Yellowknife as to whether we should have fee-for-service physicians or whether we should not.

In passing, I would like to say that I believe right now in the Inuvik region we have a good working relationship with Inuvik Medical Clinic We have a group of physicians who care about the people of the region, and I would do everything as a health board to ensure that continues.

One of the other issues that came up in the Auditor General's report was the information systems. I listened last night to two groups of people telling you that the information systems had to change, and I will reiterate that. Right now what is happening is that everybody is on a different system, people cannot collect data, we send off our reports to Yellowknife, they all have to be changed into a different system in Yellowknife so they can be read and interpreted. What a waste of time, energy and manpower. It is time to stop the penny pinching about the information systems and for everybody in the Northwest Territories to be on the same one so we can electronically transport information back and forth. The people out in our stations collect information by hand. It comes into us in the hospital. We have an information system that puts it together in a package, but it is no good to anybody but us. So what good is that? It is lovely for us, but if Yellowknife wants that information we send them our hard copy and somebody has to re-enter that into their system so it can be recorded. Consequently, we now have three different times that that information is changing hands and errors are made. I believe that is something that has to happen immediately, that we do have to get on with an information system and it is going to be expensive.

One of the other things that probably was not addressed specifically in the Auditor General's report that I would like to speak to you about is the policies developed by the government, possibly without enough consultation from the field. What happens is that policies are made and then the board is left to ensure that these policies are administered. In some cases, in the business that we have, this causes us a great amount of concern. It complicates our operations, it takes our time and it lowers our productivity. A perfect example is hiring. Right now we have to get special permission to go south to hire nurses. We know that in the Northwest Territories right now there are not enough nurses to fill our needs or any other health board's need in the Northwest Territories. When we need a nurse we need a nurse. Having to make special arrangements to go south in order to advertise and then proceed with that advertisement means that we are short-staffed. Sometimes that is not a good thing especially when we are talking about nursing stations. We are looking for a highly skilled select group of people when we talk about the nurse practitioner. Therefore, possibly there should be areas of your policies where health boards could have a chance to override that policy.

The business incentive policy is a good policy. I know what it is meant to do, yet at times for us it is a very expensive policy and our budget does not reflect the amount of monies that we need for us to have to pay that additional amount.

The one recommendation in the Auditor General's report that we did not agree with wholeheartedly was that you should consider the desirability of eliminating the recruitment function from the H.R.M. division. That particular function is valued by

the I.R.H.B. It is used extensively for both nurses' and physicians' recruitment. It gives us the opportunity to have someone with their eyes and ears Canada-wide that we can feed into. It is my thought that that particular position could also be extended to ensure that we are attracting aboriginal peoples to enter the health careers.

Right now we have an A.N.S.I.P. program. We have been working on a health upgrade through Arctic College, and are working on a nursing program through Arctic College, but working on seems to be the name of the day. I think we have to get on with it and do it.

The C.H.R. program has proved to be probably one of the most productive, one of the most useful programs that has happened in the last while. We have our people in our communities working with the people in the communities. They are trained, skilled and they have been a great advantage to the people who are doing the primary care of the people in the communities.

I think it is time now that we went that step further. We have to attract our young people into health care. How do we do that? We do it by getting out into the schools, by giving some incentive to young people to finish their grade 12, to want to go into the health care field, to show them what incentive there is to work in the health care field and to support them as best we can through that process. We have learned, through experience, and I am an educator so I am speaking from two experiences here, that when we send our young people into southern institutions they often do not experience success. Therefore, if we really want them to be successful and to become health career oriented then I think we have to develop programs within the territories that are field-based so that we can allow them the opportunity to learn what they need to learn, and to have the practical experience that they need to have so they can become professional people and take over the care of their own.

In closing, sirs, I would like to say that I believe that nothing but good can come out of self-reflection or out of an external review of any system when and if the outcomes are viewed as constructive and not totally critical. We have a long road ahead of us, I believe, and we must walk that road together, the three of us, the government, the department and the boards. I say again it is time to stop pulling the system apart. It is time to take the information we have, put our energies into finding out what model we want to follow, putting a plan together to get us to fulfil that model and to get on with the job. The reason that we are all here, is for the quality of care for the people of the Northwest Territories.

I would also like to say that I believe in the health care field, our boards, our facilities and our staff that we have some of the most caring, dedicated and competent people that you could ever wish to find. I believe they also would like to know where they are going and how they are going to get there.

At this time I would like to invite you when you are finished at this session to feel free to go up to the hospital and tour the facility. I know our C.E.O. would be more than happy to ensure you see the facility and the programs that go on within the Inuvik Regional Health Board. Thank you for your time.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments from the committee? Mr. Whitford.

General Comments

MR. WHITFORD: Thank you, Mr. Chairman. When you talked about the models for the delivery of health care in the territories, it is true there is no one set model as outlined by anybody, be it the departments or the boards. To a large extent there is a model in place but it has many different shapes. Its shape in the Inuvik region is a little different from the one in the Kitikmeot and the Keewatin, which is probably good. I agree with you that there has to be, at some point, some standardizing of that model. I am sure we will come around to "The N.W.T. Way". Are you familiar with that? Did anybody discuss that with you at all?

MS. HANSON: The first of it was in the Strength at Two Levels document. The board discussed it at that time and immediately responded to the department with a letter saying that we were not willing to enter into any negotiations until such time as we had clarification on what that meant for us. It has been left at that.

MR. WHITFORD: That goes along with one of the things that you mentioned about something the department and the boards are doing seems to be coming from a top down approach. Yellowknife, because we are in charge of it now, dictates what the policies will be without much consultation.

MS. HANSON: I believe so, yes.

MR. WHITFORD: It brings us around to one of the things you spoke about in your presentation about the M.O.U. being very necessary. Those are probably my words, I was trying to get your words exactly, but in essence without it there is no clear understanding of what it is that is required and under what authorities boards can operate. There seems to be nothing firm. I agree with you that it should be dealt with as quickly as possible. You mentioned it is going to be a lengthy, difficult and costly process. Do you have any suggestions for a timeframe? What would be reasonable? This could go on forever.

MS. HANSON: That is a difficult question for you to pose to me. I would think once a consultant is hired the process would happen immediately by consultation with the health boards and with the department. I would say there should be a preliminary draft in place probably within six to eight months. What I believe has to happen then is that has to become a working document that is open to review and change. I do not think we are going to get it right the first time. That is why I say to you it will probably be a lengthy process. I believe it needs to happen immediately. It is probably the one most positive step forward that the department and the government could possibly take as far as pulling us together in unity. I know all the boards would be anxious to be participants in that. I would say in probably six to eight months we would have a working document that everybody would have ample input into, it would have been reviewed and discussed several times. It would be put into place as a working document for regular review and monitoring to ensure it fits our needs. I do not think if we write it in stone immediately, what is going to happen is that the loop holes are going to show themselves and then we are stuck.

How do we change this again?

CHAIRMAN (Mr. Zoe): Do you have further comments, Mr. Whitford? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I have one question in the area of information systems. You mentioned that there would be an error rate. Would you have any idea how much error there might be in the different systems when the information is transferred? Is there a way of checking that? Have you followed up on that to see if there are errors?

MS. HANSON: There can be. Again, sir, that would take a lot of time and effort to double check that, and it would have to be a manual check I would think. I can assure you that we are all human and that errors are made.

MS. MACDONALD: Sometimes the error is that we are not gathering things in a like manner, so that the information is gathered one way in one place. Therefore, the count comes up to a certain number. Then in another place it is counted a different way, and the result is that when it is being looked at either within a region or when it gets into being compared with other regions, it looks like one might be high and one might be low.

We were just having a discussion this morning about medevacs. Some of the staff were saying people were taking the counts from records that had been sent to Yellowknife and another one was doing it from information that came from the communities. In one it looked as if there had been a big variance, but when they took it from the communities there really had not been much change in the year. That was probably because the documents they may have been using were different documents. I do not know the situation. I also do not know whether or not there truly was not much difference or a lot of difference. Those are the kinds of things that can lead to a lot of wasted time because people are running around trying to figure out what the truth is, and they are running around trying to justify a change or why is there more, or why is there less of something and there is really no need for it. So we are wasting time, and in particular the people right at the front end in the communities who should be spending their time working with people and providing health care, are spending an incredible amount of time gathering statistics. To a lesser extent we are probably employing a lot of people in the system to do this work too, but maybe we can reconcile that a little better by saying that is what they are hired to do. We are wasting money, of course, but that is what they are hired to do. Whereas, you feel a lot worse about wasting the time of the nurses, clerk interpreters and C.H.R.s doing this sort of thing, and they are probably the ones who are taking the brunt of our lack of systems.

CHAIRMAN (Mr. Zoe): Are there any further comments?

MR. ARNGNA'NAAQ: What kind of system are you on now?

MS. MACDONALD: The health board, for accounting, is on H.B.I.S. It has M.H.O. for payroll and M.I.S. as an accounting code. Having said that, we have our own in-house system for gathering information. The result is that a lot of statistical information gets gathered and is used only for in-house, and if it has to be sent on to Yellowknife only hard copies can be sent to them and they have to take it off and put it onto their system. We input into their C.H.M.I.S., but we input onto paper as opposed to electronically. There are a number of systems, even within what is used in the health board the systems do not work with each other. They do not in turn work with Yellowknife. In some systems, as Jean was mentioning last night, they have one system where some of their computers can transfer something electronically to Yellowknife, but we do not have those capabilities to the same extent. I guess that is part of this lack of uniformity. It is a matter of the type of hardware and software that we have, and the kinds of protocol in terms of gathering the information. Those are all parts of systems, but the thing is because everybody has been doing them in isolation and bits and pieces and there is no overall plan for it, things do not fit together. So, what happens is that decision making locally and on a territorial basis is really compromised by it.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Do you have a dollar figure or percentage of time that is spent trying to answer questions that are received from the department?

DR. DEKOCK: I do not believe so. I will ask Raj Downe to respond to that because she has worked with that quite a bit.

CHAIRMAN (Mr. Zoe): Basically, what my colleague is asking is that in terms of time and effort from the board staff, do you have a guesstimate as to how much time if you can put a dollar value to it to see what percentage of the board's time is spent on information that the department is requesting? Do you have a ball park figure?

MRS. DOWNE: I have not done an analysis, per se, but we do spend a lot of time trying to put information together. I could probably do some sort of an analysis and figure out how many hours of time we spend on, for example, putting information from our accounting system together when preparing budgets. For example, currently we have the M.H.O. system for our payroll, and to have that information inputted on our accounting system we have to pull the data from the M.H.O. system and then physically make journal entries manually, then the data into our accounting system. That takes time and it could create errors. The staff may mean to put 25 and they put 52, something like that. I will have to do an analysis, I have not done one, but we do spend a lot of time taking information from one system and putting it into another system manually and then putting it into another system.

CHAIRMAN (Mr. Zoe): Are there any further questions? On this system that you have in place was it the board that developed their own system, or was it imposed from above to the board to have this particular system in place? Are you quite happy with the system you have in place within your region?

MS. HANSON: We were asked, "did we want to go into H.B.I.S.?" As a board we said "no, we do not." Work the bugs out of it first and then we will deal with it. A short while later we were told we were going on H.B.I.S. We had no choice.

CHAIRMAN (Mr. Zoe): That is quite interesting. Who was it

in the department that told the board?

MS. HANSON: I could not tell you to tell you the honest truth. Do you know, Raj?

MRS. DOWNE: Actually that was in March, 1991. I believe what had happened, I was not in the facility at that time, I was away on holidays and when I came back I was told that the deputy minister at that time, Mr. Cowcill, had phoned and told the C.E.O. that not only would we have to go on the H.B.I.S., but we would have to go on the H.B.I.S. on March 1. So we were not even given the choice of going on any particular month or any particular time, we were just told that we had no choice but to go on H.B.I.S. on March 1, 1991. That is also the year end and that in itself creates a lot of work pressure for all the accounting staff. Not only the accounting staff, all the administrative staff have to deal with an extra workload at the year end.

CHAIRMAN (Mr. Zoe): I am surprised, because I know some other boards are not using H.B.I.S. For instance, Stanton Yellowknife Hospital is on M.H.O. system. I am surprised that the boards let the department impose the system on them.

MS. MACDONALD: My understanding of H.B.I.S. system is that it was to be implemented on the transfer boards. It was always my understanding that Stanton wished to stay, it was piloting the M.I.S. system. There were two things, one was that it was piloting M.I.S. and the other was that it was not one of the transfer boards, so there was not an agreement that those boards would go on. Boards which have gone on to it, with the exception of Fort Smith which was scheduled to go on and then did not, was part of the transfer agreement at the time that H.B.I.S. would be put into these boards.

CHAIRMAN (Mr. Zoe): Do you have any further comments?

MS. HANSON: I would like to add a comment. This is another example of why the boards feel so frustrated and also the staff. We do make decisions and the next thing we know our decision is over turned. This causes frustration and anger. If we had a nice lengthy cordial conversation regarding why we should do a certain thing and how much help we would be to everybody else, I do not think we would have felt as pressured. Another thing which I think is important for you to realize is that as a board we only get together a few times a year. I do not think board members even knew about that particular decision until the next board meeting. I was not on the executive at that time. We chalked this up as another one. That is where these frustrations come from. I am sure there is a very logical reason why we needed to do that and needed to do it by March 1, but it was never communicated to us in a way that did not make us feel like, once again, big brother is telling us how we will do it.

CHAIRMAN (Mr. Zoe): I have a question with regard to training. You mentioned training in your presentation and in particular for the nursing program. You indicated that this is still in the development stage. It is my understanding that it has been in the development stage for the past three or four years. You commented that you wanted them to get on with it and have something in place within a certain time period. Is that correct?

MS. HANSON: That is correct. Training is a big issue and one that I chose not to delve into in my presentation. Seeing as you have opened the door, there are several levels of training that are really needed. The one I spoke about was that we really need to open the door to our young people to enable them to get into the health profession. The working back and forth with Arctic College is commendable but let us get on with it. Again, I really feel that this has to be an integral part of "the plan" when we put "the plan" together. So we will do that.

The other thing which I think is really important is the training of boards. It is something which is really necessary. You take people out of the communities, who are lay people with no health care background, they come into a meeting, the meeting tends to be very intimidating and very high powered because there are an awful lot of things on the agenda, there are a lot of decisions which need to be made, and you are trying to deal with all of that. It is very important that the board members feel comfortable in making those kinds of decisions. I think that although agreed when we became a board in 1988, we had a two day session with a gentleman about board roles and responsibilities, and he gave us two documents which are hundreds of pages long. As a lay person with a full-time job I am not going to sit down and read that every once in a while. When a new board member comes on board you cannot just give him those two binders and tell him this is all you need to know. It might be except that I think it is based on a southern model. It is the experience which you need and the being taken step by step through the intricacies of the system and the programming and all of those things that board members need.

I have a real aversion to flying someone in from the south to tell us what it is that is good for us. I think that we, on our board, have started to do a fair bit of board training by taking on that task ourselves. We ensure at every board meeting that we have a training session. Sometimes it is simply a presentation from one of the departments. They come in and tell us who they are and what they do. Board members are then allowed to ask questions. At other times it is where we actually give a stand-up presentation about a certain subject.

Evaluation is one, for example, which I will use. As an educator, evaluation is something which I know a lot about. Therefore, it has been my pleasure to work my board through evaluation systems, both of our C.E.O. and of ourselves, and to teach them because I am one of them and I understand where they are coming from, that this is how we go about doing things. We are very fortunate at I.R.H.B. because we identified within our budget line that we wanted training money. We felt that education for our staff and ourselves was one of the prime items needed in the budget. We have been very fortunate that this particular line has never come out of our budget. I think it is the way in which we decided that this money would be spent. Therefore board training has to be an integral part of the system. We have to ensure that our board members feel comfortable to take the steps that they need to take. You cannot bring someone into a system and have them make a decision on whether or not the hospital should be performing abortions, when they are feeling intimidated and scared about being there and are not comfortable as to whether or not they are making the right decision, and are they fully representing their people. I think that training is a really important aspect, as is evaluation.

Board evaluation in the Auditor General's report said that no boards are evaluated. I beg to differ with him. We have started. We have just scratched the surface. Our board goes through a self-examination one a year. It is small but I am hoping it will grow. I think that self-examination is where we need to start. I also believe that boards should be subject to review. Once again, that review should be by peers. In other words what should be happening is that on a bi-yearly basis there should be a team which travel to boards and do an external review of the functions of the boards. In other words, is the board meeting its goals and objectives, and if it is not, why? They should not be there to criticize but rather to say are you meeting your own goals and objectives, and if you are, good for you, and if you are not, then why are you not and how can the system help you to better do that?

CHAIRMAN (Mr. Zoe): Are your nurses utilizing the A.N.S.I.P. program which is provided by the Department of Health?

MS. HANSON: Yes.

CHAIRMAN (Mr. Zoe): Are they quite satisfied with this program?

MS. HANSON: I believe so.

CHAIRMAN (Mr. Zoe): You have talked about the line item within your budget for training. Is it specifically for boards or is it for other staff training?

MS. HANSON: I believe that in our budget it shows it as education money.

MS. MACDONALD: I believe there are two lines. One in the accounts which we have for boards that identifies board development money and then there is a separate line item for staff development.

CHAIRMAN (Mr. Zoe): Are you quite satisfied with the funding level in that area?

MS. HANSON: No.

CHAIRMAN (Mr. Zoe): Would you like to see that area looked at?

MS. HANSON: Very definitely. I think you have to train your staff. You have to ensure that your staff feel comfortable performing the duties which they are asked to perform. The only way in which you can do this is to ensure that they are kept up with their training. We would like a lot of money. If you can identify a big pot we will take it. We have identified this as a priority. This year we have had to turn down so many of our staff due to cutbacks because we do not have the money to allow them to have the training which they desire. I would like nothing better than to let them go ahead and get the training. I think we have done the best that we can. What we have asked of staff is that if we give then they should give.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: I was interested in the comments you made about the quality assurance for doctors. The Auditor General also commented on this, in section 4.6, regarding performance standards for doctors. He commented on the lack of performance standards for doctors. The Auditor General seemed to think that we should set standards for doctors in the same way that they are set for nurses. Last night we had a doctor present and we have spoken with her. She commented on this also, I sensed that she was not in support of this recommendation. Do you have any comments on this?

MS. HANSON: I personally believe that there should be standards set for physicians. They are part of the system and if there is no standard how can we measure whether or not they are doing their job? We have to come back to the word accountability. They need to be accountable to the system and to the patients to whom they deliver a service to. One of the ways that the board has of checking that is to say that this is the standard, this is the minimum level of service we will accept. We would expect them to go above and beyond that, but unless we have set that minimum level of performance it is very difficult to ever do any kind of review. As I have said to you before we are lay people. The physicians themselves, once they got into that kind of system would realize that it is to their benefit. I would think that those standards would be something which they would set themselves as to what is an acceptable level of service.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: I was interested to hear what you said about the establishment of a review board through the College of Physicians and Surgeons. To do this in the territories we would borrow from the provinces. There is probably a pool of people who could lend their expertise to us in this area. I like the idea that we have our own standards. One of the comments you made was that the public or the patients look at the doctors as if they were God. People never question the doctors or dentists. It is important as we progress that we get another opinion. The public have to be educated in this area. They need to know that they can ask more questions than they presently do.

We have heard that the Inuvik board has set a big priority on board evaluation since assuming your role. You are to be complimented for that initiative. Has the department helped you in this area? Have you received any assistance for your effort?

MS. HANSON: No.

MR. WHITFORD: That is too bad.

MS. HANSON: I should clarify that. I have not asked for any either. We did not ask the department for their input. It was something which I felt had to happen. In its infancy it is not perfect. For example, I have found that using the departmental Hay Plan performance appraisal for a chief executive officer of a health facility was ridiculous. Therefore I set about writing to every board Canada-wide to get examples of how they evaluate their C.E.O., and then pulling bits and pieces from all of that and putting together a document which I felt met our needs. As a board we have used that as an informal tool. At the present time we are still at that stage where we have to submit using the Hay Plan form. You can see, once again, where we have run into those difficulties.

The Department of Personnel in Yellowknife was of great assistance. It was when the Auditor General came to Inuvik and I happened to walk into the hospital and was introduced to him, he then asked me a couple of questions. One of them was about evaluation, and I told him that we had just developed this form. I gave the form to him. I then got a phone call from him saying that he was really interested in this and that it was something which he would like us to pursue but he wanted me to send it to the Department of Personnel in Yellowknife. We did this. The Department of Personnel then got back to me regarding the wording on a couple of things which they felt needed to be changed.

MR. WHITFORD: The Department of Personnel?

MS. HANSON: Yes, the Department of Personnel in Yellowknife.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. This fact is that you are trying to do something at this level and see some ways of going about the evaluation of boards and C.E.O.s. I am sure that other boards must be faced with this. Do six or seven boards ever get together to discuss these problems and solutions? It seems practical to do this. Have you ever had an opportunity to do this and could this be of some advantage?

MS. HANSON: It would be of great advantage. In fairness, I took over the Chair in September. I do not recall when there was ever a time when the board Chairs all came together as a group to discuss common concerns. The Chairs are sometimes called into Yellowknife by Yellowknife with their C.E.O.s to discuss the budget. However, I do not think there has ever been an opportunity. As a board Chairperson it was very interesting for me to attend the last Standing Committee on Agencies, Boards and Commissions where I got the chance to meet the Chairpersons from some of the other boards for the first time. It was great to find out that I was not alone and that there were other people having similar problems and concerns. I think it would be very valuable if we could get together as a group of boards without interference to talk about our concerns and problems, and to come up with groups of recommendations that we could all live with.

Evaluation is one of them. I am sure that all boards are struggling with it. Evaluation is a very tricky thing. It falls on a group of lay people to evaluate someone with some very high skills, in a very specific field. All we know is what we see. Sometimes this is very difficult. Our board members, perhaps, see our C.E.O. five times a year. They may talk to her on the telephone and she will deal with their problems and concerns but then we have to evaluate this person. I really think that we need to work this through. If we could standardize it territory-wide as to how we evaluate C.E.O.s, boards and the system, we would be far better off. There would then be an interchange and exchange of information, open communication and a willingness to help and share.

Last night during the presentation from the Kitikmeot it was really good for me to hear that they think they are underfunded. Of course, I think I am underfunded also but maybe I am not quite as underfunded as they are. It is good for me to hear this. These kinds of things should be discussed.

MR. WHITFORD: There is a simple but practical solution.

MS. HANSON: Very definitely. Sometimes though the practicality and the simplicity is what evades us.

CHAIRMAN (Mr. Zoe): Are there any other comments or questions? Ms. Hanson, you probably are aware that the Department of Health have appeared before our committee on January 6 and 9 in Yellowknife. At that time, Dr. Kinloch talked about the history of difficulties which have been experienced with regard to the roles and responsibilities of boards. During our hearing he was trying to explain why it has been difficult for the department to support the idea of giving boards more autonomy. He said that the effective operating period since the signing of the 1988 transfer agreement is considerably less than five years. He said that during that time there has been continuing difficulties with the recruitment and retention of important senior positions on boards, notably finance officers. He specifically mentioned the Inuvik Regional Health Board. He said that the Inuvik Regional Health Board suffered seven finance officers in one year. I do not know what year he makes reference to. However, is this still happening within this region?

MS. HANSON: No, I am pleased to say. Raj has been with us since April, 1990.

CHAIRMAN (Mr. Zoe): I would like to know the dates. It is misleading to our committee. I am not sure as to what time frame the Auditor General was making reference to. He also made statements on other issues which were reflected back in 1988 or 1989. I would like to find out if this was still happening in the Inuvik region.

MS. HANSON: It is not happening at the moment. We did go through a number of finance officers. I think part of the problem was that at that time the finance officers had two masters. They worked for the regional health board but they were also responsible to the Department of Finance at the same time. Their task was next to impossible. They had to try to keep everybody happy. At the time of transfer there were a number of things which needed to be done. I am not exactly sure of Dr. Kinloch's figures. I do not know how many we went through. It seems like a large number. We did experience a considerable turnover in finance officers.

CHAIRMAN (Mr. Zoe): Within that time frame, Dr. Kinloch mentioned seven within one year. What type of assistance did you get from the Department of Health?

MS. HANSON: That is a very good question, however I am afraid I cannot answer it. As a board member at the time I can honestly tell you that I do not know that we received any assistance from the Department of Health. Do you mean in terms of someone coming into assist the new person?

CHAIRMAN (Mr. Zoe): To assist the board to recruit, etcetera.

MS. HANSON: I am afraid I cannot answer that. I really do not know that we got any. I think the recruitment process was done by the board itself.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? You commented on the human resource section of the Department of Health. You indicated that with respect to training they have to go out into the field and try to recruit the young people. Are you suggesting that this particular section within the Department of Health is not as pro-active as they should be?

MS. HANSON: In one sense I am. I think they play a major role in as much as they are banking upon, which we can call when we are in need of someone and they keep records of people. My personal belief is that they should be more pro-active. I think that this division should do a lot more to attract aboriginal peoples into these professions. I see that as an expanded role. I think that is one area where what we need to talk about is a refocusing of what should be happening, not cutting that one out, but refocusing on what it should be doing. I do not think we can get along without it. I think we need it. I would also like to see it take on an expanded role to ensure that we are getting on with these programs, both the A.N.S.I.P. program and the programs that we need to develop our own nurses, aids, lab technicians, physio-therapists, etc. The boards themselves do not have the time or the money to do this.

At the school level when a young person comes to me and informs me that he/she wants to be a nurse, doctor, C.N.A., and I have a young woman right now who wants to be a C.N.A. and I have to send her to the south, if she wants a certificate. There was a program through Arctic College and it may still be there but right now there is no access to it. Some of our students need upgrading in the science and math areas. There has to be a facility that the Department of Health guides to upgrade students to the point whereby they can be successful in health careers, which are science and math oriented for entry level. I see that this is an important role which the department could be playing by promoting health care careers throughout the territories, not only in the promotion of them but overtly going out and finding people to fill these programs and to run them.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford, do you have any further comments or questions?

MR. WHITFORD: Mr. Chairman, in section 2.7 of the Auditor General's report he suggested that many of the financial monitoring functions within the hospital and health facilities division and the health insurance division should be consolidated within the finance and administration division of the Department of Health. What implications would this reorganization have on you? Would it become easier to deal with the department if this was the case?

MS. HANSON: I think I will refer that question to my two colleagues who would be working directly with it.

MS. MACDONALD: I think it would be more appropriate for Raj to respond for Inuvik.

CHAIRMAN (Mr. Zoe): Mrs. Downe.

MRS. DOWNE: From our point of view it will make sense to combine all of the functions under one control because they are all finance and administration related. Then we would have to deal with one group of people instead of dealing with three separate groups of people as we do now.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions? Mr. Whitford.

MR. WHITFORD: At the first set of public hearings the director of health facilities explained to the standing committee that there are differences between boards of governance and boards of management. What is your assessment of this distinction? Is it helpful to consider and has this model been discussed with you?

MS. HANSON: No. It certainly has not been discussed with us. At the time of transfer when we became a board we were told that we would have the ability to control and manage the facilities within our region. From what we have learned over the last four years, that is not the case. We can control, manage and deal with the functions within certain guidelines and parameters. We are not a management board as such right now. Whether we govern, I think that is semantics, personally.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Mr. Chairman, is the decentralization of the health insurance service division to Inuvik and Rankin Inlet going to be of benefit to your board?

MS. HANSON: That is a catch 22 question. Yes and no. As a community we certainly look forward to the influx of peoples and the creation of jobs. It is our understanding that probably we are going to lose one of the wards that we had to close down due to fiscal restraint to that operation. I do not know if this is going to help us at all. I do not see any help for the board having that billing system in Inuvik. Perhaps Raj would like to add to that.

CHAIRMAN (Mr. Zoe): Mrs. Downe.

MRS. DOWNE: From my point of view, what I see happening is that it will not have any impact on us and it will not help us as a board or as an organization. If a division is going to be split and sent into two different regions there would then be questions or disparities in assessing the policy or procedure. For example, if each of the boards are not sure of how to apply a policy in a certain case they phone someone in the Department of Health, within the H.I.S. division, and ask for direction. If the division is divided into two different areas, Rankin Inlet and Inuvik, someone from the Baffin would call Rankin Inlet and probably could get a different interpretation of the policy, and someone from the Kitikmeot would call Inuvik and get yet another interpretation. There will be disparities as to who gets what kind of benefit. That is my point of view on this.

MS. MACDONALD: I have one concern which has not been mentioned by Raj or Dale. I perceive it to be that it will cost more to operate it in several locations and certainly as an over all system under a lot of scrutiny about our costs. I would rather see costs spent on operations in the field than this, notwithstanding the economic benefits to Inuvik. Perhaps they should bring the whole of the H.I.S. to Inuvik.

CHAIRMAN (Mr. Zoe): Are there any further comments? I have one more question for Ms. Hanson. I posed a question to Mr. Maksagak with regard to a statement made by Mr. Eckalook who is the Chairman of the Baffin Regional Health Board. He made a statement indicating he felt the Department of Health has been reluctant to give boards additional powers or enable them to have more autonomy because the board structure or membership are all aboriginal people. He thinks that part of the reason for the department not giving them more autonomy was that the department thinks they are not capable of handling the responsibilities that would be given to them. He indicated this to us during our hearings in Rankin Inlet. I posed the same question to Mr. Maksagak yesterday. He generally agreed with the statement made by Mr. Eckalook, Chairman of the Baffin Regional Health Board. Would you agree with that statement?

MS. HANSON: Yes but with some riders. When we became boards four years ago we had no notion of where we were going, what we were doing, or how we were going to do it. Therefore, the department had a responsibility to ensure that the boards were able to manage, operate and control the facilities under their control. I think that the boards themselves have grown. I think we are out of the diaper stage and we are now at the toddler stage. We want more autonomy. We have learned the system. We have learned what our people need. We have learned about how we can possibly go about getting it. What we need now is to be given the chance to do it. It is so analogous to a child growing up. The parent has to keep a very secure hand on the child when the child does not have the skills to go on their own. As the skills grow the parent has to start letting go and allow the child to make a few mistakes but to keep him within close proximity. I think this is very analogous here. The Department of Health needs to rethink and refocus and start giving us a little bit of leeway. That does not mean that we are not accountable. We are wholly and totally accountable for the money that we are given, the programs which we run, and to the people we serve. I think it is very important that we are given with one hand but we are guided. This is a long-winded answer to a very simple question. Yes, at first they had every need to hang on tight but now they have to start letting go and they have to let us learn by our mistakes. They also have to be there to be big brother, or mom and dad. In other words we really need them. What has to happen is that we have to start working together for the same end. We are not opposed. We are all doing the same thing for the same reason. We are going to have to work this through. We need the department but the department also needs us. We have to start this communication with a little give and take.

I get very angry when I think one of the needs in our region is this and we do all the paperwork and send it to Yellowknife, and they say no. Nothing makes me angrier. If I am a board of management then give me my board, and give me my management monies and let me manage them. On the other hand the other half of me says that this is all very fine and good but three months down the road and you have spent all your money, what are you going to do? I think there has to be an equal balance. I do not think it has anything to do with aboriginal peoples being not able to handle it. It needs time and training, some give and take and some open lines of communication which are not present right now.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? I would like to thank the Inuvik Regional Health Board for appearing this morning. It was a well thought out presentation and I really enjoyed it.

MS. HANSON: Thank you.

MRS. DOWNE: I would like to make one clarification on the information system, on the accounting system specifically. After we were forced into taking on the H.B.I.S. system for our accounting system, as recently as this past summer we have struck a working committee which is made up of some of the directors of finance, myself and staff of the Department of Health. We are working together to identify our needs and to come up with a system which will help us support our needs and be able to do our operations in an effective manner. There is a working committee at this point in time.

CHAIRMAN (Mr. Zoe): Thank you. We will take a five minute break.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): The next witnesses to appear before us are representatives from the Inuvialuit Regional Corporation. For the record can you please introduce yourself.

MR. GRUBEN: Thank you, Mr. Chairman. I am Roger Gruben and I am the Chairman of the I.R.C. I also have Gloria Allen who is the I.R.C. representative to the Inuvik Regional Health Board with me.

CHAIRMAN (Mr. Zoe): Please proceed with your presentation.

Presentation by the Inuvialuit Regional Corporation

MR. GRUBEN: Mr. Chairman, I would like to welcome you, the committee and staff members to the western Arctic. I would like to thank you for the opportunity to comment on the Auditor General's Comprehensive Audit of the Department of Health. I make these comments on behalf of the Inuvialuit Regional Corporation. As you know, the I.R.C. represents the political interests of approximately 5,000 Inuvialuit in the six western Arctic communities of Inuvik, Tuktoyaktuk, Aklavik, Holman, Sachs Harbour and Paulatuk. In 1984, after ten years of negotiation, the Inuvialuit concluded a land claims settlement with the Government of Canada. In that agreement we retained ownership of 35,000 square miles of land, received financial compensation on a scheduled basis and had enshrined a series of rights and benefits.

Additionally, a social development fund was set up under the agreement and charged with the responsibility of addressing the social and cultural needs of the Inuvialuit in the areas of health, housing, education, elders and other matters. I.R.C. as the parent corporation is mandated to implement the final agreement.

I applaud the efforts of the Auditor General who, on behalf of the elected Members of the Legislative Assembly, did a very thorough and complete evaluation on a very difficult task. I also applaud the Legislative Assembly for their foresight in realizing that critical problems relating to the deteriorating levels of health services in the north needed to be addressed.

The issues and problems identified are very accurate and reflect many of the positions taken by the Inuvialuit both at the I.R.C. and at the community level.

Having said that, however, I feel that the healthy public concept could have been better served if the scope of the audit looked more at actual health programs rather than the organizational management structure of the Department of Health and the regional health boards. The organization end or the management structure of the department and the entire Government of the N.W.T. was thoroughly reviewed as part of the Strength at Two Levels report which was completed in 1992. In our opinion there is a duplication of effort as much of the information contained in the Auditor General's report could have been obtained from the Beatty report.

A transfer of health from the federal government to the territorial government was intended to improve the delivery of health services to residents of the north. It is apparent that possibly the reverse has happened. This is evident because health delivery services deteriorated in the communities in the western Arctic after transfer as a result of inadequate financial resources. The G.N.W.T. given the available financial resources that it had could not provide the same level of service as Health and Welfare Canada. The intent of devolution of health care to the N.W.T. was to bring health care services closer to the people being served. It is our belief that this has not occurred as the department continues to demand budget cutbacks thereby reducing medical services.

Because the mass confusion at senior levels affects both the department and the boards, the front line care givers at the community level are affected, as well, which results in low staff morale. Low staff morale in the community translates into a low quality of services to residents. It is essential that all levels of the bureaucracy work cooperatively towards the goal of a healthy public.

I.R.C. believes strongly that the Inuvik Regional Health Board should be substantially down-sized. At the present time, there are 18 members on the board making it cumbersome and costly to operate. A down-sized board, as a suggestion, should consist of a chairman and five members representing the major interest groups and the communities in the Inuvik area. It makes a great deal of sense from both the management and organizational standpoint to have a smaller board responsible for the delivery of health services in our region. A smaller board does not mean that there will be less community input into health issues.

I.R.C. advocates that I.R.H.B. sponsor, on an annual basis, a regional health conference where community members are able to address their health concerns. In addition, community health committees could access the board through the public members.

In concluding my opening remarks, I must comment on the author's main source of information for this report. It is obvious, and has been pointed out in the report, that most discussions were with senior managers of the department and the boards. We have no way of determining how aggressive the authors were in attempting to talk to health board members, although, in the report, it does state that there was an effort made with front line care givers, community health nurses and community members. It is our belief that if a dialogue had occurred with community members, the authors of this report would have had a better understanding of the problems.

I would like to specifically address certain sections of the report in greater detail. In the executive summary, in light of strained financial resources, we must state that research and studies conducted by the Department of Health must be prudently undertaken and with a view to not duplicating previous efforts. The department requires a clear, decisive mandate for organization and planning purposes in order to effectively and cost-efficiently deliver programs to the public.

I believe it very critical that the impact of land claims on health issues could have been addressed in the report. After all, aboriginal people, through claims agreements, will, in some fashion either directly or indirectly, impact on health and the delivery of such in the Northwest Territories. For example, the I.R.C. is very much involved in designing forums of public self-government. These models of government will obviously contain abilities for communities or agencies to assume more authorities over programs, such as health. Although the Auditor General's report does not address this issue, it will have to be addressed in the future.

I would like to deviate from my written comments here to elaborate on that point, Mr. Chairman. We know that the community health committees have been set up through the Department of Health. There is representation on those committees from those at the community level. Even in Tuk, where I come from, there is confusion as to the make-up of the community health committee. There is confusion as to its responsibilities in relation to having input into the health system. For instance, those members at the community level on the health committee feel that they have a responsibility and they have the authority to input into decision-making at the local community service health delivery system. Unfortunately, in many cases, this is not happening. There seems to be an attitude within the health service department that those at the community health committee level are involved in the process only as a courtesy. Unfortunately, this translates into difficult and sometimes very unnecessary situations. I believe that the issue of more responsibility from the central government level to the regions and eventually to the communities, when we are talking about the issue of devolution, community self-government, aboriginal self-government or public government systems, there has to be the recognition. There should be a complementary effort between those at the community level, within the health care system as professionals, at the regional health board, as well as within the department itself.

In conclusion, the issue of the involvement of aboriginal organizations, particularly as it relates to planning for the devolution of certain types of services, such as health to the regions and to the communities and the involvement of the aboriginal groups in the design of the devolution or the program delivery, is a requirement. I believe, you, as the Standing Committee on Public Accounts, can initiate this. It is very important that the regional health boards, the department, the community health committees, the municipalities, community corporations, which are claims organizations, and the parent organization, know their respective roles in the delivery of health care and services as well as the planning.

We know there is much confusion between all parties as to their respective roles and responsibilities and, in many cases, unfortunately the above-mentioned groups are jockeying for power and authority, sometimes at the expense of delivery of care and services to clients.

It is extremely critical that the regional health boards are representative of the region. Representation should include community as well as native organizations' representatives, always keeping in mind the size of the board. There should be a clear definition of roles and responsibilities between the parties who are working together on the issues of health. The planning and delivery of health services will be impaired until such time as the roles and responsibilities are defined. Planning and delivery must be cooperative and complementary between all groups. The issue of planning and cooperation should extend into departmental relationships as well. This, in turn, will lead to greater efficiency and more value for money spent. The definition of roles and responsibilities, in our opinion, is required immediately.

It is also critical that the Government of the Northwest Territories resolve its outstanding financial problems and arrangements with the federal government. It goes without saying that without adequate financial resources, delivery of health services will be substandard and erratic. In this particular case, I will refer to your difficulties as the Government of the Northwest Territories and the Legislative Assembly in coming to agreement on money owing.

On the organizational structure, it is quite apparent that the confusion that exists on roles and responsibilities arises out of central government bureaucrats not wishing to devolve responsibilities and authorities. However, unless this issue is addressed at the political level, and transmitted and monitored by politicians to civil servants, that the government policy is to decentralize, the situation will never improve.

We must impress upon the standing committee Members that the planning and delivery of health in the N.W.T. is a major component in models of self-government that politicians in the north are now in the process of defining. For instance, the assumption of health care and services is addressed in the I.R.C. regional government draft legislation. Unfortunately, I do not have a copy of that available with me, but I will table that with your staff so that you might better be able to relate to my set of comments on that issue. Although these types of self-government initiatives or devolution are addressed in constitutional discussion papers, the efforts and the contents of those discussion papers will be meaningless unless government commits to ensuring its political will is transmitted and adhered to within the civil service.

If I can use an example, the Government of the Northwest Territories has now made it a priority that they wish to decentralize, that they wish to devolve services from the central authority to the regions and eventually down to the communities. However, a case in point, Sachs Harbour, a number of years ago, tried to go through that route of assuming more responsibilities. The political will was there from the Cabinet Ministers. However, the political will was not transmitted to those civil servants within Yellowknife and Inuvik. Therefore, the actual transfer of responsibilities to Sachs Harbour, although it was a good idea, did not work. To me, it was a clear case of those persons or departments within certain levels of authority did not wish to devolve more authorities and responsibilities to the regions and to the communities. We have attempted to address that subsequent to that exercise. Even today, you can still witness that that attitude is very much prevalent within the department.

On the issue of board members, I spoke about the attitude of those within the civil service toward board members. In many cases, it is patronizing. Many people can say that it is as if they were extending a courtesy to the board members in the role that they have. We all know that many board members are not health professionals. Because of this, they are seen by the health professionals, in many instances, as not having expertise to make fully informed decisions with respect to health issues. This becomes increasingly obvious when a board member is aboriginal.

The Inuvik Regional Health Board members can cite examples where senior hospital management made decisions without board input and subsequently brought them to the regional health board for rubber-stamping. However, the Government of the Northwest Territories, the regional boards and the sponsoring agencies of the board members can help to bridge this gap by introducing effective training for board members on issues dealt with by their respective boards. Training should be effective. It should be ongoing. There should be allocated funds that will not be automatically cut during times of budget restraint.

It seems that the issue of training, particularly as it relates to board members, is always highlighted as a requirement, as a necessity, but unfortunately, when budgets have to be cut training seems to go out the door. That is very unfortunate and I do not think that the board members will be able to be as effective and as complete as board members unless they are allocated funds that remain within the budget on a consistent basis.

Mr. Chairman, on board members, I am not talking about board members being given training to act in terms of what a board member should do, for instance, on how to conduct themselves in a board meeting. Those kinds of issues can be dealt with in other forums. Many people can gain those responsibilities through experience. I am talking about workshops and training for board members on issues that they have to deal with through their respective health boards.

I would like to comment on health care professionals and what we consider to be a necessity for these professionals to be knowledgeable about their clients. For example, they should be aware of their traditions and cultures so that they are better able to understand and deliver health services. The I.R.C. believes that cross-cultural orientation programs would resolve many of these misunderstandings.

Mr. Chairman, if I can refer to an item that is currently in the media, it refers to an unfortunate incident in Yellowknife involving a snowmobile. In that particular series of events, following the determination of what happened and the resolution of not allowing that type of event to happen again, a representative of health services indicated that maybe a possible solution to that problem was to disallow snowmobiles from within the city limits. I used that example because, to me,

that is a very clear case of how, as a by-stander looking in, there possibly is a requirement for the health professional to better understand the needs of the people within the region, who are its clients, and the need to allow a certain type of activity, in this case snowmobiling within a certain area. It is their way of life. Can you imagine how those clients, within that area, would react to that particular kind of statement? It does not really make sense, although I understand that the health care professional is trying to resolve a difficult situation and that he is trying to offer a solution. I think that the solution does not meet the circumstances. The possible way to bridge this misunderstanding would be for some type of cross-cultural orientation for health care professionals as they come into the area of employment. Understand your regions and your people. It makes for better service delivery, in our opinion.

During the days of negotiating the health transfer, the I.R.C. pointed out many times that it would not make sense from an efficiency and cost-control standpoint, to have the Department of Personnel recruit for the Department of Health on a territory-wide basis. As it states in the Auditor General's report, that problem has become more paramount. It is more noticeable. It may make sense to involve those two departments on a regional level because they are in close contact and proximity to each other. However, when you try to do it on a territorial-wide basis, there is a time delay for the recruiting of professionals. There are increased costs because of the distances between the parties who are supposed to be working together.

On the issue of financial issues as raised by the Auditor General, it is obvious that the larger the composition of the regional boards, the more funds are required to be allocated to that infrastructure to the detriment, in many cases, of program delivery. I would say that this is not the wisest use of diminishing financial resources. Again, I refer you to my earlier comments of down-sizing the regional health boards to make them more representative and effective and still keeping in mind the responsibilities of the board and the diminishing resources.

On the issue of medical travel, I believe that the Department of Health, in this case, doctors and nurses, should exercise more understanding on requests for travel. For instance, concerned parents, spouses and relatives, many times suggest the need for travel sometimes related to perceived emergencies or life threatening situations. That is from their point of view. That is how they perceive it. However, they are often not given the respect they deserve for their requests and their reasons for such by health care professionals. In many cases, the requests are denied and this sometimes results in life threatening situations which could have been entirely avoidable.

I come from Tuk, Mr. Chairman and board Members, and I know of an instance in Tuk where the family brought the issue of an individual who was suffering from some medical problems. They brought the issue to the local health care professionals. There was not an understanding arrived at. The locals wanted to have this person brought to the regional centre, Inuvik in this case, to receive treatment or analysis. Because of the lack of understanding, respect or willingness to work together with the locals, that situation became such that that person had to be sent by medevac all the way to Edmonton. That is the kind of issue that I refer to where, if there was a better working relationship, both at the community level and the willingness to discuss issues and to arrive at understandings together with the ability to make decisions together on certain issues we, could avoid these types of situations.

Mr. Chairman, I hope that the standing committee Members will consider our comments and concerns. I thank you for the opportunity to make this presentation. I would like to point out to you that you have attached to the presentation, letters from the chairman of the health committee in Tuk to the health care system. It explains some of the situations that I have referred to in our report.

CHAIRMAN (Mr. Zoe): Thank you. Are there any comments or questions from the committee? Mr. Whitford.

General Comments

MR. WHITFORD: When you speak of patronizing attitudes toward board members, where would something like this come from all levels in the Department of Health?

MR. GRUBEN: Because we are more involved at the regional level, that attitude is more at the regional level. It goes back to accommodation of issues, health care professionals taking direction or receiving input from what can be considered non-professionals in particular areas. That type of situation needs improvement.

MR. WHITFORD: Do the boards have enough authority to give direction?

MR. GRUBEN: That is part of what I was saying about the definition of roles and responsibilities. The regional health board feels they have authorities in certain areas. I believe they should have the authority to give direction to the region and to the health care professionals within the system. Unfortunately, that really has not happened in many cases. If you wish us to cite specific examples, Gloria is here, who can provide you with those examples possibly after we are done talking.

MR. WHITFORD: What about the hospital management staff? Would that be part of the problem as well?

MR. GRUBEN: To a certain degree it is there. On many occasions, too, there are decisions that are being taken by the regional health board. Those decisions, in certain instances, are over-ruled by those at headquarters. Again, that is what I call the definition of roles and responsibilities, which are not clearly defined.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Whitford.

MR. WHITFORD: I was especially interested in your comments about the community health committee because there were similar comments that we have heard on Tuesday from the Baffin Regional Health Board. Health committees are established by local governments so that they are actually closer to M.A.C.A. than they would be to the Department of Health itself. Is that the experience in this area? Would your

group feel that they should be taking a different role in this?

CHAIRMAN (Mr. Zoe): Mr. Gruben.

MR. GRUBEN: Let us talk about it from the community level in Tuk. The responsibility for the setting up of the community health committee is with the municipality. There is a problem already because we say that at the community level we would like to have all of the agencies represented. Do not forget that you have the municipality and the claims-related bodies, of those that I represent, and we both feel that we have a responsibility to input comments into health delivery. As we recognize that the delivery of health and the responsibility for health, in many areas, is the government's, we feel that, at the community level, there should be a process put into place where the community can agree as to how they should come together, who should be represented and how they should relate to the regional health board. It is very unfortunate, but even in my community, there is jockeying for power. There is jockeying for who is going to have the final say as to representatives to the community health committee. I do not think this makes for working relationships that will improve the issues that we are charged to deal with.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: If your suggestion on page two of your presentation were to be enacted, it would make it even worse. I agree with you in part that a board of 18 members is pretty unruly. That is a lot of members. I am not sure whether or not that board does have its full complement. It is a very large number, and downsizing would probably make it more manageable. Who is going to be represented on it? You said one from each of the five communities?

MR. GRUBEN: Mr. Whitford, I hope that you are not presupposing that the aboriginal groups and the community agencies are not able to work together. I hope that you are not meaning that.

MR. WHITFORD: I am only trying to interpret what you are saying.

MR. GRUBEN: What we are suggesting here is, first of all, the regional health board is too large, cumbersome and costly in the ability to make decisions quickly and timely. We have addressed the need at the I.R.C. level that we can work together at the regional level to assign members jointly between us and the communities. It is very easy to ask the I.R.C. to go to a community like Tuk and say, "Can we agree on a representative from there to the health board?" Let us say Inuvik, which has more representation than some other communities, could they not be asked to do the same thing with a view to down-sizing the board to make it more effective? I bet if there was a requirement for the agencies, collectively, to look at putting that kind of system into place, it could possibly be done. I speak for my own communities. I know that it can be done with the possible exception of Inuvik because we have diverse populations. We may have to look at meeting all the requirements of the different groups. Again, I still do not believe and I do not accept any initiatives that say it cannot be done.

MR. WHITFORD: Do not get me wrong. I did not say it could not be done. I am supporting what you are saying that 18 is too many, but how would we go about selecting board members? You pointed out that there will be problems in other interests wanting to participate. I was only suggesting that 18 was probably too big. What would be a good size?

MR. GRUBEN: When I was talking to some of my representatives in the communities, they pointed out that very same thing, saying, "do you know what is going to happen when you go up there with one plus five? Somebody is going to say that is not going to be enough. Somebody is going to say, 'How do you work at it?'" I said, why do we not low-ball it first because it gets to the issue of the diminishing resources. I think it makes that point. It also makes the point that there has to be the cooperation and the coordination of various interest groups to come to work together, in this case, of appointing members to the regional health board. You are very perceptive in that sense.

MR. WHITFORD: When it comes to appointments, will there be other ways of making it more equitable and more responsive, accountable or whatever the case may be? What about an election of an individual to a board, something like town council or certain other things that are elected by the people of that community to represent him on that board, rather than being appointed? Appointments have some downsides to them. They are a quick and good way of doing it, but elections would certainly speak the mind of the community. Would that be, in the future, a way to go?

MR. GRUBEN: That is a possible approach. Let me refer back to the I.R.C. draft legislation on the creation of a regional government, a public government. I would like to use the example of how we would choose our representatives to the regional council that would represent the six communities in the confines of the regional government. We say that there should be elections to have people to the regional council. However, we also say that there should be one representative per community, and then maybe some at large so that you have people representing the entirety of the region. We are talking about a form of government that reaches out to many communities and many different groups. It would deal with the issue, as well, of major centres possibly having more representation but also bringing it into the democratic level of fairness. If you wanted to refer that particular type of possibility to the representatives of the regional health board, I guess that is one possibility. There are many different possibilities.

For instance, in Inuvik, you have the town council, I.R.C. and the Gwich'in Tribal Council. Who is to say that we cannot get together and jointly come up with a representative or a process to define a representative? I use the issue of Inuvik because it is a location where you have diverse interests and different ethnic groups. It may be that there is more of a requirement in this particular setting to have that cooperation between all groups involved in the system. Whereas, in Tuk, because of the population there, it is much more simple, but the concept still applies, that you have your different agencies within the community coming together and agreeing on what their representation should be.

CHAIRMAN (Mr. Zoe): Are there any further comments and questions? If not, I would like to thank the I.R.C. for making a presentation to us this morning.

MR. GRUBEN: Thank you.

CHAIRMAN (Mr. Zoe): Thank you very much. Are there any further witnesses from the public who would like to make a presentation to our committee? If there is not, the committee is adjourned until 9:00 tomorrow morning to reconvene back in Yellowknife. Thank you.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PROCEEDINGS

PUBLIC HEARINGS

YELLOWKNIFE, NORTHWEST TERRITORIES

FRIDAY, JANUARY 29, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

FRIDAY, JANUARY 29, 1993

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Deputy Chairman

Mr. Fred Koe

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Mr. Ludy Pudluk
Mr. Tony Whitford

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Transcript

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Ms. Elaine Berthelet, Assistant Deputy Minister

Mr. Jim Antoine, M.L.A. for Nahendeh

Northwest Territories Health Care Association

Mr. Adrian Wright, Chairperson

Ms. Wendy Colpitts, N.W.T. Resident

Northwest Territories REgistered Nurses' Association

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Ms. Suzanne Marsollier, Past-President

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Northwest Territories Native Women's Association

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Ms. Riki Sato, Executive Director

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

JANUARY 29, 1993

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): Good morning, committee Members, public, Dr. Kinloch and Ms. Berthelet. I would like now to call the public meeting of the Standing Committee on Public Accounts to order. Everybody knows who I am. I am Henry Zoe, M.L.A. for North Slave and Chairman of the Standing Committee on Public Accounts. Before I begin today, I understand we have a busy schedule in front of us. I would like to ask Members if they would introduce themselves for the record. I will start on my left.

MR. WHITFORD: I am Tony Whitford of the constituency of Yellowknife South.

MR. ARNGNA'NAAQ: I am Silas Arngna'naaq, the M.L.A. for Kivallivik.

MR. PUDLUK: I am Ludy Pudluk. I am the M.L.A. for the High Arctic.

CHAIRMAN (Mr. Zoe): It is our purpose here today to continue with our review of the Comprehensive Audit of the Department of Health that was completed by the Auditor General. This report was transmitted to us in October and was referred to our committee for a public review. The committee held public hearings in Yellowknife earlier on this month, January 6, 7 and 8. At that time we heard witnesses representing the Office of the Auditor General, the Department of Health, Stanton Yellowknife Hospital and the St. John Ambulance. On January 25 and 26, we held public hearings in Rankin Inlet. At that time we heard from the Keewatin and Baffin Regional Health Boards, the Kiguti Dental Clinic, and the M.L.A. for Keewatin Central, the Honourable John Todd. On January 26 and 27, we held public hearings in Inuvik. At that time we heard from the Inuvik and Kitikmeot Regional Health Boards, the Inuvik Medical Clinic and the Inuvialuit Regional Corporation. We have a great number of witnesses registered today to appear before our Standing Committee on Public Accounts. We will begin this morning hearing from the Deputy Minister of Health, Dr. Kinloch. Due to the number of outstanding issues raised as a result of our first hearing and our travel to Rankin and Inuvik, we have allocated 40 to 50 minutes for this presentation. We are running behind schedule already. As there are a number of registrants, we will allow 40 to 45 minutes. Witnesses will be asked to make brief presentations or a brief opening statement. I would encourage witnesses to keep introductions to ten minutes so we can get into discussions with you. I would like to ask for the cooperation of all members. If there is information which cannot be covered in our limited time today, we can always follow up with correspondence at a later date. With those comments, I will ask Dr. Kinloch or one of the representatives of the Department of Health to proceed with your opening remarks.

DR. KINLOCH: Thank you Mr. Chairman. I shall be very brief. Mr. Downe kindly provided Ms. Berthelet with a briefing on the discussions that were held in Rankin Inlet and in Inuvik and we have a general idea of the nature of the questions that may arise. In the interest of accommodating your tight schedule today, I would suggest that we proceed directly to the questions.

General Comments

CHAIRMAN (Mr. Zoe): Are there any comments or questions? Dr. Kinloch, during our public hearings in Rankin and also in Inuvik, we heard a number of comments from the health boards. I questioned them in regard to the statements that were made by the Department of Health, by yourself or Mr McClelland, and I quoted something that Mr. McClelland said at the time. It said, "both the Financial Management Board and the Standing Committee on Finance raised questions of the Department of Health and have sought assurances from the department that operational, hospital and health boards are effective and being carried out with due regard for efficiency and economy." During that morning Mr. McClelland continued on and I quote him again, "Mr. Chairman, here is an indication from one of the management letters that we received from auditors in this respect. As you know hospitals and health boards have to have an annual audit. It provides a financial information statement and it also provides management letters

I will read to you an extract from some of these letters and it will give you, and certainly our accountant friend, Mr. Koe, an appreciation of some of the problems that are here. I had Fred on the committee then.

Mr. McLelland went on and indicated that "one of the audit letters says that the accounting systems, controls and procedures are not implemented. As a result, financial statements are materially inaccurate, senior management reports are not formally made to review the monthly statements, billings are months in arrears, bank reconciliations were not properly completed," He continued on, "Manual paycheques were issued and not recorded." At one point he indicated that over $100,000 of cheques were unrecorded "Responsible managers did not receive regular monthly financial statements. Fixed access listings were not maintained."

He said, "Mr. Chairman, that list goes on and on."
I am raising this simply to emphasize the magnitude of the work and the degree of frustration that these have caused both the board and the department staff." These remarks raised, when I was listening to that, an impression that one of the

concerns which exists in boards is there is an apparent lack of ability to manage all of their finances. That concerns our committee greatly because, if it is true, it would certainly influence our understanding of the board autonomy issue that we have made reference to on a number of occasions.

Since our committee was concerned, I asked our staff to obtain the management letter that Mr. McClelland was quoting from. We did receive a copy from your officials, and I have noted a particular date on it.

That management letter he quoted from was dated 1988. Now, that makes me wonder whether your officials were being fair with our standing committee by referring to letters that were, in my view, outdated.

The committee is concerned that this information was presented during the public hearing on January 7. We want to be clear that we are not happy regarding the type of information your officials were presenting to us. It seems to us as though your officials -- and the key ones, in respect to the relationship between boards and the department -- attempted, in my view, to create an impression that financial management competence is presently lacking in one or more of our boards. It is a matter which should be considered when evaluating the issue of board autonomy, but in doing so, he used information that was close to four years old.

I have great concern about that type of information that was being forwarded to us. Dr. Kinloch, I do not know if it was intentional, but it was misleading to our committee to use outdated information, and it is a very serious matter. When we are asking for a specific situation, I would anticipate that the department gives us current information. I was not happy after I read the letter given to us by your officials. It dated back to 1988. It was not a realistic presentation of today's situation. When one of your officials made a statement to that effect, to me, when I was listening to him during the hearings, it sounded like it was today's situation, but it was not.

When we were up in the Keewatin, I specifically asked the board if they thought it was fair for the department to use this type of information. They were appalled by the department's presentation with regard to the Keewatin, as it made reference to the Keewatin Regional Health Board. I raised that with them and they were not happy. They were surprised and really appalled by what the department gave our committee. I have a great deal of concern in respect to the actions of your senior official in your department. I wonder if you can comment on the issue that I am raising. Dr. Kinloch.

DR. KINLOCH: Yes, Mr. Chairman, I am happy to have the opportunity to comment on it as I think it is important to note that Mr. McClelland's remarks did not specifically refer to the Keewatin Regional Health Board. They were intended to indicate the nature of difficulties that boards and the department had experienced over the time period covered by the audit, from 1988 onward. Indeed, we could have provided you with detailed management letters for 1992, which indicated the same sort of difficulties. However, it was not our intention to point a finger at specific boards but rather to point out system difficulties that were experienced notably during the start up period.

Last week I presented some data to the Standing Committee on Finance that I think might be helpful to this committee in setting out the year-end experience of the boards individually over the period covered by the audit, recently completed by the Auditor General. I will leave this with your committee researcher. Briefly, it shows rather wild fluctuations from projected budgets during 1988, 1989 and 1990, and then, over the last two years, a rather significant reduction, and a bottom line which is quite commendable. For example, in 1991-92, the year-end position was less than 0.1 per cent off the projected budget, which is pretty good.

One of the points that Mr. McClelland was trying to make, and I know that I had attempted to make in my own statement, was that we have all been going through a learning process. There have been difficulties in attracting and retaining qualified people at all levels in the system. The system is now achieving some maturity, and I think it is beginning to show in these objective measures.

CHAIRMAN (Mr. Zoe): You can see Dr. Kinloch that when your officials act in this manner it creates a perception of disrespect, and also, patronizing attitudes that are referenced in the Auditor General's report under section 2.11. I was not happy with the manner your officials outlined or made a general statement in regard to the status of various boards across the territories. I understand he was trying to use it as a general statement but it was not current information that he was using, and that bothered me when I looked at that letter he was using. It was misleading our committee as that was not accurate. He should have used, in my view, the latest management letter. He could have given us an overview of all of the boards and that way we could have had a true picture of exactly what is happening in the field. The perception is there and the board, when I questioned them, indicated that is the type of thing the department is always trying to do to them. They do not have any respect for them. They patronize them and so on. Any comment on that?

DR. KINLOCH: Mr. Chairman, yes. I think it is unfortunate that this specific board was identified. It was not our intention, as I indicated, to finger any particular board but rather to point out the sorts of difficulties that have been experienced. I think that what Mr. McClelland presented to you, in fact, was representative of difficulties that we had experienced. Some of them persist. Most of them are not evident in current year management statements. We are by no means over the difficulties of managing finances in a regionalized system. We expect that it will be necessary for us to be vigilant, both centrally and at the regional levels, if we are to maintain adequate controls. I do not see any evidence that quoting from a management report on an unnamed board in any way should be viewed as patronizing. I think it was a statement of fact.

CHAIRMAN (Mr. Zoe): It is a statement of fact, but pertaining to 1988! It was not a current situation! When I questioned the Keewatin Regional Health Board, they were furious about the fact that this particular outdated information had been used to make a general statement about the current status of board abilities across the territories. They were not happy because they know that other boards are doing better than that statement made by Mr. McClelland. They indicated themselves that they have improved since 1988. They were saying that the

department should not be making this type of general statement. They were furious and I was not surprised to hear them say that. After I read that letter, in my mind, he was misleading us in regards to the general status of board abilities across the territories. Would you like to comment?

DR. KINLOCH: If I may just state something that I pointed out initially, it was not our intention that any particular board be singled out for comment. Mr. McClelland did not specifically refer to the Keewatin board. He made reference to the difficulties that had been experienced. He could have drawn selectively from reports across the system early in the period, but he chose simply to use one report. I think that it is unfortunate that the Keewatin has been singled out in this matter. However, it was not our intention to do so.

CHAIRMAN (Mr. Zoe): I do not think Mr. McClelland was trying to single out the board. He made a general statement. He did not make any reference to Keewatin. He just said, "Here is one of the management letters," and he made a general statement. When we looked at that old information about one of the boards we found that it was Keewatin. He should have used current information to make a general statement of any sort. He should have tried to use the current information available, not make reference to a management letter that was dated back in 1988 to show the overall management of our boards' abilities within our system. I do not think that was fair.

DR. KINLOCH: Mr. Chairman, I think perhaps the best way to assure you that we were not attempting to mislead the committee is to provide you with a whole set of management letters covering the period of the audit from 1988 to 1992. I think a review of those documents will satisfy you that Mr. McClelland's comments were representative of difficulties experienced early on. You will still find some difficulties today but of a different nature, affecting different boards. It is my impression, and Mr. McClelland's, that the situation is improving.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: This is just to follow up on the remarks that you have given to the questions and comments that Mr. Zoe has made. I was not here at the very beginning of the hearings in the first of this month. With the information that you are giving us now with regard to the boards, and from the discussions that we have had with the various boards, one could see talking to them and to the C.E.O.s that they are certainly at different levels. Different regions are at different levels of having the ability to carry on their duties. I was just wondering, do you have a plan at this point to train the boards to a level where you, as a department, feel comfortable with giving more responsibilities? When would that be?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman. Yes, we do have a plan to support the boards at several levels. First of all, in ensuring that all board members are adequately orientated to their jobs and supported through continuing education efforts, we expect to support this through a contract with the Northwest Territories Health Care Association. The other areas where we intend to provide support are directly to finance officers and to C.E.O.s. Already there are regularly scheduled meetings of finance officers, at which time common problems can be dealt with. Thirdly, we are looking to provide direct support from the department, that is, to have our financial people travel to the boards and spend time with them working through their budgets or other difficulties that may come up in a hands-on support role so that there will be an understanding of the difficulties that exist in the field and an ability to talk to the finance officers on a continuing basis, knowing the type of problems they are dealing with. Beyond that, to continuing education programs for finance officers. There are also support efforts aimed at improving the systems that finance officers must use. We have, as you know, multiple financial systems in the field and this has been a source of confusion and difficulty. We expect to come to agreement on a single system, a single method of maintaining accounts, which should make life easier for everyone. As this process continues, we expect that the degree of control that is being processed by the boards will increase. We will be much more comfortable with them managing their finances and you will be much more comfortable with the way those finances are managed as well.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: That raises a number of questions. Is there some sort of written plan for training the boards? If so, does that come from an overall plan of where the department is heading as far as the boards are concerned?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, it represents rather a collection of activities that have been underway or are under development at the moment. The expectation is that boards will continue. Boards will play an increasing role in the planning and management of the health care system and, increasingly, the department will step back into a supportive role.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Have you, in the formation of these development plans, consulted with the boards as to where this plan should take place? Have you gone over with the boards or the plan that you are developing?

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I believe it is more of the nature of moving toward what boards thought they were set up to do in the first place. They believe that they were to have full management responsibilities for activities within their region. They have been unhappy with the degree of control exerted by the department. I think that we are now coming to an understanding that the department has a proper role in exerting control to ensure that the statutes, regulations, policies and procedures of the G.N.W.T. are adhered to. We expect that this will be much clearer to everyone once the memorandum of understanding is completed. This will set out the respective roles of the department, the board and the relationship between the two. That is something that we expect to have accomplished early in this next fiscal year.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: What I understand you are saying is that the development of this plan for the boards is coming from the boards themselves and the department will take a controlling or monitoring role as far as the boards are concerned, some time in the future?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, the roles will be spelled out in the memorandum of understanding. There will be a continuing element of control because of certain requirements of the Government of the Northwest Territories, the Financial Administration Act, for example. Increasingly, we would see ourselves in the department as acting as consultants to the boards and of monitoring activities. As long as they are within agreed upon limits, boards would continue to manage.

MR. ARNGNA'NAAQ: I have just one small question.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Could we get copies of the plan that you are developing for the boards sometime?

DR. KINLOCH: Mr. Chairman, yes. I think you might find it helpful to review the terms of reference for the memorandum of agreement, which covers a long list of things which will be spelled out in detail as to who is doing what.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Any further comments or questions? Mr. Whitford.

MR. WHITFORD: You mentioned something about the multi-systems that are currently being applied or used throughout the various regions causing problems. Everywhere we have gone so far, we have heard the same thing that there are too many systems in use and it is cumbersome. I wonder why, in this day and age, something like this has been allowed to go on for so long? None of the boards or regions are talking electronically to each other through the smoothness that a system in this day and age should be operating in. It puzzles me as to why this is allowed to go on. You mentioned, in your remarks, that you are going to go to a single system, but when is this going to happen?

CHAIRMAN (Mr. Zoe): Thank you. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, the committee has been set up with representation from the Department of Health. The Department of Health, Finance and the boards review the current needs of boards for financial management and then look at the available systems that might exist as options with the aim, early in this coming fiscal year, to make a recommendation as to the system and the procedures that should be followed by all boards. This would be a collective decision, one that would satisfy the requirements of G.N.W.T. generally, the Department of Health, and the boards. The terms of reference for that exercise exist now in advanced draft and should be available shortly.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: There are two other systems that are still currently being used. I think there are three or four of them. There are still other ones that are in headquarters now. Are those going to be changed to make this one kind of system that all can use? Are we going to have to still use these other systems for whatever reasons? The problem is that none of these things talk to each other. I am not a computer expert but it stands to reason that these systems should be compatible so that you do not have to do things manually. You should be able to say, "Here is my disk, you plug it into your computer." This should be the objective, but it does not seem to be the direction that the department is going. If you are only going to correct one thing, it is not going to make these systems compatible. I fail to understand why the department does not just bite the bullet and go ahead and do something like this.

CHAIRMAN (Mr. Zoe): Thank you.

DR. KINLOCH: Mr. Chairman, the aim is indeed to have systems that are entirely compatible so that it will be possible for us to access information directly and to avoid the re-entry of data or having to do manual exercises to respond to questions. The department does not feel to be in a position to impose a system on the boards, rather we wish to develop one collaboratively with them. We wish to develop a system that will meet both our needs. We expect to accomplish that by the end of this coming fiscal year.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions or comments? Mr. Whitford.

MR. WHITFORD: H.I.S. and C.H.M.I.S., these are systems the Auditor General had recommended be consolidated. Is this going to happen?

CHAIRMAN (Mr. Zoe): Dr. Kinloch.

MR. WHITFORD: I think generally the boards would be happy with a system that everyone understands. Right now, I understand that some places are not even on electronic mail. I do not know whether Stanton is even on HP Desk or E-mail. We cannot talk to them over at Stanton board on our systems right now. That same thing applies to other places. We have asked, "Are you on electronic mail?" The answer was no. Some are and some are not. It is hard to understand why that is not happening. It should be universal.

MR. ARNGNA'NAAQ: Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, we are talking about three different kinds of systems, the first is a communications system represented by HP Desk Manager. At the moment Stanton is not on that system. Other boards are and we use it extensively.

The second set of systems are the financial systems, the Manitoba Health Organization System, the H.B.I.S. and a couple of others that are used by boards. Those systems are being reviewed by the joint committee consisting of Finance, Health and the boards.

There is a third set of systems and these are the H.I.S., the

health insurance services system, and the community health information system. Those systems are being reviewed and will be upgraded over this next year in preparation for the decentralization of the health insurance services operations. The aim is to have linked or compatible systems so that data from one can be linked to the other. All of these things are proceeding concurrently.

CHAIRMAN (Mr. Zoe): Thank you.

MR. WHITFORD: I have just one further short question. Is Fort Simpson on HP Desk?

DR. KINLOCH: Mr. Chairman, I do not know. I cannot remember.

MR. WHITFORD: I can remember that, until very recently, that hopsital did not even have a computer.

CHAIRMAN (Mr. Zoe): We can write to them and find out if the deputy minister does not know. What system does Simpson have?

MR. WHITFORD: (Microphone turned off.) Yes, I know. HP Desk? You do not know.

CHAIRMAN (Mr. Zoe): Are there any further questions or comments from the committee?

MR. WHITFORD: I have more questions.

CHAIRMAN (Mr. Zoe): Sure, if you would like to continue?

MR. WHITFORD: Well, I guess we could go on forever.

CHAIRMAN (Mr. Zoe): I have one if you do not mind, Mr. Whitford?

MR. WHITFORD: All right, go ahead.

CHAIRMAN (Mr. Zoe): I would like to go back to the public hearings again, when we were in Inuvik. It relates to what we talked about earlier, when you first appeared before us, Dr. Kinloch, in regards to human resource management objectives, particularly, relating to the opening up of the health care centres for aboriginal people. I pointed out that one of the department's definitive objectives for 1992-93 was to develop a strategy for attracting northerners into the health care careers. I have asked the department senior official in this area, Mr. Lange, whether such a strategy existed when he appeared with you on January 8. Mr. Laing indicated that a number of projects have been undertaken within the strategy and made reference to the successful career access brochure.

The committee requested a copy of that strategy and we received this one-page strategy which included things like going to fairs, producing a colouring book, going to meetings at Arctic College to discuss potential nursing programs, and there are other things on here. However, within this strategy there are no deadlines for completing these various tasks, and no standards on how many items are supposed to be produced. There is no indication of who is accountable for the task. One of the worst things is that there is no description of how the outcome of these activities are going to be evaluated. This one page that they have given us for attracting northerners into a health career is not a strategy, in my view. It is not for those reasons that I have indicated earlier. There are no deadlines. We do not know who is going to be accountable for which task. They have named a number of things. Dr. Kinloch, do we have an appropriate strategy document within the department, or is this it?

DR. KINLOCH: Mr. Chairman, I think what you have there is a summary of initiatives. For some of them there is extensive documentation and we would be happy to provide that to you. For some, however, the objectives are not as clearly set out as you would like or as I would like. It will be our intention to improve them.

CHAIRMAN (Mr. Zoe): That is specifically what we asked for, the strategy, not a summary of the strategy. I would like to see the strategy. If you can provide that to our committee, I would appreciate it. Are there any further comments or questions?

MR. WHITFORD: Just a comment on that, Mr. Chairman. We were looking to see how some of these things would bear out in the end. What is going to be the end result of the production and distribution of a health career information book highlighting successful aboriginal health careers? It is fine to have some pictures and things, but the objective there is to stick out our chests and say we do have this or that person there. There should be a target or an objective as to what this is going to do. Is this going to promote a certain age or gender group, to pursue a health career? Each of these items that you have listed is well and good, but what is going to be the end result of producing a colouring book for school children? Will it make them familiar with health issues and, therefore, become interested in pursuing something like that? Targeting summer placement of post-secondary health career students, how is this going to foster their career? What would the objective be? Is it going to give them enough incentive to continue back so that they can pursue this? We fail to see this within this document. Although you have explained it is just a summary, it appeared fairly loosely linked. There is no connection between them. What we are looking for is something with a little bit more substance to see what the objective would be and how this was going to come about.

CHAIRMAN (Mr. Zoe): Thank you.

DR. KINLOCH: Yes, Mr. Chairman, we can provide materials such as that. By way of a general approach to the encouragement of aboriginals to serve as providers of care, it is our ultimate objective that aboriginal people will be represented in the health professions to the extent they are represented in the general population. Between now and then, we have some intermediate objectives, some of which are easily quantifiable. For example, we would like to have 25 students enrolled in the access program to the R.N. program in September of 1993. Others which are not so quantifiable are colouring books in all of the primary grade schools, the ultimate aim of that is to encourage young children to think of health careers. Perhaps, it will be possible at some point down the road to evaluate the success in planting that idea in young minds. The ultimate aim is to have graduates and practising health professionals from the aboriginal populations serving in the N.W.T. health system.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions or comments? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Mr. Chairman, I was just reviewing some of the notes that I was writing during our hearings with the various boards. A number of the areas that came up had to do with the memorandum of understanding. When we discussed those with a couple of the boards, some of the phrases that were used were "inadequate meetings, having no input into the M.O.U.," "that this was something that was created completely by the department." " There was no input from the boards. To make a memorandum of understanding which would be appropriate for both the boards and the Department of Health, a third party should be involved in the formation of these memoranda of understanding." I am just wondering what you would think of something like that?

CHAIRMAN (Mr. Zoe): All right, Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, firstly, I think it is important to recognize that the general outline of the elements to be included in a memorandum of understanding have been determined for us by a Cabinet direction. Second, at a meeting of the N.W.T. Health Care Association in the fall of 1992, there was an agreement that the N.W.T. Health Care Association would act as an intermediary between the department and the boards in structuring a steering committee that would develop the terms of reference and then oversee the development of the memoranda of understanding. It is possible that some of the boards did not understand that arrangement, or that the Association could act in an intermediary role, but we are, nonetheless, distributing material about the process to the boards. They now have in their hands the draft terms of reference and the intended approach for any comments they wish to make. Perhaps what we are seeing is simply another learning process of how the Health Care Association is going to function effectively as an intermediary. The aim was simply to streamline the process so that it would not be necessary to have a large steering committee. Clearly, it will be necessary to ensure that we have communication links to the boards.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngna'naaq, any further questions or comments?

MR. ARNGNA'NAAQ: It certainly has been a learning process. It is something that I went through when I was working with the Keewatin Divisional Board of Education when they were forming a board. The approach taken by the department at that time appears to be very different from the way the Department of Health is approaching it. Have you looked at how they are forming boards and the way that other departments may be creating boards, questioning how it is they are working with the boards and so forth?

DR. KINLOCH: Mr. Chairman, in general, yes, we have. Indeed there have been reports on the functioning of the boards of education as opposed to the health boards. It really is up to the Department of Health and the boards to work out their own arrangement within the framework that is provided for us by Cabinet. To some extent we can learn from others but it really is a task that we have to work out ourselves.

CHAIRMAN (Mr. Zoe): Thank you. Any further questions? Mr. Whitford.

MR. WHITFORD: Yes, I just wanted to go through a couple of things that came up during our reviews in the two regions, and a concern that this committee has about the way information was presented by the department when the officials were here as witnesses during the first week of January. I would like to quote a comment that was made by yourself on January 6 when you explained some of the history behind the reasons for conflict over levels of board autonomy. The quote that I have is, "The signing of the transfer agreement is considerably less than five years and, during that time, there has been continuing difficulties with the recruitment and retention of important senior positions on boards, notably, qualified financial officers. The Inuvik Regional Health Board suffered seven financial officers in one year." I know the department's testimony suggests that there are difficulties in the financial management ability of the boards, this time because there are insufficient financial officers and the Inuvik board is used as an example in that quote.

When we were in Inuvik this past week on January 28, we asked the witnesses representing the Inuvik regional board about this and they said this information was three years old. They said that the problem with the turnover in financial officers had been largely due to a situation in which most of the financial operations were provided through an unpopular M.O.U. by the regional Department of Finance personnel who could not even be supervised by the board's managers. They also said that during that time, and I quote, "As a board member, I really do not know that we received any assistance from the Department of Health. I think the recruitment process was done by the board itself." Recognizing the importance of providing this committee with accurate information, I wonder if you would clarify the context of those remarks that you made on January 6?

DR. KINLOCH: Mr. Chairman, again, my remarks were intended simply to reflect the sorts of difficulties that the system had experienced. The difficulties of recruiting and attracting trained financial staff were not restricted to Inuvik. The Keewatin board had some similar difficulties. It is a problem when there is no continuity in these important areas of management, notably in finance, that number of seven is well-known throughout the system. There was no need to omit the word Inuvik, everyone knew that was the situation. I cannot speak to whether the department was not helpful in recruitment but, certainly, that would not be the situation today. Our efforts and interests are to ensure that the boards are well-staffed with competent people because, if they are not, the whole system suffers.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you. I suppose the boards have a difficult task out there and certainly, comments like that would have an impact on their credibility and on their morale, especially when it is made from very senior officials in the department.

The Auditor General said, in section 2.5 of his report, that the department should recognize the improvements made by the boards since 1988 and amend the directives to reflect the current needs. Surely since 1988 there have been great improvements and those should have been pointed out as well.

If you have a finance officer that has been there longer, it should have been mentioned too. It is difficult for the boards to function without getting a little shot in the arm once in a while. It seems that many problems occurred long ago and there have been great strides made. However, you continue to quote facts from then and not more current facts. It suggests that there have not been any improvements. Why we mention this, Mr. Chairman, is because, in all of the places we have gone, with one exception perhaps, there has been a great deal of friction between the boards and headquarters. It is difficult because, every time we go somewhere, they chip away at the department and the relationship between the boards and the headquarters. When we hear these things, it is understandable why they are not happy with headquarters.

CHAIRMAN (Mr. Zoe): Just to follow up on what my colleague is saying, especially when the department officials are making various general statements pertaining to boards and the relationship, rather than improving between the department and the boards, especially in public statements about various boards, is just not there. You are creating a more negative impact, in my view, when departments are always basically bad-mouthing the boards. It is not positive. The department is always taking a negative view. That is why the boards' relationship with the department is getting worse because the department is making certain statements that are having a negative impact on the overall relationship. I believe that is what my colleague is also trying to say. Dr. Kinloch.

DR. KINLOCH: Mr. Chairman, I can understand how, taken out of context, it might be viewed in that manner but it is important to recall the context of the Auditor General's report, which is based on a period from 1988 to the present. It is a public document. In attempting to provide comment to this committee, we felt it was necessary to review the experience of the whole period and to admit that there have been difficulties, but overall, to indicate that the situation is showing a significant improvement. We feel much more comfortable with the degree of financial control, for example, than we did even two years ago. Also, while there undoubtedly have been some frictions between the department and the boards, this situation has been improved in the last year and, particularly, in the last few months. We do not see any particular merit in dwelling on the difficulties of the past but rather look to more collaborative arrangements in the future.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: I just wanted to finish up what the Auditor General had said in section 2.5 of the report and I had quoted that, "The department should recognize the improvements made by boards since 1988 and amend the control directives to reflect the needs of the present day". The department's response to that was that the department will review financial controls in consultation with health boards. Mr. Chairman, the recommendation is not to review financial controls but to amend them. I wonder if Dr. Kinloch can indicate whether the department is willing to make this happen? And, when will this come about?

DR. KINLOCH: Mr. Chairman, the discussions surrounding the memorandum of understanding are intended to deal with many of those situations, but I feel I must point out also that the department is not free to release the boards from some of their accountabilities because they are set out in statutes of the Government of the Northwest Territories. Also, the discussions surrounding the memorandum of understanding are coloured by the directive which we have from Cabinet.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I had one quick question. In talking about the financial system as well as the various systems where you keep track of what is going on in the regions, some of the boards mentioned that they are spending a great deal of time. We asked if they could put it down into a figure of dollars and how much time they are using, if they are able to put a dollar figure into how much time they are spending on responding to requests from headquarters. They were not able to say, but one of the boards mentioned that it probably takes ten to 15 per cent. Other boards said, it probably takes one person-month to try and answer questions from the Department of Health. There seems to be a vacuum. That is my impression. With that and the problems that the boards have mentioned to us, I am wondering if you plan on getting the boards together somewhere at some point in time to go through some of the problems that are going on.

DR. KINLOCH: Mr. Chairman, we meet regularly with the chief executive officers and chairs of boards, usually twice a year. There is a meeting scheduled for the second week in February, at which time we will review several items that are viewed now as having priority, such as the arrangements for the memorandum of understanding. There are close linkages between the department and the boards at many levels. Some of the contacts are unnecessary in the sense that we could, if we had the proper information systems, obtain the information directly from the system without bothering people. Until we get those systems set up, it will continue to be an annoyance to us and to the boards.

I recognize that many of the questions are not questions that the department generates of itself, but rather, they are intended to satisfy the requirements of the Financial Management Board Secretariat. There are many conversations between ourselves and the boards in comparing acceptable submissions for forced growth, for example. We hope that our new operating systems will cut this down significantly.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: The meetings that you discussed or mentioned just now, are those meetings where they all get together or does the department meet with them individually? In the second week of February, will that be all the boards together in one room with the Department of Health?

MR. KINLOCH: Mr. Chairman, yes, it is all of the boards, the C.E.O.s, the board chairs, and sometimes the R.N.O.s or finance officers as well. There are general meetings. There are special meetings where the R.N.O.s or the finance officers would get together. The Minister usually meets privately with the chairs, who are accountable to her. I meet with the C.E.O.s. Directors from the department are present for most, if not all, of the meetings. We encourage private discussions to take place at breaks.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further

comments? If not, I have a few more questions I wanted to ask pertaining to our public hearings that we had in Rankin and Inuvik. One was specifically to the Kiguti Dental Clinic. There was a reference made in the Auditor General's report, but I am running out of time. I have Jim Antoine, the Member for Nahendeh, on stand-by. He is waiting for us to call him so we can link him up. He wants to make a presentation by telephone to us, so I do not want to keep Mr. Antoine waiting. I will get our staff to correspond with you in regard to that particular issue that I wanted to raise with the department. I wanted to question you, Dr. Kinloch, in regard to the comments that they have made in our public hearing. I will get our staff to communicate with you at a later date. For now, I would like to thank Dr. Kinloch and Ms. Berthelet for appearing before us this morning. Thank you. We will take a two minute break while we link up.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): Only Silas and myself are here, Tony is on the phone upstairs. He should be right down. I notice that you left copies of your presentation here with Alan Downe. I will start even though they are not here, Jim. Perhaps I will get you to introduce yourself and the constituency that you represent. Tony and Ludy just walked in. I have all the committee here now. I will get you to proceed with your presentation.

Telephone Presentation by Mr. Antoine, M.L.A. for Nahendeh

MR. ANTOINE: Thank you, Mr. Chairman. My name is Jim Antoine. I am a Member of the Legislative Assembly whose constituency is Nahendeh. I am pleased to have this opportunity to address the Standing Committee on Public Accounts today by phone because I consider the review of the Auditor General's report to be very important to this government and to the people of the Northwest Territories.

Mr. Chairman, the delivery of health services is a major financial consideration for the Government of the Northwest Territories, but more important than that is the availability and type of health service we have impacting significantly on the quality of life for northerners. With dollars becoming tighter each year, it is essential that the Department of Health operate in an effective and well planned manner. In the spirit of fiscal restraint, the people of the Northwest Territories have to be sure that our limited health dollars are not being lost through holes in the government administrative framework. We must expect and insist on full value for money in the administration of health services. It is for that reason that I believe the work of the Auditor General is so important. When I was a chief of the Fort Simpson Dene Band and was involved with the Aboriginal Development Corporation in the Deh Cho, I welcomed this sort of objective review of our local administration.

In much the same way, the Auditor General's report provides the Department of Health, the Government of the Northwest Territories and the Members of the Legislative Assembly with an opportunity to stand back and look at the snapshot of our health administration for a change is necessary and it will help us identify what to do and how. In order for this process to lead to a positive result, however, there needs to be a responsive and constructive attitude on the part of the Department of Health. Frankly, Mr. Chairman, statements have been made by departmental officials at certain points during your hearings the first week of January that have made me wonder whether those basic attitude requirements presently exist.

I would like to touch on four or five points in the Auditor General's report that I support and should, in my view, be regarded as priorities, as well as one section of the Auditor General's report that causes me concern. Secondly, I want to make these recommendations, which, I believe, will go a long way toward resolving some of the Auditor General's concerns about departmental infrastructure. Finally, I would like to raise some concerns with the department's formal response to the Auditor General's report.

Chapter three of the Auditor General's report deals with the lack of a strategic plan with the Department of Health. I think that the report, as well as the comments you have heard during these hearings, Mr. Chairman, leave little doubt that the department's lack of strategy has created problems in every aspect of the delivery of health services. I am shocked by the fact that there is no specific plan, that legislation appears to be outdated or inadequate and that the policy basis within the department seems to be sadly lacking as well.

Section 3.2 of the report is particularly important because it deals with the department's failure to plan where and how to allocate its human resources. Because of this, nurses at the community level are often overworked and do not receive enough support. I would like to quote page 16 of the Auditor General's report. "Under the primary health care model, community health nurses are the front-line caregivers. Although hospitals have adequate staff levels to rotate nurses for shiftwork, community health nurses are required to be on call 24 hours a day, seven days a week. The distribution can be traced back to the lack of planning."

I have to disagree with the Auditor General's illustration, although I do agree with his conclusion that this is a problem which arises from the inadequate job the Department of Health has done in planning how to distribute its human resources. Perhaps there are significant nursing positions in Yellowknife, Iqaluit and Inuvik, but you should also be aware of the situation at the Fort Simpson Hospital. I believe that it is under-resourced and that the nurses and other staff in the hospital frequently have to work long hours and have experienced periods of high stress. The consequence of the department's lack of human resource planning pertain to more than just the community health nurses. They are also creating problems with respect to the operation of the hospital in Fort Simpson. I would expect in the other facilities known as "cottage hospitals" as well. I agree strongly with the Auditor General's comment that studies should be completed to assess nurses' work loads across the Northwest Territories.

I do not buy the department's excuse that it is too difficult to develop adequate workload assessment tools. Perhaps, if the Department of Health diverts some of its existing energy away from monitoring finances of health boards and focuses more on planning and policy development, they would be able to find a way. The difficult part will come when the results of the work load assessments are finalized and it becomes necessary,

perhaps, to tell Stanton Yellowknife Hospital or the Inuvik Regional Hospital that some of the nursing dollars are going to be allocated to provide better coverage at the community health centres and in smaller hospitals. It will then be a matter of political will on the part of the Minister and her department to make the changes that should be made.

I have one additional point to make about planning for health services. Over the course of the past several months, Fort Simpson has been involved in the planning process that is supposedly intended to identify health needs in our community and in the region. I have been extremely concerned about the way this planning process has been initiated. Decisions about the stages of the process, the organization, the review methods and the participants to be involved, were all made in Yellowknife, and the community had a process imposed on it with the expectation that we would have to buy into it and become involved. When is the Department of Health going to realize that is not the way things are supposed to be done in the Northwest Territories?

In any planning effort, the people of the affected communities should be involved right from the very outset. The department should build the kind of assessment and focus on the variables that elders, community leaders and service consumers feel are necessary. Through subsequent discussions, a better understanding has now been generated between our community representatives and departmental officials. People from Fort Simpson and the area are now feeling better about participating, but it could have been different. We do not need to waste money and create a strain between government and communities by pushing ahead with planning activities that the service consumers do not find to be relevant or appropriate. This department is going to have to learn a lesson about starting to consult with communities earlier in the process if it wants its planning efforts to lead anywhere.

Those were my general comments about the lack of departmental planning for health services. However, there are many specific examples of problem areas in the department which relate to the lack of planning. One of these is in regard to the department's absolutely unacceptable record of hiring aboriginal people. I know that other Members of the standing committee, officials who appeared from Stanton Yellowknife Hospital and several media reports have all commented on it, so I plan to keep my remarks brief on this one.

I just want to point out that, for years, the territorial government has blamed its failure to promote career development on the education system. This idea of passing the buck to the Department of Education and to other schools and communities is an old trick. It is just a way of avoiding accountability. Mr. Chairman, the Department of Health should realize that it is a part of the education system. If the department has been unable to increase the number of managers and health care professionals, then it should be the place where the motivation to change is coming from.

It is time for the department to start taking a pro-active approach to supporting skill development and training that would enable aboriginal people to take a rightful place in the administration and delivery of health services. It is time for them to stop sitting back and waiting for the school system to turn out graduates that the health officials regard as good enough to join their club. Brochures will not do it. Holding committee meetings to talk about the possibility of a nursing program will not do it either. Blaming aboriginal people for high drop-out rates at community schools will not do it either.

The department's human resources division should take an entirely new approach. It should get out into the communities and identify people who are interested in health. It should then develop an individualized training program which gives access to the courses and support to assist them as they need to broaden the skills they already have. There can be an increase in the number of aboriginal people in the health system, but it will not happen unless the departmental officials get out of their comfortable offices in the Centre Square Tower and reach out pro-actively to the communities.

I want to talk about another specific example, which arises out of the lack of direction, which characterizes the Department of Health. Several months ago, Ms. Cournoyea announced that there will be several massive decentralization initiatives taken throughout the government. In many ways, this is a very welcome announcement. I think that, for many years, people have hoped to see the administration of programs and services move out of Yellowknife and into community settings where they would be closer to the people who use them. However, because there is no strategic plan for the Department of Health, it is my view that the government is planning to decentralize the wrong services at the wrong time.

As you know, Mr. Chairman, there are currently plans to decentralize the health insurance service division to Rankin Inlet and Inuvik. This is the part of the Department of Health which pays the doctors' bills and other medical costs. I have never seen the reason why the government chose to decentralize this particular division. Neither have you, Mr. Chairman, or any ordinary Members, because the rationale for this decentralization has never been announced.

There are two problems with this. First, the Auditor General, in his report, has indicated that it would be more efficient if the financial functions of the health insurance services division would be consolidated within the Department of Health's finance and administration division, which is managed by Darrell Bower. Second, the amount of effort the department is having to devote toward preparing for the decentralization of health insurance services is preventing it from carrying out some of the other important planning and management tasks that must be done.

I noted, from my review of the department's comments to the committee during the week of January 5, that they were having to put much of the work that needs to be done on computer information systems on hold. This is because it is taking too much time and so many resources to implement the decentralization of health insurance services.

I would like to suggest to you, Mr. Chairman, that the department has its priorities wrong. I cannot see how having this highly technical financial function decentralized to the regions will bring government any closer to the people. The H.I.S. staff may be living in Rankin Inlet and Inuvik, but they will still be reporting directly to Yellowknife. There would not be any benefits to the health system, although, of course, there will be a small positive impact on each community in terms of

housing and PYs. As a result, the potential for greater efficiency through consolidation of financial activities within the department's organizational restructuring will be lost.

I think that the Department of Health should concentrate on decentralizing those areas of administration which have a direct impact on the people and where there are real and measurable benefits to the delivery of health services. I want to make a suggestion about it. I would like to see the Department of Health forget about the decentralization of health insurance services, and instead, devote its full energies to the decentralization of the administration for Mackenzie Regional Health Services.

I think that it is absolutely ridiculous that health services for the Mackenzie catchment area are managed out of Yellowknife. It is inefficient and prevents good communication with communities on key health issues. I also think that it is one of the reasons why the establishment of regional health boards with Dogrib and Deh Cho communities have been delayed. Maybe if Mr. Menzies' units were outside Yellowknife, they would realize the benefit that comes from local input into the delivery of health services. I think of this as a serious recommendation to the Standing Committee on Public Accounts. I hope that it is possible for you to reflect this position in the report that you bring back to the Legislative Assembly.

I would like to move on to comments on the Auditor General's findings in chapter eight. These deal with management reporting and accountability. I feel that your view should focus carefully on this area. I note that, when the Standing Committee on Public Accounts tabled committee report no. 13-12(2) on June 25, 1992, one of the statements it made was that, "the Standing Committee on Public Accounts will work closely with other committees of the Legislative Assembly." I was glad to see that, Mr. Chairman, because, as the new Chairman for the Standing Committee on Finance, some of the recommendations we had made in the past are directly relevant to the points which the Auditor General has made.

For instance, I would like to draw your attention to one of the recommendations made by the Standing Committee on Finance when it reviewed the Main Estimates for 1992-93. This is in committee report 17-12(2), which was tabled on September 14, 1992. The Standing Committee on Finance commented that it needed to know what the department expects to accomplish with money put into health programs. It is true that the Department of Health was the only government department that provided key result areas in the main estimates that S.C.O.F. was also concerned that the indicators were largely unmeasurable, leaving us not knowing how successful the department has been in achieving results with the resources provided.

The Standing Committee on Finance recognizes that there is a difference in measuring output and measuring effects of the Department of Health. Too often, the Department of Health seems to measure its activities in terms of the paper that has been produced or whether a meeting was held rather than evaluating whether or not anything has actually been improved. The Auditor General refers to this as the department's tendency to measure output rather than outcome. I believe that is a very important point to remember. That has to change.

S.C.O.F. recommendation number 15 indicated that, at an absolute minimum, the following performance measurements should be reported in 1993-94 Main Estimates. One, mortality and sickness statistics and trends; two, public satisfaction with health programs and services; three, backlog statistics; four, local employment and health care; five, health cost containment; and, six, health facilities utilization. I would note that the Department of Health had commented in the past that it may have difficulty compiling these sorts of measurements because of its inadequate computer information systems. The Standing Committee on Finance expressed concern about those inadequacies and recommended that action should be taken in that area. I trust that the department will take that very seriously, Mr. Chairman, because I simply cannot visualize how the Standing Committee on Finance will be able to accept future budget submissions without outcome-related performance measurements. I hope that I can count on the Standing Committee on Public Accounts to underscore these instances on management accountability in your report to the House.

In closing, I just want to express my concern about the way the department has been responding to the Auditor General's report. I think that even the casual reader will note that very little effort went into the varied comments the Department of Health made in its management response to the Auditor General's findings. Simply writing down "Agreed" as a management response tells us nothing about what the department is going to do, how it is going to do it, and most important, when it will be finished. This can be interpreted as a somewhat arrogant -- attitude as though the department is saying that we do not need to know what it will be doing.

I was trying not to draw that interpretation, Mr. Chairman. But, then I saw a copy of the opening remarks made by Dr. Kinloch, the Deputy Minister of the Department of Health, when he appeared before your committee on January 6, 1993. Rather than giving us a constructive outline of how the Department of Health would implement the Auditor General's recommendations, I found that the deputy minister's remarks were defensive and unproductive.

If we want to make our health system better, there is no point in seeing the Department of Health take the position that the comprehensive audit is flawed because it did not consider other jurisdictions, blaming the department's shortcomings on past history with the Legislative Assembly or making statements that "the responsibility for health services is clouded by the special relationship between aboriginal people and the federal government." I found all of Dr. Kinloch's comments unacceptable and I believe that this should be noted. Even though the Department of Health has stated that it takes the Auditor General's report seriously, those remarks have made me wonder whether or not they are really going to do something about it.

The problem with the department may be one of attitude. I note from Dr. Kinloch's remarks that he went into great detail about the qualification of his senior managers and listed all the different countries where they have worked. He stated that it is their judgement that "the N.W.T. has one of the best health services in the world." I do not think it really matters what the senior managers think. I would like to see them, instead, reporting what the people in the communities, who use the

health services, members of the boards who are supposed to operate, manage and control the health facilities and the staff who work for them, think. That is who I would like them to get the information from. I believe that he would not find many of them who believe that our health system is the best in the world. It is true that we might have some of the best ideas in the world, but clearly our system for making those ideas happen has some very serious flaws.

The Auditor General's report identifies a number of areas where the system can be improved. I hope that the Department of Health, under the direction of its new Minister, adopts a more positive and constructive attitude. Mr. Chairman, the end result of that process will be an improved health system for the people of the Northwest Territories. That is critical. We cannot continue to get by with inefficiencies that have been created by the lack of a comprehensive plan and with the strained relationship which exists between the department and the health boards. I look forward to seeing your committee's report when it is brought into the House, Mr. Chairman. I would like to thank you very much for the opportunity to present my views to the Standing Committee on Public Accounts. Mahsi, Mr. Zoe.

CHAIRMAN (Mr. Zoe): Thank you. Mahsi Cho. Are there any comments or questions from the committee? Mr. Whitford.

MR. WHITFORD: That is a very good presentation, Mr. Antoine. Thank you.

MR. ANTOINE: Thank you, Mr. Whitford.

CHAIRMAN (Mr. Zoe): Mr. Antoine, in your statement, you made reference to Mackenzie Regional Health Services. Could you to elaborate more on what you were saying about that?

MR. ANTOINE: The Mackenzie Regional Health Services, which is now headquartered out of Yellowknife, serves the Deh Cho area as well as the North Slave area and a couple of communities in the South Slave. If it can be moved out of Yellowknife into the areas that it serves, it might give better service. I am seriously recommending that be moved to Fort Simpson.

CHAIRMAN (Mr. Zoe): Do you mean to decentralize the board out of Yellowknife?

MR. ANTOINE: That is right. It is not a health board yet. It is just Mackenzie Regional Health Services.

CHAIRMAN (Mr. Zoe): The Mackenzie Regional Health Services is in existence, but it has a public administrator who is running the board.

MR. ANTOINE: That is right. Tom Menzies is the public administrator. That whole operation should be moved into the field.

CHAIRMAN (Mr. Zoe): All right. I just wanted to get your views on that, to be more specific. As you are probably aware, Mr. Antoine, my region, the Dogrib region, has been almost making that same suggestion, but I thought the two regions were indicating back in 1988, prior to the transfer taking place, that the Deh Cho and the Dogrib region wanted to create or have their own board in place. Has that view been changed, that the Deh Cho is no longer considering having their own health board for their area?

MR. ANTOINE: No, that has not changed, Mr. Zoe. In fact, in the recommendation, I am stating that one of the reasons why the establishment of a regional health board for the Dogrib in the district communities has been delayed is because the Mackenzie Regional Health Services is headquartered in Yellowknife. They did not see any need to move into the regions. From the Deh Cho communities, their position is still the same as 1988, where they would like to have their own health board.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions from the committee? Mr. Antoine, I appreciate you making your views known to our committee. We will take your submission into consideration very seriously. You made a number of good points in your presentation that I am quite supportive of. I am sure they will be reflected somewhere within our report to the Legislature. I am running behind schedule now. There are no further comments or questions from the committee, so, once again, I would like to thank you for appearing before us, Mr. Antoine. Mahsi Cho. We will talk to you again later, Jim.

MR. ANTOINE: Mahsi.

CHAIRMAN (Mr. Zoe): If we require any further details specifically on the presentation that you made, our researcher will be getting in touch with you.

MR. WHITFORD: I would also like to compliment you on your excellent presentation, and the many useful points you made such as the comments on the decentralization part of it. We want to continue the discussion on that at a later time. We have heard comments similar to that in other areas.

MR. ANTOINE: All right. Bye.

CHAIRMAN (Mr. Zoe): Bye.

CHAIRMAN (Mr. Zoe): We will continue on. I do not want to take a break. We are running behind. Are there any representatives from the N.W.T. Health Care Association? I would like to call them to come to the witness table and introduce themselves for the record. If they could kindly proceed with their presentation.

MR. WRIGHT: My name is Adrian Wright. I am the chairperson of the Northwest Territories Health Care Association. I have a written presentation, which I would like to provide to the committee just to make it easier for you to follow along with what I have to say.

CHAIRMAN (Mr. Zoe): Thank you. Proceed, Mr. Wright.

Presentation by the Northwest Territories Health Care Association

MR. WRIGHT: Firstly, if I can just enlighten you as to the make-up of the constituency of the Northwest Territories Health Care Association. We have eight full members, who are the eight boards that exist in the Northwest Territories, seven

boards and the Mackenzie Regional Health Services, Stanton Hospital Board, H.H. Williams which is in Hay River, Fort Smith, Kitikmeot, Keewatin, Baffin and Inuvik. We also have three affiliate members, which are the three senior citizens' residences in Fort Smith, Hay River and Yellowknife, as well as one affiliate member, which is the Churchill Health Centre. The eight full members are all represented on our board, which essentially determines the policy and business of the association.

I appear here today by myself, as we have no executive director at the present time. We will have one full-time starting probably in June of this year. As is said in the outline that I have given you, we certainly applaud the Assembly's decision to seek the assistance of the Auditor General in preparing this report. We think that it is a useful summary of the various deficiencies and difficulties that have existed in health care in the Northwest Territories since the transfer. We think that it should provide a good working document for us to go forward with from this point on and deal with some of the problems that have arisen over the years.

If I can start with those, perhaps our association's main concern over the years has been that there has not been a sufficient delineation of the role of boards and the importance of boards in administering health care in the north. It is our view, and we have expressed this previously, that boards should be given the responsibility, the authority and the appropriate funding to administer the programs for which they are responsible.

I understand that previous witnesses who have appeared before this committee have suggested that there is some dispute as to whether the various boards in the territories are perhaps boards of governance, boards of management or advisory boards. It is our position that those models are not particularly useful. What we should be moving toward, whatever the boards are right now, is independence and being able to manage their own affairs. We believe this is consistent with the approach which was set out in the Strength at Two Levels report and with the thrust of government, which is to decentralize. We also believe that it is consistent with the model for health care throughout Canada, which is generally to have boards running hospitals and health care facilities.

We simply believe that boards are in a much better position to know what is needed within their region, to find the appropriate skills and to set up the appropriate qualification and training that is necessary. That is not possible from Yellowknife. You cannot have a middle ground. You have to have it one way or the other. You either have to give the responsibility to boards or not. I say in the presentation that we are somewhat heartened by the fact that more recently we have seen within the Department of Health a greater acceptance of the responsibility of boards and hope that trend continues. It is certainly a concern that our association has had for many years and we would like to see that fundamental principle, the importance of boards, highlighted in your report.

The Auditor General refers to some specific issues that have irritated relations between boards and government over the years. One of them is the information system, and I do not purport to be an expert on health information systems. People require a great deal of training to be well versed in that area, but I do not think you need to be a rocket scientist to understand that if you are working with different information systems, you are going to have difficulty being able to talk properly. It is almost like someone from your region, Mr. Chairman, trying to speak in his language to someone from Mr. Arngna'naaq's region. That is one of the difficulties that we have had over the years. Health has essentially taken the position that you cannot run your operations responsibly, yet we do not have the information to be able to make the decisions that are necessary. I notice, in reading the Auditor General's report, that the Department of Health basically agrees with that position taken by the Auditor General. We are heartened by that. I understand that steps are slowly being taken to remedy the situation. That is something that I do not think we can emphasize strongly enough. If the situation is going to improve, or if boards are going to be able to manage responsibly and efficiently, there has to be a common information system that is able to gather and collect information and present it in a way that is usable and effective.

I attempted to touch base with some of the boards before coming here today. One comment that I have heard many times, both before making this presentation today and previously, is that it is very frustrating for boards in the regions to attempt to try and solve the problems they have when Yellowknife is telling them that they cannot, for instance, have a dietitian because they do not have the need for it or this nursing station does not have enough funding for interpreters, or whatever the problem is. If boards are given the responsibility and they are given the budget to administer, they should be able to administer that as long as they stay within the bottom line and the programs are delivered. It should be up to that board to decide how the money is spent. You have probably heard many times in your hearings earlier that one of the greatest frustrations is that boards cannot move money from one line to another in their budget. That is something that has to change. We understand that the Department of Health needs to have accountability and it needs to know that, if money is given to a board, it is going to stay within budget and the programs are going to be delivered. If the board cannot administer its funds efficiently, it is simply not going to be able to do its job appropriately.

There should be some incentive in the system for boards to manage efficiently. If there is a surplus at the end of the year, the board should be able to keep that, otherwise we run into the same problem at the end of the fiscal year, of spending lots of money on computers or whatever because, otherwise, they are going to lose the money. There is no point in that. It is wasteful and it is not a productive use of the taxpayers' money. It is in everyone's interest for boards to be encouraged to manage in an efficient way.

Another issue that has been a concern to our association over the years is board orientation and training. Perhaps this is an area where we can accept some responsibility. We see this as being our function. If boards are to function, obviously they have to be orientated on what they are supposed to do. They have to get some training in the complexities of health issues and what their responsibilities as trustees are. Government certainly has a responsibility to fund that kind of thing, but if we say that boards should be independent of government, then it seems to our association that the training they get should be provided by an agency that is independent of government. We

expect and hope that we will be able to do that shortly, when we have our executive director in a position to do that. In fact, we have discussed with the Department of Health the possibility of some funding being provided to allow us to set up those kinds of programs. You cannot expect boards to understand complicated budgets or financial statements without some kind of training. It just is not realistic. If you do not have that, then obviously the Department of Health is going to be in a much better position to say that the board is not able to manage in a responsible fashion.

We are concerned about the lack of continuity that many boards have had with their membership. It goes hand in hand with what I have said about orientation and training. If you spend the money and take the time to train someone properly, then it is frustrating if they do not stay around long enough for you to benefit from that. Somehow, we have to encourage people to stay -- to make the commitment and stay on boards longer. If we do not, we are going to open up the entire board system to criticism. It will not work.

I have not mentioned this in the outline, but similarly, I think we have to have a nomination process that works. People have to feel represented. The situation in the Mackenzie is not acceptable. Those people have to feel that they have someone who is representing their interests. Within the health care system, it is almost like they do not have an M.L.A. There has to be a board set up that is going to represent those people.

Similarly, we have to re-examine the regions that have not been established for the various boards. The Keewatin, the Kitikmeot and the Baffin probably make sense. I do not think a great deal of thought went into the way the pie has been cut up in the western Arctic. It seems to me to be arbitrary. It is something that we have to look at. It is something that has to be re-examined.

I say in the outline that we feel it is time for action to be taken. There has been much discussion to date. I think it is time for some steps to be taken to start moving forward some of the issues that we have addressed. We believe one initiative that is a positive one is the memorandum of understanding initiative that is ongoing between the Department of Health and the association. I understand there has been some concern expressed as to the extent to which some of the boards are aware of what is going on and I would certainly be happy to enlighten you as to where that process stands, if that is of interest to you. I welcome your questions.

CHAIRMAN (Mr. Zoe): Before I go to my committee Members, during our travel, we had public hearings in Rankin and also in Inuvik. In Rankin, the chairman of the Baffin Regional Board, Mr. Eckalook, made a comment that the Department of Health was not giving enough authority to the board. In his view, he stressed to us that it seems like it is because the board members are of aboriginal descent. In our following public hearings, I kept asking various boards about what Mr. Eckalook had said. I asked the vice-chairman of the Kitikmeot Regional Health Board, "Do you agree with the comments that Mr. Eckalook made in Rankin?" Mr. Maksakgak, the Vice Chairman of the Kitikmeot Regional Health Board basically agreed. He said, "Yes, I agree with his comments." Mr. Gruben, representing the Inuvialuit Regional Corporation, also made similar comments. Can I get you to comment on that to see if the Northwest Territories Health Care Association basically agrees with the comments that we have been hearing from various health boards?

MR. WRIGHT: I guess, to be candid, I have not heard that from our members. That is not to say it is not happening, but I have not heard it. The way I can express the concern would be to go back to the issue of orientation and training. All that has been done to date is that there is a trustee orientation manual that has been issued by the Department of Health. I do not think that document is something that the average aboriginal person is going to pick up and read. If people are not properly orientated and trained, then it is going to be very easy for bureaucrats in Yellowknife to say, "You are not competent to function, to do your jobs as board members." I think we have to go back to that. We have to go back to getting people properly orientated and trained because, then, they will be able to deal with the issues. If the message they are getting from the Department of Health is that they are not competent to do this, they will be in a better position to say, "Yes, we are."

I am from Yellowknife, and the board I am on is the Stanton board, which is a predominantly non-aboriginal board. Unless I hear it from the members, and I have not, I am not in a position to say one way or the other whether or not that is the case. I would have to defer to what people, like Mr. Eckalook, are saying.

CHAIRMAN (Mr. Zoe): By listening to the people who made presentations to us, to me, there appears to be an attitude problem with the department. Would you agree that there is that type of problem that is in existence right now within the Department of Health?

MR. WRIGHT: If you ask people in the Department of Health, I think they would agree that they do not have the sufficient familiarity with what is going on outside of Yellowknife. I think that they would agree that they simply do not have a real feel for what is going on. They read the numbers. I am not saying they are not in contact with the regions, but I have lived in the north for over eight years, and unless you are constantly going into the communities and have a sense of what is going on, you may as well be in Ottawa. You are not going to have that understanding. Most people in the Department of Health have been there for a comparatively short period of time and if they have travelled anywhere, it has been more to the south than into the communities. To be fair to them, that is one of the big reasons for the problem. I would not disagree with what you are saying, though. I do not think they are that tied into what is going on in the communities.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I wanted to comment on a few of the things that you mentioned because I agree with them when you were referring to the different systems that we are using. It has been stressed to the department a number of times now. It seems so odd that all this time has passed and they keep picking up a new system and using it without much thought of the consequences. It is very frustrating to the regions not to be able to talk the same computer language. A private corporation could never get

along like this at all. If I.B.M. or Bell Canada or somebody else operated like this, they would have been broken up long ago. It is frustrating that it is taking so long for them to recognize this. It is taking so long to even start thinking about doing something about it. By the time they do something about it, much frustration has gone by. I think it is a point that is well made.

The other issue is on the boards' independence. We have heard that as well, that they want to have more independence when it comes to transferring money and line objects. They do not have the control to do that right now. They are looking forward to doing that. You mentioned about the uncertainty of dealing with surpluses. If a board does acquire a surplus, there is no incentive to do this because it is removed. On the other hand, I wondered about over-expenditures in some areas. How would that be accountable? Right now, I gather what they do is that they penalize the board. They say, "If you overspent by $100,000, we will give you less next year or you have to make it up out of your own budget." If there is a surplus, they take it back. That is not quite fair. How do you deal with that?

MR. WRIGHT: I suppose they can go to F.M.B. to cover the deficit as well. How should that be dealt with? There may be many reasons why there is a deficit. It may have nothing to do with the way the board has been managing its affairs. The problem with the Department of Health, and we see it at this hospital all the time, is that you can have a baby boom and end up having to pay a great deal of overtime. There is really nothing you can do about it because you have a budget to work with and they made a conclusion that you are not managing in a responsible way. There has to be some investigation or analysis as to why there is the deficit and maybe less finger pointing as to what the culprit is or the reason for bad management. It may well not be bad management.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: We have heard board members express that they do not have the proper orientation or training. I wholeheartedly agree with you that there should be something done about that. The other thing is about board involvement in the process of hiring. Did you mean hiring or appointment of board members? We heard, in our travels, from medical people as well, that educational boards are involved in hiring teachers, but the health boards are not involved in hiring nurses. We heard it suggested that they should be part of that. Did you mean just an appointment of board members?

MR. WRIGHT: I mean hiring of all personnel in the health centres. I am not saying that the Department of Health should not have a role to play in that. It may well be that the board does not have the people, for example, to appropriately interview a physician. Take Kitikmeot, for example. They have one position on their staff. That is not to say that lay people, administrators or board members cannot help. You may have the most competent position in the world, but if you are not prepared to be sensitive to an aboriginal culture, you may be the wrong person to be up there. I think that is the area in which boards certainly could play a useful function. Definitely, the Department of Health should be providing some support when you are staffing positions. It only makes sense. I think it is unfair to expect that boards are going to have those various kinds of expertise. I think it should be a cooperative working effort. That is probably the point that we would like to make more than anything else. We should be working together more rather than fighting and drawing lines.

I want to re-emphasize a point I made about the training side of things. I understand that there has been a fair amount of criticism of the Department of Health and the lack of orientation training. I am not saying that is not warranted to a point. I do not think that the Department of Health should be doing it. I really do not think it is appropriate. But, if you are trying to say that boards should be independent, why should we be having government doing the training? It seems to me that they have an immediate axe to grind. Government should be encouraging someone independent. We say it should be us, we would like it to be us. Maybe we are not the appropriate body, but we think it should be us. Government should be providing the funds, but the training should be provided by someone who is independent. That is the only way it is going to be credible.

CHAIRMAN (Mr. Zoe): Most of the hearings' comments were made to that effect, that they want more resources toward their own board so they can do exactly that, so that they are in control of who does the orientation. They do want the Department of Health to give them orientation with regard to the programs that they administer or the specifics. They can then call in officials from the Department of Health to explain their role and certain things to that effect. The Inuvik Regional Health Board made a suggestion that it could be people like your association that can be doing these types of things for all boards across the territories. We heard those types of comments made at previous public hearings. Mr. Whitford.

MR. WHITFORD: What would be required to get that in place?

MR. WRIGHT: First, the Department of Health would have to find some money to fund the program. I understand that is in the works. They would have to call for proposals. If it was in our case, they could deal with us directly and we would outline how we would go about doing it. The person we are hoping to come on board as our executive director would be a good person to do that.

MR. WHITFORD: Would the department be responsive to a suggestion like that?

MR. WRIGHT: I think they would, from one of my more recent conversations with them. I think that is an important point to make. I have been fairly critical of the things that have happened. We have seen a big change in the Department of Health over the last six months or so. It may well be because of the heat they are getting from people like you. That is positive. That is what should be happening. To be fair, things are becoming much more cooperative and have improved over the last six months or so.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. When we were in the two regions, any time we started discussing passing on authority from the department to various boards, they really did not seem to have any idea how this authority will be passed on, other than through the memorandums of

understanding that will be created. When they talked about the memorandum of understanding, they sounded like they did not have any input into these M.O.U.s. They suggested that there should be a third party involved in the creation of these M.O.U.s. When I mentioned this to the department officials this morning, they indicated that they had more or less given that area to the Northwest Territories Health Care Association. At this point, it sounds like the boards still do not realize or feel uninformed about what these M.O.U.s will consist of and how they will have input into it. Is that something that the association is working on?

MR. WRIGHT: I will give you a bit of an idea of what has happened so far. We set up a steering committee from our association, which has four members on it, myself, our directors from Fort Smith, Inuvik and Rankin Inlet. Terms of reference have been developed. They were developed by the Department of Health. The Department of Health has been quite open to any changes that we have made. We had sent out invitations for a consultant. The process is being developed in the terms of reference for the consultant to put forward a proposal as to what the cost would be and the consultant will meet with the steering committee. The process will start. The consultant will then go out to the various regions, find out what their concerns and problems are and then meet with the steering committee to come up with a draft, which would then be reviewed and be subject to change.

That is essentially how far the process has gone as far as the terms of reference are concerned. Since we represent the boards, it seems to be incumbent on us to keep our members informed. If the members are not aware of what has been going on, we have to take some of that responsibility. For example, I understand that the members of the Stanton Hospital had said that they were not familiar with the process that was going on. I have to take responsibility for that because I should have kept them more aware. They have, since, seen the terms of reference. They know what is happening now. I do not believe there is any significant degree of a problem with what is going on.

We had one consultant come back with a response to our proposal about two or three weeks ago. We felt that we would like to see more than one response. It is always healthy to have comparables. We have gone out for a second invitational tender. Hopefully, we will be in a position within the next few weeks to look at a second round of proposals and get the process on the move.

I want to stress that there are people who sit on the steering committee who have said that they do not want the process to be rushed. They are most concerned that we have a product that is going to stand the test of time. If we rush the process, we are going to end up with something that may not be as useful as it could be. I know that you have indicated that you would like to see the process moved forward. Certainly, so would we, but we also want to see it done in a proper and responsible fashion. We have also indicated that it should be slowed down so that a good job is done.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Mr. Chairman, the idea of the M.O.U.s were announced originally at the N.W.T.H.C.A. annual meeting. I understand, at that time, that the Minister of the day announced 15 elements of what the M.O.U.s should consist of. I am wondering if the N.W.T.H.C.A. was consulted before those 15 elements were created.

MR. WRIGHT: A draft term of reference was circulated to the N.W.T. Health Care Association, and before that became final, we were consulted. We were not consulted before he put together his speech. Before the term of reference went out to the consultants, those elements were run past the association. We were asked for our comments. I believe that if we still wanted to make changes, the Department of Health would be open to that. That has been my feeling of the process all along.

One thing you said is that the idea came up at the Minister's speech at our A.G.M. Memorandums of understanding have been a topic of discussion since I have been involved in health care. It is just that now there has been a renewed effort by the Department of Health to get some in place. They have been a point of contention for years because that is essentially what the problem is. There is nothing that sets out what the Department of Health's responsibilities are and what the boards' responsibilities are. There were drafts that were circulated some time ago that were totally unacceptable to the boards. That is why this three-way process, with the association, has been undertaken.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further comments? If not, I believe we have another witness ready to appear before us. I would like to thank you, Mr. Wright, and your association, for appearing before us this morning. If we do have any further comments or questions, we will advise our researcher to get in touch with the N.W.T. Health Care Association.

MR. WRIGHT: I know he knows how to get a hold of me. Thank you for asking us.

CHAIRMAN (Mr. Zoe): Thank you. I would like to have Mrs. Colpitts come and do her presentation now.

Presentation by Mrs. Colpitts

MRS. COLPITTS: Yes, I can see everybody looking at their watches because their stomachs are rumbling. I do not think I will take very long. It is not an issue at all related to what has been discussed by the last presenter and maybe not all morning. It is just one small thing that I thought I should bring to your attention since you are looking at the expense of the medical health system in the north. It is a method to reduce the expense of medical insurance claims. It arose from a personal situation in our family. It involves the medical treatment that could have been provided either in the hospital or outside of the hospital if a registered nurse was in attendance and with frequent check-ups back at the hospital.

In making a claim for this situation, I found that the N.W.T. Health Insurance Program would pay the patient only for the in-hospital treatment, not for the home care treatment, even though the latter was infinitely less costly. If the regulations of the Health Insurance Program were more comprehensive and less stringent, they just might have saved the G.N.W.T. some

money. I want to present the case to you. If you indulge me, I will explain the particulars of a case, which I think is a classic example, but I hope I will not go into any extraneous detail.

A student in our family was at school out of territory, and he contracted an infection in his ankle that required him to have intravenous medication four times a day for four weeks. That is a long time to be in a hospital. After two weeks in the hospital, the registered nurse at the school declared that she could perform the intravenous daily routine so the student could attend classes when not having treatment. This was one month before school matriculation exams, so it was important for him not to miss many classes. However, frequent trips back to the hospital and physiotherapy was also required. The hospital doctors reluctantly allowed the student to finish his treatment in this home care manner. It was a long ordeal, but I can say, all ended successfully.

We, as parents, then tried to claim for the expenses covering this period. This included the cost of medicine, which was over $250, medical supplies, like syringes, cleansing solutions, etc. and taxis to the hospital because the school was some kilometres away and the student was on crutches and, finally, physiotherapy at the clinic in the adjacent college, but N.W.T. health insurance would not pay for any of this. All this was declared ineligible. They claimed that we, as parents, had private medical health insurance that would cover this. This private medical insurance covered only 80 per cent of one of the medicines and 80 per cent of the physiotherapy treatments. We had to pay for all the medical supplies, like syringes, which were $35 a shot and many were needed, frequent transportation to the hospital and the 20 per cent that was not covered. The total came to about $400. I tried to appeal this decision from the N.W.T. Health insurance, but still was not given any credit toward these expenses.

What amazes me is that, if the student had stayed in the hospital for those two weeks to finish his treatment, the health insurance would have paid a minimum of $550 a day for fourteen more days, which equals $7,750 without batting an eye. However, they would not pay $400 to save them the $7,000. The doctors, in this case, would have preferred the patient to stay in the hospital. The patient would have been more rested, albeit probably a bit bored. His studies could have continued with some persuasion of the teachers to coach him somehow during this period. I would have saved myself a great deal of frustration and not been $400 out of pocket.

After this experience, I have to admit, I am certainly recommending to other patients that they take the more expensive option of staying in the hospital because the government will pay for that one and not the cheaper one. It seems to me that, because of this short-sightedness on the part of our Territorial Health Insurance Program, the G.N.W.T. is paying more costs than are required and encouraging claimants to incur these costs.

The fact that my classic case took place out of territory is really irrelevant. The same case could easily arrive in a territorial hospital. It probably has many times. A Stanton patient might have a family member at home in Yellowknife who is a registered nurse able to perform some of the daily treatment with regular check-ups or an exact analogy could be a student in one of our divisional board residences, for example, Iqaluit, who needed the same treatment as my child. He or she could have been looked after by the nurse in residence and still continue classes with a few trips to the local hospital, but N.W.T. health insurance would not pay for this. It would rather pay to keep the patient in the hospital.

There are rules and regulations that the health insurance will only pay for hospital services to ensure that if hospital services be performed outside the walls of the accredited institution called a hospital, then too bad, no financial help. I suggest, in this era of escalating health costs and financial restraints, we should not be bound by regulations that cost us far more money than other options just because these options are not mentioned in the regulations. It seems to me this is a situation where bureaucracy rules the system rather than the system controlling the bureaucracy by adjusting the regulations when it is apparent that it is necessary.

It should be noted that the home care method of medical treatment is not covered in the health insurance plans of other provinces. However, does the N.W.T. only have to follow what others do? Is there no reason why they cannot take the initiative and change the medical coverage to a practical, modern format? Nor is this home care type of coverage really totally alien to the G.N.W.T. since health care is discriminant on racial lines in the N.W.T. I believe certain aboriginal groups can claim for home care expenses. Expanding this idea for all claimants, and ensuring that it includes home care that is optional for hospital treatment, would be more cost-effective to the N.W.T. Health Insurance Program. Since health insurance claims are one of the most costly items in our budget, I suggest that it be urgently considered.

That is, essentially, an item that I thought should be explored Are our regulations so stringent that they cannot be changed? How long does it take them to change when there is obviously a need for it?

CHAIRMAN (Mr. Zoe): While you are talking about the situation, when you were dealing with the Department of Health, health insurance services section, in your assessment, what kind of attitude did they have when you brought this classic situation to them?

MRS. COLPITTS: I went through the various clerks. They were very pleasant in saying that, unfortunately, they do not cover this. With every claim I had in regard to physiotherapy, they actually had a form letter that was obviously written up before saying they do not cover physiotherapy anywhere but in the hospital. When I claimed medicine outside the hospital, they had another form letter they already had written. They are prepared for these things. They are very pleasant about it, but they do not consider an individual case. I did have somebody else in the Department of Health who did take my case a little bit farther and he said he got absolutely no interest in it. That is what happened. I found them very pleasant, but not prepared to bend the rules in any way. They have to stick to their rules, but there are a couple of wrong rules in there that should be changed.

CHAIRMAN (Mr. Zoe): That entire area should be reviewed. Did that young person in your family fully recover?

MRS. COLPITTS: Yes, he is back playing hockey and rugby,

so I guess he is all right.

CHAIRMAN (Mr. Zoe): Are there any comments or questions? Mr. Whitford.

MR. WHITFORD: I think there is some move in the Department of Health to review those kinds of cost-saving situations. I am not sure the status of it, but it had been suggested during a previous administration where alternate forms of medical care can be given that would provide the same service and reduce costs considerably. Your point is certainly well made. It shows where common sense can save a great deal of money, but rules prevent that from taking place. You mentioned that you pursued the matter with the health insurance services section. They are going to decentralize that to the regions. Would this have made a difference in your ability to deal with it?

MRS. COLPITTS: No, I think this has to do with policy, which would be adhered to in every region. Sometimes they put the onus on the doctors. If the doctors say it is all right, it is all right, they will cover it. I think that is putting much onus on the medical profession, but that is the way they do it. In this case, the doctors said, "All right. I will allow this treatment outside of the hospital." It seemed to me that should have covered all worries, but it was not good enough for the health insurance people who do the claims.

CHAIRMAN (Mr. Zoe): Are there any further comments before we adjourn before lunch? We have a tight schedule to follow today. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I am following up on the question that you, Mr. Zoe, had asked. He asked about what their attitude was with health insurance services, you mentioned that when you got these form letters, you went to the Department of Health. Is that correct?

MRS. COLPITTS: It was a division called health medical claims. You put in a claim form and all your receipts, etc., and a clerk comes out, takes your file and says, "I am sorry. We cannot cover this, but we can cover that." That is what I got.

MR. ARNGNA'NAAQ: I thought you mentioned that you went to the Department of Health and the official said he was not interested.

MRS. COLPITTS: Somebody else in the Department of Health, who is not part of the medical health insurance division at all, I believe, looked into my case to see if he could persuade them. I do not know how much persuasion or contact he had with the health insurance people, but I think he had some conversation with them. They just said, "It does not fall under the rules and regulations, so too bad."

CHAIRMAN (Mr. Zoe): You have made a very valid point. It will be generally reflected within our report to the Legislature. Any time we can save money, we always make suggestions to that effect. Thank you for making a presentation to our committee. With that, we will adjourn our hearing until 1:00 p.m. this afternoon.

---LUNCH BREAK

CHAIRMAN (Mr. Zoe): I will call the committee back to order. I believe we have the N.W.T. Registered Nurses' Association appearing before us. Could you kindly introduce yourself and proceed with your presentation to the committee?

MS. MOFFITT: My name is Pertice Moffitt and I am the President-Elect of the Northwest Territories Registered Nurses' Association.

MS. MARSOLLIER: My name is Suzanne Marsollier. I am the Past-President of the Northwest Territories Registered Nurses' Association.

CHAIRMAN (Mr. Zoe): Thank you. Go ahead.

Presentation by the Northwest Territories Registered Nurses' Association

MS. MOFFITT: The Northwest Territories Registered Nurses' Association is a self-regulating body of registered nurses established to protect the public by ensuring competent practitioners. As the collective voice of nurses, the association promotes the advancement of the profession of nursing and the health of the residents of the Northwest Territories. The Northwest Territories Registered Nurses' Association welcomes the opportunity to comment on the report of the Auditor General.

In today's environment of economic restraint, the challenge for all governments at the federal, provincial, territorial and municipal levels is to provide quality services and programs in an efficient, effective manner. The report of the Auditor General identifies some fundamental changes required for our health care system to work efficiently and economically while maintaining the elements which are key to it.

"Many problems can be solved with clear vision, leadership and good will on the part of the players." N.W.T. Registered Nurses' Association believes this statement from the executive summary captures the essence of what is required: vision, leadership and goodwill. Clear vision will provide the people of the Northwest Territories with a clear idea of what the health care system will become and their role in it. Leadership is required to empower the people of the Northwest Territories to take an active role in the management and provision of health care services and programs. Goodwill is required of all players within the system so partnerships may be developed, misunderstandings may be cleared up and a long range plan developed which will provide direction for the future.

Historically, the provision of health care has been provided by southern trained nurses working in nursing stations or health centres scattered across the Northwest Territories. Involvement of the people has been limited to supportive roles such as the C.H.R., the clerk interpreter and the health care aid. Generally, if people were sick, they visited the nursing station, they saw the nurse, they were treated and they were told to return for follow-up. In other words, the focus was on illness versus wellness. Though health teaching was done, the focus was not on health promotion and prevention, but on curing the illness. The responsibility to get well was seen as the responsibility of the health care professional, not the responsibility of the patient himself.

In 1988, when this government assumed responsibility for health care from the federal government, a unique system of health care delivery was envisaged. Regional health boards were set up to provide an opportunity for the people to become involved in a meaningful way in decisions affecting their health. Though problems exist as indicated in the Auditor General's report, it is important to note the structure is basically a sound one. Numerous royal commission reports, such as the rainbow report, are a vision of health from Alberta, and the report of the Nova Scotia royal commission on health care, indicate that our structure is viewed by other provinces as the model to follow.

Along with their involvement in regional health boards, the people of the N.W.T. need to have greater involvement in the provision of care at all levels. They must be empowered to realize they have the capability to be the health care professional delivering the care. It is recognized that obstacles exist, such as the high illiteracy rate and the low percentage of students who graduate from high school, but these barriers can be overcome. It is hoped that the diploma nursing program will soon be a reality in the Northwest Territories. To make this happen, we will require vision, leadership and commitment from all players.

In line with the above thought is the need for individuals and communities to assume increasing responsibility for their health. Health is a state of being and is greatly influenced by a person's lifestyle. Many of the major health problems which exist in the Northwest Territories could be minimized if certain lifestyle changes were made. Smoking, drug and alcohol abuse and family violence are examples of ongoing problems that are a significant drain on the government's budget. Costs are not restricted to the Department of Health, but involve other government departments, such as Social Services, the Housing Corporation, Justice and Education.

Part of the government's role is to develop and implement healthy public policies to provide a supportive environment for the people to live in. Seatbelt legislation, penalties for drinking and driving, no smoking by-laws, workplace safety regulations and rules governing the disposal of toxic wastes are examples of healthy public policy which make the environment a safer and healthier place to live.

In addition to the above changes, traditional values of the family and the elderly must be revived and strengthened. Many services currently provided by paid health care workers can be supported by family members and friends. In the future, individuals and family members will be called upon to care for their disabled, sick or elderly family members in their home for as long as possible before accessing the formal health care system. People need to realize the dollars available for health care is not endless. The current structure and the perceived benefits support the principles of primary health care as defined by the World Health Organization. Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and the country can afford.

The N.W.T. Registered Nurses' Association believes that people of the Northwest Territories need to embrace the principles of primary health care. In conclusion, there are fundamental changes which need to take place if the health care system is to work efficiently and effectively, while meeting the needs of the people of the N.W.T. What is now required is for politicians to provide leadership in the development of a vision in the expression of goodwill and the empowerment of the people to actively participate and take responsibility for their own health and health care. As John D. O'Neill pointed out in his article, "The Impact of Devolution on Health Services in the Baffin Region, Northwest Territories: A Case Study," conflicts and political perspectives must be resolved to ensure parties work toward achieving a balance in the evolving health care system.

The Northwest Territories Registered Nurses' Association has been meeting on a regular basis with representatives from the Department of Health, the Northwest Territories Medical Association, the Northwest Territories Health Care Association and the Northwest Territories branch of the Canadian Public Health Association. The group will soon be meeting with the Minister of Health to share our views and help shape the future health care system. We hope the government will enable us to continue to be active partners in the development of a vision for the future. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Are there any comments? Perhaps I will start first. To the past president, you made reference in your presentation that other jurisdictions are looking toward our model. What is our model that we have up here? I think it is referred to as "The N.W.T. Way". Do you know what that is? In your perspective, can you tell us what you think "The N.W.T. Way" is?

MS. MARSOLLIER: The reference made in regard to the comments made in those two reports is the establishment of regional health boards in the provinces that has not existed. That structure, which allows people to participate in the delivery of health care, is a very good one. That just started in 1988 and is very much approved and there is a will to model that in the provinces. That is what the reference is made to.

In regard to what my view of what "The N.W.T. Way" is, that is a very interesting question. We were not active participants in that model. As was presented, we were as new to it as everyone else was. Having not had that beginning, I can only speculate. I am not sure that is of any benefit to anyone. When you look at the model or what was presented to us, there are some principles of primary health care put in there that are not clarified or articulated in a way that is easy to understand. Some of the actions that were proposed are based on primary health care principles, which we made some reference to in regard to the World Health Organization, a mandate toward health for all.

CHAIRMAN (Mr. Zoe): Is there any type of documentation that the department has given to your association pertaining to what is supposed to be "The N.W.T. Way"?

MS. MARSOLLIER: We were given the literature that was given to everyone else. Do you have something so I would know what you are talking about?

CHAIRMAN (Mr. Zoe): Basically, the principles of "The N.W.T. Way" was not the actual model. It was not specific. There was just an outline.

MS. MARSOLLIER: It certainly is not a comprehensive understanding of the principles of primary health care. They took some components of it. As we mentioned in our report, health does not belong to the Department of Health alone. When you look and have an opportunity to review primary health care principles, it is very strongly advocated that the determinants of health, those things that make us all healthy, good education, proper housing, sanitation, being able to flush a toilet, employment, economic development, those are the things that make people healthy, not just being able to access a nurse in a nursing station or a physician in a clinic.

CHAIRMAN (Mr. Zoe): Is this the document that you referred to?

MS. MARSOLLIER: It looks like it.

CHAIRMAN (Mr. Zoe): That is all we received, too. It is a tabled document in the Legislature that makes reference to "The N.W.T. Way". In your presentation, you strongly emphasized the primary health care principles to be incorporated. Within this document, you are saying that some components of it were incorporated, but not fully. It appears to me that when they were developing this model, there was no consultation between the department and your association.

MS. MARSOLLIER: We had begun some discussion in January of 1992 with other health associations, the N.W.T. Hospital Association, the Medical Association and started to work on some statement of principle that would fall behind the model. No, not really. In fact, this document that you refer to was the catalyst to those associations gathering together to say, "The Auditor General's report said what we came to a conclusion of in January of 1992. We need to work together as partners." At that time, there was much animosity that had been created by this document. We felt that we needed to get together and get to know each other because the medical association did not really talk to the nursing and hospital associations. The C.P.A. did not talk to anyone. Nobody talked to each other, including the government. The people, the government and the professional associations did not talk. That document probably has far more value than we give it credit. It caused this dialogue to occur, which, without this dialogue or partnerships that have been formed, we would be very far behind in attaining what we all want for everyone of us, and that is the health. I looked at this document as being a discussion paper as opposed to an end product. Of course, that is just my perspective.

CHAIRMAN (Mr. Zoe): Are there any other questions? I will raise another one, if I may. There is reference made to nurses in the Auditor General's report under chapter three. The Auditor General's report identifies a number of human resource planning problems, particularly as it applies to nurses who work in the territories. Apparently, the nursing service division in the Department of Health was supposed to carry out an assessment of the nurses' workloads. My understanding is that this study was never completed. The Auditor General commented that the department should develop appropriate workload assessment tools. The department has stated that these are not available. Could I ask your association's viewpoint in regard to carrying out the appropriate workload assessment? How would you see it done?

MS. MARSOLLIER: This is an issue that the entire nursing profession, internationally, is struggling with in developing a workload measurement system. Other professions have been more successful in developing such a tool, but because of the diversity of activities that nurses do, we go into many other professions in the kinds of things that we do and maybe for other reasons that just do not come to my mind. The development of such a tool is a very important mandate right now, but because the nursing services have not been able to come up with one or do one in the way that they would like to, it is a reflection of the state of the nursing profession in that respect all over the place. Did you want to add anything to that?

MS. MOFFITT: I think there is one thing that could be added. There are workload measurement tools for hospital nurses that have been developed that are used quite extensively. There are very few community health indicators to say, "How many points in terms of workload do you give to a school visit talking to the children, versus how many points do you give to someone with a broken leg at the health centre, and how many people are required to carry out the care?" There are no indicators. Whatever they develop, it would be brand new and it would probably be used by many jurisdictions, especially within the federal government, or other people who are doing very similar work to what is being done in the north. The nurses are working in an expanded role as a primary health care worker in a much different way than they are in the south.

MS. MARSOLLIER: In a sense, what they have been asked or mandated to do is pioneer work basically for probably the world. It is not to state that there are not nurses doing these kinds of things in Africa and Europe or wherever. It is just that we are advanced in that we are asking to be able to measure this. Those tools have not really been formally structured for this setting.

CHAIRMAN (Mr. Zoe): I assume that you have a national organization. Is there a national organization looking into these types of things?

MS. MARSOLLIER: Very much so. They have identified them as a very serious mandate that they wish to achieve because it has major repercussions for many other issues as well.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. With the response that I have heard just now, are you saying that there is an evaluation of some sort coming out from the national association of nurses?

MS. MARSOLLIER: It is my understanding that there is some collaboration between the United States and Canada that is going on right now. How far they have achieved, I do not have that information. It is certainly something that has been identified.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I think the presentation was well put forward. It answered some of the

things that I, and subsequent questions to the Chairman, know about a vision of health and leadership in the territories. The Chairman asked a question I would have asked about "The N.W.T. Way". It seems that we have almost come full circle or soon to be going full circle. There was a time in the north when local involvement was all we had. It looked after everything for a social well-being. At some point in time, we delivered health and social care in a form of justice such as it was. There was a move. All of a sudden, it was replaced. It was all taken away and replaced by a southern model for health and social services, and justice to an extent. They replaced it with a model and without any kind of consultation or involvement, and certainly a lack of inclusion.

My grandparents and aunts used to deliver children at home without high mortality. I guess there were a few deaths, but not to the extent one makes it out to be. Things have come a long way since then. You do not even dare deliver them in some communities now, even with nurses there. We go to high cost, high tech. systems. Now, we are looking at going back to some of that. It is surprising, when you come from a region, and they do not even deliver children in that region. It is something that has been done for a long time. They want to get back to it. What puzzles me, as a Member of the committee, in my short tenure with the Department of Health, is that there seems to be a lack of vision and leadership. I hear this from other presenters. It is not a healthy situation to find ourselves in. We hear much criticism about the Department of Health. From some of the criticisms, I wonder, through meetings such as this one, if we can find some answers. Why do we not have more local participants? Why are northern people not involved in the health professions? You have to look hard and long to find an aboriginal nurse. I do not think you can find an aboriginal doctor in the territories right now. One that I am aware of practices out of Comox. That seems to be an area where we do not have any people. I am wondering why. Is the department not making a conscious effort? Are the nurses not making a conscious effort? We see many more school teachers, plumbers and mechanics because we probably have models to follow. Surely, by this time, we should have had more nurses and doctors. I was wondering if you could offer suggestions as to how we could go about it? Is there some way we can come up with more suggestions that would see some improvement in that area in the next five or ten years?

MS. MARSOLLIER: I think you will see an improvement in the next five to ten years. It will not happen all of a sudden. There will be some improvement because there seems to be more interest generated. For example, if the diploma nursing program goes through, I think that has generated more interest. I think, for the record, there are something like five aboriginal nurses in the N.W.T. Three of those are southern aboriginal nurses. Some of them are working in health centres. There is a Dene nurse, Virginia Bayha who is in the University of Alberta going into her third year in nursing. She is very keen to go back to her community. As an association, we would support and want that. There are something like six to ten students in post-secondary programs right now wanting to be nurses. I do not know if all of them will come back. This is my own perspective. I am not speaking in terms of the association right now. I do not know if they will all come back to the territories, but several of them have said they will. We may see a change. One of the basic problems is that we do not have enough people graduating with math and science. Those are basic requirements to get into nursing programs. I do not know if there is a way that we can speed it up. We can be out there for children. We have developed many posters on being a nurse. We have gone to career fairs recently. We went to the one in Rae hoping to get more children interested in nursing. I think it is going to take a while to happen. Within the next five years, you will probably see three or four nurses come out of programs. They are in the programs now. There is one medical student from the Inuvik region. I do not know if he plans on returning.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. That lends some hope. I will remain optimistic, but in the 1950s, there was a C.N.A. program. As a result of that program that was run out of the Fort Smith hospital, there were many more nursing assistants in hospitals across the territories. Some of them went on to be nurses. They are probably retired now. I know two of them are. That was a good start. It probably allowed northern people in with whatever level of education they had. It is true that we do not want to say that there is a level for northerners and there is a level for southerners, but it should still be available for those who would choose to do that. Like the teachers' assistants, that generated, in turn, many qualified teachers. First of all, they had to get their foot in the door. They had to get in there, hands on, like it, and then get thirsty and hungry for more. They then pursued it. The medical profession should be something like that as well. For some reason or other, it has fallen by the wayside. I wondered if that might be something that we could go back to. Although it may have been primitive and not the best thing to do, it worked, as opposed to what we are trying to do now and it is not working. We had many more C.N.A.s back then, than we have today. As bad as it was, let us not throw it away, but go back to something like that. Can we do it? Should we do it?

MS. MARSOLLIER: That is part of the proposal that we have in regard to the nursing program that we mentioned before. There will be different levels of entry into this program so that you could even have the beginning for people who wanted to be community health representatives. If they wished to go further, there was an opportunity for them to become C.N.A.s. Once that occurred, if they wished to become registered nurses, there was the diploma program. That is the way it is being proposed and will allow far more people to be able to enter into it. As you say, it is like a look-and-see, "All right. I will be a C.H.R. and I am going to get a feel for this. Yes, I really like doing this, but I want to do more." They can, then, go back and do the C.N.A. program and then come back again and, if it is really to their liking, they go into the registered nurses program. This will all be provided within the boundaries of the Northwest Territories. You do not have to go south to get this education. It happens right here.

CHAIRMAN (Mr. Zoe): You made reference to that program. The Department of Health, the Nursing Association, the Department of Education and Arctic College are all involved in it. What is puzzling me, listening to all the four or five of them who are supposedly developing this program, it has been going on for the last three or four years, and ever since I got elected, they have been developing this. Every year, we review their budget. There is an objective stated for that particular

area saying, "We are going to develop this program." When is it ever going to end? When are we going to have the final product? I am getting to the point where it does not take that long to develop a particular program.

MS. MARSOLLIER: I am afraid we only recently got permission from both the Department of Health and Education. It would be a year or a year and a half ago. You may have heard about it. It has been talked about for three or four years, but the association, and the people who are participating in this, have just very recently been given the go ahead to start working on it. Without the commitment from the government, we could not start. It was like having our hands held back. There needs to be funding to develop proposals, look for consultants, et cetera. That was not there.

CHAIRMAN (Mr. Zoe): That is surprising since the Department of Health has been telling us differently.

MS. MARSOLLIER: The Department of Education was the last one to give us the okay. Without them, we could not go ahead. It may be that the Department of Health had said all right. It has to be affiliated with Arctic College.

CHAIRMAN (Mr. Zoe): What stage are we at in the development? Do you know?

MS. MOFFITT: I think they were getting very close. They have certainly developed a new draft proposal that is out. There is research being done now on the funding, that we know about that is going on. I have heard rumours that an access year may be planned as early as the fall of 1993. I have not seen that in writing. I have just heard that. My belief is that the intent is that they move on with this program.

CHAIRMAN (Mr. Zoe): All right. Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: From the program you say you are working on developing, that is something different from the program that was held or run by Arctic College a number of years ago in Fort Smith.

MS. MOFFITT: Yes. That program was a certified nursing assistant program. The program that they are proposing is for registered nurses.

MS. MARSOLLIER: That is the final outcome. There will be different levels that could come out of that. There will be the C.H.R., the C.N.A. or the registered nurse.

MR. ARNGNA'NAAQ: They could build themselves up to a certain level. All right.

MS. MARSOLLIER: Mr. Whitford was referring to this. You need to give people the flavour of what they are getting themselves involved in. "Maybe I do not want to do this, but give me a try and then I can decide from there."

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: It does not seem like anybody is talking to you, letting you get involved in it.

MS. MARSOLLIER: Our executive director, who had to be in southern Canada with the Canadian Nursing Association, is the chairperson of that committee. That committee is going great gusto. The indications are that we are going to be starting something very shortly, perhaps even within this year. It is that imminent. I apologize for sounding vague on this, but we are without our executive director here, who is very much in there. We can certainly provide that information for you. She should be coming back shortly.

CHAIRMAN (Mr. Zoe): All right. Are there any further comments? Mr. Whitford.

MR. WHITFORD: I was wondering when this got into high gear.

MS. MARSOLLIER: Within this past year.

MR. WHITFORD: All right.

MS. MARSOLLIER: A year or a year and a half is the most that we have had the go ahead to work on this.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. One of the presentations we heard this morning had a lot to do with the way human resources are distributed in the Northwest Territories. I do not know how involved or whether you work with all the nurses across the territories, but the indication we got from the presentation was that our policies under the Department of Health are such that we handle the hospitals well. They are well resourced with nurses, but the outlying communities may not be as much. He referred to them as "cottage hospitals." They may not have the human resources to have as efficient incoming and outgoing patients as they should have. Do you have any sense of that across the territories as an association? This is something that was noticed by someone, an M.L.A., who made the presentation. He indicated that it sounds like, from the report we have, the Stanton Yellowknife Hospital, Inuvik Regional Hospital and Fort Smith, the larger hospitals seem to be all right but they have the manpower to handle the clients coming in and out. He indicated that it may not be so, that the nurses who are in the smaller communities may be overworked. Is there any kind of indication that you have received from any of the communities that would respond positively to that?

MS. MOFFITT: Yes, I believe that is true. The nurses do work long, extended hours in some of the communities because there may only be two or three of them. It may be that they get called back two or three times in the night. I have also heard nurses say that the community is usually quite responsive to that as well. Some communities will say, "The nurse has been up all night. She is not going to be in in the morning." They take that role themselves. I think it is fair to say that. Other communities do not have that same rapport with the health centres, so you do not always get that. Maybe they do not know the nurses as well either. It is important, even at that level, that nurses and communities are collaborating and really working as a team. You will hear nurses in the communities talk about burnout. They will say it is the long, continual hours of being called back in and having a disrupted sleep. When your sleep is disrupted like that, you

just do not function the same way.

CHAIRMAN (Mr. Zoe): With that, I would like to know if there is a system that would be able to evaluate what we have in the territories and say, "This would be more even if the nursing personnel were distributed this way." Have you been asked for any kind of information like that from the department or do you have any kind of system that might make it more equitable for communities?

MS. MARSOLLIER: In regard to the partnerships that we alluded to in the last part of our report, which said that we were meeting with all of these other associations and the government and we were hoping very much to meet with the Minister in the near future, there has been much work going on in that way. Before this can all happen in regard to how many nurses we need, maybe the nurses we have right now are enough, it is just the environment they find themselves in, if the communities are not working with those nurses. If it is the attitude that health is something you go and get at the nursing station, if that is not ever dealt with, if we do not start challenging and saying, "No, health is something that belongs to me. I am responsible for making sure that I get my good night's sleep, that I do not drink too much alcohol when I want to have some fun, that I make sure that my kids go to school and that I feed them before they go to school," and if those things are not all in place, the nurses' jobs, even if you put ten nurses in there, are still not going to make a difference. It is very important.

The government or the Department of Health is starting to do what they call community assessments, where they find out things. They may say, "All right, in this community, we have mostly very young people. There are hardly any old people there. Most of them are just little kids with many young moms and dads. That means, then, we need to focus on child care and mom and dad care." Then, you talk to each other. You develop a committee, maybe that is not the best word, but you sit down and you say, "All right, in our community, most of the kids are young and we are young ourselves. Our needs are we do not like it when our kids always come down with earaches, chest colds, bronchitis or whatever. What is it that we could learn that will make this better for our kids and so that the nursing station is not going to be overworked?" We referred to collaboration with the government and the boards and we talked about the associations and the boards. There is an even more basic collaboration that has to occur, and that is between us, as individuals, and the professionals. It has to happen.

MR. ARNGNA'NAAQ: I have one brief comment, Mr. Chairman. Somebody has been mandated to do something of that nature, where they are trying to educate the people in the communities about what it is that makes a person healthy. They go into the schools. Again, we get into a catch 22 situation where they really do not have the time to be able to do that because they are often so overloaded with patients coming in day or night. Is that correct?

MS. MARSOLLIER: That is right.

MS. MOFFITT: I think it is correct, Suzanne, but one of the things that just hit me, though, is the role of the community health representative. It is to be a very pro-active health promotion person. Because all of those community health representatives are local people usually, speak the language and know the people, they are key people in providing this type of care and getting out there with changing lifestyle and working together. The nurse would work with them.

MS. MARSOLLIER: I would like to add one more thing. I keep going back to the community. If you are in a community where most of the teenagers are getting into trouble all the time, if the police are always having to bring them to court, they are breaking into schools or whatever, it is our responsibility, as parents of those children, to get together and say, "What are we going to do about this problem?" There is not enough of that going on. I guess it is part of what we were saying here. The politicians, the government, the professionals, but we, as moms and dads, also have to be leaders. Probably we would make more difference than anything the government or the professionals could ever do.

CHAIRMAN (Mr. Zoe): Earlier on, my friend was talking about the workload situation. One of our Members, particularly Mr. Antoine, from Nahendeh, indicated that, in his view, he noticed that the nurses who are working at the Fort Simpson hospital, their workload situation seems to be more than the larger hospitals, for instance, Stanton or the one in Inuvik. That is what he was implying. Has your association observed that type of thing between hospitals, not necessarily the nursing stations versus hospitals? Mr. Antoine noticed between the bigger hospitals versus the smaller hospitals, that the workload situations for nurses in smaller hospitals were even more than the ones in Stanton or Inuvik. That was my understanding of what Jim was saying.

MS. MARSOLLIER: They were taking care of more people. One person was taking care of more people than Stanton. Is that what you mean?

CHAIRMAN (Mr. Zoe): He did not really get into specifics, but he implied that, in smaller hospitals versus larger hospitals, the nurses had a heavier workload.

MS. MOFFITT: Nurses will say one to four. One nurse to four patients and I do not think that is what you are saying. I think what he may be seeing is that the nurse's role in those smaller hospitals is different than a nurse's role in Stanton, for example. In a smaller facility the nurse is responsible for many types of patients, a paediatric, a small child, an obstetrical patient, someone in labour or an elder. They do a wide range of nursing care, whereas in Stanton, not that there are not some nurses who do everything, but it may be a ward who are all surgical patients. Out in the small hospitals they also do the laboratory work. They do some of the X-rays and physical therapy. It is a wide, wide range. Not to say that is any different from some small rural hospitals in the south that are also like that. They are just used differently. It is almost like apples and oranges is it not? You cannot compare what it is like in our big hospital to what it is like in our little hospital.

CHAIRMAN (Mr. Zoe): Obviously Jim noticed that because he has travelled to various areas. In looking at his situation, he observed that nurses, in his own little hospital in Fort Simpson, are doing all those type of things that you indicated. That tells me something, maybe by saying those types of nurses should be classified differently. I do not know what he is trying to say

as he really did not say it, but with the workload assessment, if they can develop something, maybe we could address those type of things. That is why it is so important to try to get the workload assessment tool in place so that all of these considerations for different types of nurses can be looked at. I think that is what you are basically trying to get at, in my view at least. Mr. Argna'naaq.

MR. ARNGNA'NAAQ: I just wanted to get back into training a little bit. In the Auditor General's report, I do not know if you have reviewed the report, in section 4.8.2, I was just reading through it. It says, and I will quote from it, "We found that training dollars are not distributed equally between the doctors and other health care staff. For example, the department allocates funding for the advanced nursing skills in-service program of approximately $400,000 for 365 nurses. By comparison, a doctor on contract has the benefit of two to three conferences per year which can add up to between $8,000 to $10,000 per doctor for their professional development. From our interviews with department management and nurses on the boards this is viewed as a constant source of discontent amongst the community health nurses, who under the primary health care model, are intended as the front line caregivers in the N.W.T." The assessment of the distribution of dollars between the doctors and the nurses, I would like to get your response on whether you have a view on it.

CHAIRMAN (Mr. Zoe): Ms. Moffitt.

MS. MOFFITT: I can just make one comment in terms of the community health nurses. It is very difficult to find nurses to replace them when they go out, and there is no place in their community where they can get that education. I know that, if you were to talk to a nurse from some small community right now and if she is a nurse who has been around for a long time, she would probably say to you, "We lost our second trip out." I hate to say this, but we hear it a lot from our nurses. When they used to have a second V.T.A., that second trip out, they would usually spend their money, upgrade, take a course or whatever on their own. It may not have been provided that way. I know some of the regions have tried to assist by giving them educational leave. I do not know what else to say. We have tried from the association's point of view to make our bi-annual meetings an educational proportion of the meeting so they have opportunities, not so much the community health nurses, but more the hospitals for things such as tele-medicine. It is an ongoing issue. Part of it is the expense, the numbers of nurses compared to the numbers of physicians, and it is a very difficult situation in this time of cost-effectiveness. We can appreciate how costly it is to travel from the small communities in the north to some place to get this educational opportunity for the nurses in the communities.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: All we have in the Keewatin region are nurses. We do not have a hospital so we do not have doctors. We only have doctors that come in and out. With this being the case, it disturbs me that we have nurses who do not have the funds to be able to go out and get further training. In the Auditor General's report, they make mention of A.N.S.I.P., that is a program. Would you say that the funding for that is sufficient? Is it something that we could carry on with, as I do not know, what its mandate is?

MS. MOFFITT: Actually, this is a very worthwhile program the government has implemented. In fact it was offered in a large degree by one or two of the universities in southern Canada up until ours was started. I do not believe that it even exists in the south anymore for political reasons. It is an invaluable program here. It meets not only the needs of the nurses in the nursing stations, but it also meets some of the components for the nurses in the public health units and in the hospital setting. It is very comprehensive. It runs all year round now. There are different components of the program that are offered instead of it being back to back. They offer components so that, if someone is interested in the community health component, they will attend just the obstetrical, management or public health. I cannot even remember all of the different components. We would love to have it so that there were more dollars and more people could come to it. It is a very much recognized need and it is fulfilling that need in a sense that the program is available. It would be nice if more people could access the program. I just do not think we live in Utopia here. I know that there are limited dollars.

CHAIRMAN (Mr. Zoe): Any further questions? Mr. Whitford.

MR. WHITFORD: Mr. Chairman, when we were travelling we heard a bit about standards for the medical profession, doctors, nurses and other practitioners. In the Auditor General's report it says that the department should set performance standards for doctors. It recommends that in this report in section 4.6. While we were travelling to Inuvik we heard from a doctor from the Inuvik Medical Clinic. Their representative argued that this would be inappropriate as the medical doctors have a system of a peer review. They do this. However, the nurses themselves have a peer review procedure under the Nursing Professions Act, but they also have performance standards that their employer or employers use to evaluate their performance. Doctors do not have that. They have peer reviews only if called upon to do it. There is no performance standard set or anything like that. As we are looking for suggestions to assist either the Auditor General in his recommendations or the department to benefit the northern people, could you offer any suggestions for your medical colleagues within their association for the Department of Health, that would help us in this area?

MS. MARSOLLIER: That is something that we are very proud of. We only came into existence in 1975 and, as we told you at the beginning of our presentation, the purpose of our association is to protect the public. By doing that we are responsible for making sure that the nurses who are working here are competent and that if there is evidence of incompetency, we have the responsibility of discipline. Those are our two mandates. Those are the two reasons why we exist. It is very important that I give this message to you. It is with great pride that we have done this since 1975, and you can perhaps appreciate that, at that time, most of the nurses in the nursing stations were working for the federal government. This association was created during a time when there were very few nurses who would join this association because the terms of employment of the federal government were that you did not have to belong to an association. You could if you wished but they did not make them. Despite those odds, it was created, an act was made and passed by your

government and we continue to monitor our professionals and to develop standards which the employers, who are you, the government, continue to do. The doctors find themselves in a very different situation in that even though we feel that we are a very small number, they are considerably smaller in number than we are. The amount of energy, and I cannot begin to explain to you how much energy is required to do what our association does, is 90 per cent volunteer effort of people like myself, Pertice and many other people, who give generously of our time for no money to maintain this ability to protect the public. The physicians find themselves in a very small number and this energy that we have committed ourselves to is something that is beyond what they are capable of doing by themselves at this time. It is my understanding that they are looking to the government to assist them as they are so few in number. I think that you have the cooperation of the physicians on this issue.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: I seem to have the message. I see what you do and it is greatly appreciated, believe me, the professionalism of the nurses and the doctors themselves. I will go on the record and say that they are like gods. When they say there is something wrong with you, there is something wrong with you.

MS. MOFFITT: That is it.

MR. WHITFORD: Confirming that standards are set by the Department of Health, the government, is this a desired thing?

MS. MOFFITT: I think that the doctors in Inuvik, who, I think, you are referring to, are fearing the unknown. I think it is the good will of the medical association to cooperate and get assistance from the government. It is not that it would be the government mandating structures or standards, what it would be is a collaboration between the physicians and the government in developing those standards. There would be excellent models from the southern jurisdictions. As I explained to you, there is a tremendous amount of volunteer energy that has to be generated and they just do not have the resources to do that by themselves.

MS. MARSOLLIER: I think they collaborate in terms of registration with Alberta's association and some of the other associations who do have peer reviews and audits. It may be, and I certainly cannot speak on behalf of doctors, that they will adopt another province's protocol so they could become ex-officio members or something like that so they have a review system. I will tell you one of the problems that I know of from a nurse who was in administration in Inuvik years ago, it was in the 1980s. We had a nurse who was not registered with the Northwest Territories' association, and we felt she was unsafe to practise and was incompetent. She was fired from the hospital. In terms of our professional behaviour, we always report people who we feel are unsafe practitioners to our professional association. When I did that with her province, the answer was this is outside of our jurisdiction, she is in the Northwest Territories. So, of course, nothing happens with that. I do not know, but I wonder if that may be something to be considered as well when it comes to what is set up between affiliating groups of people.

CHAIRMAN (Mr. Zoe): Any further comments? If not, I would like to thank the representatives of the N.W.T. Registered Nurses' Association for appearing before our committee.

MS. MOFFITT: Thank you.

MS. MARSOLLIER: Thank you. It has been a pleasure.

CHAIRMAN (Mr. Zoe): We will take a short, two minute break.

MR. ARNGNA'NAAQ: Maybe we should ask if there is anything else that they would like to add, then by all means they should write to us.

CHAIRMAN (Mr. Zoe): Sure, if you feel that there are any other additional comments that you would like to make, you can always submit it in writing to us. We will take it into consideration before we make our report.

MS. MARSOLLIER: I will instruct our executive director to bring you up to date on the process or where they are with the nursing program.

CHAIRMAN (Mr. Zoe): Thank you. With that, we will take a two minute break.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): We have Mr. Erasmus from the Dene Nation appearing before us. Mr. Erasmus, if you can proceed with your presentation to the committee.

Presentation by the Dene Nation

MR. ERASMUS: Thank you, Mr. Chairman. Good afternoon committee Members. I would like to thank you for this opportunity to make the Dene Nation's comments known on the Auditor General's report. The Dene Nation has a health program that tries to keep abreast of what is happening in our communities concerning health matters. We have had a chance to study the report and we have some comments that we have put together. I believe that you each have a copy of some of our comments in front of you.

I would like to make some observations that we have and to comment generally on them. If you have questions, I could try to answer them as best I can. First of all, we have to focus in on the issue of health as a treaty right that our people understand to have between ourselves and the federal government. We have a special fiduciary relationship with the Crown and because of that we find health is a guaranteed right. So, when we talk of the administration of health, it brings in a whole different connotation from other people. It also brings in the question of accountability. Whoever is providing the resources, the programs and the services has to account to our people. I think, first of all, we have to bring that into focus. Specifically, with us if you look at Treaties 8 and 11, there is in both specific mention to health. Our people were reassured at treaty time that their health care matters would be taken care of. It is specific in the treaty.

With the transfer of the administration of health to the G.N.W.T., we go back a number of years, where at the time all of our people collectively were negotiating a comprehensive land

claim with the federal government and the transfer was viewed within that as part of a transfer that would occur. Our people looked at it as an interim transfer that would later fit into a self-government arrangement that our people would put into place. So, you find that the Dene chiefs, for example, have never fully endorsed the transfer. They have never said that the responsibility from the federal government to ourselves as a bi-lateral one goes to the territorial government. We basically said we are aware the transfer is taking place and in the future, it has to be open to our tribal councils, our First Nations or whatever organizations we have developed that have the ability to take on those responsibilities. I want to remind the committee of that.

The auditor makes specific reference to the transfer. It talks about the intent of the transfer. It specifically says in chapter two, the transfer was to pass more decision-making powers to the communities in the north. However, "the boards contend that the spirit of the transfer has been delayed because, when the transfer took place, the government failed to state its intentions." It did not clearly state what its intentions were. It does not specifically refer to the policy here, but from my own experience and recollection, we had no problems with the agreement itself as the agreement talked of giving control to the communities which is what we were concerned about, but when the territorial government's policy came out, it talked more of having central control.

The auditor then gets into the problem of who really has control, is it Yellowknife or is it the communities? This has been going on since the transfer. The government says this has to be cleared up very quickly otherwise we are going to have a lot of problems and health is very complicated. It is a very serious issue to deal with. There is no room for those kinds of misunderstandings as we have peoples' lives who we are dealing with.

The auditor talks of how they believe the department and the boards do not function as effectively as they might, due to, very bluntly, the department trying to control the boards. That was really never the intent from the communities' point of view. If we are talking of a self-government exercise, if we are talking of clearly setting up a unique situation in the north or in Canada where people can institute their own programs, then we have to let that power rest in the hands of the people. I feel that the auditor is supporting the communities' view on this.

In terms of the transfer, it is pretty clear that in the executive summary in the first chapter, it talks of the high population of aboriginal people on page three saying that, "We expected to find progressive programs to help aboriginal people play a meaningful role as employees in the system yet the equity programs are not being pursued aggressively and the lack of results is obvious." You have a transfer, top and middle management people are not being plugged into the program by aboriginal people and we are still having, not in all cases, primarily non-native people, many from the south, who are in the higher echelon of administering the programs which calls for high turnovers. There appears to be a lack of sensitivity to community people.

Those are general comments that you are aware of. I felt that I was compelled to echo what the Auditor General is saying. We believe that there is much work that can be done to take a hard look at this in a constructive way. We know there are problems. Let us begin to look at solution-orientated activities in order that we can provide the best resource with the dollars that we receive.

If you look at the comments that we provided you with, we begin to talk about part of the weaknesses that we find is that there is an inability in the funding mechanisms both public and private to keep up with the high cost of medical care. Part of the problem we find is that first of all there are inadequate dollars. There is just not enough money to do the job correctly. Compounding that you have a lot of bureaucracy and it is well known that the north has more bureaucrats per person than anywhere else in the country. It is a given. We have a lot of bureaucracy. Within the bureaucracy, the particular departments are not coordinating or functioning together in a comprehensive way. In other words, departments are working on their own. They are not exactly sure what others are doing.

Personnel might be hiring people within the medical profession and the medical profession or the Department of Health might not be working as closely as they might. I really think that you have to look at how the departments might be able to link together, pool their resources and begin to prioritize much better. I think the G.N.W.T. has been trying to do that by bringing together health and social services and so on but they still have a long way to go in terms of rectifying that. Again, the lack of adequate provisions for preventative and primary care at one end of the health/sickness continuum which we call it and the need for long-term care at the other.

We are finding, in the communities where we do not have full-time doctors, that we have C.H.R.s or nurses who are kept very busy. There are many things they cannot do. For example, just by doing health promotion to help people understand A.I.D.S. or H.I.V. prevention, many things people ought to know, interpreted in the languages and having a good working relationship with the community people, we are finding that these people are overworked. They are being overburdened by the heavy workload and there is a lot of stress. Many of them are good people and they are on the fringe of quitting and doing something else. We need a support mechanism.

We have to be able to help these people in order that they can do their job comfortably and in order that the people in the communities feel comfortable with them. Again, access to health care. We find that many of our people feel that there are inequities to access that affect our population. On the surface, people may not feel that there is a problem, as health care is available to everyone, but we find that many of the professional people, however professional or prepared they are to do the job in a clinical sense, are not prepared mentally in the sense of being culturally sensitive or community knowledgeable or orientated most of the time.

For example, we have many people who complain that when they go to a doctor, I just use a doctor as an example, to get treatment for an ailment, many times they are asked if they have been drinking. There is a stereotype that, because you are native, your problem is associated with alcoholism. You immediately start off with a bad relationship with the professional and you just want to get out of that office. I suppose the doctors or the professional people do not know

the social organization or the structure of the communities.

For example, when we amongst our people talk about being healthy or helping a person who needs assistance within our own society, generally, before the Europeans came here, the people who helped the ill were our own doctors, our own experts. They were an integral part of the community. They were related to people by kinship. They were respected and they provided an important function to the community. Now you have someone who is outside of the community coming in. They do not know how the people really function among themselves, they do not understand them to a great extent and it is very difficult for our people to give all of the information to feel comfortable.

There is a lack of acceptance and the awareness necessary to have some of the healing take place. In other words, there is a gap, there is a void that our people find. I find it difficult to express. If we are going to continue to have doctors coming in and we have not had our own doctors for many years, for example, then these people ought to be sensitive. They ought to try to spend more time in the communities. They ought to put more appreciation in people wanting to heal themselves. Again, the distribution of health manpower. The report talks about how it appears that the department has not really prioritized yet and really figured out where and how people ought to be distributed in the field versus the bureaucracy. We find that in some regions, we have adequate people who are doing the job. In other regions, there is a great lack of expertise. We do not have the quality of professional care in our regions. The department has to begin looking at that long-term planning and re-adjust that kind of alignment.

We find difficulties where the medical profession is not taking a holistic approach to diagnosing illnesses. We find that much like the western ideology, people are geared towards certain specializations. If you are an economist then that is your field. If you are a political scientist then that is your field, the same is true in history, the culture and so on. The way our people look at this whole aspect is that you cannot eliminate any one sector in healing people.

When we look at the world, everything is interrelated and we feel that health promotion and understanding of healing has to take that approach. We also feel that many times we need second opinions. The doctors' opinions are not always the correct ones. We need to get away from this idea that a pediatrician, for example, is the only opinion. We need much more of a rounded approach to diagnosing people.

Very briefly, those are some of the comments. I could go on talking about the Auditor General's report. We feel that the Auditor General is being very straightforward and is making important recommendations. We want to take a more comprehensive look at it. We have not been able to look at it as well as we would have liked. We have not really had a chance to talk with as many people in our communities as we would like to.

We are planning a health meeting in March of this year where we are bringing our leadership, some of our elders and our youth together to review the transfer, review the whole area of health in the north including mental health, alcohol and drug abuse and so on. Out of that I am sure that we can have more opinions. We would like to continue commenting on this and providing more opinions to you. If you have questions, as Members, I am prepared to try and answer.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. The submission that Mr. Erasmus has made is quite thorough and it touches on a good number of areas. On the second page, the last item you mentioned was the increased involvement of consumer participation in the delivery of health services. In the Auditor General's report, the Auditor General points out that problems exist in the department's approach to communicating with the public. On one end they are saying they should involve the consumer a little bit more and the Auditor General says that the department is having troubles communicating with the public. What role would the Dene Nation play in this area? What recommendations would you have for the department that they could use to improve their public communications?

CHAIRMAN (Mr. Zoe): Mr. Erasmus.

MR. ERASMUS: I think the approach people would like, it is not so much the central office playing a major role, but, as I was saying earlier, reaching out to the communities and the regions that are accumulating the responsibility over health and health care. People are learning more and more about what their rights are. Generally, I feel the unquestioned world of the medical field is beginning to become much more of a real one to people or one that is more approachable. Slowly, the gap is being bridged, but, by having much more effort given to interpreter's services, for example, it is much like legal interpreting when you get into body functions and surgery. For example, someone needs to have surgery and it needs to be explained to them, what the process is, what does it mean and what is the potential of having a particular operation. The doctor must go out of his way to explain precisely in easy to understand language, as we have incidents where someone can be operated on and they do not know what the operation is but they are consenting.

I think, first of all, we need interpreters who know the language, who know the body parts and the functions, as it is difficult to explain in our aboriginal languages. I think just that example alone can go a long way in making people feel comfortable and that their rights are not being infringed upon. I feel that we are quite open to talking about how people may get rid of this fear they have of going to hospitals, dentists and doctors. There are many people in our communities who will not go to a doctor or the hospital unless they are basically on their death bed. There is a reason for that. We have to dig down deep and find out what that is. There are many old people who have never gone to a doctor in their lives. You may see them limping down the road. They will bear that pain rather than go into the unknown.

MR. PUDLUK: Thank you, Mr. Chairman. In subsection three of the Auditor General's report, it states that the Department of Health does not have a plan. The Dene Nation is trying to do some work in the health area. How is your work in this area being affected by the absence of a strategic plan? Are you able to give us an example of the areas where your work has been slowed down due to this lack of planning?

CHAIRMAN (Mr. Zoe): Thank you. Mr. Erasmus.

MR. ERASMUS: The fact that there is no plan has an unsettling effect because when the transfer took place our people assumed they would have control in the communities and in the regions. That was the intent. That was the reason why people did not object. As the report says, since then there has been a dispute between the communities and the department on who really has control. That has happened and it is going to continue to happen until we have a long-term plan that really spells out clear intentions, clear areas of jurisdiction and what the field is going to look like down the road. It is an unknown. It makes it difficult for us as the trust factor is not there.

As I was trying to say earlier, we are dealing with people's lives, medevacs, for example. A lot of people have their fingers crossed when there is a medevac because they do not know if the person is coming back home. I do not want to exaggerate but I think there are many ways we can improve the system. One way, if a strategic plan is not in place, is the department has to be very open as to how people are feeling or what is happening in the communities.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. In your presentation you talked about, and you used a doctor as an example, when they come into the community they are not sure of the culture. In responding to a couple of the questions here, you give a sense that the caregiver and the people in the communities have a difference which do not mix very well, which would say to me that when caregivers are coming into the communities or into the Northwest Territories, there should be an orientation program of some sort for these people. Maybe even people who have been around for a long time should go into a cultural program where they get to understand who they are working with or for. If there were to be an orientation program created by the department, what elements of such a program do you feel should be mandatory?

MR. ERASMUS: I think orientation is something that should be taken seriously. The mandatory part would be knowing the languages of the people, the social structure, the economy of the people and knowing more about the communities. There are cultural orientation programs that are designed which are very good for people who need to be introduced into different societies. You can adopt formats that are out there. I think we have to sit down and begin to work that out. The department should be open to doing that with the Inuit and also with the Dene and Metis. I think we can go a long way in that area.

You find some places in the south where traditional medicinal practices are recognized in hospitals. They are recognized by health boards in the south. We could probably go a long way by recognizing that our people have traditional methods of healing. Midwifery for example. Mid-wives have been here since the beginning of time for our people and they still exist. They are still in our communities. If we would give recognition to many of the midwives, my grandmother was one, they have an educated understanding of the people in the community. Many of them are leaders. They have brought most of those people from the community into the world. For example, if these midwives were working with doctors to help and assist the person who is already playing that role, we could go a long way.

We also have people who have other traditional medical practices. We have herbal doctors. These people are recognized in some hospitals in the south as practitioners. They are brought into the hospitals. In a mental health sense this really helps the people of the community because they are not seen as a patient who is neglecting his own people and going to the European society.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: I get a sense that it should not be only the care givers who get the orientation. Should the people in the communities also get the orientation? Is this something which you are alluding to?

MR. ERASMUS: I think we can be both. I am trying not to be overly critical. I know there have been mistakes. We are all aware of this. We know that we can improve the system. I would like to focus on the solutions. I realize from our end that we have a lot of learning to do. We can probably cut costs. We can probably help the administration if we sit down and begin to look at this as a serious problem. I feel that the department should not be put on the defensive when people talk about improvements. This is constructive and we are trying to improve the situation rather than condemn.

CHAIRMAN (Mr. Zoe): Mr. Erasmus, you have provided us with a written presentation. Once we have reviewed your presentation thoroughly, and if we have any questions, our staff will be in touch with you. Mahsi Cho for appearing.

MR. ERASMUS: Thank you.

CHAIRMAN (Mr. Zoe): I will call upon our next witnesses, the Union of Northern Workers' representatives. Please come forward and make the necessary introductions.

Presentation by Union of Northern Workers

MR. WIGGS: Thank you, Mr. Chairman. I am Scott Wiggs, the Regional Vice President with the Union of Northern Workers in Yellowknife. We have a short presentation.

CHAIRMAN (Mr. Zoe): Please proceed, Mr. Wiggs.

MR. WIGGS: Thank you. The U.N.W. represents 7,000 workers across the N.W.T. Our largest bargaining unit is made up of employees working for the G.N.W.T. Of that unit, probably the largest occupational group is our health care professionals who are estimated at close to 1,200. This includes about 450 nurses. One of the problems with this review is that the front line workers were not interviewed. The U.N.W. was not consulted. Only senior bureaucrats in the department and members of health boards were interviewed by the Auditor General's office. This is a serious shortfall with that report.

The audit says that we expected to find progressive programs to help aboriginal people play a meaningful role as employees in the system. Aboriginals make up about 11 per cent of the department's staff compared to 45 per cent of the work force.

There is no simple solution for increasing the number of aboriginal employees in the health care system. There is a need to educate more potential affirmative action candidates in health care trades. A good start are several courses offered by Arctic College, the community health representative program and certified nursing assistant program. This course is inactive for the time being. Research is also underway for a northern nursing diploma program.

However, there must be positions for candidates to fill. For example, Stanton Yellowknife Hospital has reduced its C.N.A. positions by up to 12 positions over the last decade. Once a person has passed their schooling the next step is into the work force. The U.N.W. supports the affirmative action hiring policy of the government as long as it is applied fairly. If the policy is not applied properly, people who are unqualified and unsuitable end up filling jobs. Workers hired under a badly applied affirmative action policy may become frustrated and quit. It sours their taste for government employment and has a detrimental effect on their self-esteem.

The audit says that high turnovers in health can be avoided by making sure that employees are suitable for the jobs they are hired to fill. Suitability must be closely looked at during the hiring process. Often through sudden resignations vacant positions must be filled quickly. This results in hasty hiring decisions. Perhaps not enough consideration is given to the suitability of the candidate and their ability to work amid a different culture and harsh climate.

What is suitability? One factor that could be considered to determine suitability is a candidate's track record of community involvement. It is essential that community nurses be highly involved in the community. This helps gain the trust of the community and it helps the nurse adapt to the community and chances are he/she will stay longer.

Even if properly applied, the affirmative action policy has limits. During its eight years of existence it has helped fill all of the entry level positions in health care which are available. Many health boards have a much higher rate of aboriginal employees because many of the jobs with the health board are entry level jobs. Aboriginal participation is low in the specialized department jobs. This points to the need for career plans for health care workers once they gain entry level positions. These would include training programs that combine on the job experience, academic courses and other hands-on training so people can progress up the career ladder.

Aboriginal people whose culture and tradition is oriented towards oral and not written communication seem to excel in a more hands-on type of education and training. One training obstacle to overcome is getting people to apply in the first place. The department and health boards have experienced problems in getting aboriginal people to apply for training programs. Dynamic hands-on recruiting campaigns may be more successful in getting aboriginal people interested in applying for training funds. A health care display at a Yellowknife mall publicizing careers in the field proved to be popular. The career fairs and recruitment campaigns must be lively and interesting. They should seek out interested participants beginning at the high school level. Advertisements in newspapers advising that training funds are available are likely to draw little interest and a waste of scarce government dollars.

The audit says that training and development costs come out of discretionary funds. Boards should be allocated funding specifically for training. In a time of fiscal restraint, access to training money is low to non-existent. If a line item for training is placed in a board's budget, the board can plan training opportunities. It can set up career plans for employees and not just one shot training opportunities at the last minute. Several studies by the Canadian Nurses Association, "Nurse Retention and Quality of Work Life, the National Perspective, November, 1990" and by the N.W.T. Registered Nurses' Association, "Nurse Recruitment and Retention in the N.W.T., June, 1990" point to the importance of education leave. Health care professionals pursuing health care careers need ongoing training. If they do not keep up with the changes in health care technology as well as other services and knowledge improvements they become obsolete. Training must be distributed where needed and in a fair and equitable manner. The U.N.W. has taken steps to negotiate fairer processes into its collective agreements. At H.H. Williams Hospital in Hay River we represent about 100 nurses and support staff. Each nurse gets one educational course for every two years of service. Depending on the cost and the length of the course the employer will pay between 50 and 100 per cent of the cost.

Unfortunately, the G.N.W.T. is only half committed to education leave. Nurses can apply for education leave but the final decision rests with management. There is no requirement that education leave be granted, at least not under the G.N.W.T. U.N.W. collective agreement. Trips out for courses help nurses and health care professionals increase their knowledge and network with other nursing and health care professionals, both in the north and in the south, and act as breaks away from isolation. However, we have found that many employees never get education leave because managers turn down their applications for a variety of reasons. The one most often encountered is the inability to find a replacement while they are scheduled to be on education leave.

A common reason why nurses leave the north is burnout. Often they are on call 24 hours per day, seven days per week. They can never get away from their job to pursue other social and community activities. To help solve this problem the U.N.W. has negotiated a job-share agreement for health care professionals. They can share their job with another qualified person. The health department and the boards would be encouraged to recruit a reserve of nurses to be able to share jobs with incumbent nurses. This would make setting up job-share agreements easier.

The audit mentions that the department and boards must be able to keep track of how well people work. Also boards and the department fail to encourage consistent monitoring of employee performance. There is already a process in place. The G.N.W.T./U.N.W. collective agreement provides for an employee performance review. Managers should be properly trained in the purpose of performance reviews and how to develop them. Exit interviews are mentioned as a way of discovering why employees are leaving their jobs. The only problem with an exit interview is that an employee may report what they think management wants to hear rather than what the employee truly feels.

The audit repeatedly talks about the turf battles between boards and the department. Time burned up in jurisdictional battles between boards and the department could be better used directly serving the public. Part of the problem could be that it may be unclear what is departmental jurisdiction versus what is health board jurisdiction. Also, when it is not clear who is in charge the public's confidence in the health care system may be undermined.

People orientated managers must be hired by both the department and by health boards. Front line health care workers in Inuvik were subject to the dictatorial style of a certain manager for several years. The end result of bad management is that everybody loses. The front line staff suffer morale problems which effects their service and thus the general public suffers. The situation in Inuvik deteriorated so badly in 1991 that the workers eventually staged a community protest and were joined in solidarity by many sympathetic members of the public.

There are pros and cons to fully independent health boards. From the U.N.W.'s perspective it is probably easier for us to deal with a centralized department. The U.N.W. has no official position on whether boards or the department should be in control of health delivery. One thing is for sure, though, it has to be one or the other. There has to be a full commitment to live with either the department being in control or the boards being in control.

There are pros and cons to having health boards run the show. In a community it is easy for front line workers to communicate their concerns to local leaders, such as regional health board members. At the same time, though, fully independent boards will result in some duplication of government resources. For instance, the G.N.W.T. Department of Government Services and Public Works staff no longer does maintenance of the housing authority assets. The housing authority does it. The community has a D.P.W. maintenance shop from when D.P.W. once took care of public housing, and now there is an additional shop belonging to the housing authority. This is a duplication of government resources.

If the government is going to devolve health delivery to fully independent boards, the department must take steps to train members of the boards to handle their jobs so that the authority can be fully devolved to them. Local leaders are naturally most in tune with what is happening in their communities, much more so than a distant Department of Health. Anyone who has lived in a community or even visited one knows how everyone knows everyone else. If regional boards have full authority to run their own affairs the input offered by front line workers in communities will have more success in being actioned. This requires effective local board members who know how to represent the concerns of their constituents and be able to run an efficient operation at the same time.

The government should review the types of training programs that are available for board members. Storefront for Volunteer Agencies based in Yellowknife offers financial management training courses for volunteers. These course are available across the N.W.T. Some of these courses may be useful to health board members. There is a high turnover, 70 per cent, in the 1990 report of N.W.T. nurses. We have already discussed some ways to reduce this. It is also essential that during times of fiscal restraint no cuts be made to front line staff. Community health centres operate with minimal staff. Whereas it may be perceived that a hospital can absorb cuts to front line staff, a community centre certainly cannot. This applies to all staff at community nursing centres.

The U.N.W. experienced a situation last year where a janitor resigned from a nursing station during the hiring freeze of 1991. The position was not restaffed because the position was not deemed essential. The result was that the nurse working there also had to take care of janitorial duties. This led to the potential threat that the nursing station would have to be closed because it could not be kept clean. This example demonstrates that any cuts to health care, especially in the communities, must be avoided.

The audit indicates that the G.N.W.T. should transfer responsibility for government employee medical travel from the Department of Personnel to the Department of Health. The U.N.W. agrees with this move. The Department of Health has expertise in this area because they presently administer medical travel for everyone else in the N.W.T. Bringing the administration for medical travel claims under one roof will ensure consistency. This will lead to more harmonious labour relations between the U.N.W. and the government.

In conclusion, with changes to the health care system in the N.W.T. fewer patients will be sent out of their communities, regions and territories. In order to obtain a better system the need for qualified, especially northern, health care workers and professionals must be met. The public will have more confidence in the health care service when they are serviced by health care professionals, doctors and front line workers who have lived in the community for many years and who know the culture of the people. This will lead to a greater continuity of health care. Ideally local people will be doing health care in their own community. That day is still off in the future but everyone, managers, politicians, health care workers, unions and the public must work towards this goal. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you. Are there any comments or questions? Mr. Whitford.

MR. WHITFORD: You mentioned that the employee performance review process was jointly developed by yourselves and the G.N.W.T. The Auditor General's report points out that the performance review planning process is not working well. The department has only completed 43 per cent of its appraisals and the boards have completed 26 per cent of theirs. Given this, what role can you as a collective unit take to encourage management within the Department of Health to improve its record in the area of performance appraisals?

CHAIRMAN (Mr. Zoe): Mr. Wiggs.

MR. WIGGS: I would certainly hope that we would not have to bring pressure to bear on any of it. The audit indicates that, while the system is in place, it is not being accessed by the people responsible to use it and that is the people who do up the performance appraisals. It is hard to understand many of the reasons why, whether it is that they are responsible for too many staff or simply have not got the time to do them. I do not

think that it is necessarily a problem with the system. As we indicated, there has to be proper training in how to do a performance appraisal on an employee and to ensure that it is kept up to date and accurate. A great deal of this can be based on the employees themselves, they can say they want their performance appraisal done and that they want to see how they are doing. We certainly encourage our members to do this. However, there have been many instances where performance appraisals have not been done for two or three years on an individual employee. It would have to be the responsibility of a properly trained manager to ensure that he/she does this and keeps it up to date and current.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Arngn'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. I apologize that I was not able to sit through your presentation. I am interested in the training portion of what you discussed with respect to available funding for training and opportunities for aboriginal people. Recognizing that we are in a time of fiscal restraint and on one hand we say that we need more training opportunities, yet we are having problems keeping staff in our communities. What would you recommend as the best way to allocate funds in order that it is workable? In order to get people trained as well as keeping them in the community. Is there something which the union could recommend to the department which would reduce this?

MR. WIGGS: There are some funds available to the federal government for training for aboriginal and other disadvantaged groups. Rather than simply use up money by advertising in the newspapers and having them stagnate is to go out and actively seek recruits beginning at the high school level. This was mentioned in the report. We need to have students recognize that they too have the ability to get into these fields and to continue their education with a direction of going into the health care. That is on the public side.

On the employee side and for people who are already employees and need to undergo continuing education, while a great deal of these education programs may be paid for by the employee themselves it is simply a matter of maintaining the right to have access to the training. Whether or not there are some courses which are paid for, we have an understanding with the government that courses required by the employer will be paid. There are other courses that, while they relate to the individual's job, are not necessarily required but would give them an advantage later on and to keep them upgraded in technical knowledge and ability. In the most part the employee is willing to pay the costs associated but it is more a matter of having the right to go on these courses and the time off to do so.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: You have one resolution whereby you are negotiating job share agreements with health care professionals. Is there anything else which the department might be able to do to encourage employees to stay on in their positions?

CHAIRMAN (Mr. Zoe): Mr. Wiggs.

MR. WIGGS: Aside from the items which we already covered in our presentation and some other issues brought to bear which really do not have anything to do with this particular committee, housing, community nurses quite often are on call 24 hours per day, seven days per week. We have alleviated that somewhat with the job share agreement but that job share agreement is a voluntary issue. It is not a mandatory issue and some people still do like to have full-time jobs. However that must be a manageable job. Part of the problems in the communities are the single nurse nursing stations where they are literally on call the entire time they are there. Something which a previous speaker brought up is that we have to deliver more programs. Part of it would be training community members to assist in the delivery of, for example, educational programs on health. This may be one solution. The only other solution to a staff member being on call 24 hours per day, seven days per week is the obvious one and that is more staff.

CHAIRMAN (Mr. Zoe): Mr. Wiggs, you have touched on an issue which I find interesting but you did not want to elaborate on it. This pertains to housing. Can I get your views on what you meant by stating you did not think it was appropriate to mention that component which reflects human resources.

MR. WIGGS: Certainly. It is our view, specifically since we are dealing with health care professionals, that the vast majority of them do not come from the N.W.T. and we do not have the northern education base at the moment to supply a mass number of nurses. It is simply a matter of fact that the proposed new housing policy will, in some instances, bring about rent increases so massive that people will no longer think it is viable to remain in the N.W.T. When people see what is offered to them especially in the smaller communities and if they do not think it viable to live there it is going to be hard to replace them.

CHAIRMAN (Mr. Zoe): Thank you. Through our hearings and in speaking with community members in the two communities we have already visited I understand that there are nurses in Inuvik who have already put in their resignations because of the housing policy.

MR. WIGGS: There is definitely that potential, Mr. Chairman. I personally have not heard of any yet but it has certainly been bandied about in various professional sectors.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? I would like to thank the U.N.W. for making a presentation. If we have any further comments or clarifications we will get back to you and perhaps we can ask you to respond to our concerns.

MR. WIGGS: Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Thank you, Mr. Wiggs. We will take a two minute break.

---SHORT BREAK

CHAIRMAN (Mr. Zoe): We have with us this afternoon the representatives of the Native Women's Association of the N.W.T. For the record can you please introduce yourself.

Presentation by Native Women's Association

MS. ALLEN: I am Bertha Allen, the President of the Native Women's Association, and I have with me Riki Sato, the Executive Director.

CHAIRMAN (Mr. Zoe): Good afternoon ladies. Can you please proceed?

MS. ALLEN: I would like to thank the committee for inviting us to express our views. We will not touch on every aspect of the report in our presentation. We will touch on issues that we see as very important to the health of the aboriginal people. The main advantage of devolution of health care was that the health care services should be closer to the people served and to be sensitive and responsive to their wishes. The Native Women's Association of the N.W.T. agrees with many problems and issues stated in the Comprehensive Audit of the Department of Health.

For example, politicians must take the lead in defining the kind of health care model that meets the needs of their constituents while accommodating fiscal restraint. The Legislative Assembly needs to make necessary legislative and policy changes. The organizational structure of the health care system is in disarray. The partners in the process are generally not working together to make things flow smoothly. Planning systems are almost non-existent. Systems for monitoring are deficient and need major overhauls. There is an inadequate process for meaningful measuring for management performance.

The response of the Native Women's Association to the Auditor General's report are as follows, there have been enough reviews and recommendations made internally and externally, and we must have vision so that we can target what kind of health care services we want to have ten years from now. Accordingly, the legislation and policies need to be changed. There must be open communication between the people in the communities and the department so that we can evaluate the progress made in the health care services. Employees who deliver health care programs must change their attitudes from competing for power in the system that does not accomplish much. Uses of health care services in the communities must be able to measure their performance. There is a lack of regard for economy and efficiency in the operations. Two hundred million dollars are spent for 58,000 people. Yet, there seems to be a lack of financial commitment to some programs which are important to the people in the communities.

As the report stated, many causes of death in the N.W.T. are preventable. For a number of years there have not been enough programs to deal with preventative care such as nutrition, home management or dental hygiene. It is time that the departments consider the input on the health care issues from users of the health care services in the communities.

The mandate of the Native Women's Association is that we develop programs for native women by native women so that we function in areas that affect our daily lives, be it socially, culturally, educationally, economically or politically. That is our policy. With our limited resources we deal with certain issues or problems. Four areas which are very important to the native women in the communities are: midwifery, community health representative program, medical interpreter/escort and hospital/ social worker, hopefully these will be programs. This is what the Native Women's Association wants. Information on health care programs so that we can evaluate their effectiveness at the community level. We want to ensure that health care programs are delivered to the people of the N.W.T as they were meant to be. We want to be involved in planning and evaluation. Southern views, opinions and technology may be valuable and useful but they must be adjusted to reflect our unique society.

In closing, the Native Women's Association advises the department that we want our input considered in places of the health care programs such as planning, evaluation and adjustment. All programs should be reviewed by the users and adjustments be made to be effective to serve the people. Our health care programs must reflect the unique society of the north. We need to learn to integrate southern education and technology with our tradition and lifestyles. There should be open communication between the people in the communities, health boards, department and non-government organizations. Open communication and sensitivity to the people served would cut down on the costs and create effective health care services. It would take people in the community less time and frustration to be heard and improve our health care services in the north.

For example, budgets for midwifery projects should be made available for the next five years so we do not have to look for money every year. We could learn from our neighbours in Alaska. They have legislation and experience in midwifery programs. As the department learns from other countries or provinces we can change them to meet our needs in the N.W.T. We must have training program updates so we can adjust the program to improve the present situation. Those who successfully complete training programs and gain actual experience are likely to go to a nursing school for further education and professional development.

In the area of medical interpreter/escort services, these services have been requested for a long time by every region which I am aware of. Not all patients speak the English language Even if they do, they do not necessarily understand the terminology. Our elders, and there are not too many of them left, should not have to go out for medical care without a trained interpreter to escort them. We need to improve the quality of health care services training programs and professional development for the interpreter/escort program Human resource planning based on community needs would help us to encourage our young children to learn and enhance their native language skills.

In the area of community health representatives, we must relate education and training to the job. Money is not committed, at present, to provide ongoing training for community health representatives. It is in their job description that once they are hired they will have ongoing training. In speaking to some of the C.H.R.s this has not been the case. Evaluation has not been done for this program since it was started. If our original mandate is not met then we must make adjustments to the program. Legislation and policy may need to be changed to be effective. C.H.R.s are our front line workers. Unfortunately there is a high rate of burnout at the present time. If they are to be effective we would like to see the C.H.R.s placed outside of the hospital. They are meant to be community health representatives. People only look to the hospital when they are down and out and ready for their death beds. We would really

like to see the C.H.R.s out of the hospitals if possible. We could benefit by looking at the rural community health program in Alaska. They have an effective program in Alaska which I have followed up on since their land claim was settled. I really encourage this committee to take some C.H.R.s to Alaska to look at this program. Their programs have been in place for many years. We certainly could learn from them and it would save us time and money.

Hiring and resignation of employees could include exit evaluation. There are not enough aboriginal persons trained to handle health care programs. We must have long-term planning and money must be committed. Commitment without money creates frustration and discouragement. At present there is no evaluation for those who resign from their jobs. I should know this. I was an employee of the Inuvik Regional Hospital. When I left I asked to be interviewed by the management committee because I wanted to bring many issues to their attention. I did not get a reply from the committee. Even though employees offer they do not take the time to improve their services. Much time and money is spent in hiring but not enough money is spent when people quit.

Education and training are long-term investments made by the Government of the N.W.T. No evaluation on resignation means a waste of money and time for both government and employees. With most health care workers coming from the south it is important to make sure that employees are adaptable to the lifestyle and different culture.

There is an insufficient number of aboriginal hospital/social workers at present. We need more on the job training for aboriginal persons in palliative care and grieving processes. Networking with other social agencies is a necessity for the program to be successful. Again, there is a similar program in Whitehorse for the training of aboriginal social workers. I would suggest that you look at this program.

Another thing which was brought to my attention is with regard to native food. There is a policy within the Department of Health. Having worked at the hospital, if the problem really lies with administration and with the dietary staff, it is simple to put into place. They cannot use the excuse that there are no meat inspectors on site. It is impossible to have meat inspectors every time someone kills a caribou. The pork they are feeding our elders is just as harmful as the uninspected meat is to the people in the community. It has been proven that our elders, if given the proper country food, will improve. That is something that has to be stressed and here in Yellowknife I am concerned about the dietary being shut down or gone to a contract. Now, I wonder what our elders are going to be served. Pre-cooked meals? The same as if you were in the hospital in Edmonton or anywhere where you get pre-cooked meals. They are not going to get any better. The cost of bringing another one of those alcohol treatment centres. The Department of Health spends a great deal of money to send people down south. What we have to seriously look at is saving those dollars and building centres up here that are relevant to the cultural needs of the people in the regions. These are just some of the issues we want to bring forth. I know the report is a comprehensive report and we are not going to be able to touch on everything I am sure others before us have.

CHAIRMAN (Mr. Zoe): Mahsi. In your presentation you touched on the sensitivity between the health care givers and the people in the communities. In the report under managing people, chapter 4.4, employees' orientation, it talks about the need for improving employees' orientation. What do you think health care professionals should know specifically about the needs of native women?

MS. ALLEN: We really need to do a proper development of a good cross-cultural orientation, not only for native women but for all native people. As an employee at the hospital, I took it upon myself, it was not in my job description but I made sure that I negotiated with management to do some cross-cultural training with some of the new health workers that are going out into the communities. Many of the issues I have discussed in the cross-cultural orientation is the way they should treat people, especially the elders and the women who go in to see the doctor, they should have someone there as that woman is not going to say I want someone there. They should know automatically that a nurse should be present when a woman is being examined. Many of our people do not know their rights as patients. They do not say, "We want or I demand that another female is present."

CHAIRMAN (Mr. Zoe): Earlier on in your presentation you mentioned that you would like to see various programs in development. You mentioned four of them. If I recall correctly, years ago in Rae at least the native women's group from Rae had a program called the health awareness program that was contracted by health to our local native women's association that are doing the health awareness. In your presentation you also stressed that the health awareness component of it, prevention has to be addressed more so than delivering the hospital administration because, if you affect it in the front line, perhaps we will not be required to spend so much money on facilities with doctors and so forth. You did not really say it in that manner. However, that is what I perceived from your presentation this afternoon.

MS. ALLEN: You read me well because I truly believe that we have to zero in on prevention and the only ones that can be involved in order to have an effective prevention program are our own people. We have to train more para-professionals. We have some young C.H.R.s in the program now, and I hope they will decide to move on. There is talk about some of them wanting to move on up to be R.N.s. Why should they be helpers when they could be the administrator of health care in a region? We have to concentrate on more prevention. Another method of prevention is the escort/interpreter. We really think that we have to seriously look at that and the regional boards have to take a hard stand that it is time we put a stop to just anyone being picked from the street to escort people. There is too much money wasted. They have no medical terminology training and there is no guarantee that they are going to be supportive of the patient once they get out there. So, we have to put a stop to that and train medical interpreters and escorts. They will be the caregiver of the patient until the danger period is over.

CHAIRMAN (Mr. Zoe): You also indicated that there was not enough consultation between various health stakeholders as for instance your association pertaining to health. How could we improve the relationship between the Department of Health and the stakeholders? We have also heard during our public

hearings that, even the health boards are saying basically what you are saying, the department is not even consulting with them on a regular basis, especially for their input into policies or regulations or anything pertaining to health, in terms of long-term planning. How would you see your organization fit into the overall consultation network? Would it be at the community level? Each little chapter is in each community as I know that there is a native women's group in Rae. Do you see them plugging into the community structure and then into the regional structure? Or, would you see it on a territorially-based structure, where you get the input from your people to be input into the Department of Health? How do you see the networking so that we can have more input from the stakeholders?

MS. ALLEN: As I have said sometimes they forget that they have appointed you to some of these boards that I have sat on. I think I sat on T.H.I.S.'s board for ten years and I was not happy with that structure. The only way is to have some sort of a territorial structure. Right now bureaucrats are at the top and it is not healthy. We have to have some sort of regional representation at the top, good people that understand health. Much of the time they have political appointments to the hospital or the T.H.I.S. boards but they never said boo. Even if they did, they do not understand the health issues. We need some sort of a well-developed, administrative, territorial board. That is the way I see it, maybe others do not. We are looking for trouble right now with the bureaucrats giving direction from the top. The communications are not healthy.

CHAIRMAN (Mr. Zoe): Okay, that is one model. The health boards we have heard from in our public hearings are suggesting things such as we should have all of the regional health boards meeting once or twice a year to discuss general issues that affect the territories. That is a suggestion that we have heard during our hearings. At the moment the Department of Health and the regional boards are not talking to each other. They are not consulting with them. If they do, it is informal. That is one suggestion that we heard in the east and also in Inuvik. I was interested in the comment that you just made where it should be on a territorial basis. Would you look at another model, something more of an aboriginal health council that would have a direct link to the Minister of Health to advise him? You made reference to setting up some kind of a board, but we just got rid of the T.H.I.S. board.

MS. ALLEN: Yes, but you replace that with something else! Another option is the majority of people up north and the money that is given by the Department of Indian Affairs for aboriginal health, so why not an aboriginal committee that deals with health. These should be people who have no political appointments. People who have a background in health should sit on these committees. That way you do not waste your money.

CHAIRMAN (Mr. Zoe): Thank you. Are there any comments or questions? Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Thank you, Mr. Chairman. The recommendations and comments you made this afternoon are very good. To some extent I wish that it was the Department of Health officials who sat throughout our hearings all week. We heard, both from the eastern regional health boards and from the west, and various organizations such as yourselves, very similar suggestions or recommendations to the Department of Health. This is why I say the Department of Health is the one that should be here listening to the concerns of the community groups.

One of the areas I touched on, when presentations were made, was in the orientation area. You touched on the fact that care givers should be more sensitive to people. What would make a good orientation program for community health workers, nurses or people who are not in tune with the cultures of the north?

MS. ALLEN: You have to understand that many of the southerners coming up here have no idea of the culture and the history of aboriginal people. You have to take them through the history of aboriginal people so they appreciate our history, and then zero in on the health care. They have to understand our economic situation. If we ever get traditional health healers, they have to have the same respect as medical doctors. Spiritual leaders have to have the same respect as clergymen. Orientation is needed for things such as why it is important that native foods be served to aboriginal people and why it is important that old people always like a cup of tea beside them, not little cups like this, but big mugs. These are the types of things that I discuss when I do my orientation.

Old people say they feel naked when they just put a little rope on them and tell them to go to bed. The nurses are surprised, when they try to fix an old lady up, that she just puts on her stockings and her underclothes. They have to understand that is the way old people live. Another thing I explained to them is, if there is no reason, you do not have to bath them every day unless it is necessary. These people do not bath every day. Little things like this may not mean much to us, but they have to know that. You have to bring these to their attention. They have to understand that we have been taught to suppress our pain throughout our history. Therefore, our elders, especially, are still not telling where they are in pain. They have to be sensitive to look at facial expressions when they are examining. You learn with each workshop and questions that are asked of you.

The Native Women's Association has been making much noise about cross-cultural orientation to all departments. We have to meet that demand, so now we are planning two days of cross-cultural facilitators workshop starting in Inuvik. Hopefully we will get more money to do it here so more of our women are trained to go out there and deliver this cross-cultural orientation workshop. We would be able to save money then and we will not have to get Dr. Dick Van Dyke from the south to give cross-cultural orientation at great expense.

CHAIRMAN (Mr. Zoe): Mr. Arngna'naaq.

MR. ARNGNA'NAAQ: Another area of your presentation, I was interested to note, was the community health representatives. From the presentation we heard from the N.W.T. Registered Nurses' Association, they indicated they are developing a program whereby the C.H.R.s would be able to upgrade to different levels. They are trying to create this sort of program. In your presentation, it sounded like you did not know that was being developed. It sounds like there is not the communication among various organizations that would have any kind of relationship with the Department of Health. I am

wondering if you had much communication with the department to date with the various issues that you are raising about midwifery and community health representatives.

MS. ALLEN: Not since I came back in as president last spring. We are just rebuilding the association. When we first started the Native Women's Association, we brought up the subject of midwifery. When that was made public, the Department of Health sent a nurse from Edmonton to calm us down and try to discourage us from even talking about midwifery. The only time it caught attention was when male M.L.A.s got tired of babysitting their children when their wives had to go to large centres to have their babies. Peter Emerk must have got tired of babysitting, so he brought it out. It caught the attention of the department and of the media. Now, we really want to be involved. I ask you to look at it in Alaska. They have legislation. Alberta just passed legislation. We have to pass legislation here and develop a good program.

Sometimes when a program has been around for too long, its effectiveness has to be evaluated. I would seriously like to see something in the line of the rural community health workers in Alaska. Again, that is going to need legislation. The community health representatives in Alaska are the sole health care givers in the isolated communities. They have such good training that they hold their own clinics. If we looked at that, we could save a great deal of money when you look at the removal of community public health nurses from the communities. I really would like to see a program like that. There are other programs, but I am not familiar with them. The only one I have been following is the Alaska para-professional health care services. It is working very well. They have worked all the bugs out of the program. They had a great burnout, too. They wondered why. The hardest place to work is for your own people. How they resolve that problem is that they train two or three. They share their workload.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. It is always refreshing to hear about different areas. Ms. Allen and Ms. Sato had touched on a few areas that we have not had much chance to deal with. We could go on for a long time going over these areas. I would like to comment on a couple of things you mentioned. Prevention is probably one of the things we are lacking direction on. If everybody quit smoking, drinking, using so much sugar and started buckling up when we drive, it would probably cut our medical bills in half in the territories and we would have a happier, healthier society. I will not touch on the other areas, but I have a couple of questions dealing with participation and communication. In your submission, you mentioned that we must have a vision. You commented that you want your input considered. The Department of Health has proposed, as I was saying, that we have to have input. They also have visions. One of the visions they have is "The N.W.T. Way". They have pushed it maybe not to the extent that they think they have. Have you heard of that phrase, "The N.W.T. Way"? Has anybody ever contacted you to help develop a health system for the north?

MS. ALLEN: They may have called our office, but we are both back in the organization, and we certainly would like to be involved because we certainly have ideas. If there could be some sort of a secondment to us of an employee to work with us in health care because that is a big area. You have to understand health to be effective. Our staff does not have a health care background.

MR. WHITFORD: What about that development of that vision the department claims they have? Have you ever had any input into it?

MS. ALLEN: No, I have not, personally.

MR. WHITFORD: All right. That is one of the areas there seems to be a lack of communication in. Communication is a two-way street. You did touch on it. It appears that communication is from the top down. They are up there and they tell you what is going to happen. That is one area you correctly pointed out. Chapter three of the Auditor General's report comments on the fact that the Department of Health has no plans to direct where the development of health services should go. How is the work of the Native Women's Association affected by the absence of a plan? It would appear that the department has plans, but when we talked to them, they said they are looking at it and they are planning to do something. The phrase that was used from time to time was "a planning to plan" mode. They are planning to do that, but they never really get these things off the ground. How will this be affecting your work and the people who you service?

MS. ALLEN: The reason the Department of Health never really followed through with their planning is the change over of staff and no input by the Native Women's Association or any other organization. They are planning from the top without getting input. It is always on an ad hoc basis. That is not healthy planning. What we would like to do is to be able to help plan. We are here in Yellowknife. They are here in Yellowknife. Surely, they should be able to come to us for advice, not just when they need moral support on issues.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: Would this affect your work due to the fact that they are not consulting with you and not involving you?

MS. ALLEN: Of course it does. We appreciate some consultation and communication from the Department of Health. We do not want to be consulted only after a program is developed. We want to be involved from the start. We do not want to fix something because it takes time to break down their mentality.

MR. WHITFORD: They do not have an overall plan. There is no way that you know how the Native Women's Association would fit into this entire thing.

MS. ALLEN: Everyone is working in isolation. That costs money.

CHAIRMAN (Mr. Zoe): Basically, the department is always reactive rather than being pro-active.

MS. ALLEN: Crisis management.

CHAIRMAN (Mr. Zoe): There were presentations made to us

in Rankin and Inuvik. I was interested to hear from Mr. Eckalook, the chairman of the Baffin Regional Health Board. During his presentation, he said part of the reason why the Department of Health does not want to devolve authority to the board was because the make-up of the board was all aboriginal. During the hearings, I asked various presenters that same question. I asked Mr. Maksagak from the Kitikmeot Regional Health Board that same question. I asked, "Do you agree with Mr. Eckalook's statement that he made to us pertaining to health boards, that the department is reluctant to give them additional power because the majority of the board members are aboriginal?" He also agreed. When we went to Inuvik yesterday, I asked the same question to Mr. Gruben. I.R.C. made a presentation to us. I indicated to him that these were the comments made during a public hearing. I asked him for his views. He agreed with the comments made by those two chairmen. I would like to ask you the same question in terms of the comments that were made by Mr. Eckalook. Do you agree with that type of statement?

MS. ALLEN: We still get bureaucrats who have the colonizer's state of mind to keep us under control. They are having great difficulty breaking through that mentality. We are able and capable of running the program with guidance from them, not them giving us the other way around. It has to be a two-way street. We know what we want. We just want to know how do we put it into practice? That bureaucracy has to be cut down. It is too expensive and powerful.

CHAIRMAN (Mr. Zoe): Am I hearing you say that they are still in that colonial attitude? Before transfer took place, even after, that same attitude was carried over into our system after we took over. That attitude will have to change.

MS. ALLEN: I will give you a few examples. When I was on the T.H.I.S. board, I was the only aboriginal woman who stuck it out to the end. Decisions were already made. Announcements were made about the programs. They ask us to approve after the fact. That is exactly what I am stating. They are still 100 years back. They make decisions and want us to initial it after decisions are made. That has to stop.

CHAIRMAN (Mr. Zoe): We heard similar comments from most of our presenters in terms of attitude. We definitely noticed it when the department was appearing before us. Are there any further comments? Mr. Whitford.

MR. WHITFORD: I would like to find out if you have some suggestions as to how to change that kind of attitude. We have heard it expressed by most of the presenters that the department does not have a very positive attitude towards boards and local groups. I am not sure where it stems from, exactly what level of the department this comes from, the top, the middle or the lower levels of the administration. Would one change this attitude without the radical way of firing everybody and starting all over? Surely, there are some good people in there. How could we go about changing the attitudes?

MS. ALLEN: It starts with Nelson McLelland, Dr. Kinloch, nurses and hospital administrators. Those are the people who do not come to the cross-cultural orientation. These are the people you have to sit down with. These are the people who should sit in front of us, the Dene Nation, the Native Women's Association, and we will put them through a cross-cultural orientation. We know what we are talking about. We have been around for a while. This is the communication we want to see from now on. We want to be consulted before the fact, not after. When I talk to groups, I say, "You have to live by the three C's. There is "communication", "cooperation" and "consultation." You will never go wrong with aboriginal people if you use those three C's." I say that to the R.C.M.P. too. I sit on their national board.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: A thought came to mind while you were speaking. In the business world, in a firm, I.B.M., Ford or G.M., they have these high profile people who they bring in to run the show. The budget of the territorial government's Department of Health is somewhere around $200 million. That is a fairly substantial amount of money. The infrastructure is enormous. The responsibility is equally enormous. If this was in the business world, there are performance standards that are set for these Lee Iacoccas of the world. If they do not measure up, then they are out. There are also carrots and sticks. If it is a stick, of course, they are gone, but carrots, there are some incentives. I wonder if we should look at those kinds of things. I guess we do. If you want to keep your job, you do a good job. If you set some targets, in a given period of time, if you have not achieved that target, maybe we should look for another director or something like that.

MS. ALLEN: I suggest that you give us the authority to get outside professional aboriginal views of health care. I could think of the Aboriginal Nurses' Association. There are aboriginal doctors. You have to be a good administrator. You could be a good nurse or doctor, but you do not have the administration skills. If there is someone out there to sit down with, without the Department of Health, and draw up their job description, their appraisal or evaluation and show them how to plan effective long-term development of a good health care program, that is what I envisage with an outside consultant.

CHAIRMAN (Mr. Zoe): Are there any further comments? If not, I would like to thank both of you for appearing before our committee. Your presentation will be absorbed within our report. You have made many good comments, particularly with the prevention and planning aspects of it that I really picked up on. I appreciate hearing from the Native Women's Association this afternoon.

MS. ALLEN: Thank you.

CHAIRMAN (Mr. Zoe): Mahsi. That concludes our hearing for this afternoon. We do not have any more people registered to appear before us. The committee will adjourn until tomorrow at 10:00 a.m.

---ADJOURNMENT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

PROCEEDINGS

BRIEFING

YELLOWKNIFE, NORTHWEST TERRITORIES

SATURDAY, JANUARY 30, 1993

STANDING COMMITTEE ON PUBLIC ACCOUNTS WITNESSES

Department of Finance

Mr. Eric Nielsen, Deputy Minister

Department of Government Services and Public Works

Mr. Bob Doherty, Deputy Minister

Department of Personnel

Mr. Ken Lovely, Deputy Minister

Department of Education, Culture and Employment Programs

Mr. Al Gerein, Deputy Minister

STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

SATURDAY, JANUARY 30, 1993

Chairman

Mr. Henry Zoe

Deputy Chairman

Mr. John Ningark

Committee Members

Mr. Silas Arngna'naaq
Mr. Sam Gargan
Mr. Fred Koe
Mr. Kenoayoak Pudlat

Alternates

Mr. Charles Dent
Mr. Ludy Pudluk
Mr. Tony Whitford

Legislative Assembly Staff

Ms. Rhoda Perkison, Committee Clerk
Mr. Alan Downe, Researcher

Transcript

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

YELLOWKNIFE, NORTHWEST TERRITORIES

JANUARY 30, 1993

Chairman's Opening Remarks

CHAIRMAN (Mr. Zoe): The Department of Finance is now appearing before us. Mr. Nielsen, would you kindly come to the witness table? Do you have any opening remarks pertaining to the Auditor General's report on the Department of Health?

Presentation by Department of Finance

MR. NIELSEN: Mr. Chairman, no, I do not have any opening remarks. As I indicated in my letter, I am here primarily to answer questions if you have any.

CHAIRMAN (Mr. Zoe): All right. I will start, then. Under section two, it deals with organizational structure. The Auditor General, in section 2.2, has commented about the strained relationship between the health boards and the Department of Health. Much of this was observed to have arisen from the controlling approach which the department is reported to have taken. Boards have complained, for instance, about the number of requests for financial information on almost a weekly basis. Yesterday, during the appearance of Dr. Kinloch, he told the committee that this was due to frequent requests he received from your department or from the Financial Management Secretariat. Was this a fair comment for Dr. Kinloch to make, Mr. Nielsen? He indicated that the requests are from F.M.S. That is why they have to ask the boards to get all this information. I do not know if he was trying to pass the buck or not, but would you say that was a fair comment for Dr. Kinloch to make?

MR. NIELSEN: Mr. Chairman, I think, particularly during the last few years, there has been a tremendous demand for additional information throughout the government. Obviously, many of those demands arise from the Legislative Assembly and the committees' requirements. The Financial Management Board has ongoing requirements. They make demands of all departments. Wherever you have a board and agency arrangement or relationship between a department and the public, you have additional demands, particularly because some of the information systems are not in place to provide that information automatically. That is one of the things that the Auditor General has commented on.

CHAIRMAN (Mr. Zoe): F.M.S. is asking for various types of information. One of the concerns of the committee is that we have noticed, during the hearings, that the boards are saying to us that there are many extraordinary requests that are not within their system. We have asked them to try to put a figure on the amount of time that the board spends on doing information-gathering for the Department of Health. In one instance, one board indicated that about 15 per cent of their time was spent on information-gathering for the Department of Health. It varies. It seems like there is a great deal of work done by the boards. All the boards indicated that they were spending a great deal of time trying to get this additional information for the Department of Health. They are spending more time and effort trying to get all of this information rather than concentrating on their own operations. Dr. Kinloch said they are not asking for the information just for the sake of asking for it and that it is primarily for the Financial Management Secretariat. What type of information would F.M.S. request from regional boards?

MR. NIELSEN: Mr. Chairman, we have a combined problem certainly from what you have said. First of all you have the issue of the level of autonomy of the boards from the government. The boards themselves probably want to have a very high degree of autonomy and would prefer that the government asked them no questions at all. There is a responsibility of the Department of Health to be able to advise their Minister and the Financial Management Board of the financial affairs of the boards. In this case I would suggest that if there is information being requested of the boards, by the department for the Financial Management Board, this would have to do strictly with the financial operations of the boards. This would include ongoing financial management and if they are likely to be able to work within their budgets on an ongoing basis. We do ask for variance reports on a regular basis from departments. I suspect that you would get the same sort of concern from within the department that the Financial Management Board is asking for a lot of information. It would be nicer if they did not have to do this but you have to have ongoing monitoring mechanisms. Certainly if the department is asking for it I suspect that it is required.

CHAIRMAN (Mr. Zoe): Is there any way in which we can modify these to take some pressure off of the board administration?

MR. NIELSEN: Mr. Chairman, what I would have to do is look at the exact demands which are being placed. It is difficult to comment on them without knowing what kinds of questions are

being asked of the boards and what kinds of responses are required. Certainly as far as the Financial Management Board is concerned I do not believe that you would find the board is going to be asking for information that is not required to manage its financial affairs.

CHAIRMAN (Mr. Zoe): Tony.

MR. WHITFORD: Thank you, Mr. Chairman. In chapter three the Auditor General commented that the Department of Health does not have a strategic plan which it can use to set a course for the future. During our hearings we heard comments that the department is always planning but when it comes down to it there does not appear to be any kind of long-term plans as to which direction the department is taking, or how things are going to come about when they start putting these plans into action. There have been some attempts at it but it does not appear that they have a long-term plan. I wonder how this would impact on the work that the Department of Finance has to do for the long-term. Would it have an impact on the fact that there is no long-term strategy for the department in terms of capital planning, and setting up accountable systems?

CHAIRMAN (Mr. Zoe): Mr. Nielsen.

MR. NIELSEN: Mr. Chairman, the question of long-term strategy is certainly related to the stability of the department, which as we all know has been very difficult in the past few years, not just from the point of view of changes within the department and management of the department, but also with respect to the responsibilities that the department has and the changes that have been made there, not just in responsibilities but also in structure.

I think that all of those things will impact on both the management of the department and the financial management throughout the government. The degree to which it is impacted on financial management is far less than it has been on program management because the structures, from a financial point of view, are there and in place and must be adhered to. I am not sure that there has been anything of a significant concern on the actual financial management from a central agency point of view.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: If the department is going to continue on in the manner in which it is going or expand in one area or the other of health care there will be a requirement for either infrastructure or program monies. This would impact on your departments financial accountability to the federal government. Without a long-term strategy it is difficult for you to know whether or not you will need more money in the future for a different kind of accounting systems, or whether or not an accounting system is going to work. We hear a lot of criticism of methods of information-gathering. They do not seem to be compatible. Without something like this, can you think ahead?

CHAIRMAN (Mr. Zoe): Mr. Nielsen.

MR. NIELSEN: Mr. Chairman, this is not something which is just related to the Department of Health. It is related throughout the government. One of the issues raised in the Strength at Two Levels report was the whole question of management information systems throughout government and the ability of departments to make changes and make long-term plans based on the information systems which they have. The Department of Health is going through a much more difficult period because of the significant changes it has undergone and the significant demands and growth in demands for services which we have seen over the last few years. It is my understanding that as a result of reports such as this, and as a result of the department's internal management, that there is a recognition for room for improvement in the development of some of these information systems. There are some changes which need to be made in the overall management of health in the Northwest Territories to help reduce those impacts. I do not think there has been an inordinately higher concern with the Department of Health than there has been with other departments.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Mr. Chairman, in preliminary documents such as "The N.W.T. Way" they talked about the delivery of a particular unique health system to the Northwest Territories. This may suggest the restructuring of some of the facilities we presently have and the establishment of additional ones. This is in reference to capital planning.

We visited the Inuvik Hospital and in its hay-day it was a nice place and well used. When we saw it the other day, the heating system was not working properly, and the piping system within the building is not adequate to meet current technical needs. For example, the oxygen system has deteriorated to a point where they are going to have to do massive renovations to accommodate the new system. They have bottles of oxygen in the operating rooms because they cannot use the pipes in the wall. The building is 35 years old. The x-ray machine has a life expectancy of a matter of months.

They are going to go to the Cabinet and the Department of Finance at some point in time with a request for millions of dollars to do this. There does not seem to be any plan to replace this unit, either to downsize it or build a new one. Five years down the road we are going to need millions of dollars worth of new x-ray machinery for the Inuvik Hospital. This is capital. We are going to need a new building.

I started off by asking if this would effect your ability to plan and to ensure that your section would be able to compliment the Department of Health. The concern which the committee has is that there does not appear to be a long-term plan for the department. Comments?

CHAIRMAN (Mr. Zoe): Are there any comments?

MR. NIELSEN: Mr. Chairman, I do not have any personal knowledge of the long-term planning strategy within the department. I can only comment with respect to the overall government arrangements. We do have a fairly well documented and reasonable level of sophisticated capital planning for the government. While I do not have personal knowledge of the concerns and conditions of the Inuvik Hospital, that hospital would be evaluated by the department and the capital planning committee in the same manner as any other capital needs across the territories. It would fit into the capital plan at the appropriate time. It is not just a

departmental issue. It is an overall governmental issue. Certainly if it were deemed that this hospital was a high priority and the conditions were such that there needed to be an allocation of capital, that allocation would be made.

CHAIRMAN (Mr. Zoe): Surely this is going to effect your department in terms of capital planning for the overall government. If the Department of Health does not know where it is going or does not know how it is going to get there and there is no plan in place, this will effect your department. If the department does not have any plans with regard to the capital, how are they plugging into the overall government plan? Surely your department, which coordinates this, would have a concern.

MR. NIELSEN: Mr. Chairman, as I indicated there is an overall capital plan for the government. The department would be expected to plug into that plan and identify the capital structures. If there was a deficiency they would have to ensure that this was given the appropriate level of priority within the capital plan. Again, I do not have any personal knowledge of the capital planning which goes on within the department. I think that question is better directed to the department itself. From an overall government point of view, certainly on the capital side, I am not aware of any significant concerns.

CHAIRMAN (Mr. Zoe): Mr. Nielsen, there are three PYs within your department which were allocated to look after agencies on systems. They are specialists. Last year the Standing Committee on Finance suggested that these three PYs be deleted. It is my understanding that the government never accepted that recommendation. These three people are supposed to help different groups with information systems.

The H.B.I.S. system is one that they have been helping the Department of Health with. In our hearings we heard that when this system was developed there was no input from various user groups. They had no input as to how they felt about how the system should be developed or that it be compatible with their own systems. H.B.I.S. appeared and was basically shoved down their throats. It was imposed on them by the Department of Health. They felt strongly that they had no input into the development of this system. They were not too happy with the Department of Health and the people who work in your department who helped with the development of this, who were the experts and put this system in place.

Can you comment or elaborate on how this decision concerning the accounting systems were made? Should the people who are working on these various systems not be consulted? It would have been better to consult the users rather than the department imposing this on them. I am not sure what authority those three PYs have. It is my understanding that these are people who deal specifically with systems.

MR. NIELSEN: Mr. Chairman, I will respond to this in two areas. First of all, this boards and agency team within the Department of Finance do not work only with health boards. They also work with education boards, the Northwest Territories Housing Corporation, who have a clone of the Financial Information System. When the original recommendation was made by the committee it is my view that there was probably a misunderstanding of the responsibilities of the boards and agency team, and perhaps not a very good explanation provided to the standing committee on its responsibilities. Subsequent to the recommendation being made a number of boards, including the Keewatin board, recommended very strongly to the Standing Committee on Finance that this board remain in place. They sent letters in as well as from other organizations identifying that this team was providing them with the support that they required. I do not know what the Standing Committee on Finance position is on this right now but as far as I know there has not been a continued concern expressed. In fact in the response to the standing committee's recommendation the government recommended that this suggestion be reconsidered.

With respect to systems development we must recognize that the transfer took place at the same time as this system was implemented, in 1988. The transfer took place very quickly. I suppose in hindsight one could say that if we knew what was going to happen and we knew we were going to have boards, we could have started planning two or three years earlier and evaluating what systems might best be put in place for the boards.

Having said that, this was done very quickly. The government examined alternatives very quickly and decided that it would be in the short-term interest to use the government's expertise in a system and implement that system. There are a considerable number of benefits in using the government's system, not the least of which is that it is a northern developed system. It is a system which has been used effectively and where we have a number of people with expertise on it throughout the Northwest Territories. It is not something that has resulted in the need for tremendous demands for training of people coming in. There can be a fair degree of movement between systems. A good example of that is someone who has just moved from the Department of Finance over to the Mackenzie Health Board.

Having said that, I suppose you could find people within the Department of Finance who would strongly support H.B.I.S. and you could find people within the health boards that would strongly support M.H.O. You could also find the reverse. There are people who I have talked to within the health boards who are strongly supportive of H.B.I.S. and there are people within the Department of Finance who are supportive of moving away to a smaller system. There is also a misunderstanding with respect to what systems we are talking about. As I understand it there are three systems in place. They refer to the M.H.O. as the old system. I should clarify what the M.H.O. is. Manitoba Health Organization is a private company. It is not the Department of Health in Manitoba but rather a private company which has been marketing a system which is obsolete and which they will be withdrawing service on in a fairly short period of time. The requirement then is not to just replace or reconsider the use of H.B.I.S. but rather to reconsider the use of M.H.O. also.

The Department of Health has been working with the boards and the Department of Finance very recently to put in place a process which will address the needs of the boards and the Department of Health and the Government of the Northwest Territories in the long-term. The comment made by the Auditor General that there are three systems in place is quite valid. The fact that there is a difficulty in working with three systems and coming up with something which is completely compatible

to the Department of Health will address all of the government's needs is valid also. That will be addressed. We are talking about a relatively short time frame, from 1988 to 1992, we are only talking about three or four years. During that period of time there has been the recognition of a need to do something about it and there is a process in place with an expectation of a decision being made probably by the fall of this year.

CHAIRMAN (Mr. Zoe): The department indicated they understand there is a problem with the systems. Now the department is revisiting the question of who is and is not happy with what is out there. They have set up a working group to look at this. I think employees from your department are also involved with this. Dr. Kinloch told us that they use M.H.O. at the Stanton Yellowknife Hospital. We understand that there was a new upgraded system which was developed for M.H.O. Stanton was then quite happy with what they had. However, it is not compatible to the Department of Health or other boards, as they cannot plug in to it. They are unable to share information. Stanton is quite happy with their system. However, the Department of Health is not. We have a number of different systems in place but because this was raised in the Auditor General's report they are regrouping to see if they can standardize the system so that it is compatible. They have now set up a new working group to take another look at this issue.

I am not sure if they are going to accomplish anything if Stanton and the Department of Health cannot consult with the boards. If they do not consult with the boards, there is no way the boards are going to adhere to the department, even if they were to develop a new system without their input. It is crucial that the specialists from the Department of Finance and the Department of Health need to get the agencies involved. The agencies are the main users of this and they have to be able to inform the specialists regarding what type of system they have and what type of information is required. We are talking about a great deal of money if we have to change the systems which are in place and try to standardize them. I know that there has been a lot of money spent on the H.B.I.S.

You indicated that some boards were quite happy with H.B.I.S. This is not the feeling I received when those boards appeared before us. Many of them told us that the system was imposed on them and that they did not have a choice in the matter. They informed us that they were not happy with the system because they had no input into the development of it. You have indicated that some boards are happy with H.B.I.S but this is not the case. From what we have heard during our hearings I think if most of them had a choice they would get rid of it. None of the boards indicated that they were happy with H.B.I.S.

MR. NIELSEN: Mr. Chairman, I was not indicating that the boards were happy. I said that you could find individuals within each organization who would support either one. I am not here to defend H.B.I.S. or M.H.O. I think both systems have advantages. As you indicated there is definitely a requirement for the boards to get together with the Department of Health and the government to ensure that a system is developed or examined, or alternatively selected from the market place. It is not just M.H.O. which needs to be looked at. There are also other systems which are available.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Would you want to have input into anything which would be designed? Would you want to be part of the review to see whether these systems are compatible? We have been hearing that they are not compatible. I am not a computer person at all but I know that it is similar to language. You can have two groups of people present and both speaking but they are unable to understand one another. Across the territories we have that fact. We do not need to have that in electronic language. There can be systems which talk to one another and are compatible. Is your department interested in having some input in this area? We are concerned in this day and age that we are going along with systems which are the preference of someone in the department in one area and not in the other. You cannot run a $200 million service like this for very long. If they are going to do something to change, we feel that your department should be involved. Would this be a fair assumption on our part?

MR. NIELSEN: Certainly, Mr. Chairman. The deputy minister of the Department of Health has indicated to the committee that he will be tabling a document outlining the terms of reference of the working group. Our participation will be outlined in that paper.

MR. WHITFORD: Mr. Chairman, when the Native Women's Association appeared before us yesterday, they talked about the need for a vision of health care in the territories, a vision of which direction the department is heading. The department also says the same thing, that they need a vision and a plan. Since the Strength at Two Levels report there has been a draft document called "The N.W.T. Way". This is the draft of what may exist. Have you heard of this document? Has your department been involved in this in any way?

CHAIRMAN (Mr. Zoe): Mr. Nielsen.

MR. NIELSEN: Mr. Chairman, we certainly have heard of the document but without something specific I could not address whether we have been involved in it. I do not recall anything specifically in the document which was related to the Department of Finance.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Mr. Chairman, I would like to elaborate. The understanding which some of us have is that there would be implications for the Department of Finance. I was wondering if the department is working in isolation making some visionary plans without involving other parts of this government. The vision would include expansion. If one department is going to do something certainly another department such as yours should have been consulted along the way to see whether or not it is even possible. Have you had any input into "The N.W.T. Way"?

CHAIRMAN (Mr. Zoe): Mr. Nielsen.

MR. NIELSEN: Mr. Chairman, I think what we are talking about to some extent is a policy document which would flow from the Minister to the Cabinet and get some formal approval in that way but not necessarily through the Department of Finance. Subsequent to that overall kind of direction being

provided, there would be some specifics proposed and the identification of costs. This is not unusual in government to have policy direction provided by the Cabinet but with the understanding that they can only do this within funds allocated. We saw this federally, for example, with the day care program which was announced which was going to be quite an elaborate scheme. After examining it there was a withdrawal of support for that program simply because the funding was not available federally. This is not dissimilar to the kind of situation you are suggesting.

CHAIRMAN (Mr. Zoe): What role does the comptroller general play?

MR. NIELSEN: Mr. Chairman, there is an overall government policy which provides for the Department of Finance participation through the comptroller general's office. The management accounting services group within which this board and agency team is located is the group which would provide the support to the departments on individual systems developed. For example, we participated in the development of the social assistance system. Depending on the nature of the system we might participate more or less. If it is strictly a departmental system we may not participate in it.

CHAIRMAN (Mr. Zoe): The comptroller general's office monitors all of our systems. They make sure that the systems which we develop are working.

MR. NIELSEN: Mr. Chairman, they would not monitor all systems. They would monitor all of the systems which have financial implications. They would not participate in the development of a departmental system which only provides program information.

CHAIRMAN (Mr. Zoe): H.B.I.S. also involves financial information.

MR. NIELSEN: In the case of H.B.I.S. it was a matter of convenience more so than doing a thorough analysis of which system would be in place. We have a system in place and from an efficiency/cost stand point it was deemed appropriate to proceed with that system at the time. In retrospect I think that was a good decision. Having said that, as we all know, this is being evaluated and we will come up with a new system. The working group who are participating on this will contain a Department of Finance representative.

CHAIRMAN (Mr. Zoe): Would the comptroller general have a role? Would he be the one who is spearheading the evaluation of the H.B.I.S. system?

MR. NIELSEN: I do not think it will be an evaluation of the H.B.I.S. system. I think the approach which will be taken is that there will be an identification of the requirements of boards, a determination of what their actual needs are, the identification of the needs of the Department of Health, the identification of the needs of the government in terms of overall government systems, and putting this package together and evaluating what the marketplace has. H.B.I.S. will obviously be looked at as one alternative. There is more than one system out there. There are a number of system which health boards or health organizations are using.

CHAIRMAN (Mr. Zoe): Does the comptroller general's office have a role? Is he not even consulted?

MR. NIELSEN: His staff will be on the working group who are doing the evaluation.

CHAIRMAN (Mr. Zoe): Thank you. Are there any further questions or comments? Thank you for appearing. Mahsi. We will continue with Mr. Doherty with the Department of Government Services and Public Works. Mr. Doherty, do you have any opening remarks. Please proceed.

Presentation by Department of Government Services and Public Works

MR. DOHERTY: Mr. Chairman, I do have some opening remarks. I also have copies available. At the time we began services to the boards we were two departments, the Department of Government Services and the Department of Public Works. The departments began providing services to the Department of Health upon transfer from the federal government in 1988. At that time there were four new boards established in the regions and we were directed to provide services to the Mackenzie Regional Health Services, the Kitikmeot Board of Health, the Inuvik Board of Health and the Keewatin Board of Health. Other boards which were existing at the time were the Baffin, Stanton, Hay River, and the Fort Smith Health Centre but we were not providing services to those at the time.

In late 1988, early 1989, individual memoranda of agreement were signed between the board and the department which defined the types and levels of services provided. During the period of 1990-91 a review of services to health boards was carried out. There were discussions with the health boards during that time and the boards expressed a general level of satisfaction with the services provided by the Department of Public Works. As a result, boards agreed to eliminate the indirect category of services which was the Vote 4/5 arrangement of recoverable services. A new standard memoranda of agreement for four boards was developed and is currently being reviewed by the boards and the Department of Health. As a result all former Department of Public Works type services are now provided to those boards on an indirect basis, that is without cost recovery.

The government services type services, such as mail delivery, purchasing and a host of other services are delivered on a delegated or as requested basis by the individual boards. It is safe to say that the bulk of these services are delegated to the boards so that they undertake them on their own behalf with assistance and advice from the department as appropriate. For example, most boards will do their own purchasing but if they have a requirement for sea lift they will avail themselves of our department's sea lift traffic management services.

Except for major capital project management services, the coordination of services and support to each board is done directly between the individual boards of management and the department's regional managers. The management of the operations and maintenance of facilities is carried out in accordance with the department's maintenance management system. I should mention that those initial memoranda of agreement with the boards are quite extensive. In most cases

they define the responsibilities of the board, the Department of Government Services, D.P.W., and the Department of Health. In addition, procedures such as the planning and management of capital projects are defined quite extensively. It was understood at the time that capital project management would be a complex and sensitive area so considerable effort was put into defining that relationship and the roles and responsibilities of the boards, our departments, and the Department of Health.

Over the ensuing period those project management procedures have been refined and reproduced in a draft document called Capital Planning and Maintenance: Policies, Directives and Procedures manual. I have a copy of this with me. Those procedures followed are standard departmental project management procedures which reflect the special functional and technical needs of health facilities and the unique relationship of the boards in addition to the normal client/department role. I would like to mention that the development of capital standards and criteria for our unique northern health facilities is a complex and ongoing developmental process. Given the unique health characteristics of each community, which are continually changing, a capital standards and criteria document would probably never be a static document but one which evolves on a project by project basis.

Starting with the design inherited from the federal Department of Health and working with the territorial Department of Health and individual boards, we have been able to develop a project brief which is used as a guideline for defining the functional requirements of each community health station project. I also have a copy of this project brief available. Our programming staff work with local boards and the Department of Health staff to review the project brief to confirm and establish the functional requirements for each new project. In this way the functional program requirements for each community nursing station is evolving as well as our collective understanding of the northern health care needs.

While the original federal criteria were based primarily upon population, for example, it is now also driven by individual community profiles in regard to health care program needs and use, demographics, and staffing and visiting medical team profiles. Where the federal functional program included apartments for nursing staff, for example, housing is now provided outside of the facility. Not only does this reduce the capital costs of the facility but it integrates the nursing staff into the fabric of the community with its obvious benefits. Another example of evolution is seen in respect to community health education. Where the federal programs were driven by treatment more emphasis is now given on education. The public health room has therefore been pulled from the back of the health facility and is now located in more public areas of the building for evening community use. In this way, the functional program requirements for community health facilities continue to evolve.

In addition to those functional requirements new capital projects are constructed to our own public works technical standards. A post-occupancy evaluation procedure has been developed. It is described in the Capital Planning and Maintenance: Policies, Directives and Procedures manual and has been used on the Rae Lakes and the Fort McPherson Health Centres. This post-occupancy evaluation allows us and the client to go back after a year of experience with a new facility and see how it is meeting the perceived and intended needs. These experiences are then built into the next edition of the project brief.

In respect to data processing and information management, your committee has asked if there are overlapping responsibilities between Government Services, Public Works and the Department of Health. The Department of Government Services and Public Works provides the computing facilities to run the H.I.S. and C.H.M.I.S. systems. I understand that these systems were inherited as part of the transfer.

The department also provides computer programming and project management staff who assist the Department of Health in defining and developing their information and system needs. It is, however, the Department of Health's responsibility to define and ultimately approve what the systems will do and the information to be provided. Thus, there is no overlapping of responsibility.

A project was establish last year, which is intended to address the information management problems identified in the Auditor General's report. Working with the Department of Health officials, our systems specialists are preparing a "systems development plan" which when approved will form the terms of reference to the deputy minister of Health by the end of February. Once approved, this would provide the blueprint for enhancing the capabilities and connectivity of the two systems. Until this plan is complete, it would not be possible to give an accurate estimate of the time and cost for this development work. At this time however, the project manager suggests that a project of this magnitude might take as much as 24 months to complete. This completes my remarks, Mr. Chairman. I would be pleased however, to address any questions the committee may have.

CHAIRMAN (Mr. Zoe): One of the themes that stands out in the Auditor General's report is that the Department of Health has no overall plan which shows where they are heading in developing future programs, services and facilities. The department has said that they are "planning to plan." They have been stuck in that mode since we have taken over the transfer in 1988. They have been planning to plan, but we have not seen anything come out of there yet. We do not even know where the department is going next year, the year after, the next five or ten years. I do not know what plans they have for the communities that do not have nursing stations. We have communities that have lay dispensers. I have one in my region. There are a number of them in the Deh Cho region. I assume there are some in the eastern Arctic. It makes it difficult. When I asked Mr. Nielsen how it plugs into the overall government capital plans, he said, "We do have a plan in place, but the department has to plug into it." I do not know how the department is plugging into the system. Somewhere in between there, you are also involved.

You indicated in your statement that you are working closely with them in terms of the building requirements and you have a certain M.O.U. or M.O.A. that the department fixed for you to service the health boards. On one hand the government is saying, "We do have an overall five year capital plan." The department is supposed to plug into it. The government does not really know exactly what they are doing. On the other

hand, you are saying, "We know the department is stuck in there somewhere." I am not sure what is going on because there is no plan. We have not seen one yet. This is one extreme to the next. It is confusing.

MR. DOHERTY: Mr. Chairman, it would be difficult and inappropriate for me to comment on the specifics of why the Department of Health does not have an apparent capital plan. The planning that I talked about in my opening remarks relates to the specific project planning, the results from information coming out of the department's overall plan for health delivery, inasmuch as it affects the capital facilities. The Department of Health does have a capital plan. I am not trying to defend it, but my understanding of the situation is that their capital plan is in the five-year capital plan.

It is the document that determines when and where capital facilities will be built. They do have a plan. The question relates to the quality of information on which that plan is based. I will not comment on the quality of the information because I am not familiar with it. I am aware that our staff has been working quite diligently with the Department of Health planning staff, who have been working quite diligently to try to refine that information and develop a plan. It is my perception that this process is taking some time to evolve. It is not through lack of effort. I think part of it is the conflict between the department and the boards which has lengthened the process. That is probably healthy. It is healthy that there is a process of communication and conflict.

Hopefully, eventually, there will be an agreement. It is taking some time, as Mr. Nielsen mentioned. The transfer only took place in 1988. It is a short period of time. The development of a health plan for the north is a very complex issue. It does take time. In summary, on that question, they do have a plan. That is what we draw our projects from. If there are gaps in the information in the broader plan, they are usually filled by direct communication with the community, the particular board of health and the Department of Health at the time the project is put together make sure that the actual project meets the community's needs as best as it can be defined.

CHAIRMAN (Mr. Zoe): I am probably wrong in terms of the capital planning part of it. Perhaps they do have something. I am not sure. My understanding is, from listening to Dr. Kinloch and others, that component of the capital plan might be there from the way you described it. It looks like you are doing something with them. Perhaps they do have a five-year capital plan. Perhaps it is done on a yearly basis. You are commenting on the type of criteria that you use and the follow-up that you do and so forth. It is indicated in your statement.

Even if they do have a capital plan for the department, it is not linked to their overall strategic plan. We do not know exactly where we are going in terms of planning. They do not have priorities. I do not know how it all ties in. That is basically what I am trying to get at. If they do have a five-year capital plan, how could they tie it in? How could they develop that without having an overall strategic plan? It has to plug into another plan. The Department of Health's strategy has to fit into our overall government priority plans. One plan has to fit into the next. There are no connections between what is happening. It has to start from the grass roots people. The boards have to have their own little strategic plan that should fit into the overall Department of Health plan. The Department of Health plan would fit into the overall government plan. Since they do not have an overall departmental plan, how could you develop something which you do not know how it will look? Do you understand what I am trying to say?

MR. DOHERTY: Yes, Mr. Chairman. You have described the process, the requirements, quite well. You are questioning the lack of a large plan, that umbrella that covers everything else. Clearly, the quality of any decision and product at the very end is directly related to the quality of that umbrella plan and the information that went into it. That is where you get to the community consultation. There is that issue and that problem. Your question is, "How do we make our decisions in the apparent absence of some of that information?" I know that it is done on a project by project basis, on the basis of direct communication with the boards and communities if there are gaps in that larger plan. The quality of the product at the end is a function of how well that communication took place and how much information they were able to get at the start.

The success of the project depends on the people who are using it, whether it meets their needs. That is what this committee is about, to try to make an evaluation. We draw the information from whatever sources we have. The capital planning process does not stop because of a lack of that bigger plan because it has to go on. The quality of the end product is determined by the overall quality of information that has been developed at that point in time. I do not think the problem is different from most other program areas that we design facilities for, whether it is recreation, school or airport programs. The policies and planning evolves over time and some of them have evolved better than others. I hope that addresses your question.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. I would like to ask a couple of questions. The Auditor General's report recommends that if the department intended to use diagnostic and treatment data to evaluate the health status of residents to determine health care delivery, then the H.I.S. system, which tracks doctor billings, and the C.H.M.I.S. systems, which records what nurses are doing in health centres, should be merged. How much work would this be? What would it cost? Is it possible to have two separate systems, but a single reporting format? Electronically, the systems should be talking to each other because it is not very efficient to have one system to have to download, hard copy them, and reprogram it into something else. These things should be put into a bag of a few disks and talk to each other. Can we have two systems, but one reporting format? Would it be costly?

MR. DOHERTY: Mr. Chairman, as I mentioned, there is a working group that has been established to look at that question. They said that they will present a plan or a proposal to the deputy minister of Health by the end of February. That plan will recommend an approach to deal with that problem. It will recommend improvements to the basic information system, but it will also deal with the question of whether you should continue the development of those two systems, come up with a completely new system that replaces both of them or a process of linking the two. Right now, I cannot tell you which will be the best approach. As I mentioned in my opening

remarks, in talking to the project manager who works with the group, he thinks that, in either case, it will probably take a good 18 months to two years to actually design a full operational system once the decision is made which way to go. If you are going with a complete rebuild, I would guess that improving the quality of the two existing systems would be time-consuming and costly.

MR. WHITFORD: Mr. Chairman, that seems like an incredibly long time that they have known that these systems are not quite compatible. It is true we have inherited much of this problem, but surely a $200 million operation should be able to act a little quicker on this because of the cost that is involved with the way the systems are not functioning. In this day and age, it seems an incredibly long time, 24 months, for a system this size.

I understand that your department may have already studied this issue. There is a reference somewhere, that we have come across with the information the committee has, about a report called a Tamarack report. What are the findings of this report and can we, if there is such a document in place, get a copy of this?

MR. DOHERTY: I have to admit, Mr. Chairman, I am not familiar with the report myself. I would imagine it can be made available.

MR. WHITFORD: Will you assure us that, if such a report exists, we will get copies of it?

MR. DOHERTY: Certainly. I would also like to respond to the first part of the question. The estimate of 24 months would be the time to take and develop a complete new system, do all the tests and make it fully operational. Certainly, within the framework of the terms of reference, there would be recommendations as to prioritizing requirements. That would recognize that there is a current need for information. There would be a protocol of how you would improve the quality of the current information without having to wait to complete an entire new system. It is not like you are going to have to wait for 24 months before you can get any better information.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Thank you, Mr. Chairman. We have heard boards express concern that they lack autonomy. In some areas, they are more aggressive than others. In some areas, they expressed a concern that they do not have an adequate level of autonomy to function as boards of management. How much autonomy should a board or agency have with respect to managing capital assets purchased with public money? Should they have more autonomy with that?

MR. DOHERTY: Certainly, I believe that every board should have as much autonomy as the system can afford to give them within the constraints of the budget and the authorities that need to be exercised by certain levels within the system. The Minister of Health has certain accountabilities that she has to make sure are maintained. When it comes to the management of facilities, I agree that the best system is to have the people who are in the building responsible for the operation and maintenance. There is no question about it at all.

The problem we face in the north is that we have many facilities all over in a large number of communities. It is not possible to have, in each community, the kinds of resources you need to look after all of the needs of the facility. We have a structured system, where, at the community level, we look after the basic needs of the facilities, such as checking the furnaces to make sure they are working. If they happen to quit in the middle of the night, we respond to that. As we go to the regional level, we have a smaller group with more specialized resources who can respond and at the headquarters level and so forth. At the community level, we are working to improve the capabilities with more training of local people because that is the emphasis. As the quality of the knowledge and the capabilities of the people we have at the community level increases, we increase their responsibility. You work with that structured environment which shares the limited resources that you have. In doing that, we try to work very closely with each board to make sure that we understand what their particular needs are. Within those restraints, we deliver the service in accordance with their particular needs. It is one of limited resources.

Let us say we have $1 million in our roofing program, I can replace one or two roofs a year. Perhaps even one roof is a major building. You split that up between five boards, there is not enough in each pot of money to do anything. You have to move it around on a planned basis. That is the process that we apply.

MR. WHITFORD: Planning is very important in this. Mr. Doherty, you talk about capital assets. A department as big as the Department of Health must have a tremendous amount of assets. There is a system that they are proposing to keep track of all this. We talked to them and Mr. Olenek indicated that the department is working on a system. They are proposing a new program which is called C.A.T.S. It is the acronym for Capital Assets Tracking System. Has your department been consulted about the design of C.A.T.S.? What is your assessment as to whether it will provide a suitable level of effective monitoring?

MR. DOHERTY: Our systems and computer services staff is consulting with the Department of Health in the development of that system. They are at the stage where they are looking at the best way to proceed in developing this system, whether to go with consultants or develop it in-house using our own resources. They are getting advice in that direction. The management of controllable assets is a responsibility of each particular department. As you know, we have a controllable asset system that was developed in-house and it is available for departments to use at their own discretion.

MR. WHITFORD: Then, need we re-invent the wheel?

MR. DOHERTY: Their requirements are a little more complex than what that system we have developed will satisfy. Our system will count the number of chairs and tables, but when you get into some of the equipment that are in hospitals, it is more complex. We have our controllable asset system plus, in the Department of Public Works, we also have our maintenance management system, which has an inventory of buildings which is more complex than chairs and tables. Likewise, on the Health side, that particular equipment is different and the

needs are different from controllable assets for buildings. That is why they are looking at it.

MR. WHITFORD: Mr. Chairman, this is a very important part of any operation such as a department of that magnitude. Chairs have a life expectancy of so long. Trucks have a markdown date. They start costing you so much, then you get rid of them. Their life expectancy is different. The Department of Health would have that same thing too. We just came across an x-ray machine that belongs in a museum somewhere. It is true that we inherited this from the federal government, but surely there is a system that they will be able to say that this x-ray machine has a life expectancy of so long. It is true it looks nice, but it is out of date and it is dangerous. It has a date on it now that they have to get rid of it by. All of a sudden, it is going to come down on them that they have to spend $1 million. With a proper tracking system, these things can be put in place. For instance, by the year 1993, we need a new machine to replace that one. In 1990, they should start saving or planning for it. It is very important. You said you already have a C.A.T.S. type of system in place. We should just give it to them.

CHAIRMAN (Mr. Zoe): When they were talking about tracking systems, the Departments of Health and Government Services went out and got a consultant to put this proposal together for them. That is the one Mr. Olenek was referring to. It has been developed. It looks like it is going to work, according to Mr. Olenek. Since this person developed this system and the Department of Health has it now, did your department assess what this person came up with to see if it is good enough?

MR. DOHERTY: I cannot give you a correct answer on that. I am not sure at this stage in the game. I know our departments were involved in assisting and advising the department on it. We provide a service to departments. You go through a process of evaluating the needs and then there are decisions made as to how you want to proceed to implement or develop a system that meets those needs. Sometimes departments decide to go on their own and hire a consultant, in which case our people quite often work with them and advise them. In other cases, they are developed without our knowledge. This particular one, I cannot say, but I will find out.

CHAIRMAN (Mr. Zoe): Can you find out if your department has assessed that C.A.T.S. tracking system that they have developed? Has it been already developed?

MR. DOHERTY: Yes.

CHAIRMAN (Mr. Zoe): All right. Are there any further questions? Thank you for appearing before us. I do not believe we have any further questions. If we do, we may write to you before we make our final report to the House.

MR. DOHERTY: All right.

CHAIRMAN (Mr. Zoe): All right. Thank you. Our next witness is the Department of Personnel appearing before us. The Deputy Minister, Mr. Lovely, do you have any opening remarks in regard to the comprehensive audit of the report? I believe I have written you a letter.

Presentation by Department of Personnel

MR. LOVELY: Yes, I have had a few letters from you, Mr. Chairman. I appreciate them. It helped me to prepare. I do have some brief opening comments. I will be open to questions, as well, once I am finished.

I find the comprehensive audit process to be very useful. We have always appreciated the information that we get from the Auditor General's input into these audits. It gives you a very clear picture of where you are and where you need to go. They are viewed, at least within our organization, as a very positive thing.

I have looked at the recommendations made by the Auditor General. I think they are very valid, but I do think that they need to be viewed in context because, while some of the observations point to some negative aspects of the department's operations, some of those negative aspects have been beyond the department's control and have been affected by the fact that they have only been in existence as a department since 1988. They have been struggling to establish health boards, which was a monumental task, to turn over the nursing stations and the regional operations to the Department of Health and, to a certain extent, to integrate them into the government's operation. I think they have made incredible progress, in spite of the fact that there is still a long way to go. The actual transfer from the federal government's systems and operations has probably been the most challenging. I know because we negotiated with the federal government. It was not an easy process.

There were some fairly critical comments about the Department of Health's efforts to increase aboriginal employment. I think the entire government needs to work on that and we are committed to do that, but to put it into context, you have to look at the detailed organization of the department. Health has an overall representation, which is about average for all government departments of aboriginal employees, but the breakdown of that aboriginal representation is quite different from headquarters to regions.

At the headquarters level, they have about 11 per cent of their organization who are aboriginal. In the health boards, there are about 38.7 per cent. That is a low of 34.2 per cent in Inuvik and about 50 per cent in the Kitikmeot region. I was involved with the Department of Education and Health when the transfer took place. I saw some very positive things developing out of that transfer. One of them was the program that was run by the Arctic College for community health representatives.

At the time of the take over, almost all of the jobs were vacant, so Health had a monumental job of trying to find people who had the base qualifications for training, not the basic qualifications to do the job. They chose almost totally aboriginal people and they trained 34 community health representatives, who are currently in place. I think there are another nine who are currently in training. That cost a great deal of money and it was one of the best examples of interdepartmental cooperation that I have ever seen. We contributed money from the Department of Education when I was with that department. Health contributed money from their allocation and money was available from Canada Employment and Immigration to put together a comprehensive program that

resulted in almost 100 per cent aboriginal employment in that occupational category. I see that as very positive.

They launched into a health careers preparation program at Arctic College recognizing that one of the major shortcomings in our N.W.T. skills inventory is sciences. I do not think there was a great success in that program but it did help to increase the level of knowledge in sciences. There was a University of Manitoba pre-medical program. I can remember the difficulty we had in finding aboriginal people who had the base line qualifications just to get into the pre-training that was provided. My recollection is that it cost hundreds of thousands for one or two trainees very similar to the aboriginal program that the University of Manitoba uses for engineers.

The key problem that I think the department faces, especially when they look at increasing the representation of aboriginal people in the professions is the education levels. I did a quick run through of the labour force survey before I came over. We have about 10,700 native people who are unemployed between 15 to 64 years of age. Almost 80 per cent of those unemployed people have less than a grade nine education. It is obvious what we have to do if we are going to move people into the professions. We are going to have to devote more money to education, particularly post-secondary educational programs that have upgrading built into them. We also need to complement that with comprehensive career information programs in schools so that our students, before they even leave school, know that health is a viable profession for them and what they need to do to get into the profession.

I mentioned about access programs earlier. Arctic College is working with the Department of Health now to develop a nursing access program. Representation of aboriginal people in the nursing profession is very low, if almost non-existent. Finally, there is a need for some comprehensive human resource planning to be done within the Department of Health that is linked to the educational programs that can be developed and delivered by the Department of Education. We have been working very closely with all government departments, from Personnel's point of view, to develop a human resource planning process because we have not been well organized in that area over the last 25 years. It is only in the last few years that we have managed to bring together a group of departments who have an active interest in human resource planning. We finally have a comprehensive and consistent human resource planning process for the government. That is outlined in our Personnel manual, a copy of which I sent to the Standing Committee on Finance recently. We have also developed a new performance review process that the Department of Health contributed to. That process will be piloted in 1993-94 and should satisfy some of the needs that have been identified in the Auditor General's report.

As well, the Department of Health and Personnel, along with all other government departments, have been working on orientation programs. We deliver a consistent one across the government. That orientation program could be modified for use by the health boards to orient their people before or when they arrive. We have a standard exit interview process now which is being piloted. The Department of Health is using it. We are going to have much better information on why people leave the organization and how we could do better to keep them in the organization. It is important to recognize that it is not because there has not been human resource planning, it is just that there has not been a consistent process of human resource planning. It has not been coordinated from one department to the next.

The Auditor General's report indicated that there was a need for a human resource management information system. We recognize that and our own information system is called a Government Human Resources System. We implemented that in four modules over the last four years. Those modules are position control, employee information leaving and attendance and competition information. It is missing the training and human resource planning module. The problem is that there are only so many modules you can implement in one year if it is going to have government-wide application. Cost is a big factor as well. We have not had the money to be on one module per year. We have all the health boards on the system with the exception of the Stanton Yellowknife Hospital. Their needs are a bit different than the other organizations. They have decided that, rather than going on G.H.R.S., they will buy their own human resource management information system that satisfies their needs more closely than the one we can provide to them. They do, however, provide us with the information that we need to have a clear picture of what is going on in all of our contributing organizations.

Medical travel was observed upon by the Auditor General's staff. A need was identified to have better controls in place. The Department of Personnel has implemented much stronger controls now. We think we have addressed many of the Auditor General's recommendations. We are working very closely with the Department of Health to make sure that our practices are linked because we will be turning over management of employee medical travel in 1993-94 to the Department of Health so that all residents have consistent treatment. It is all done in the same way and they can make sure that they benefit from the information that is available on why people are travelling and provide home grown services that do not require having to send people out to places such as Edmonton, Toronto and other places where they have the available facilities. We think that is going to save money. That should be implemented this year. That should help us to benefit from the economies of scale that are also available from both of those programs.

In summary, I view the report as very positive. We cooperated very closely with the Auditor General's staff in the completion of the report, particularly in the human resource management area. I think the Department of Health is also supportive of those recommendations. Those are my opening remarks, Mr. Chairman. I am open to questions.

CHAIRMAN (Mr. Zoe): Mr. Lovely, I am going to be quite frank with the Department of Personnel as I have been with the Department of Health pertaining to the human resources section. I am appalled right from day one, since we have taken over the program and that entire program was devolved to our government. Surely, prior to our take-over, all the departments that were affected must have realized what they were getting themselves into, including Personnel. All those things that you described should have been done before the transfer or planned to be done right after we have taken over. It appears to me that we are just initiating that process now.

I said that long before we brought the A.G.'s office into this play last year when the Legislature asked them to deal with it because we knew there was something wrong there. Now, it is on paper, black and white. Now, they are reacting to it. All the rationale that you have given to date should have been considered a long time ago. I am appalled by, not only your department, but the overall government. To me, just from listening to you, Personnel looks after all the public servants. You are indicating that you are quite satisfied with the department's performance in aboriginal hiring. I blasted the Department of Health when they appeared before us, particularly their human resource section people. They have never been pro-active. They have always been reactive. They have not done anything, in my view.

Just from listening to you, you are sort of defending the comments that they made to us, too. Obviously, you are doing the same thing for your department. It is not good enough for me.

I realize you have not been in the Department of Personnel that long. I think it has been over a year and a half or two.

MR. LOVELY: Three.

CHAIRMAN (Mr. Zoe): Has it been that long? I am quite surprised that the Department of Personnel did not pick it up. We do have affirmative action in place. I know that the departments are supposed to be implementing this entire program, but Personnel also monitors. Did the Department of Health ever approach you people? I do not know if they said, "We need help. Look at our statistics. We are the lowest in the government." They have been for a number of years. Did they ever ask you for help? They have no plans in place. I am wondering if the Department of Health ever came to you and said, "We really need help in terms of human resource planning and everything that ties into human resources."

MR. LOVELY: Yes, Mr. Chairman, they have approached us. One of the problems that the department has suffered from, in their defence, is that they have been having an incredible time just adjusting to the establishment of the organization as a department. As you are aware, it is difficult to deliver a program with, what I consider to be, limited resources because most government departments do not have sufficient resources to do much of the work that they do, especially the Department of Health. If you look at the percentage of money that we spend on health in our jurisdiction compared to others, we are low. At least, that is my recollection of the statistics.

They have come to us over the past five years. When they first came to us, we could not help them because we could not help ourselves. It is only in the last couple of years that we have managed to organize our human resource planning sections to the point where they have been of use to the government. I am not making any apologies for that because I did not have control of the department any further back than 1990. It has taken a long time to put it together. I can tell you that there was no consistent process in place for anybody in the territorial government. While departments like Education, Municipal and Community Affairs, Transportation and D.P.W. actually had their own human resource plans, there was nothing that was coordinated across the government. That is what we are trying to solve today. My experience with the Department of Health over the past five years is that they have had so many other pressing concerns, just in terms of delivering programs to the public, that it has only been in the last couple of years that they have really been able to devote a lot of attention to things like human resource planning.

CHAIRMAN (Mr. Zoe): In your presentation, you said that you are developing some sort of career planning strategy for the department. Are you assisting the department in that area?

MR. LOVELY: I talked about the need for career information programs in the schools. I mentioned that we have developed a standard process for human resource planning which is available to the department. They are doing exit interviews. I am not sure if they have their own orientation program. I do know that they have been involved in the human resource planning process and that it is something which they intend to use. I do not know how far they have gone in developing their own human resource plan.

CHAIRMAN (Mr. Zoe): I do not think they have. I believe they are reacting to our concerns. I know that this particular section has always been reactive. They have not been proactive. We made a suggestion that they should be going to the schools to identify certain people to encourage them to get into the health career professions. I believe they are just starting this.

I was appalled by the human resource section within the Department of Health. Aside from this issue which was addressed by the Auditor General, I have been raising this in the Legislature for years. Nothing has been done. Now we are doing public hearings and the boards are telling us this. There is nothing in place. The affirmative action portion of it at the field level is better than within headquarters. We have many C.H.R.s and janitors who work in health centres. However, at headquarters it is pathetic. We do not have anybody in middle or senior management. The affirmative action statistics tell us this. It has been like this since day one. Nothing has been addressed in this area. Personnel have to be involved. I think you have to give them more of your time to assist them to develop something. They are hurting. They are the worst department in our whole government structure. More time and effort needs to be given from your department to assist the Department of Health. Something has to be done and it has to be done now. Tony.

MR. WHITFORD: The Auditor General's report talks about the monitoring of staff performance. He found some areas of concern in this area. The report states that based on 1991 information the department had completed only 43 per cent of its appraisals and the boards' average is 29 per cent. Yesterday the U.N.W. commented on the inadequate level of performance review within the Department of Health. This is a real concern to the standing committee. Can you identify what the problem would be? Is it the performance review and planning system or is it the department? Is it the system which is not good enough or the department which is not able to do it or want to do it?

MR. LOVELY: It may be a combination of the department not taking the time to complete the performance reviews and also the fact that the existing system is set up as a management by objectives system. It is really structured more for management

jobs than it is for jobs at the entry levels and in between. We have recognized this as a problem and that is why we have been working with all of the departments to come up with something which will be easier to deal with. One of the problems that many of the departments have, and the Department of Health in particular, is management by objectives has to be structured in a different way depending upon the level of the job. The way in which our systems ask for the information on the forms is project oriented. Many people at the entry levels do not have project oriented jobs, they have operational jobs. We have not done enough to help departments understand how to set objectives and then to assess the performance of the staff achieving those objectives. What we have done is modified the system so that it makes it easier for the "average Joe" to do the appraisals. One system has to be pretty flexible to respond to all of the needs. I think this will help the department improve its performance. Ultimately health boards have to be held accountable for their attention to this area. The deputy minister is not in the position to make those kind of demands.

You asked one of the earlier witnesses to talk about how much control departments or boards should have over their capital resources. It is a similar question for how much control they should have over their human resources. I agree with Mr. Doherty that they should have the maximum amount of control which is possible within existing policies. One of the key elements of that is making your staff accountable and measuring their ability to achieve their objectives. This is one where I think a central level needs to be encouraging and demanding but it is certainly not going to be in a position to do the appraisals themselves.

CHAIRMAN (Mr. Zoe): Thank you. I have question with regard to aboriginal hiring. I do not know exactly what the problem is. I understand that we cannot recruit aboriginal doctors because we have so few in the country. I realize this. It takes years before someone becomes a doctor. With regard to the middle and senior management positions, one does not require their Ph.D. to become a manager or fill an officer level job. One of the problems within the department is that perhaps they have their qualifications set too high. Do you have to be a R.N. to fill a job at the administration level? You do not need to be a registered nurse to be an administration officer. I wonder if the department has ever done an evaluation of their job descriptions and qualifications to see if they are set too high. I believe they are in some case, particularly for administration type jobs.

Certain medical knowledge would be of assistance for some positions such as being the head of a division within the Department of Health. If you are a chief medical officer you would need some sort of understanding of medical knowledge. I believe many of our positions have their standards set too high. Has the Department of Health ever done any evaluations of their positions? I wonder if this could be a suggestion to your department to advise the Department of Health to look at the possibility that they may be setting their qualifications too high for some of their positions. There are not many aboriginal people at the administration level within the Department of Health, especially at headquarters. This is appalling. This whole area should be looked at.

MR. LOVELY: Yes. There are two sides to that equation. Generally speaking about the government, there are limited human resources available to departments and as funds are cut back you find that you really have to search further afield to find skilled people to do more work than they used to have to do because they have to cover more areas of responsibility. In some ways you need better qualified people these days than you did when you had smaller programs and less responsibility. I think all departments could benefit from a review of qualifications.

We recently looked at some of the decentralized positions, the positions which are going to Rankin Inlet, Inuvik and Iqaluit. We found that it was very possible to reduce the qualifications which had been identified as required as essential in some of these job descriptions. As a result of this we are making recommendations to the departments so that they will be in a position to hire more local people when they move. I believe the Department of Health could benefit from the same kind of review.

One of the difficulties that they have experienced in hiring aboriginal people is that they are a relatively short-term department within our government. The other departments have had more exposure to native people in middle management jobs. You will see that in many of the other government departments there is a higher representation. You have also mentioned this. As that representation improves you will see the departments hiring more and more aboriginal people. It is almost like they have not broken in yet in the Department of Health because we are still adapting to the federal environment that was present when people were actually doing these jobs somewhere else. We are still, to a certain extent, hiring the same kind of people that we did then. As more and more aboriginal people are brought into their workforce you will see a marked improvement over the years. We can do some things to improve it more quickly and your suggestion of a review of the qualifications is a good one.

CHAIRMAN (Mr. Zoe): I am not suggesting that we lower our standards. However, I am asking about what it takes for a particular person to do a particular job. I believe that some of them are set too high.

The committee has noticed that the Department of Health is not utilizing our in-service training programs. They have not asked for their own PYs to train positions or to use our in-service program through the Department of Education. They are not proactive. They do not even try to get training positions which are offered through other departments. They are not doing anything. Perhaps this is another area that Personnel can encourage them to start looking at?

MR. LOVELY: Mr. Chairman, one of the problems is that the in-service training program has limited resources. I am sure Mr. Gerein will attest to this. There are fewer opportunities available now than there were. I used to manage the in-service training program at the time when the community health representatives were trained. We diverted at least $1 million per year out of that program to the Department of Health so that they could train those community health representatives using an Arctic College program. While we did not give them the actual PYs, we gave them the money so that they could train the people to do the jobs. They have used the program

in this way. Recently all of the departments have been at a disadvantaged position because there has been less money available. I have had discussions with Dr. Kinloch and I know he does have plans to use the public service career training program. I do think it could be useful at the headquarters level where people could be hired on a term basis and others trained for their jobs.

CHAIRMAN (Mr. Zoe): This is what we will be suggesting to the Department of Education. They should try to assist the Department of Health. They are one of the worst departments within our system at the moment. When we spoke with them they were not using one position out of the in-service training program which is provided by the Department of Education. They never even applied for it. You have to apply for it in order to get it. There was no move from within the department to utilize this program. Other departments are utilizing it. When you are discussing this whole area of human resources with the Department of Health, perhaps your department should suggest that they start utilizing these other programs which are available.

MR. LOVELY: Another suggestion may be to identify the health professions as priority occupations. We have the ability to focus their funding in government in all of our staff development programs toward priority occupations. We have not actually identified particular occupations as priorities but the health occupations are one, in my opinion, which could easily be designated as priorities.

CHAIRMAN (Mr. Zoe): I think health careers are the best professions to get into in Canada.

MR. LOVELY: Everyone is sick with the recession. I guess that is it.

---Laughter

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: Was the Department of Personnel involved in the development of a draft program called "The N.W.T. Way"?

MR. LOVELY: Not to any great extent. We may have received copies of it in the earlier stages.

CHAIRMAN (Mr. Zoe): Are there any further comments or questions? I would like to thank you for appearing before us. If we require additional information our staff will write to you.

MR. LOVELY: Thank you.

CHAIRMAN (Mr. Zoe): The next witness is the Department responsible for Education, Culture and Employment Programs. Please proceed, Mr. Gerein.

Presentation by Department responsible for Education, Culture and Employment Programs

MR. GEREIN: Thank you, Mr. Chairman. I have copies of my opening remarks and some charts available for you and the Members. Mr. Chairman, you will find that as we go through this your interview with Mr. Lovely has already touched on a number of issues which I am going to be talking about. Both of our departments are in the business of investing in people and dealing with our human resources in the territories. Mr. Chairman, and Members I appreciate the opportunity to comment on the Comprehensive Audit of the Department of Health. You have suggested that I particularly comment on the sections of the report which deal with employment equity, human resource planning and training in general. My presentation, Mr. Chairman, I realize may not fully address your interests or concerns and I look forward to your questions to allow further discussion on any of those issues.

The Department responsible for Education, Culture and Employment Programs has responsibility for the coordination and delivery of general staff training programs and has recently become responsible for the promotion of employment equity. We are integrating this latter responsibility with other responsibilities for career development and counselling provided through the career centres in Iqaluit, Rankin Inlet, Cambridge Bay, Inuvik, Yellowknife and Fort Smith. The audit report made some specific observations on employment equity in section 4.2 which I would like to comment on.

Levels of education and qualifications of the N.W.T. work force limit the jobs that people can access. Overall, the unemployment rate for the N.W.T. is approximately 16 per cent but a comparison of unemployment and education is very revealing. Individuals with a grade seven to nine education have an unemployment rate of 31 per cent. Those with a grade ten or grade 11 education have an unemployment rate of 15 per cent. Those with a grade 12 have an unemployment rate of five per cent.

The Auditor General report's observation of the significance of increasing the number of high school graduates is critical for all occupations, Mr. Chairman, including health. Recently there has been much discussion on the current results of the education system and how they can be improved. Obviously, Mr. Chairman, this has been a focus of my department's efforts and those of our partners in education. Before students can graduate from grade 12 they have to stay in school and progress from grade ten to grade 11. So far we have increased participation rates of students in high school grades from over 40 per cent in 1990 to up to 65 per cent this year. This begins to compare to the national average. Our graduation rates however are still unacceptably low at 24 per cent. We project that with improved accessibility through grade extensions that the rate will improve to 36 per cent by 1994-95. We hope to reach the national average of about 67 per cent in the next five to seven years.

The department is committed to improving the results of schooling together with local education authorities, communities and parents. It is a task we cannot achieve alone. I have provided some general background tables on schooling and N.W.T. labour market for the information of the committee.

The Auditor General's report also refers to the nursing diploma program. It is being developed this year and is proposed to begin in September of 1993. It is a proposed two year program with an access year. Completing one year of this program would qualify an individual as a certified nursing assistant and with two years students would graduate with a nursing diploma. This program is being designed to be

accredited and students would then be able to continue with their third and fourth year in a bachelor of science nursing program in a southern university if they so wished.

The promotion of nursing as a career is also mentioned in this section of the Auditor General's report. I am sure that you are aware that the Department of Health has a health careers promotion officer. My department coordinates its career promotion activities with that of the Department of Health. For example, the health careers promotion officer is invited to career fairs held for secondary school students. We ensure that our efforts are coordinated through an interdepartmental committee. Health has produced a careers brochure. We are currently preparing a profile of nursing occupations in consultation with Health for general career counselling purposes.

The report also touches on the health bursary program. It points out that the Department responsible for Education, Culture and Employment Programs already provide extensive funding assistance to aboriginal students. Forty students or some 3.4 per cent of the total number of students enrolled in post-secondary programs are studying in health related fields. The Department of Health does coordinate the bursary program with this department in that they do not provide funding to students who are already receiving funding from the student financial assistance programs. It may be worthwhile, however, for the department to review this program because most aboriginal students who are interested in post-secondary education can and do receive student financial assistance. Mr. Chairman, I have also provided you and the committee with some detailed statistics on post-secondary students studying in the health field this year.

Human resource planning is another topic mentioned in the Auditor General's report in section 3.2. The Department responsible for Education, Culture and Employment Programs does not have the responsibility for human resource planning for the G.N.W.T. We are a partner, however, in the process and we do participate in a G.N.W.T. Human Resource Planning Committee which is chaired by the deputy minister of the Department of Personnel. This committee sets priorities for training and recommends applicants for education leave. Education leave is one of the general training programs which the department provides. Training and development was a topic you requested I refer to in section 4.8 of the report. This year, Mr. Chairman, education leave was reduced in budget from $700,000 to $350,000. Twelve candidates are receiving support to complete their training. Of these 12 candidates, one individual was nominated by the Department of Health from the Hay River Regional Health Board. The Department of Health has also decided to support an additional candidate on education leave this year from the Baffin Regional Board with their own funding. In the past two fiscal years from 1990 to 1992 six individuals, nominated by the Department of Health, were receiving education leave support provided through the government's educational leave program.

The public service career training program is another program which provides training for G.N.W.T. employees. Mr. Chairman, it was mentioned earlier that it provides opportunities for staff to take training to prepare them for officer and management level positions in the public service. It provides training for 60 to 70 candidates annually over a two year period and has an 85 per cent success rate. Health had ten candidates in this program over the last two years. In addition, the department also provides for training courses for general staff development. These courses range from time management to training in computer programs. Arctic College also delivers general training programs for the public.

The idea of a G.N.W.T. management training program was discussed in the Standing Committee on Finance recently. It is something which we will be considering for the future. It certainly would assist all of the departments to provide the training which staff need to advance. Thank you, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Mahsi. You mentioned that there were six people nominated from the Department of Health to receive education leave. Of those six how many were aboriginal people?

MR. GEREIN: Mr. Chairman, I will provide this information to you later.

CHAIRMAN (Mr. Zoe): You also mentioned that you had ten candidates in the public service career training program in the health related field. I will ask the same question again. How many of these ten were aboriginal people? Have you been tracking those ten candidates to see where they are?

MR. GEREIN: Again, Mr. Chairman, I will provide you with this information. The educational leave system does its own tracking based on the progress of the student. If they were to come to a point where their success was of such a low level, they would drop off the program. Having them in the program indicates that there is ongoing advancement. I will provide this information to you in writing.

CHAIRMAN (Mr. Zoe): I am interested in knowing about the ten candidates that have gone through this career training program.

MR. GEREIN: Would you like names?

CHAIRMAN (Mr. Zoe): Yes. You mentioned the bursary program which the Department of Health offers. I am not sure of what you are trying to say. You said that many people are getting student financial assistance and that is why they are not getting bursaries. Is this what you are saying?

MR. GEREIN: Mr. Chairman, what we are trying to say is that if students become eligible for the bursary program they are not doubled funded from the student financial assistance program and vice versa.

CHAIRMAN (Mr. Zoe): Mr. Gerein, perhaps the bursary program needs to be looked at.

MR. GEREIN: This is what we are suggesting, Mr. Chairman.

CHAIRMAN (Mr. Zoe): Perhaps this program should be an incentive for individuals who want to get into the health career professions. Perhaps we can tap into the bursary program. We are having problems in this area within the health professions. People who get into this area can also qualify for the health bursary program rather than being denied just

because they are already receiving funding through the Department of Education under the student financial assistance.

I questioned them on how many aboriginal people receive funding and there were very little. I asked if they were keeping track of the people who use the bursary program and how many of them are from within our system. I asked them if they monitor it to see if we are getting people into our system that we do fund through the bursary program. This whole area needs to be looked at so that perhaps it can be used as an incentive. I believe the program states that if you are receiving funding from another source you cannot qualify for the bursary program. Perhaps we can utilize the bursary program to enhance and get more people interested in the health career professions. Mr. Whitford.

MR. WHITFORD: Page four states, "the department coordinates this program with this department and that they do not provide funding for students who are already receiving funding from student financial assistance. It may be worthwhile for the Department of Health to review this program." When should this program be reviewed? Should we do it now or wait?

MR. GEREIN: I feel that we should be examining this entire area as soon as we can. Certainly the nursing program has been the initiative over the past six months or so. The Member asking the question played some role in helping push along the crystallization of the program, I am hopeful, we will be offering this fall. We can continue to improve in these areas. I have spoken with Dr. Kinloch, from a labour force and skill training point of view, and that we need to examine the hierarchy of skills required to deliver professional services and see if we can reduce some of the barriers to access of northerners who work in the health professions. We see ourselves in some areas as moving against ourselves. As we try to increase the level of service, we increase the level of qualifications required of our work-force, which goes in an opposite direction to the existing supply. We need to look at these areas seriously.

We have also been talking to the Stanton Yellowknife Hospital. They had been moving to a system where there were no certified nursing assistants any longer and having all of the physicians at a registered nurse level. We have been talking to them about this. I believe there are things which can be done to open the health field up to more para-professionals. This is a matter we are just beginning with the Department of Health.

CHAIRMAN (Mr. Zoe): Are there any further comments? Mr. Whitford.

MR. WHITFORD: We have heard from the Department of Health and others over the last little while. The responsibility or lack of it seems to switch back and forth. We have heard in our hearings from government officials in other departments that the reason there is not more aboriginal people working for the government is because the educational system has not turned out the numbers of health care professions. What do you think of that statement? Should you be the one bearing the brunt of this criticism of why there are not as many aboriginal people in the health care professional or within the department? I would like to move away from the professional part of it because there are many jobs within the Department of Health that do not require university qualifications.

MR. GEREIN: Mr. Chairman, I would say that the Department responsible for Education, Culture and Employment Programs is definitely squarely in the front line in terms of having to take responsibility and action in increasing the supply of people with the suitable backgrounds to build successful careers in officer and management level positions, including the health professions. We see this coming. It is a developmental thing. I believe we see it coming through the high schools.

I was out in Rae yesterday. When one is down about the business we are in, all one has to do is go to Rae and look at the school there. Mr. Chairman, we expect to have approximately 60 grade 12 students next year in the Chief Jimmy Bruno High School. From that, I would forecast that we are going to have greater than one graduate from that school. In 1991-92, Mr. Chairman, we had no graduates from the Dogrib area in grade 12, much less 60 grade 12 students. We had perhaps in the order of ten students enrolled in grade 12.

In terms of increasing the supply side which is absolutely critical to all of the departments and being able to meet and have people who have the fundamental understandings of the sciences and languages, and of being able to communicate properly in scientific and technical areas, even if you are an invoice clerk you need to understand many of the words in order to be making appropriate judgements as to coding, etc. Literacy and numeracy skills are very important. Seventy two per cent of our aboriginal population are considered to be illiterate. The Canadian definition of that is anyone who has less than grade nine education.

Yes, we have a responsibility. No, we are not trying to pass it on. Yes, we are trying to work with the departments to develop programs that are sensitive to where we are in real time. With the nursing program, we are having an access year prior to the first two formal years of training. This will allow us to take students with a basic grade ten, 11 or 12 grouping of skills and upgrade their science and languages skills to a level where they can start taking on the scientific and technical training required of a level one and level two years. People who have full certification in grade 12 can go directly into the first year. People who are already certified, C.N.A.s, will be able to go into the second year of the nursing program and graduate after one year. We are really trying to build on this laddered approach so that we can build skill levels and continue to give people a chance to build on their education as they go along.

CHAIRMAN (Mr. Zoe): I understand what you are saying about taking the criticism. Do you feel that it was fair for the Department of Health to make those type of comments directly to your department? In my view, after looking at his own operation within the Department of Health, Dr. Kinloch was trying to pass the buck to Education. He was trying to say that it is not a departmental fault that they did not have enough aboriginal people or enough people trained in the health career area. He was trying to say that it was not his responsibility and that it was the responsibility of the Department of Education. Do you feel that the comments made by Dr. Kinloch were fair?

MR. GEREIN: I would think that Dr. Kinloch was speaking to the supply side. He is saying to give him some people who are qualified or capable of entering in the health professions area and he will give you health professionals in our system. I think this is a reasonable comment. At the same time I would say that coming from the employment and education side of our government and having a mandate, I think that all of us can be more proactive in terms of participating in the development of programs which are sensitive to our place in real time.

I believe Mr. Lovely talked about where health was in terms of "youth of an organization" or "maturity of an organization." I think some of these things are factors. If you are struggling with program delivery, service levels and peoples lives you would tend to deal with them first and perhaps shuffle off the responsibility to education. There is quite a bit that we can do. Again, I am very concerned with the trends in government and elsewhere with respect to training and the need for retraining in our time of restraint. If you cut back on the number of personnel you have and have 12 people to do a job, you could ladder it and provide more opportunity for less skilled people or for skilled people with limited skills to progress. You limit that, you limit your ability to deal with affirmative action programs.

The other thing which comes out also is the cash to deal with developmental needs in an organization. As soon as you do a three or four per cent cut, those are the things which go because the travel for program delivery is needed. These remain. You need to buy stamps and make long distance telephone calls. The things which go are the things which appear discretionary but we should not considered them as such. This is what happens. It really squeezes the system and squeezes the chances of seeing significant increases in aboriginal participation in our government work force. It puts managers in a very difficult position.

CHAIRMAN (Mr. Zoe): I appreciate what you have said with regard to accepting the responsibility for increasing the supply of aboriginal people within the health system. However, there are situations where aboriginal people have been trained but they still cannot get hired. It appears from what we have heard there could be attitude problems which exist among supervisors and within the system, on boards and also within the department. I do not think that you would take the responsibility for this.

What pressures could you place on other departments to hire your graduates, particularly in the Department of Health?

MR. GEREIN: Are you talking about graduates from our management programs?

CHAIRMAN (Mr. Zoe): Yes. All of the people who are coming through our system through the Department of Education.

MR. GEREIN: Mr. Chairman, among the charts which I have passed out are the employment breaks by grade level.

CHAIRMAN (Mr. Zoe): You are producing a number of people through your system. There have been problems, particularly in the Department of Health, with regard to hiring either at the board level or within the department. Even though we have the supply, it appears that they are having problems with the hiring of graduates that you are pumping out. What kind of pressures can you put on the Department of Health to hire the graduates you are producing? It appears that there is an attitude problem either at the board or the departmental level and particularly with supervisors.

MR. GEREIN: Mr. Chairman, obviously you have gained some insights into the Department of Health which I am not familiar with. What I can comment on is the fact that people who have a grade 12 education, and among them are aboriginal people, some 78 per cent of those people are employed. What we are saying is that there is not a great number of people who have qualification who are not already in jobs. The question to me then would become, "has Health been getting their fair share of those number of people with qualifications?" That, Mr. Chairman, is a judgement you would have to make. As the deputy minister responsible for Education I am quite happy with the outcomes in terms of employment of people who are actually qualified.

One of the other charts indicates a number of people with university education. You can see in the 1989 labour force survey that of all of those in the territories who have a degree, four per cent are aboriginal people. One hundred per cent of those people are employed. The previous chart I gave you was the one which dealt with the number of people who had grade 12. Some 78 per cent of those are employed and you need to consider that there are mothers and other people who would not be actively seeking employment in that chart also. There are very few and I believe I said five per cent, who had grade 11 or more who were not employed.

With the changes that have been made in the Department of Health in recent times you might see an increased aggressiveness in terms of trying to get their share of the number of people who do have the skills to participate in the delivery of health programs.

CHAIRMAN (Mr. Zoe): Mr. Whitford.

MR. WHITFORD: It has been my observation that many times we are reactive to needs rather than proactive. I am referring to being able to look into the crystal ball and find out what the needs are going to be and work toward meeting those needs. We tend to say that we need a number of people now and because we do not have them here, we will have to hire them from somewhere else.

On the other hand we need to know when there is enough. There has to be a coordination between the Department of Personnel who know what kind of demands there are, the host department and the Department of Education. These three need to work together to meet a projected demand. When we first took over, the Department of Health should have been able to say that they were going to need nurses because there is a turnover and they should have been able to confirm that with the Department of Personnel. That is just an observation. It still bothers me that we are reacting rather than being able to predict. It is not a science by any means that we can accurately predict the number of graduates we are going to need in the year 2000 and have them all trained and ready to go on stream at that time because there are forces that govern us.

There are programs that we had that worked fairly well that could meet some of the needs. The Department of Health is not made up entirely of nurses and doctors. There are also administrators, people such as Mr. Bower over there. The Northern Careers Program identified areas within the department and they targeted those areas for recipients. They said that they knew there was a high turnover in this area and we are going to train people specifically for that on-the-job, and anybody coming in would have known that they were only going to be there for a short period of time. It worked fairly well. The federal government benefited from this program. This was a federal program. The territorial government benefited greatly from that federal program also because we went head hunting and picked off many of the graduates.

I would like to know what we are doing to help northern aboriginal people to move into the health administration careers, accountants, and purchasers, so that we can identify positions like this and train for it. Then we can promote Mr. Bower to a higher level, of course.

---Laughter

There are areas where there is a lack of people to draw on and consequently we have to go south. I am referring to specifically targeting. In this way, the departments and individuals can be held accountable. They can be asked why they have not met the targets.

MR. GEREIN: Mr. Chairman, the Member makes some very valid comments and criticisms. Perhaps on a more general basis to deal with labour market matters in terms of forecasting needs relative to occupational groups, there has been some work going on in this area. There have only been a few areas where we have actually succeeded in introducing programs which are responsive to those needs. I can point to the Teacher Education Program. For example, we know approximately what our needs are going to be. We are currently forecasting what our requirements are going to be for the year 2000. We have set for ourselves a target of 50 per cent aboriginal educators by the year 2000. We are now developing an investment plan for us to get there. This is a critical part.

I see the Department of Health doing similar things now with our participation. Some of it may have come as a result of changes in the department and pressures being brought to bear on the department. Nursing was identified as the single largest occupational grouping in the territories. There are over 400 positions in nursing. That in itself is the basis for the establishment of a nursing program. I am anticipating that we are going to be doing the same thing in the engineering technologies also. We need to develop a firm foundation of analysis and research before we start investing to make sure that we can continue to both have the supply of candidates who are going to enter that and also have jobs when they graduate. We are able to do those things.

The Public Service Career Training Program, Mr. Chairman, is the only program which comes close to the federal government's program. There are 70 positions and they are allocated across the government and the regions based on the size of the work force in each one of those locations. Each region has a committee which deals with the senior managers from that region in terms of allocation of the training person year to the departments. Again, it does require the initiative of the department to bring forward proposals and compete, in essence, for those resources. The resources are limited. There are only enough resources for approximately 60 to 70 persons depending on the level at which you want to train them. For example, if you are trying to train a regional director, you will probably start off with a more qualified aboriginal person with some kind of a proven track record, so you are not able to start him off at a low salary, you need to start where they are and progress up the ladder toward the regional director level. It depends on what jobs you are dealing with in terms of how many person years you can actually pay for within that allocation.

A great deal of it depends on the department's aggressiveness and in terms of access to Public Service Career Training Program. We always have more demand for the program than we have cash. Departments who are particularly busy are not as good at preparing their proposals to compete among the departments.

CHAIRMAN (Mr. Zoe): Thank you. Of all of the people who appeared before us during our hearings either here or in the communities -- and most of them were senior health officials -- not one of them was aboriginal. Not one of them. None of the C.E.O.s of the health boards were aboriginal. The finance officers who came to the table with them, and even within the Department of Health, not one of them was aboriginal. Is that a supply problem or is it because of an attitude problem that led our health system to reduce its demand for aboriginal people?

MR. GEREIN: Mr. Chairman, I do not have adequate knowledge of the department to give you my own diagnosis of the corporate culture of the Department of Health. It would be unfair of me to do this. I can perhaps give you a feeling about my own department in terms of corporate culture and attitude. I certainly could not assist you in terms of giving you feedback on people's predisposition to hiring aboriginal people, either in training programs or in management programs. I just do not have enough information. Thank you.

CHAIRMAN (Mr. Zoe): Thank you. Mr. Whitford.

MR. WHITFORD: Was the Department of Education, Culture and Employment Programs ever consulted in the development of "The N.W.T. Way"?

CHAIRMAN (Mr. Zoe): We have been asking everyone who appears before us this question.

MR. WHITFORD: This involves everyone, it involves Education, Personnel and D.P.W. Our government department appear to be working in isolation of each other. We all affect each other in some way or the other.

CHAIRMAN (Mr. Zoe): Mr. Gerein.

MR. GEREIN: Mr. Chairman, yes the department has been involved. There is an inter-agency committee which has existed among the social agencies of our government, Education, Social Services and Health. We have been attempting to deal with a whole range of issues relative to

education and the handling of students in the schools and the services to students. I do not know how much of that is reflected in "The N.W.T. Way". I would have to ask my staff. I have only been here a year.

MR. WHITFORD: Were you ever sent a document?

MR. GEREIN: Not that I am aware of in the year I have been with the Department of Education.

CHAIRMAN (Mr. Zoe): Thank you. I would like to thank you for spending a few hours with us this morning. Thank you for appearing before us. Mahsi.

MR. GEREIN: Thank you. It is always educational.

---Laughter

CHAIRMAN (Mr. Zoe): The Auditor General's office have been here with us yesterday and today. Do you have any comments or observations? If not, this concludes our meeting for today. The next meeting will be at the call of the Chair.

---ADJOURNMENT