Northwest Territories Legislative Assembly

12th Assembly, Third Session

Standing Committee on Agencies, Boards and Commissions

Final Report On

Health and Hospital Boards in the Northwest Territories.

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Chairperson.

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EXECUTIVE SUMMARY

The Standing Committee on Agencies, Boards and Commissions has completed its review of health and hospital boards in the Northwest Territories. The Standing Committee held public hearings in Fort Smith on January 22, 1992 and organized a day of consultation sessions in Yellowknife with representatives of health and hospital boards on November 21, 1992. In addition, the Committee has met on several occasions over the fourteen-month review period to consider written submissions and research material.

Based on this review, the Standing Committee on Agencies, Boards and Commissions finds that there are serious grounds for concern with respect to constraints faced by health and hospital boards in the Northwest Territories. This has the potential to negatively affect the administration of health facilities, programs and services.

Since the transfer of health responsibilities from federal to Territorial authority in 1988, many Northerners have held the expectation that health services would be operated, managed and controlled by regionally-based health and hospital boards. This has been accepted as an approach that would allow decisions regarding the regional administration and delivery of health services to be made by the people who are most closely affected by them.

The Standing Committee on Agencies, Boards and Commissions is concerned that this well-reasoned approach is not working as it should. There is a disconcerting level of confusion about the roles which should be played by the Department of Health and by health and hospital boards. The Standing Committee also found that the degree of centralized control presently exercised over the boards by the department is, in many cases, excessive. This, in the Committee's view, has led to counterproductive conflict and strain within the health system.

An ***Interim Report*** [CR No. 9-12(3)] was tabled in the Twelfth Legislative Assembly on December 10, 1992 and indicated that *"a serious state of affairs presently exists within the administration of the Territorial health care system"*. Although there has been some initial progress toward the development of agreements defining respective roles for the department and the boards, the Standing Committee has found little evidence to suggest that the "seriousness" of the situation has lessened appreciably.

Clearly, some direct action needs to be taken to clarify and redefine the respective roles of the department and the boards. It is the Standing Committee's position that the Legislative Assembly could provide badly needed direction to this process by formally acknowledging that the boards are the primary agents for the management and delivery of health services to regions and communities across the Northwest Territories. The role of the Department of Health should more properly be one of *supporting*, rather than *directing*, the management decisions of health and hospital boards.

As noted in the ***Interim Report,*** a process is now underway to establish a *"master memorandum of understanding"* (MOU) aimed at clarifying issues of authority and accountability. The Standing Committee on Agencies, Boards and Commissions applauds this initiative and takes the position that it should be considered a high priority by the Minister of Health and the boards. At the same time, however, the Standing Committee recognizes that changes in legislation and in the prevailing attitude which has been observed to exist within the Department of Health will also be required if existing problems are to be resolved.

Generally, the Final Report emphasizes that, with a system in place that relies on *"Boards of Management"*, it is important for the Department of Health to stand back and allow them to manage, providing technical assistance and support as required. This will necessitate a sense of trust and collaboration on the part of all health stakeholders that appears to have been largely lacking to date.

A change in outlook will be necessary if the parties are ever going to be able to address the significant barriers which were observed by the Standing Committee to hinder effective administration within our current health system.

The Standing Committee on Agencies, Boards and Commissions was deeply concerned, for instance, with the apparent absence of Territorial planning and direction with which to guide health expenditures and services. Although all health and hospital boards are presently engaged in planning initiatives to some extent, the Standing Committee observed that these currently occur in isolation. The Committee noted that it is essential to develop better mechanisms for channelling boards' planning initiatives into headquarters, where they can be coordinated within a larger Territorial framework. However, needs assessment and strategy development cannot be centrally imposed -- *health planning must be a regionally driven process.*

The Standing Committee on Agencies, Boards and Commissions notes that there seems to have been much discussion about the balance between health board autonomy and fiscal accountability. The Committee takes the position that increased board autonomy and internal accountability controls are not mutually exclusive. Indeed, the Standing Committee was rather impressed with the commitment that health and hospital boards have demonstrated to improving financial procedures and expertise over the years since the health transfer.

Clearly, the well-documented deficiencies which presently exist within computerized accounting and statistical systems, the amount of time board personnel have to spend dealing with information demands from officials in Yellowknife, and the inadequate funding base inherited from the health transfer have been very real barriers to fiscal management by the boards. Also of concern to the Standing Committee was the current lack of incentive provided to the boards for appropriate administration. Accordingly, the Standing Committee on Agencies, Boards and Commissions is proposing that a new policy should be put in place to allow health and hospital boards to use budget surpluses to support specific projects aimed at improving health conditions or awareness in their regions.

The Standing Committee believes, as well, that there needs to be a renewed emphasis on human resource development within the health and hospital boards. Some specific concerns about boards' records of aboriginal hiring, staff training and interpreter/translator services were specifically considered during the Committee's review.

By far the greatest area of concern regarding human resources, however, was the very unacceptable level of orientation and training that has been offered to trustees who sit on health and hospital boards. The Standing Committee on Agencies, Boards and Commissions was dismayed to observe that funding levels for board training, departmental support and available information materials were all clearly inadequate. The Standing Committee believes that, to ensure that appropriate priority is accorded to board orientation and training in the future, specific statutory responsibilities in this regard should be established in legislation.

Members of the Standing Committee also felt that certain barriers exist with respect to the ability of boards to have effective input into the establishment of health policy and priorities. Additional mechanisms must be developed to enable health boards, as well as community, regional and aboriginal organizations to provide input to senior decision-making levels within our health system. Effort also needs to be directed toward a joint strategy for dealing with the erosion of non-insured health services. For these reasons, the Standing Committee on Agencies, Boards and Commissions proposes the development of a Territorial Health Advisory Committee.

The Standing Committee on Agencies, Boards and Commissions spent considerable time, as well, examining various models for the structure and organization of health and hospital boards. In this respect, the Standing Committee believes that the wide demographic diversity and range of health needs which exist between regions should be recognized by allowing each board to define the structure which best meets the needs of the people who live within that region or catchment area. The Standing Committee is also of the opinion that a priority should be placed on studying the potential election of health and hospital board trustees.

The Standing Committee on Agencies, Boards and Commissions was dismayed to note the delay which has existed with respect to appointments made to health and hospital boards. Appointments have not been regularly made and boards have had to cope with lengthy periods of membership vacancy. A more expedient and consistent approach to board appointment is necessary.

While many of the concerns which were observed with respect to health and hospital boards are complex and deeply rooted in the history of the Territorial health system, the Standing Committee is of the opinion that solutions can be found. Members of the Standing Committee agree with a board representative's comments that, *"placing blame is a waste of time and energy"*, and realize that now is the time to move forward toward new partnerships and effective health management.

The Standing Committee on Agencies, Boards and Commissions wishes to acknowledge the thoughtful input received from all witnesses during the public hearings and consultation sessions. The Committee would thank both the current and previous Ministers of Health for information and suggestions they have provided over the course of the review.

The following recommendations are included in the Standing Committee's *Final Report on Health and Hospital Boards:*

Recommendation #1

THAT THE LEGISLATIVE ASSEMBLY FORMALLY SUPPORT THAT BOARDS OF MANAGEMENT ESTABLISHED UNDER THE *TERRITORIAL HOSPITAL INSURANCE SERVICES ACT* ARE THE PRIMARY AGENTS FOR THE MANAGEMENT AND DELIVERY OF HEALTH SERVICES TO REGIONS AND COMMUNITIES OF THE NORTHWEST TERRITORIES;

AND FURTHER, THAT THE ROLE OF THE DEPARTMENT OF HEALTH SHOULD BE ONE OF SUPPORTING, RATHER THAN DIRECTING, THE MANAGEMENT DECISIONS OF HEALTH AND HOSPITAL BOARDS.

Recommendation #2

THAT THE MINISTER OF HEALTH SHOULD ACCORD A HIGH PRIORITY TO THE FINALIZATION OF THE MEMORANDUM OF UNDERSTANDING CLARIFYING THE ROLES AND RESPONSIBILITIES OF HEALTH AND HOSPITAL BOARDS.

Recommendation #3

THAT THE MINISTER OF HEALTH SHOULD SEEK ADVICE FROM HEALTH AND HOSPITAL BOARDS ACROSS THE NORTHWEST TERRITORIES WITH RESPECT TO AMENDMENTS THAT SHOULD BE MADE AT THIS TIME TO THE *TERRITORIAL HOSPITAL INSURANCE SERVICES ACT* OR OTHER STATUTES TO ENSURE THAT HEALTH LEGISLATION RELECTS A PHILOSOPHY SUPPORTING REGIONAL AUTONOMY;

AND FURTHER, THAT THE MINISTER OF HEALTH BRING FORWARD RECOMMENDED AMENDMENTS TO THE *ACT* BY THE FALL SESSION IN 1993.

Recommendation #4

THAT ALL REQUESTS FROM THE DEPARTMENT OF HEALTH TO HEALTH AND HOSPITAL BOARDS FOR BUDGETARY, STATISTICAL AND OTHER ADMINISTRATIVE INFORMATION SHOULD BE MADE ONLY BY THE DEPUTY MINISTER OF HEALTH;

AND FURTHER THAT INFORMATION REQUESTS SHOULD BE LIMITED IN NUMBER AND SCOPE TO ONLY THOSE WHICH ARE ESSENTIAL FOR THE EFFICIENT AND EFFECTIVE OPERATION OF TERRITORIAL HEALTH SERVICES;

AND FURTHER THAT THE TIME-FRAME FOR BOARD RESPONSE TO DEPARTMENTAL INFORMATION REQUESTS SHOULD BE REASONABLE AND ESTABLISHED WITH DUE CONSIDERATION TO OTHER PRIORITIES WHICH HAVE BEEN IDENTIFIED AT THE REGIONAL LEVEL.

Recommendation #5

THAT THE MINISTER OF HEALTH CONSULT WITH THE HEALTH AND HOSPITAL BOARDS TO DEVELOP POLICIES AND STRATEGIES WHICH ALLOW SURPLUS RETENTION UNDER CIRCUMSTANCES IN WHICH BOARDS CLEARLY DEMONSTRATRATE APPROPRIATE FISCAL MANAGEMENT.

Recommendation #6

THAT THE MINISTER PREPARE AMENDMENTS TO THE *TERRITORIAL HOSPITAL INSURANCE SERVICES ACT* TO ESTABLISH A REQUIREMENT THAT ORIENTATION AND ONGOING TRAINING BE PROVIDED TO MEMBERS OF EACH BOARD OF MANAGEMENT ESTABLISHED UNDER SUBSECTION 10.(1);

AND FURTHER, THAT THE CONTENT OF MANDATORY TRAINING SHOULD BE ESTABLISHED BY REGULATIONS DEVELOPED THROUGH CONSULTATION WITH HEALTH AND HOSPITAL BOARDS;

AND FURTHER, THAT THE MINISTER BRING THE NECESSARY PROPOSED AMENDMENTS AND DRAFT REGULATIONS BEFORE THE LEGISLATIVE ASSEMBLY BY THE FALL SESSION IN 1993.

Recommendation #7

THAT THE MINISTER OF HEALTH ESTABLISH A TERRITORIAL HEALTH ADVISORY COMMITTEE COMPRISED OF REPRESENTATIVES FROM ABORIGINAL ORGANIZATIONS AND THE CHAIRPERSONS OF EACH REGIONAL HEALTH BOARD AND HOSPITAL BOARD IN THE NORTHWEST TERRITORIES.

Recommendation #8

THAT EACH HEALTH AND HOSPITAL BOARD SHOULD BE ALLOWED TO DEFINE ITS OWN STRUCTURAL FRAMEWORK, INCLUDING THE MAXIMUM NUMBER OF MEMBERS AND SYSTEM OF COMMUNITY AND ABORIGINAL REPRESENTATION.

Recommendation #9

THAT THE MINISTER OF HEALTH ENSURE THAT HEALTH AND HOSPITAL BOARDS REMAIN FULLY CONSTITUTED BY FILLING MEMBERSHIP VACANCIES THROUGH THE TIMELY APPOINTMENTS OF MEMBERS.

Recommendation #10

THAT, IN ACCORDANCE WITH RULE 94(4), THE EXECUTIVE COUNCIL TABLE A COMPREHENSIVE RESPONSE WITHIN 120 DAYS OF THE PRESENTATION OF THIS REPORT TO THE HOUSE.

INTRODUCTION

The Standing Committee on Agencies, Boards and Commissions, under the authority given to it by this House, has now completed a review of issues related to the operation of health and hospital boards established under the *Territorial Hospital Insurance Services Act.*

Throughout the review process, the Committee focused on the following aspects:

- the mandate, composition, organizational structure and function of health and hospital boards across the Northwest Territories;
- initiatives undertaken across the Northwest Territories by health and hospital boards relative to health planning, program development and service delivery;
- pertinent legislation, regulations and policy, particularly as they pertain to the authority of the boards and of the Minister;
- appointments of members to health and hospital boards;
- models for board structure, composition and function;
- working relationships between the boards, the Minister and the Department of Health;
- current barriers to the delivery of health services and programs across the Northwest Territories by health and hospital boards;
- action taken by the Government of the Northwest Territories in response to a *Review of Selected Regional Health Boards and the Territorial Health Insurance Services Board,* completed by the Standing Committee on Agencies, Boards and Commissions during the Eleventh Legislative Assembly, and reported in October 1990 as Committee Report No. 4-90(2);

- specific matters related to Board organization and operation brought to the attention of the Standing Committee by representatives of health and hospital boards and by professional associations working in the health care field;

- assumptions, analysis and recommendations within the *Strength at Two Levels* document regarding health and hospital board operations; and,

- progress in the establishment of agreements and clarification of relationships between the Department of Health and the boards since the tabling of an *Interim Report on Health and Hospital Boards* by the Standing Committee on Agencies, Boards and Commissions on December 10, 1992.

THE REVIEW PROCESS

The Standing Committee on Agencies, Boards and Commissions held public hearings on the matter of health and hospital boards in Fort Smith on January 22, 1992 and heard from the former Minister (the Honourable Tony Whitford) and his officials, as well as representatives of the NWT Health Care Association and the NWT Medical Association. Written submissions were later received from the NWT Registered Nurses' Association and the Keewatin Regional Health Board.

On November 21, 1992 the Standing Committee on Agencies, Boards and Commissions met with representatives of the Baffin Regional Health Board, the Inuvik Regional Health Board, the Keewatin Regional Health Board, the H.H. Williams Memorial Hospital Board of Management and the Stanton Yellowknife Hospital Board of Management. As well, a written submission was subsequently received on February 9, 1993 from the Kitikmeot Regional Health Board.

Consultation has taken place, as well, with various Ministers of Health and senior officials in the Department of Health regarding organizational and historical aspects of the interaction between boards and the department.

The Standing Committee on Agencies, Boards and Commissions wishes to acknowledge the cooperation and thoughtful input received from individuals and organizations appearing as witnesses or submitting briefs during public hearings and consultations.

REASONS FOR THE REVIEW

The impetus for this review was generated from a number of sources:

- A 1990 report by the Eleventh Legislative Assembly's Standing Committee on Agencies, Boards and Commissions had made recommendations respecting service agreements between the Department of Health and the various health and hospital boards, as well as the dissolution of a board of central authority previously established under the *Territorial Hospital Insurance Services Act*. When the current Standing Committee on Agencies, Boards and Commissions was established by the Twelfth Assembly, there was considerable interest in following up on the Government's response to that report.

- The *Strength at Two Levels* report [Tabled Document No. 12-9(1)] included extensive commentary and recommendations regarding future directions in the delivery of health services and programs. Recognizing that these carried specific implications for health and hospital boards across the Northwest Territories, members were of the opinion that principles outlined in the *Strength at Two Levels* document required some scrutiny from the Standing Committee on Agencies, Boards and Commissions.

- The Standing Committee on Agencies, Boards and Commissions was also aware that, in many cases, board structures and organization are seen as too large and cumbersome. Committee members were interested in exploring board models that would improve board efficiency, while still achieving valuable principles for the representation of regional interests.

- The Standing Committee became aware that, in some cases, health and hospital boards have been hindered by Ministerial delay in making appointments, sometimes to the point where it has been difficult for boards to even meet. The Standing Committee became interested in reviewing the process through which appointments are made.

- Funding for health programs has been recognized as a contemporary concern for governments at both the provincial and federal level. Without a doubt, the health care field, in general, has entered a period where fiscal pressures are requiring jurisdictions to *"make do with less"*. More than ever before, emphasis must be placed on ensuring value for money in the organization and delivery of health services. The Government of the Northwest Territories has certainly not been immune to those considerations and, in fact, difficult funding issues may extend back to arrangements that were made around the time of the 1988 transfer agreement. The Standing Committee on Agencies, Boards and Commissions recognized that it would be timely to review health and hospital boards in light of current health funding trends.

- The transfer of responsibility for health services to the Government of the Northwest Territories was intended to achieve greater aboriginal involvement in the management of health services. The Standing Committee was concerned that there should be a vehicle for aboriginal groups to have direct input into the development and implementation of health policy and wished to review the structural organization of the health system in this regard.

- Over time, the Standing Committee has become aware that some health and hospital boards have experienced periods of internal conflict. Other boards have encountered periods where relations with hospital or regional staff have become strained. For instance, at one point, labour relations at the Inuvik Regional Hospital deteriorated briefly to an extent where staff initiated a letter-writing campaign and submitted petitions to the Legislative Assembly. Although such internal discord has appeared to be the exception rather than the rule for the operation of health and hospital boards, it seemed relevant for the Standing Committee on Agencies, Boards and Commissions to review the over-all framework in which they function.

- The Standing Committee on Agencies, Boards and Commissions was also aware that health and hospital boards have undertaken a great many positive initiatives over the past several years. Since there is considerable evidence to suggest that many of these initiatives are proceeding largely in isolation from each other, it seemed valuable to review some of the accomplishments boards have achieved and to identify common elements in each.

- It is also accurate to note that, in some respects, this review was launched in response to a number of concerns that had been brought to the attention of the Legislative Assembly over a period of time. These tended to relate to the autonomy of health and hospital boards or health planning matters at the constituency level. In some cases, members of the Standing Committee had received concerns expressed by individuals regarding the nature of health service delivery.

INTERIM REPORT

On December 10, 1992 the Standing Committee on Agencies, Boards and Commissions tabled Committee Report 9-12(3), which commented on certain aspects of the status of health and hospital boards. The *Interim Report* concluded that a serious state of affairs existed within the administration of the Territorial health care system, particularly with respect to a high degree of conflict, role confusion and inefficiency in the relationship between the Department of Health and the various boards established under the *Territorial Hospital Insurance Services Act.*

The *Interim Report* also made note of a process that was to lead to the establishment of a *"master memorandum of understanding"* (MOU) between health boards and the Department of Health. The purpose of this agreement would be to clarify and establish authority, accountability and levels of autonomy. The Standing Committee commented that this process should be accorded the highest priority by all parties. The Standing Committee also indicated that, during the period between the tabling of the *Interim Report* and the delivery of a final report, it would monitor this departmental initiative to ensure that it was proceeding according to previously announced time-lines and with appropriate direction and input from the health and hospital boards.

CONTEXT OF THE REVIEW

It is important to note that the Committee review process took place in a dynamic environment, during a period in which considerable public and political attention was focused on health issues. Various factors have influenced the procedures that were used and the context in which findings have been presented.

Ministerial and Administrative Transition. During the review period, for instance, four successive Ministers of the Territorial Cabinet have held the health portfolio on an assigned or acting basis. There was also a change in the appointment of the Deputy Minister. This has meant that the Department's approach and priorities when dealing with boards has varied somewhat at different times. Accordingly, observations made by the Standing Committee at one point of the review may have been less or more salient at another.

Notwithstanding these Ministerial and administrative transitions, however, the Standing Committee has noted that the fundamental concerns of boards have remained largely consistent throughout the review period.

Related Reviews of Health Issues in the Legislative Assembly. Over the course of the review of health and hospital boards, the Standing Committee on Agencies, Boards and Commissions has been mindful of a comprehensive audit of the Department of Health that was undertaken by the Auditor General of Canada at the request of the Eleventh Legislative Assembly.

The Office of the Auditor General examined various issues related to departmental organization and operations, covering the period since the health transfer in 1988. The final report was transmitted to the Speaker of the Legislative Assembly in October 1992, and was formally tabled on November 17, 1992 [Tabled Document No. 5-12(3)]. The Auditor General's report has been referred to the Standing Committee on Public Accounts and is presently the subject of a public review process.

The Auditor General audited the Department of Health and not the health or hospital boards. Accordingly, the Standing Committee on Agencies, Boards and Commissions has not carried out a systematic review and will not comment specifically at this point with regard to recommendations in the Auditor General's report. That is the mandate and purpose of the public review process now undertaken by the Standing Committee on Public Accounts.

However, members of the Standing Committee on Agencies, Boards and Commissions do agree that the Auditor General's report on the comprehensive audit is a very important document and largely relevant to this review. Certain sections of the Auditor General's report do comment on departmental procedures and approaches with respect to its interaction with the health and hospital boards. These were referred to frequently during consultations with board representatives and during Committee deliberations. Where findings made by the Standing Committee on Agencies, Boards and Commissions either parallel or differ from those of the Auditor General, and where principles identified during the Committee review are illustrated by the Auditor General's findings, these will be noted in this current report.

In addition to the Public Accounts Committee's review of the comprehensive audit of the Department of Health, the Special Committee on Health and Social Services is proceeding with its mandated examination of global issues with respect to the organization and delivery of services and programs.

It is hoped that findings included in this current review of health and hospital boards by the Standing Committee on Agencies, Boards and Commissions may also be of assistance to the other two Committees of the Legislative Assembly that are now in the process of reviewing other aspects of our health system. Where issues raised during the review of health and hospital boards could more properly be examined under the terms of reference of these other reviews, care has been taken to draw them to the attention of the respective Standing or Special Committees.

Critical Health Issues. Over the course of this Standing Committee's review of health and hospital boards, as well, there have been a number of significant health issues that have come to the attention of the public at large and have been the focus of some fairly intensive media scrutiny.

- Considerable public interest, for instance, was generated in response to concerns over abortion procedures at Stanton Yellowknife Hospital. An independent review was carried out by a Ministerially-appointed panel, with recommendations to be implemented by the hospital board.

- A bacterial epidemic in the Keewatin Region, which claimed the lives of two children, was brought under control approximately three months prior to the review process, with the Regional Health Board playing a key role.

- Concerns over the administration of the Fort Smith Health Centre resulted in the resignation of several board members, the appointment of a Public Administrator, the establishment of an inquiry under the Territorial *Public Inquiries Act*, and the subsequent cancellation of the inquiry.

- The Legislative Assembly has seen considerable debate during this period over capital planning procedures, health care policy and leadership.

- Implementation activities are underway, at the departmental and Cabinet level, for the decentralization of Health Insurance Services and for the consolidation of the Departments of Health and Social Services.

- A dispute with the Government of Canada over outstanding payment of health billings has now resulted in legal action before the Federal Court.

- Very recent announcements by the Minister of Health respecting the incidence of AIDS/HIV infection have presented new challenges for health and hospital boards within the Territorial health system.

- Health issues have not been unique to the Northwest Territories. Jurisdictions throughout North America are struggling to keep pace with new technological developments, difficult resource allocation decisions and spiralling health care costs.

While these issues have provided an interesting context for the review of health and hospital boards, they are not the specific subject of this report. However, they may have contributed to a continuing public interest in health matters and were referred to at certain points in consultations with board representatives. Within this current political environment, where people are confronted almost every week with new reports about health care funding, administration or delivery, an examination of health board roles, responsibilities and operations was very timely indeed.

Uncertainty Over Government Directions. Finally, it is relevant to note that the Standing Committee's review of health and hospital boards has been hindered somewhat by the lack of an over-all framework which outlines the Government's vision of our health system. Presently, the Government of the Northwest Territories has no comprehensive "strategic plan" to guide decisions about the current structure or future development of health programs and services. This was noted as a major deficiency in the aforementioned report of the Auditor General.

Nowhere was the Standing Committee able to find a specific outline of the role that was intended for boards when health services and programs were originally transferred to Territorial responsibility in 1988. In fact, the expectations that were created about board autonomy at the regional level, among aboriginal organizations and in Yellowknife seem, in retrospect, to have been very different. Current legislative parameters for defining *"what boards should do"* are open to differing interpretations, as well. Relatively little seems to have been done to clarify these discrepant perceptions over the four years since the health transfer, and this may well be at the root of many of the difficulties which presently exist.

In reviewing the current status of health and hospital boards, the Standing Committee was hindered, to a degree, by the absence of systematic planning for board development and authority in the Northwest Territories. It was impossible, for instance, to compare present observations against benchmarks or standards defining what boards should be doing. Ideally, this would have been an important component to this review.

Even the absence of a plan for the future of the Territorial health system, however, did not prevent the Standing Committee from developing an accurate understanding of relations between boards and the department, or of the various barriers to effective administration which presently exist at the board level. Concerns about role confusion, board orientation and training, and communication were also very apparent and are commented upon extensively over the course of this report. Present models for board structure and composition were reviewed by the Committee, as well, particularly in light of the need to recognize regional diversity.

It is hoped by the Standing Committee on Agencies, Boards and Commissions that this *Final Report* will offer a practical view of some of the issues which exist with respect to the role of health and hospital boards in the Territorial health system. More important, it is the Committee's intent, in bringing forward a series of constructive recommendations, to propose a course of action which will improve a currently unacceptable state of affairs.

AN OVERVIEW OF HEALTH AND HOSPITAL BOARD ISSUES IN THE NWT

The Standing Committee on Agencies, Boards and Commissions wishes to express its dissatisfaction with respect to a very serious state of affairs which presently exists within the administration of the Territorial health care system.

In an earlier *Interim Report on Health and Hospital Boards in the Northwest Territories,* the Standing Committee commented that:

> When responsibility for health was transferred to the Government of the Northwest Territories in 1988, the decision was made to establish a system of health and hospital boards rather than centralizing authority for administrative affairs in Yellowknife. The goal was to ensure that communities and regions would be able to take responsibility for the administration and delivery of the health care services required by their residents.
>
> After approximately four years, there are strong signals that the entire scheme is not unfolding as it should. There is a real risk that, unless significant adjustments are made in the prevailing approach used by the Department of Health, the development of a community-based foundation for the administration of health care services may be headed for failure.
>
> Members of the Standing Committee on Agencies, Boards and Commissions were dismayed by the degree to which conflict between the health boards and the Department of Health is exerting itself on our health care delivery system. When one Regional Health Board Chairperson was asked by the Committee to identify the "biggest stumbling block" to meeting the health care needs of her region, she responded clearly and simply:
>
> *"The Department of Health".*

The Standing Committee on Agencies, Boards and Commissions has noted that, although some preliminary steps have been taken to define respective responsibilities, concerns about the status and role of health and hospital boards have continued to characterize the Territorial health system since the *Interim Report* was tabled two months ago. Perhaps to expect otherwise would have been, unfortunately, unrealistic. The specific problems are too numerous and too rooted in a history of poor communication and inter-organizational mistrust to allow an easy solution.

The Standing Committee on Agencies, Boards and Commissions was dismayed by the amount of evidence it received describing relations between the boards and the Department of Health as strained and unproductive. A number of very specific areas of dissatisfaction appeared to arise from the interaction between boards and the Department of Health. To a large degree, however, each of these reflected two common factors: role confusion and overly centralized control.

Some of the information that has been brought to the attention of the Standing Committee on Agencies, Boards and Commissions over the course of its review has been particularly illustrative:

For instance, at the November 21st consultation sessions in Yellowknife, a representative from the Baffin Regional Health Board noted that:

> ***"Between 1982 and 1988, the Baffin Regional Health Board made sound progress, and only after the total health transfer in 1988 was there more centralization. This eroded the board's ability to have greater flexibility in resolving regional issues.***
>
> ***Health boards are a common factor in managing hospitals everywhere in the world, but this has not always been appreciated by (the) department in the N.W.T., who are not aware that this is not a new process".***

At the same meeting, a representative from the Inuvik Regional Health Board offered the following view of relations between the Department of Health and the boards:

> ***"... I think the boards really are trying to do their best, but somehow, for some reason, we do not seem to be able to get our needs identified by the Department of Health. I really believe that. This is not a Department of Health bashing either. I believe that the people here (in Yellowknife) do a great amount of very good work, but I think what they do not understand is that they have never lived out in the satellite communities. They do not know what it is like, nor do they understand that my needs in the western Arctic are very much different than Baffin's needs or Keewatin's needs".***

A written submission received from the Keewatin Regional Health Board in June 1992 summarized the problem in the following terms:

> **There has been, and there continues to be, confusion on the part of the Department of Health regarding the role of Health Boards as an integral part of the delivery of health care services to the people of the Northwest Territories.**
>
> **This confusion on the part of the Department of Health officials often leads them to intrude on the operating mandate of the Health Board.**
>
> **The partnership in the delivery of health care services is, for the most part, weakened when there is a continual conflict between the partners.**
>
> **In order for the health care system to fulfil its mandate to the people of the Northwest Territories, there must be the clear definition of the roles of the partners in the overall delivery of health care.**

Board representatives, no doubt, have a vested interest in presenting a particular "side" of the story. However, similar objective evidence of systemic problems was found in the October 1992 report of the Auditor General of Canada on his comprehensive audit of the Department of Health:

> **The specific issue is the rivalry, sometimes bordering on animosity, between boards and the Department. There appears to be a lack of trust, a one-way paper flow, poor communication and inappropriate control by the Department. In our view, what should have been help and monitoring has turned into control. Monitoring is desirable and expected, but it needs proper information and performance systems to provide the right kind of data. These have not been developed ...**

Clearly, there are strong indications to the Standing Committee on Agencies, Boards and Commissions that serious problems exist within the organization of the Territorial health system, particularly with respect to the role confusion and control conflicts which surround the function of health and hospital boards.

PLACING THE ISSUES IN HISTORICAL CONTEXT

It can be argued that many of the issues confronting health and hospital boards today cannot be fully understood without considering the historical context in which the current system emerged. A summary of relevant background features is included as Appendix C to this Committee Report.

The Standing Committee on Agencies, Boards and Commissions noted that the history of these problems was recognized by the former Minister of Health (Hon. Dennis Patterson) in a September 21st, 1992 address to the Northwest Territories Health Care Association, when he stated that:

> ***"It should not be surprising that there continue to be implementation problems. Many difficulties have arisen because the respective roles of government and boards had not been defined with sufficient clarity. The intentions were set out in the Trustee Manuals, but perceptions and expectations coloured their interpretation and application. So, instead of concentrating our efforts in the last four years on developing a model and a strategic plan for the future, there have been debilitating skirmishes over alleged infringement or perceived excesses of board "autonomy".***

Similarly, the Standing Committee found it useful to review the following comments on this same subject, included in the very thoughtful written submission received from the Kitikmeot Regional Health Board:

> **From the beginning, it seemed everyone was struggling, no one was sure of who was to do what, and initially everyone did whatever had to be done, just to ensure service provision continued. Quickly, the larger and stronger groups were able to take off on their own, and the various constituents began vying for power and resources.**

While these perspectives place today's problems in the proper historical context, however, the Standing Committee on Agencies, Boards and Commissions knows that there is little to be accomplished by blaming past events and process. Instead, emphasis must be placed on identifying and correcting the various organizational factors which contribute to the perpetuation of these problems today.

THE ADVANTAGES OF HEALTH AND HOSPITAL BOARDS

The Standing Committee on Agencies, Boards and Commissions recognizes that an approach which allows boards to act as the key delivery agents brings many strengths to the administration of health services. These were pointed out by several of the representatives who attended Standing Committee consultation sessions. They pointed out that health boards create a "closer-to-home" philosophy within the administration of health services and engender a sense of ownership in the community. At the same time, a board allows varying community interests to be balanced when making decisions about health programs and services.

Generally, health boards in the Northwest Territories have been able to provide the kind of structure that is open to community input and is reflective of other decisions that are being made by the community leadership. When appointments are made regularly and judiciously, it facilitates administrative continuity since it rarely involves the replacement of more than one or two board members at a time. As well, health boards can, and have, become adept at seeking out trustees with particular skills required for the operation of health care facilities and programs.

These views were not unique to the board representatives with whom the Standing Committee consulted. In his report on the audit of the Department of Health, the Auditor General of Canada pointed out that:

> **Regional boards have many attractive features. They allow local involvement in key issues, they can be more responsive to the cultural sensitivities of the people, and they put the decisions and resources where the communities can be actively involved in deciding how to use them.**

The Standing Committee noted that this has been recognized for many years at the national level, as well. In a 1972 brief to the Minister of National Health and Welfare, for instance, the Canadian Hospital Association commented that:

> **The quality of patient care would inevitably be the loser if decisions were left entirely for the hierarchy in the department of health in the provincial capitals of the country, and in the offices of National Health and Welfare in Ottawa.**

This is not to criticize or condemn the good intentions of those in positions of substance and responsibility in those departments. The fact simply is that the control of quality patient care could not afford to come under the umbrella of bureaucratic jurisdiction. The community hospital board is the chain that joins together the patient and his needs, the community in which he lives and the government that, as paying agency, is certainly entitled to a hand in what must be a partnership endeavour.

The Standing Committee on Agencies, Boards and Commissions was of the opinion that a health system in the Northwest Territories must be delivered by bodies that are representative of the people who are served. In addition, a well-working system of health and hospital boards empowers communities and provides a sense of responsibility for the health status of people living within the region.

INITIATIVES BY HEALTH AND HOSPITAL BOARDS IN THE NWT

The Standing Committee was interested in learning more about some of the recent initiatives that had been undertaken by health and hospital boards, so asked each of the representatives participating at the November consultation sessions to provide an overview of some of the key projects underway in their respective regions.

The Standing Committee was impressed with the range of creative and responsible initiatives that were outlined. Without exception, each of the health and hospital boards were able to describe key activity areas which not only reflected the needs of the community but had potential to enhance the delivery of services and programs.

A complete listing of all the specific initiatives that have been undertaken by health and hospital boards across the Northwest Territories would be too extensive for inclusion in this report. However, the Standing Committee particularly noted the following projects as examples of the important work that has been carried out at the board level:

- In the Baffin Region, for instance, the board has reorganized specialist schedules in a way that has actually increased the number of specialist visits to communities. This has proved cost-effective in reducing medical travel costs and has been welcomed by the residents of Baffin communities.

- In the Inuvik Region, the board is spearheading a major strategic planning exercise and evaluating the potential for a palliative care area in the hospital to assist people who are terminally ill and their families.

- As well, the Inuvik Regional Health Board is carrying out a major renovation of the transient centre.

- Suicide specialist services to the Inuvik region will now be delivered by the Regional Health Board, through a contract with the Department of Social Services, and needs evaluation for speech pathology services has been undertaken.

- The Stanton Yellowknife Hospital Board of Management has taken on a strategic planning process to review the mission and goals of that health care facility, and is now moving on to a major functional review of current programs and services.

- The board at Stanton Yellowknife Hospital has also made considerable progress in implementing cross-cultural awareness training for hospital personnel, and is incorporating this as an integral component of resource management within the facility.

- In Hay River, the Board of Management for the H.H. Williams Memorial Hospital has been actively exploring potential avenues for delivering mental health care, aimed at meeting community and regional needs.

- The Keewatin Regional Health Board played a key role in establishing a new dental clinic in Rankin Inlet which has created additional job opportunities and improved access to dental care.

- New contracts with the Churchill Health Centre have enabled the Keewatin Regional Health Board to reduce costs for pharmaceutical and pharmacist visitation services while improving inventory control.

Upon reviewing the range of initiatives and projects mounted by the health and hospital boards over recent years, it became very clear to the Standing Committee on Agencies, Board and Commissions that a lot of good work is being done at the community level. Clearly, these are not boards which meet often and accomplish little. The impression that was left with the Standing Committee was that health and hospital boards in the Northwest Territories have been able to achieve a level of maturity and operational effectiveness that is not recognized in their current working relations with the Department of Health.

ENDORSEMENT OF THE PRINCIPLE OF A BOARD-MANAGED HEALTH SYSTEM

Perhaps what has been missing is a formal recognition that it is necessary to have health and hospital boards assume the leading role in the management and delivery of health programs and services. This need was summed up during Standing Committee consultations by the representatives of the Baffin Regional Health Board, who pointed out that:

> ***The question of the future of health boards should be resolved quickly. There is a definite need for such boards which are responsible for a wide range of complex issues. For the health system to work effectively and efficiently in the most cost effective manner, the decisions should remain in the control and management of the health boards. Decentralization should continue to the regions and down to the community level where appropriate.***

The Standing Committee on Agencies, Boards and Commissions agreed with the importance of addressing this matter directly. To some extent, the significance of health and hospital boards has been intuitively accepted since the health transfer. However, in reviewing proceedings in the Legislative Assembly and its Standing Committees, the principle has not, to date, been formally acknowledged.

While boards should take the lead role in decision-making about the management of health care facilities, programs and services, the Standing Committee believed that this will not succeed without a carefully established partnership with the Department of Health. Within that partnership, the department should be responsible for over-all coordination of Territorial health policy and fiscal appropriations. It also has an important role to play in providing technical consultation and support. Certain monitoring and control functions required under the Territorial *Financial Administration Act* will need to be carried out by the department, but always remaining mindful that the boards should be recognized as the legitimate management authority.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that it is important to formally recognize principles surrounding the primacy of the role of health and hospital boards in the management of the health system.

Recommendation #1

Therefore, this Committee recommends:

THAT THE LEGISLATIVE ASSEMBLY FORMALLY SUPPORT THAT BOARDS OF MANAGEMENT ESTABLISHED UNDER THE *TERRITORIAL HOSPITAL INSURANCE SERVICES ACT* ARE THE PRIMARY AGENT FOR THE MANAGEMENT AND DELIVERY OF HEALTH SERVICES TO REGIONS AND COMMUNITIES OF THE NORTHWEST TERRITORIES;

AND FURTHER, THAT THE ROLE OF THE DEPARTMENT OF HEALTH SHOULD BE ONE OF SUPPORTING, RATHER THAN DIRECTING, THE MANAGEMENT DECISIONS OF HEALTH AND HOSPITAL BOARDS.

ROLE CONFUSION IN THE HEALTH CARE SYSTEM

The health system in the Northwest Territories has been visualized as a partnership involving elected legislators, the Minister of Health, her department and the communities as represented by the health and hospital boards. Throughout the review of health and hospital boards, the Standing Committee on Agencies, Boards and Commissions was dismayed by the confusion which surrounds the respective roles to be played by these various components.

It was noted that the Auditor General observed considerable discrepancies which exist in the prescribed roles, perceived roles and practised roles assumed by each of the partners in the health system.

Historical Elements. Certainly, some of this can be related back to the manner in which board responsibilities and authorities could not be fully defined at the time of the 1988 health transfer [see Appendix C]. During the Standing Committee's public hearings in Fort Smith, the former Deputy Minister of Health pointed out that the transfer process left various parties with very different expectations as to the authorities and levels of autonomy to be accorded to boards. The fact that *some* boards have been perceived as more "experienced" and "capable" because of their pre-transfer existence has also led to confusion about the role that should be played by *all* boards.

Confusion over Statutory Provisions. As well, the lack of role clarity can be related to the statutory provisions which establish health and hospital boards. Subsection 10.(1) of the *Territorial Hospital Insurance Services Act* grants the Minister of Health the authority to establish a Board of management for one or more health facilities. Section 13 of the *Act* states that:

> 13. Subject to the regulations, a Board of Management
>
> (a) shall manage, control and operate the health facility or facilities for which it is responsible; and
>
> (b) may, subject to Part IX of the *Financial Administration Act,* exercise any powers that are necessary and incidental to its duties under paragraph (a).

The Standing Committee on Agencies, Boards and Commissions noted that there does not seem to be a common consensus within the health system with respect to the interpretation of the statutory powers and duties of Boards of Management created under the *Territorial Hospital Insurance Services Act.* The health and hospital boards appear to have taken the position that they should be interpreted very broadly; the Department of Health has taken the position that they should be interpreted more narrowly. The multitude of arguments that are raised to support each position simply underscores the depth of the problem and the inadequacy of the legislation.

The Strength at Two Levels Report. Complicating the picture somewhat, as well, has been the treatment accorded the health system in the Northwest Territories by the *Strength at Two Levels* document. Much of the Standing Committee's activity in the earlier parts of the review was occupied by a consideration of the substance of this report. This was largely in response to very notable levels of attention in the legislature, among professional associations in the health field, and within the public at large.

The Standing Committee noted that there was some general support for certain concepts included in the *Strength at Two Levels* account of "The Northwest Territories Way". However, the report did a very poor job of describing practical aspects surrounding the implementation of this approach. A great many factual inaccuracies were included, and these were identified by the Northwest Territories Health Care Association when it appeared before the Standing Committee at public hearings in Fort Smith. As well, some of the assumptions about future directions for health care delivery and planning that were included in the report did not conform with information that the Committee received from the Department of Health.

The Standing Committee noted that the *Strength at Two Levels* report has contributed significantly to the uncertainty surrounding the roles and responsibilities of health and hospital boards. Descriptions of health services and programs were provided in a fashion that conveyed a department-driven approach, and sections of the report which questioned the over-all efficacy of board processes in the Northwest Territories led to unwarranted speculation about the future of health and hospital boards.

Autonomy versus Accountability. To a large degree, the central issue has often been presented as one in which the boards are striving for more "autonomy" while the department is struggling to ensure "accountability". This is unfortunate. The Standing Committee on Agencies, Boards and Commissions takes the position that the goal of achieving community control over the management of health facilities and services is not necessarily inconsistent with the goal of appropriate fiscal accountability.

This is recognized by the boards themselves. During the November 21st consultation sessions, members of the Standing Committee were impressed with the commitment that board representatives conveyed with respect to effective and efficient management procedures. The board representatives, as well, demonstrated a solid acceptance of the principle that the Department of Health needs to exercise some central authority role in ensuring that the portion of the public purse which supports health services is appropriately allocated and spent.

Indeed, one of the most effective summaries of the accountability process that the Standing Committee encountered over the course of its review was offered by the chairperson of the Inuvik Regional Health Board:

> *... what I am saying to you is that I think, as boards of management, we have to be trusted enough to assure that, first of all, we do work within the budget that we are given, that we do use the resources we are given to meet proper needs, and we should be held accountable and that accountability should be to the Minister of Health ...*
>
> *... So I think what we have to see is, indeed, the three levels: the Minister who is totally accountable for the entire territory, the Department of Health who should be there to assist the boards to be accountable and to work with us, as consultants, to enable us to do what is necessary within our diverse regions.*

The Standing Committee on Agencies, Boards and Commissions agrees with the concept that accountability can be maintained within a health system that accords clear management responsibility to health and hospital boards. It noted that the Northwest Territories Health Care Association, at its 1992 Annual General Meeting, adopted a statement which defines the characteristics of an autonomous board [see Appendix D]. None of the elements of this statement are inconsistent with the basic principles of fiscal accountability.

Memorandum of Understanding. The Standing Committee on Agencies, Boards and Commissions has already made note of the important initiative that is underway to develop a "master Memorandum of Understanding" between health boards and the Department of Health. The NWT Health Care Association has agreed to coordinate drafting and consultation activities and a contractor is to be retained to facilitate the process. Since bringing forward the *Interim Report,* the Committee has noted that progress in this regard has been slow. The original time-lines proposed by the former Minister of Health would have seen the substantial completion of this agreement by the start of the 1993-94 fiscal year. It is now unlikely that this target will be reached.

The Standing Committee is concerned that this process should not be allowed to become too cumbersome. The MOU is urgently needed.

The Standing Committee also noted that some board representatives were concerned that both the process leading to the establishment of the MOU, and the substance of the MOU itself, should not be defined by the Department of Health. There seemed to be an absence of trust, in at least some quarters, that the department would listen to, and work cooperatively with, the boards. Instead, there was some concern that the Department of Health would attempt to "impose" both a model and the content for the MOU upon participants. The Standing Committee on Agencies, Boards and Commissions is of the opinion that this cannot be allowed to happen.

Members of the Standing Committee are of the opinion that a "top-down" approach will simply not work in this case. The Department of Health must treat the health boards as equal partners in this process and not attempt to dictate basic content parameters. The MOU will only work if there is an equal sense of ownership among all the parties to it.

The Standing Committee took special note of the fact that the Health Care Association is involved in the process leading to the establishment of the MOU. This may well be a commendable approach. The involvement of the Association in the process, however, should not be seen to diminish the accountability of the Minister of Health and her department. The Standing Committee is of the opinion that time-lines for completion of the MOU must recognize the urgency of the present state of affairs in the Territorial health system. The Standing Committee believes that it is the Minister's responsibility to ensure that the process continues to progress at a steady pace. Should circumstances arise which hinder its timely completion, it is expected that the Minister will take a direct role in resolving difficulties and returning the initiative to the fastest timetable the process will allow.

For their part, however, the boards must also assume a constructive approach to building the Memorandum of Understanding. It was members' perception, during the Committee's consultation sessions on November 21, 1992 that the boards were willing to approach this initiative as a collaborative and positive venture. That positive outlook will need to continue in order for the process to be successful.

In light of these considerations, the Standing Committee was concerned to learn that, at least in the early stages of the process, several board representatives reported that they had not been regularly advised as to progress on the MOU initiative. To reiterate the position previously taken by the Standing Committee in its *Interim Report,* this effort will not succeed unless it is based on ongoing information exchange and a collaborative approach. It is not enough for the department to rely on the information channelling capabilities of a voluntary organization like the Health Care Association. The Department of Health must continue to play a role in ensuring that the respective parties to the MOU are fully briefed as to the status of the initiative.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that, at this point, the initiative to establish a Memorandum of Understanding on roles and responsibilities within the health system will go a long way toward finally dispelling the uncertainty and confusion that has surrounded the status of health and hospital boards since transfer. This is essential to ensure the efficient operation of Territorial health facilities, programs and services.

Recommendation #2

Therefore, this Committee recommends:

THAT THE MINISTER OF HEALTH SHOULD ACCORD A HIGH PRIORITY TO THE FINALIZATION OF THE MEMORANDUM OF UNDERSTANDING CLARIFYING THE ROLES AND RESPONSIBILITIES OF HEALTH AND HOSPITAL BOARDS.

A Question of Attitude. The Standing Committee on Agencies, Boards and Commissions is concerned that, to a large degree, the problems which surround the debate over board autonomy, accountability and role appear to have arisen as much from differing attitudes among key officials as they have from the historical and legislative factors expounded upon earlier.

Throughout the review, the Standing Committee heard that departmental officials working in Yellowknife were perceived by boards and their staff as being reluctant to accept input, possessive about information and, at times, condescending. The sum of this perception has been that some senior public service managers within the Department of Health may be presenting impediments to effective board function, simply through the approach they are bringing to their interaction with board officials.

The Standing Committee is concerned about the considerable evidence before it which suggests that there is too much central control. Members heard about a situation in which requests for medical technology were denied by headquarters but direction was provided to spend the money on a floor polisher. Boards related repeated instances in which needs had been identified and dollars had been found to support new programming, but the process was halted at departmental direction. It has seemed to the Standing Committee that the Department of Health has crippled itself with an inability to accept that health and hospital boards are capable of carrying out important responsibilities and is now unable to stand back and allow regionally-driven initiatives to proceed as they should.

This, to be fair, may be a consequence of the lack of definition surrounding board roles. Once the MOU is finalized, it will be important for the Minister of Health to motivate a shift in outlook among her senior officials. The department must realize that goals can be better achieved if the central authority moves away from trying to "run things" in the regions and moves instead toward a process where it assists boards to best achieve their own priorities.

Where it is not possible to shape these new attitudes through staff inservice training and supervision, the Standing Committee would urge the Minister to take more final action. Clearly, it is the opinion of the Committee that the current posture within headquarters operations at the Department of Health *must change*. If the change cannot be achieved with current personnel, then the replacement of officials should be contemplated.

Legislative Review. The Standing Committee on Agencies, Boards and Commissions has confidence that the establishment of an MOU will contribute greatly to the correction of existing problems. However, the Committee is concerned that this will not necessarily go far enough.

During the Eleventh Legislative Assembly, the previous Standing Committee on Agencies, Boards and Commissions brought forward a report in October 1990 which recommended that the *Territorial Hospital Insurance Services Act* should be repealed and replaced with one *"that better reflects the Government's philosophy of supporting regional autonomy"*.

Although subsequent amendments dissolved the Territorial Hospital Insurance Services Board, a major overview and shift in legislative framework have still not been undertaken.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that the MOU process should not be seen as a permanent alternative to legislative review and amendment. Indeed, it expects that, during the negotiations leading to the establishment of an MOU, many useful concepts will be identified that should be better reflected in legislation. As well, the imprecise statutory provisions which define board structure and authority in the *Territorial Hospital Insurance Services Act* should not be allowed to hinder the establishment or implementation of the MOU. Where these "get in the way", legislative amendments should be undertaken immediately to correct this.

At the present time, the Standing Committee does not wish to recommend specific changes to the legislation. These will be more appropriately identified through the consultation process between the Department of Health and the boards.

The Standing Committee on Agencies, Boards and Commissions believes, however, that legislative review and amendment, when identified through consultation with the boards, should not be delayed.

Recommendation #3

Therefore, this Committee recommends:

THAT THE MINISTER OF HEALTH SHOULD SEEK ADVICE FROM HEALTH AND HOSPITAL BOARDS WITH RESPECT TO AMENDMENTS THAT SHOULD BE MADE TO THE *TERRITORIAL HOSPITAL INSURANCE SERVICES ACT* OR OTHER HEALTH LEGISLATION IN ORDER TO BETTER RELECT A PHILOSOPHY WHICH SUPPORTS BOARD AUTONOMY;

AND FURTHER, THAT THE MINISTER OF HEALTH BRING FORWARD RECOMMENDED AMENDMENTS TO THE *ACT* BY THE FALL SESSION IN 1993.

BARRIERS TO EFFECTIVE ADMINISTRATION

Throughout the review process, matters were brought to the attention of the Standing Committee on Agencies, Boards and Commissions as issues which were hindering the effective administration by health and hospital boards.

ABSENCE OF TERRITORIAL PLANNING FOR DELIVERY OF HEALTH SERVICES

The Standing Committee heard many comments, for instance, about the lack of an over-all "strategic plan" for health services. Health and hospital boards described a sense of continuing uncertainty about the directions which should be taken in the design of new programs and services, priorities for the enhancement of existing ones, and responsibilities for addressing emerging needs. This was summed up at the November 21st consultation sessions by the chairperson of the Inuvik Regional Health Board, who pointed out that:

> ***I think the first roadblock is no plan. I think everybody is working in isolation. We are all working for the betterment of the health of the people of the Northwest Territories and, yet, there is no plan.***

The same concern was echoed by all the boards and was well described in the written submission received from the Kitikmeot Regional Health Board as, "... **a lack of Territorial vision and direction to guide the focus of hospital and community board expenditures and services**".

This deficiency was noted, as well, by the Auditor General of Canada who stated that: "**Without a plan, NWT health care has no clear sense of where it is going or how to get there**".

Health Planning Occurs in Isolation. The Standing Committee did observe that, almost without exception, each health and hospital board had developed its own process for regional planning. During the November consultation sessions, for instance, the Stanton Yellowknife Board of Management outlined for Committee members the ambitious and very promising measures it has undertaken to examine the facility's role and needs up to 1995. Larger planning processes will build on this to review current programs, assess the potential for further repatriation of services and assess global space needs.

Similarly, the Keewatin, Kitikmeot and Inuvik Regional Health Boards have also mounted comprehensive planning initiatives to identify regional needs and to develop workable approaches to meeting them. The Board of Management at H.H. Williams Memorial Hospital has been actively assessing current space parameters to identify new potential for increased utilization of the facility. And, representatives of the Baffin Regional Health Board outlined a model that would be followed during a regional needs assessment study, scheduled to commence in November 1992.

While the Standing Committee on Agencies, Boards and Commissions was very impressed with the various initiatives that had been undertaken by the health and hospital boards themselves, members were concerned that these activities had been pursued largely in isolation and were confined to a regional perspective. There seemed to have been relatively little sharing between the boards with respect to the design and implementation of planning exercises. Departmental involvement was described by some board representatives as attempting to exert a controlling or delaying influence.

There was also concern over the observation that there is no system which channels the results of the excellent planning exercises which are taking place at the regional level into an over-all framework for the delivery of health services in the Northwest Territories. Regional planning exercises often seem to be regarded by Yellowknife headquarters as "competing" with the over-all approach which the department wishes to follow; yet, that departmental framework has not been articulated.

The Standing Committee was concerned that this absence of direction has created a barrier to administrative effectiveness throughout the system. Without a well-developed vision for health care delivery and health promotion, it has been difficult to coordinate such aspects as capital planning, program goal-setting and community participation.

Further, the absence of a planning framework in this area worsens the role confusion which predominates the Territorial health system and risks inefficiency through the duplication of services. This was pointed out by the Kitikmeot Regional Health Board in the written submission provided to the Standing Committee in February 1993:

> **The KHB would add that the lack of Territorial vision has also led to role confusion between hospital boards, health boards and the department -- hospitals appear to be expanding outside of the provision of acute care services, into continuing community care. This area is now serviced by health boards. We question if it is cost efficient and effective to duplicate community care expertise that currently exists in health boards and the department. Such duplication further compromises the department's ability to allocate scarce resources.**

In addition, the lack of health planning has been an impediment to the appropriate allocation of human resources throughout the Northwest Territories. This was highlighted in the Auditor General's report:

> **Getting the right kind of health care people to the places where they are needed across the Territories is a major challenge requiring effective resource planning. All the parties and the people should know exactly what they can expect. From our survey results and press reports, we noted there was confusion about health care delivery in the regions, and residents are not sure what to expect.**

When the Standing Committee on Agencies, Boards and Commissions took all this evidence into account, it found that a clear need exists for a comprehensive, easily-understood Territorial plan for the delivery of health services.

Planning Must be Regionally Driven. At the same time, the Standing Committee wishes to emphasize that Territorial planning must be based on the unique needs and priorities which exist within the regions. These are best identified by the health and hospital boards.

Planning cannot be an activity which is imposed. Right from the earliest stages of needs assessment, there must be a recognition that the people who live in the regions of the Territories are the ones who best know what is necessary to have healthy families and communities. As the chairperson of the Inuvik Regional Health Board pointed out:

> ***... I also believe that if we have a department-run needs study, then we have a department-run answer and I do not believe that is what we want.***

The Standing Committee on Agencies, Boards and Commissions was concerned to hear health and hospital boards express opinions that planning exercises have not involved a sense of "partnership" with the Department of Health. They have been seen as processes which have been developed in Yellowknife and implemented from a "top-down" perspective.

Over the past year, the Department of Health has devoted considerable attention to developing a process for a *"Health Facilities and Services Review"*. A framework for this process was developed and included stages for:

- identifying key participants;
- collecting and verifying profiles which show population and service user characteristics;
- identifying opportunities to improve effectiveness and reduce costs;
- developing options and strategies;
- preparing action plans and evaluation criteria; and,
- assessing progress and reviewing plans.

Concerns were expressed to the Standing Committee that, even though the procedure called for consulting with "key participants" at each stage, the *design* for the review had been drawn up in headquarters and imposed on the regions.

For this reason, there was considerable initial concern over the process, especially in the Deh Cho region, where it was felt that the community had no control over the type of review that had been undertaken -- and in the Keewatin, where there were concerns that this approach would conflict or compete with regional planning efforts which were already farther advanced.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that the time has passed when this Government can say *"We are going to study what the communities need ... this is how we are going to do it ... and this is the point at which the 'key participants' we identify are going to become involved"*. That centralized approach is too reminiscent of a previous era, and it is not likely to be accepted in the future.

A Territorial Plan for Health Services. During the Fort Smith hearings on January 22nd, 1992, the NWT Health Care Association, which represents all health and hospital boards, made a presentation which included the following recommendation:

> **That the Department of Health take immediate steps to consult the health/hospital boards to implement shared planning programs for effective and efficient health services to the respective communities being served.**

The Standing Committee on Agencies, Boards and Commissions agrees that it is essential for a plan to be developed. While the Committee considers it the Minister's statutory and administrative responsibility to *coordinate* inter-regional planning, the *content* of any plan can only be developed through a partnership between her department and the boards. Health and hospital boards should have direct input, not only into the substance of the plan, but also into the process through which the plan will be put together.

INADEQUATE INFORMATION SYSTEMS

Without exception, all health and hospital boards indicated that the current state of information processing within the health system was a serious barrier to effective administration.

The Standing Committee was dismayed by the degree to which incompatible and inadequate systems exist. Equally disconcerting has been the apparent inability of the Department of Health to take a lead role in correcting these deficiencies.

Board staff have had to cope with a myriad of systems that are apparently incapable of exchanging information and do not meet administrative or planning needs. For their part, the boards appeared to have done their best in coping with the current situation, as many have successfully developed their own internal procedures for re-entering data or designing intermediate reporting formats. However, this has resulted in a system in which neither financial nor statistical information can be communicated and reported with efficiency.

The Standing Committee on Agencies, Boards and Commissions is aware that the Auditor General's report deals with the matter of health information systems at some length and that this has been a subject of considerable attention by the Standing Committee on Public Accounts.

Because this item fits more properly within the Public Accounts Committee's mandate, the Standing Committee on Agencies, Boards and Commissions does not intend to make a specific recommendation on the matter of information systems at the present time. However, it should be recognized that members of this Standing Committee are of the opinion that specific corrective action should be considered a government priority.

DEPARTMENTAL REQUESTS FOR INFORMATION FROM BOARDS

Health and hospital boards expressed a continuing concern, over the course of the review, with respect to the frequency and type of information demanded on a regular basis by the Department of Health. Board representatives found that the department, over the past several years, has forwarded numerous requests for administrative information, line-by-line budget substantiations and service delivery statistics. Without exception, the boards found departmental demands for information to be excessive and unnecessary.

During the November consultation sessions, for instance, the chairperson for the Keewatin Regional Health Board pointed out that:

> ***We spend inordinate amounts of time justifying budget expenditures on a line to line basis that are five per cent over the budget item amount. In some cases, these are budget line items of $300 and $400, yet we have to justify a five per cent variance for those items. It is ridiculous when we are dealing with $20 million and $30 million budgets, to be worrying about $5 and $10. I am not saying that we wish to be financially irresponsible. I am saying we have to review the system and look at what it is we are attempting to do.***

The Baffin Regional Health Board described departmental monitoring procedures as *"excessive"* and a *"constant irritant"*, while the chairperson of the Inuvik Regional Health Board commented that:

> ***The control of the Department of Health line-by-line budget is also one of our greatest concerns ... I think that, as boards of management, we should be allowed to manage. If we are not boards of management, then please tell us so.***

The Standing Committee is concerned that these demands for more and more detailed reporting represent a hindrance to effective administration at the regional level. Board officials have found that it is often difficult to complete activities that have been established as regional priorities, because of the time that has to be spent preparing reports for Yellowknife.

The chairperson of the H.H. Williams Memorial Hospital Board astutely noted that, in addition to detracting from effective administration, this also has the potential to divert attention away from patient care, itself:

> ***I have been involved with health care in the Northwest Territories for 28 years now, off and on. I have seen such an incredible change that has taken place from the days when patient care seemed to be ultimate. Now we hardly ever hear the word. Patient care almost always gets forgotten in pursuing all the other things that have to be done, the documentation of what we do.***

The Standing Committee on Agencies, Boards and Commissions is aware that certain information requirements are imposed on the Department of Health by the Financial Management Board and, in some cases, the Standing Committees and Members of the Legislative Assembly. Further, certain sections of the *Financial Administration Act* require the department to take responsibility for appropriate over-all fiscal management of the health system and this, in turn, requires departmental officials to access information from the boards. Upon reviewing examples of the number and type of requests, though, the Committee has formed the opinion that the department's demands for budgetary details and the frequency of specific requests for statistical and administrative reports are, in fact, excessive.

To a large degree, the root of this problem may lie with the aforementioned inadequacy of information systems. If appropriate, well-working systems were in place, information could be centrally accessible without imposing additional reporting requirements on the boards.

Just as inadequate information systems are contributing to this problem, so too are departmental attitudes and procedures. The Standing Committee on Agencies, Boards and Commissions is of the opinion that the excessive line-by-line monitoring by departmental officials reflects a headquarters perception of health and hospital boards as incapable, undependable management bodies. There appears to be an unwillingness at departmental headquarters to stand back and allow the boards of management to manage.

This is further compounded by information flow procedures within the Department of Health. Currently, departmental demands for information about board operations are generated in a number of divisions and are forwarded from a number of staff levels.

Directors, associate directors, analysts, consultants, administrative officers, medical officers and a range of other mid- to senior-management officials in Yellowknife frequently pepper board administration with demands for information related to their latest internal work assignments. Often, information is required on relatively short notice. Sometimes information demands by one headquarters division appear to duplicate or overlap those made by other divisions. And, in a majority of cases, board administration is provided with very little understanding of why the data are required.

It is hoped that the aforementioned *"master memorandum of understanding"* (MOU) between the department and the health and hospital boards will clarify requirements that the boards must follow in forwarding information to the department.

Until the MOU is finalized, however, the Standing Committee on Agencies, Boards and Commissions is of the opinion that information flow between the boards and the Department of Health is in definite need of senior-level coordination. Members of the Standing Committee are of the opinion that this coordination should be achieved by channelling all departmental requests for board information through the Office of the Deputy Minister of Health.

By establishing the Deputy Minister as the single coordinating source within the department, the Standing Committee believes that overlap in the content of information requests could be eliminated, better consideration could be given to reasonable time-lines for board response, and headquarters information needs could be vetted to ensure that they were essential to the operation of the health system.

In summary, the Standing Committee on Agencies, Boards and Commissions believes that the number of demands for detailed information currently placed on health and hospital boards by the Department of Health are constituting a serious barrier to effective administration. While this situation will likely be addressed by an improved information system and role clarity achieved through the MOU process, the Committee is of the opinion that senior coordination of information requests is necessary at the present time.

Recommendation #4

Therefore, this Committee recommends:

THAT ALL REQUESTS FROM THE DEPARTMENT OF HEALTH TO HEALTH AND HOSPITAL BOARDS FOR BUDGETARY, STATISTICAL AND OTHER ADMINISTRATIVE INFORMATION SHOULD BE MADE ONLY BY THE DEPUTY MINISTER OF HEALTH;

AND FURTHER THAT INFORMATION REQUESTS SHOULD BE LIMITED IN NUMBER AND SCOPE TO ONLY THOSE WHICH ARE ESSENTIAL FOR THE EFFICIENT AND EFFECTIVE OPERATION OF TERRITORIAL HEALTH SERVICES;

AND FURTHER THAT THE TIME-FRAME FOR BOARD RESPONSE TO DEPARTMENTAL INFORMATION REQUESTS SHOULD BE REASONABLE AND ESTABLISHED WITH DUE CONSIDERATION TO OTHER PRIORITIES WHICH HAVE BEEN IDENTIFIED AT THE REGIONAL LEVEL.

INADEQUATE FUNDING BASE

During the Standing Committee's review, board representatives frequently noted that the original health funding base transferred from the federal government has proved inadequate for meeting either current or future needs. Representatives of the Baffin Regional Health Board, for instance, pointed out that currently there is no base funding to cover annual leave and sick leave of community-based nursing personnel, so these dollars must be drawn from other areas. Several boards mentioned that training opportunities for health care professionals are restricted by shortages in the funding base.

It was suggested by some health and hospital boards that a system of standards should be established to dictate levels of service to be delivered in the various health care disciplines to communities and hospitals within the regions. Dollars could then be allocated according to the real cost of meeting the defined standards.

The Standing Committee is of the opinion that the Department of Health should consider ways of accepting the challenge to establish a system of standards that are comprehensive enough to meet communities' potential needs and, at the same time, are realistic in light of current fiscal pressures on the health system. Because such global issues were somewhat beyond the scope of the current review, it was felt that the Special Committee on Health and Social Services might find it fruitful to explore issues surrounding the inadequacy of the funding base for health services and, specifically, might examine possibilities for funding allocations based on a more systematic set of service delivery standards.

LACK OF INCENTIVE FOR SUCCESSFUL MANAGEMENT

During the course of the Standing Committee review, representatives of health and hospital boards pointed out that they have made significant strides in improving internal control and management procedures over the past several years. They expressed concern that this does not appear to have been recognized by the Department of Health. To a large degree, the same control directives and budget allocation procedures have remained in place since the transfer.

The Standing Committee on Agencies, Boards and Commissions heard several boards advocate for new block funding approaches and a system of global budgeting. It may be difficult to implement such approaches, on a system-wide basis, until all health and hospital boards are on a par with respect to management resources and expertise. Development of the concepts involved should be initiated now, however, with a view toward possible implementation of block funding procedures within the next three to five years. Principles related to these new approaches to board funding should emerge as the result of discussions between the department, the health and hospital boards and other stakeholder organizations. Perhaps some of the analysis now being undertaken by the Special Committee on Health and Social Services will add to this process, as well.

As a more immediate observation, though, the Standing Committee on Agencies, Boards and Commissions noted a need for some consideration of a surplus retention policy, which would apply under circumstances in which health and hospital boards have clearly demonstrated appropriate management performance.

This need was outlined in the written submission which the Standing Committee received from the Board of Management at Stanton Yellowknife Hospital:

> **As boards and their staff work to maintain financial stability, there is currently no reward in the present funding system. Boards should be able to keep a percentage of surpluses generated, in recognition of the work they have done. This money could then be used for specific projects which fall within the board's mandate, but perhaps do not receive priority in funding.**

Similarly, during the November consultation sessions, the chairperson for the Board of Management at Hay River's H.H. Williams Memorial Hospital commented that:

> ***Our hospital has a pretty good track record when it comes to staying within our budget ... I hate what happens, and not just in our department but in all government departments, when it comes to the end of the year about mid-March and we have to spend the money that is there because if we do not spend it, we will lose it ... I would love to have the opportunity to direct the board and the hospital in using funds in a very responsible way and getting a little bit of recognition for it.***

Perhaps the most illustrative comments in this respect were brought to the Standing Committee's attention by the Inuvik Regional Health Board. Facing a chronic under-utilization of hospital bedspaces and an increasing need for fiscal restraint, the Board closed a 19-bed ward in 1991-92. This was accomplished without any staff layoffs or major capital renovation costs and has resulted in a significant increase in percentage utilization of the facility.

Yet, there has been virtually no recognition of the very appropriate management approach taken by the Inuvik Regional Health Board and, in fact, when she appeared before the Standing Committee in November, the chairperson expressed frustration with the way the effected savings have not been allowed to improve health services in the region. She stated that:

> ***... we have certainly taken a great big bite out of the amount of money that was required to run health services in our region, with the understanding that we are closing an entire ward in our hospital and losing 19 beds. I think we have done our part.***
>
> ***What bothers me about that is when we ask the Department of Health for a speech pathologist, what happened to our 19 positions? Why can we not take these resources and use them as we see fit? We have done our part, now please, in reciprocation, please allow us to do what we feel is necessary for the needs of our region.***

The Standing Committee on Agencies, Boards and Commissions believes that there is much merit in the notion that, where health and hospital boards have effectively demonstrated appropriate fiscal management resulting in year-end surpluses, that they should be able to retain a significant proportion of the surplus funds for regionally-identified priorities. Any policy to this effect, however, would need to be developed through a joint consultation process between the department and the boards. Surplus retention policies should not be developed within the Department of Health and imposed on the health and hospital boards.

Some cautions may be in order. It is wrong to assume that a surplus in one budget category is an automatic indicator of appropriate spending decisions; surpluses should never be generated by cutting back below basic service delivery levels, maintaining periods of critical staff shortages, and so on. Further, boards must be mindful of the fact that the retention of surplus dollars is best regarded as a source of one-time-only funding, and that they should be careful not to create later-year funding shortfalls by using this money to support ongoing programs or services.

The Standing Committee on Agencies, Boards and Commissions is of the opinion, however, that these limits could be easily reflected in a well-written policy directive and that, in balance, the advantages of a surplus retention incentive far exceed the risks.

Recommendation #5

Therefore, this Committee recommends:

THAT THE MINISTER OF HEALTH CONSULT WITH THE HEALTH AND HOSPITAL BOARDS TO DEVELOP POLICIES AND STRATEGIES WHICH ALLOW SURPLUS RETENTION UNDER CIRCUMSTANCES IN WHICH BOARDS CLEARLY DEMONSTRATRATE APPROPRIATE FISCAL MANAGEMENT.

HUMAN RESOURCE DEVELOPMENT WITHIN HEALTH AND HOSPITAL BOARDS

The Standing Committee on Agencies, Boards and Commissions took special note of the needs which exist with respect to human resources within health and hospital boards. The Committee was concerned with the current state of professional resources within board operations and also with the manner in which board members themselves have been recognized and developed as human resources.

PERSONNEL ADMINISTRATON WITHIN HEALTH AND HOSPITAL BOARDS

The Standing Committee was aware that the report of the Auditor General of Canada has provided a fairly extensive treatment of the prevailing approach to *"Managing People"* within the health system, including some aspects of human resource management by health and hospital boards. The Committee also understands that this has been one of several points on which the Standing Committee on Public Accounts has focused during its current review.

Accordingly, comments in *this* report will not be comprehensive but, rather, will touch on those areas which members of the Standing Committee on Agencies, Boards and Commissions identified as important for the purpose of the current review.

Representation of Aboriginal People within the Health Care Field. One of these pertains to the number of aboriginal people currently engaged in health care careers in the Northwest Territories. During consultation sessions with the health and hospital boards in November, members of the Committee noted a uniform commitment on the part of board representatives to increasing the number of aboriginal people entering and finding employment in the health field.

The boards have experienced varying levels of success with respect to aboriginal hiring. The Auditor General reported that, although the proportion of aboriginal staff at *regional health boards* ranges around 40%, the percentage working in hospital settings in western urban centres is much lower. This was consistent with figures provided to the Standing Committee by health and hospital boards during the November 21st consultation sessions.

In addition, it was brought to the Standing Committee's attention that a majority of the aboriginal people working for all health and hospital boards are employed in jobs that would be most accurately described as "support positions", and generally at the lower end of the salary schedule.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that the current level of representation by aboriginal workers within the health system is unacceptable. The workforce which delivers health services at the community level should be reflective of the population it serves. There must be a renewed emphasis toward achieving this goal.

The over-all strategy for attracting aboriginal people to work in the health system is probably best developed at a Territorial level and coordinated by the Department of Health. In this respect, relatively little seems to have been accomplished.

However, it is important that *all* stakeholders in the health system should see themselves as part of the solution. The Standing Committee on Agencies, Boards and Commissions believes that there is much that health and hospital boards could do in terms of promoting community awareness of health careers and in providing support to staff who are of aboriginal descent. A priority should be placed on identifying and implementing such strategies by each of the health and hospital boards.

Staff Training. The Standing Committee on Agencies, Boards and Commissions is concerned that current fiscal pressures should not result in less access to training opportunities for health and hospital board staff. Although board representatives were generally satisfied with current programs for training staff, there was some concern that funding shortages may limit accessibility and, therefore, impact on the quality of care and on staff morale.

As well, there was some concern in the Baffin Region about the status of the
Outpost Nursing Program. Apparently, this is a training resource that has worked well in meeting the training needs of professional staff in the Baffin Region but Territorial involvement has recently been curtailed.

Interpreter/Translator Services. Members of the Standing Committee on Agencies, Boards and Commissions raised a number of concerns with respect to interpreter services that are provided within hospitals and other health care facilities throughout the Northwest Territories. There was a general apprehension that insufficient attention has been placed on ensuring a systematic approach to the delivery of these essential services.

It was noted, for instance, that the interpretation of medical terminology and treatment instructions requires a level of linguistic understanding and confidence that cannot be obtained through casual hiring of part-time interpreters. This is particularly important when patients who are not fluent in English are medevaced to Southern medical institutions.

Of particular concern to the Standing Committee, as well, was the fact that interpreters in hospital settings are classified at a lower level than those in the Territorial Language Bureau. As a result, there has been consistent difficulty at some hospitals with respect to recruiting and retaining persons for these positions. Board representatives indicated that this has been a serious point of contention for them, as well.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that a major review should be undertaken by the Department of Health with respect to current adequacy and future directions for language services within the Territorial health system.

ORIENTATION AND TRAINING NEEDS OF BOARD MEMBERS

The Standing Committee on Agencies, Boards and Commissions was dismayed and extremely dissatisfied with the level of support currently provided to persons who are appointed to sit as members of health and hospital boards. Funding for board training is inadequate. The level of consultative support received from the Department of Health is insufficient. And materials describing the statutory and operational responsibilities of board members are outdated and untranslated.

The Standing Committee noted that, almost without exception, board representatives identified the unfulfilled orientation and training needs of their membership as a critical issue.

The Department of Health has produced a *Trustee Manual* which outlines many aspects of board members' roles and responsibilities. However, the nature of the language used within the *Manual* becomes very technical in certain sections and the volume of material included within it makes it difficult to locate needed facts. Further, there is a need to update the *Manual,* particularly since recent amendments to the *Territorial Hospital Insurance Services Act* have altered the structure of the budgetary review process to some extent. But members of the Standing Committee also found it incredible to note that this *Manual* has never been fully translated into Inuktitut or other aboriginal languages. This is apparently in spite of repeated requests from the health and hospital boards themselves.

Several boards have attempted to develop their own orientation and awareness sessions through an organized series of briefings and seminars from staff. While this internal commitment can be applauded, the Standing Committee was extremely concerned to note that there is very limited information and support available for board members, either from the Office of the Minister of Health or from the Department of Health.

In some instances, this may foster a need for board members to rely unduly on their senior staff for policy interpretation or abridgement of untranslated materials. It sometimes becomes difficult for board members to take an independent stance because they have not been provided with sufficient background information about their roles and responsibilities.

The issues confronting boards are complex and members require adequate orientation and training. Not only are they dealing with budgets of several million dollars, but they are also in a position of having to understand complicated and rapid changes in the health environment. This is not possible unless they are provided with the relevant information in a format that is accurate and easily understood. Speaking in Inuktitut, the chairperson of the Baffin Regional Health Board provided an important example of this during the November consultation sessions, when he pointed out that:

> ***I have been told about A.I.D.S. and I would like to talk to my people to care for themselves. I think we have to be aware that a lot of Ministers just keep things to themselves when they should be talking to people about these matters.***

Whether it is an unfamiliarity with current disease patterns or confusion about government budgeting principles and procedures, the fact appears that there has been relatively little central support for building awareness, management expertise and confidence for many board members.

The Standing Committee on Agencies, Boards and Commissions finds this to be unacceptable. The current situation is one in which the decisions of boards become prone to departmental criticism because board members are assumed to lack skills, experience or understanding -- while, at the same time, those conditions are perpetuated through a lack of attention to orientation and training.

The responsibility for correcting this state of affairs lies clearly with the Minister of Health. Board members are appointed by the Minister under the *Territorial Hospital Insurance Services Act* and it should be incumbent on her to ensure that her appointees receive the information and support they require in order to carry out their difficult role.

Appendix D:

1. Officers

   - Chair, selection input from the Board and preferably a person who has been a trustee for a minimum of one year; officially appointed by the Minister of Health.

   - Vice Chair, selected from within the Board.

2. Trustees - representative of the community and selected according to interest in Board functions, ability to be a responsible board member and for the expertise the person will bring to the Board; officially appointed by the Minister of Health from a prioritized list of names submitted by the Board Chair.

3. Committees - (e.g. finance, policy, education, publicity, etc.) as required to manage Board functions efficiently and effectively; selected from within the Board.

Support

The NWTHCA believes that an autonomous, working Board will be successful when the Board and the Administration are committed to supporting each other.

It is recognized that most trustees are volunteers and that most are very involved in their jobs, communities and families. Therefore, all trustee committees should have a senior staff member assigned to it, and, those staff members should do 90 percent of the follow-up work for the committee.

Trustee Orientation and Development

The NWTHCA believes that responsibility for trustee orientation and development must be a shared commitment by the Board, the Chief Executive Officer and the individual trustee.

Conclusion

The NWTHCA recommends that the "NWT Health Board Trustee Handbook Volume 1 and Volume 2" prepared by the Territorial Hospital Insurance Services, continue to be used as an orientation and a guideline for health care trustees.

References:

NWT Health Board Trustee Handbook, Volume I & II, Territorial Hospital Insurance Services, Department of Health, GNWT.
OHA, Hospital Trusteeship, A Guide for New Trustees, October 1989.
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MHO, A Guide to Self-Evaluation of your Governing Board, 1988.
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Rozovsky, Lorne E., "Codes of conduct of Trustees: A Guide", Health Care, April 1987, pp 34.
Regan, Thomas G. "Enhancing Hospital Governance", Acadia University, April 1992.
Shulman, Ron & David Preiss, "Hospital Boards: Developing a Vision", Hospital Trustee, March/April 1991, pp. 19.
Hopper, Glen, "Reflections on Trusteeship", Hospital Trustee, September/October 1990, pp 10.
Shelvy, Lloyd, "Governing Board: Responsibility to the Community", MHO Board Chairman, October 1988, a presentation paper.
Smith, David H., "Trustees and Health Care Priorities", Trustee, November 1991.

Appendix D:

NORTHWEST TERRITORIES HEALTH CARE ASSOCIATION

BOX 280, HAY RIVER, N.W.T. X0E 0R0 TELEPHONE: (403) 874-2448 FAX: (403) 874-6406

BOARD AUTONOMY STATEMENT

The NWTHCA believes that an autonomous, working Health Board will exhibit the following characteristics:

Powers and Responsibilities

1. Establishment and implementation of all operative policies.

2. Monitor all financial activities to ensure appropriate business-like management.

3. Provide an annual report of the Board's operations to the constituents and to the government.

4. Ensure legal protection of the facility and the services.

5. Appoint a Chief Executive Officer to be responsible for the day to day management of health services.

6. Make provision for safe and adequate facilities to provide the required health service needs for the consumers.

7. Periodic review and evaluation of effectiveness of services.

8. Ensure orientation for new trustees.

9. Ensure continuous education and development programs for trustees.

10. Conduct all Board business through meetings held at regular intervals.

11. Negotiate and administer contracts for purchase of goods and services.

12. Conduct self evaluation of the boards effectiveness.

Board Selection and Organization

The NWTHCA recognizes that the Minister of Health must have input into trustee selection because he/she is ultimately responsible for Board activities.

The NWTHCA further recognizes that the Board must exhibit responsibility in selecting suitable vacancy replacements by outlining for the Minister, the expertise needed on the Board, by providing the names of more than one nominee, if possible, along with a biographical sketch of the nominee(s) and to prioritize the trustee nominee list for presentation to the Minister of Health.

.../2

Appendix C:

The hospitals in Yellowknife, Fort Smith, and Hay River were already managed by boards prior to the 1988 agreement, and have become known as the *"pre-transfer boards"*. The Baffin board is generally included in this group as another *"pre-transfer board"*, but had already assumed responsibility for regional operations prior to the completion of the second phase of the transfer.

Following the signing of the 1988 agreement, regional health boards were created for the Keewatin, Kitikmeot and Inuvik regions, and these have become known as the *"post-transfer boards"*. Presently, there is no regional board for communities in the Deh Cho, North Slave and South Slave areas.

The fact that the various health and hospital boards in the Northwest Territories emerged at different points in the chronology of Territorial health services is often cited as a reason for conflict over autonomy and accountability issues.

The boards have, at least to some extent, perceived the Department of Health as trying to maintain control over key issues of program delivery because it needs to hold back "all the boards" because of the inexperience or resource deficiencies of "some of the boards". The Auditor General's report on the comprehensive audit comments that:

> Some boards are more powerful than others, and receive more resources than others. This can cause jealousy and resentment. The Department in Yellowknife is not helping the grand plan because it questions the capabilities of boards to do the things it feels should be done.

This background was reviewed by the Standing Committee on Agencies, Boards and Commissions to place the current issues outlined in the report in some historical context.

At the same time, however, the Standing Committee does not take the position that past events should prevent contemporary solutions from being found.

Appendix C:

The final phase, which culminated with the formal signing of a federal-Territorial agreement on August 25, 1988 effectively transferred the remaining health services and programs.

At that point, the Government of the Northwest Territories assumed responsibility for six hospitals, forty-two health centres, six public health centres and eight satellite health centres. From the outset, there was a stated commitment to devolve responsibilities for health services to a system of regional boards.

To at least some degree, however, the role confusion which plagues the system today can be seen to have stemmed largely from the speed and the process with which the two governments finalized the transfer agreement itself. It was not until October 16, 1987 that the federal Cabinet approved the process for the third phase of the transfer and announced the date for completion of the agreement. Only ten months later, the agreement was signed in Yellowknife.

The hurried "final days" of the transfer negotiations must have placed considerable stress on Territorial officials with respect to establishing a workable framework for board and departmental responsibility.

Regional steering committees had apparently been considering a framework for board structures and powers since March 1987, and the department had held consultations with aboriginal organizations. However, eleventh-hour troubles with the negotiation of transfer of National Native Alcohol and Drug Abuse program monies, ownership and control issues pertaining to patient records and consideration of Metis inclusion in the *"no prejudice"* clause occupied much of the concern during the latter stages of the transfer negotiations.

Accordingly, the transfer occurred with certain aspects of board structure and power still less than fully clarified. Right from the start, then, an unsteady foundation was laid for board development which has likely done much to contribute to current problems.

This may have been compounded by differences between boards in terms of the development of their capability to perform health management responsibilities.

Appendix C:

SOME COMMENTS ON THE HISTORICAL BASIS FOR CURRENT HEALTH AND HOSPITAL BOARD ISSUES

The Standing Committee on Agencies, Boards and Commissions has come to the realization that some background is necessary to fully understand many of the current issues confronting health and hospital boards.

From 1945 until 1960, the Medical Services Branch of Health and Welfare Canada was the only government organization delivering health care in the Northwest Territories. While the Medical Services Branch obligations were to the aboriginal population only, it had undertaken to provide services to everyone with the catchment area of its facilities until a Territorial health care system could be developed. By 1957, a process for the "transfer" of responsibilities for health services and programs was being conceived and, in 1960, the Government of the Northwest Territories established the Territorial Hospital Insurance Services Board.

From 1960 until 1988, the Territorial health system emerged. At the delivery level, initial Territorial responsibilities consisted of reviewing the budgets for three hospitals, located at Fort Smith, Hay River and Yellowknife, as well as providing funding for the Long Term Care program at the Inuvik Hospital. By June 1975, however, the federal Minister of National Health and Welfare had written to the Commissioner of the Northwest Territories confirming Canada's commitment to transfer health services at some later date. In 1978, the Government of the Northwest Territories established the Department of Health.

In 1981, a three-phase process was implemented to effect the transfer of health responsibilities to the Northwest Territories. The first phase involved the transfer of the Frobisher Bay General Hospital (now Baffin Regional Hospital) and clinical services in the Baffin Region, and was complete by December 1982.

The second phase involved the transfer of remaining health services in the Baffin Region from Health and Welfare Canada to the Government of the Northwest Territories, and was complete, except for the transfer of nursing station facilities and staff housing, by August 30, 1986.

Appendix B:

Witnesses (continued):

Keewatin Regional Health Board:

Ms. Elizebeth Hourie Palfrey,
Chairperson.

Dr. Bruce Peterkin,
Chief Executive Officer.

Stanton Yellowknife Hospital Board of Management:

Mr. Don Yamkowy,
Chairperson.

Ms. Lynn Olenek,
Executive Director.

Appendix B:

Witnesses Appearing During Review Of Health and Hospital Boards

January 22, 1992
Public Hearings.
Fort Smith, N.W.T.

Honourable Tony Whitford,
Minister of Health.

Mr. Robert Cowcill,
Deputy Minister of Health.

November 21, 1992
Committee Consultations,
Yellowknife, N.W.T.

Baffin Regional Health Board:

Mr. George Eckalook,
Chairperson.

Mr. Trevor Pollitt,
Chief Executive Officer.

H.H. Williams Memorial Hospital Board of Management:

Ms. Florence Archibald,
Chairperson.

Inuvik Regional Health Board:

Ms. Dale Hanson,
Chairperson.

b) review the operation of all such agencies, boards, public committees, councils and commissions, with a view to improving operations, including reducing possible redundancy and overlapping;

c) make recommendations on the continuance or re-organization of individual agencies, boards, public committees, councils and commissions.

No./ᓇᓴᐅᑦ 14-12(1)

Appendix A:

Northwest Territories Legislative Assembly/ᓄᓇᕗᑦᑕᐃᒪᖏᑦ ᓴᓪᓕᐅᔨᓐᓂᑦ

Motion
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TERMS OF REFERENCE FOR THE STANDING COMMITTEE ON AGENCIES, BOARDS & COMMISSIONS

WHEREAS it is required by Rule 95(2) that the Terms of Reference for all Standing Committees shall be approved by the Legislative Assembly;

AND WHEREAS the Standing Committee on Agencies, Boards & Commissions has considered the matters of their Terms of Reference;

AND WHEREAS the Standing Committee is now prepared to present their Terms of Reference to the Legislative Assembly;

NOW THEREFORE I MOVE, seconded by the Honourable Member for Yellowknife Centre that the following Terms of Reference for the Standing Committee on Agencies, Boards & Commissions be approved:

The Standing Committee on Agencies, Boards and Commissions shall:

a) have the authority to review and comment on the annual reports of agencies, boards, public committees, councils and commissions to which the Legislative Assembly, the Executive Council, a Minister or the Commissioner make some or all of the appointments;

b) inquire into such matters as may be referred to it by the Legislative Assembly; and

c) establish its quorum to be five Members including the Chair.

The Standing Committee on Agencies, Boards and Commissions may on its own authority:

a) examine and report on the methods by which it believes appointments, terms and memberships, and remuneration of members should be made to agencies, boards, public committees, councils and commissions;

Date of Notice/ᖃᐅᔨᒪᔭᐅᓂᖅ ᑲᑎᒪᔨᓂᖅ ᑕᒪᓐᓇ: December 9, 1991
Date of Introduction/ᑕᖃᐅᔨᓴᓂᖅ ᑕᒪᓐᓇ: December 9, 1991
Disposition/ᖃᓄᐃᓕᐅᑕᓂᖅ:
Carried/ᐊᔪᖃᑎᒌᖅ:

Moved by/ᐱᒋᐊᖅᑎᑕᐅᔪᖅ: Mr. Koe
Seconded by/ᑐᓴᖃᑎᒌᖅᐅᔪᖅ: Mr. Lewis
Ruled out of Order/ᓇᓗᓇᐃᔭᐅᔪᓐᓇᖅ:

The Standing Committee on Agencies, Boards and Commissions believes that its review of health and hospital boards has now provided the mechanism to which the Kitikmeot Board referred. It is hopeful that the current report can be used as an initial step in the process that will lead to a more efficient, better defined and more accountable role for health and hospital boards in the Northwest Territories.

During the review, however, some concern was expressed by board representatives about whether there would be effective follow-up on recommendations and suggestions arising from the current review. Some seemed to believe that past reports on health administration and, in particular, board submissions have tended to "gather dust" in government filing cabinets.

The Standing Committee on Agencies, Boards and Commissions wishes to emphasize that its current recommendations and suggestions are forwarded in a serious and urgent context, and that specific government action is anticipated.

Recommendation #10

Therefore, this Committee recommends:

THAT, IN ACCORDANCE WITH RULE 94(4), THE EXECUTIVE COUNCIL TABLE A COMPREHENSIVE RESPONSE WITHIN 120 DAYS OF THE PRESENTATION OF THIS REPORT TO THE HOUSE.

CONCLUSION

The Standing Committee on Agencies, Boards and Commissions is concerned about the current status of health and hospital boards within the Territorial health system. The present confusion over roles and responsibilities, and the sense of conflict which often pervades the relationship between boards and the Department of Health is a source of strain and inefficiency. The existing situation cannot be allowed to continue.

The Standing Committee has proposed that matters could be improved if greater clarification is provided regarding the respective roles of the boards and the department. A new outlook is also needed, away from centralized control and toward regionally-driven management of health facilities, programs and services. Decisions should be made by the people who are going to be most affected by them.

The Standing Committee on Agencies, Boards and Commissions realizes that it is sometimes difficult for government bureaucracies to shift away from the manner in which things have been done previously. In that regard, there is a role to be played by the Legislative Assembly in charting the course that should be followed and in laying down expectations for a new approach to health service management. This was pointed out in the written submission received from the Kitikmeot Regional Health Board:

> **These issues can only be resolved if the Legislative Assembly takes a lead role in setting the direction. Placing blame is a waste of time and energy. The Assembly must quickly set up a mechanism to review the data gathered to date, and to follow through with the direction its constituents have identified. The Assembly must ensure that roles and accountabilities are clearly delineated, and that there is an appropriate mechanism to ensure equal distribution of scarce resources for a valued commodity ... health.**
>
> **Once this is done, the Assembly will have the ability to hold the department and the boards accountable for their respective actions.**

There is no reason for any continued delay in making appointments to health and hospital boards. Where board re-structuring initiatives are underway, these should be planned well enough in advance that they do not interfere with the ongoing membership status of the board.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that the Minister of Health must take steps to ensure that board appointments are consistently made to fill vacancies. Situations should not be allowed to arise in which board operations are halted because there are insufficient members to carry out the work that needs to be done.

Recommendation #9

Therefore, this Committee recommends:

THAT THE MINISTER OF HEALTH ENSURE THAT HEALTH AND HOSPITAL BOARDS REMAIN FULLY CONSTITUTED BY FILLING MEMBERSHIP VACANCIES THROUGH THE TIMELY APPOINTMENTS OF MEMBERS.

BOARD APPOINTMENTS

The Standing Committee on Agencies, Boards and Commissions recognized that a serious problem has existed with respect to delays in the appointment of members to health and hospital boards. This issue was highlighted at the November 21st consultation sessions by a number of board representatives, and was articulated most clearly in the written submission received from the Board of Management for Stanton Yellowknife Hospital:

> **This is a definite area of concern which our board has experienced ... The length of time which it takes for an appointment to proceed through the system is extreme. We recognize the Minister has heard our concerns and also are aware that other boards may suffer from this as well.**
>
> **The length of time creates problems when only a few members remain to carry on the function of the board. Some committee work does not get accomplished in a timely fashion.**
>
> **The time delay also does not present the board in a positive light to its community. Someone will come forth indicating their interest in serving on the board, and by the time the appointment process occurs, the interest may have waned, or the individual receives the impression that they are not wanted and turns their community interest to something else.**

Appointments to health and hospital boards have been delayed, in many cases, far too long. The Standing Committee found it incredible that, at one point in early November 1992, five of the six boards in the Northwest Territories had membership vacancy rates over 25%. And, during the same period, the Stanton Yellowknife Hospital Board of Management was lacking ten of its fifteen possible appointments.

The Standing Committee was also concerned that some quarters appeared to associate the delay in board appointments with a Legislative Assembly motion to postpone filling membership vacancies on all government boards and agencies. This motion carried on December 12, 1991. It was introduced by the Standing Committee on Agencies, Boards and Commissions through Committee Report 1-12(1) and was intended only to provide a brief review period, without limiting government appointments over an extended time-frame. In fact, the motion specifically stated that appointments should be postponed *only* until March 31, 1992.

Creation of Representative Bodies to Replace Mackenzie Regional Health Services. The Standing Committee on Agencies, Boards and Commissions took special note of the fact that a large section of the population within the Northwest Territories remains unrepresented on any health or hospital board. Presently, health facilities and programs serving Deh Cho and Dogrib communities are managed by a Public Administrator through the Mackenzie Regional Health Services -- an administrative arm of the Department of Health.

The Standing Committee is aware that there are strong feelings on this issue, and a sense that pre-transfer commitments for community control of health services have not been honoured. Although there have been repeated assurances that the decentralization of health services to regional or community authority is under consideration, there has remained no real progress in this regard over the four years since transfer.

The Standing Committee on Agencies, Boards and Commissions is dismayed and concerned that this matter remains unresolved. Notwithstanding efforts made during five successive Ministerial administrations, the departmental bureaucracy remains more entrenched in the "Mackenzie Region" than ever before.

Members of the Standing Committee are of the opinion that some change must take place in this respect. The current colonial-style system needs to be replaced by structures which allow the people of this large region to take responsibility for this important area of community living.

The Standing Committee on Agencies, Boards and Commissions does not wish to make a specific recommendation on this matter at the present time. The focus of the current review is on existing health and hospital boards, rather than on identifying a framework for the regions in which community participation in health service delivery is absent.

However, the Standing Committee is hopeful that its comments will be noted by Cabinet and by the Special Committee on Health and Social Services as a perspective which must be dealt with in the very near future.

Election versus Appointment of Board Members. The Standing Committee on Agencies, Boards and Commissions spent considerable time examining the question of whether health and hospital boards should be elected or appointed.

The Standing Committee recognizes that there are a number of advantages associated with the election of health and hospital boards. Responsiveness to community interests is facilitated by the fact that elected board trustees may see themselves as accountable to the voters rather than to the Minister. Further, the visibility that board members achieve through the electoral process increases their public profile and, as a result, may make it easier for the community to identify them as prospective sources of information or advocacy during times of need.

At the same time, it must be recognized that there are also disadvantages to the election of health and hospital boards. For instance, it may be difficult in some regions to structure an electoral process which results in adequate representation of all the various ethnic or socioeconomic groups in a community. Within a system where boards are appointed, it is possible to target certain types of expertise among prospective trustees, while this is less controllable when members are elected. Frequently, as well, concern is raised about the prospect of "special issue candidates" mustering bursts of support from public interest organizations and monopolizing board membership to achieve their limited advocacy goals.

The Standing Committee on Agencies, Boards and Commissions noted that there was little or no support for the election of trustees among the board representatives who participated in the review. However, the Committee is also aware that there has been recent interest expressed in some communities with respect to the election of trustees to health centre boards.

At the present time, the Standing Committee on Agencies, Boards and Commissions is not prepared to make specific recommendations on this matter. However, the Committee agrees that this is an issue that should be further studied by the Department of Health, and that a Discussion Paper should be prepared for consideration by the Legislative Assembly and health stakeholders.

Some board representatives commented on the apparent need to increase sensitivity to cross-cultural communication within the Department of Health. They have perceived senior departmental officials as preoccupied with the notion that, *"boards do not work because because people do not say anything when they come to the meeting"*. The chairperson of the Keewatin Regional Health Board, stressed that:

> **... somehow we at some point in time have to get the message across to the department that because a unilingual person comes to a board meeting and does not talk a lot it does not mean that they are not participating. It means they have a different method of approaching the issues we are dealing with.**

The *Territorial Hospital Insurance Services Act* requires the Minister of Health to satisfy herself that the areas served by the health facility or facilities are adequately represented on the membership of the respective Board of Management. The Standing Committee believes that this requirement should not be seen to restrict the Minister from working with each health and hospital board to develop the sort of structure that it feels would best meet the needs of the region or community it serves.

Recommendation #8

Therefore, this Committee recommends:

> **THAT EACH HEALTH AND HOSPITAL BOARD SHOULD BE ALLOWED TO DEFINE ITS OWN STRUCTURAL FRAMEWORK, INCLUDING THE MAXIMUM NUMBER OF MEMBERS AND SYSTEM OF COMMUNITY AND ABORIGINAL REPRESENTATION.**

As another example, the Stanton Yellowknife Hospital has proposed a model for board reorganization which incorporates formal representation from outside Yellowknife. This is in keeping with the hospital's blossoming mandate as a regional facility.

On the other hand, the Board of Management at H.H. Williams Memorial Hospital in Hay River has a smaller and more localized membership structure, which also reflects the historical and continuing involvement of the Pentecostal Assemblies Sub-Arctic Mission Society.

The Standing Committee on Agencies, Boards and Commissions believes that it is very appropriate for each health and hospital board to develop an individual structure which best reflects the character of its respective region. While the Standing Committee is of the opinion that the management capabilities of all health and hospital boards should be developed to equivalent levels, the way boards are structured should be flexible enough to reflect regional interests. In other words, neither the Minister nor the department should attempt to impose a certain membership structure on health and hospital boards simply for the sake of Territorial consistency.

This was emphasized to the Standing Committee when the chairperson of the Keewatin Regional Health Board noted that:

> ***I think one of the things we have to keep in mind is that board make up should not be unilateral. What works in our region, may not necessarily work in the Kitikmeot and may not work in the Baffin and, certainly, may not work in the western Arctic.***

In general, the Standing Committee on Agencies, Boards and Commissions was very impressed with the priority that health and hospital boards were seen to place on recommending appropriate representation from all sectors of their community population. The Standing Committee noted a high proportion of aboriginal representation on regional health and hospital boards, as well as a recognition of the importance of increasing participation by aboriginal groups and individuals among the two predominantly non-native hospital boards in the Western Arctic.

BOARD STRUCTURE AND COMPOSITION

The Standing Committee on Agencies, Boards and Commissions spent a considerable amount of time during its review examining current structural frameworks of health and hospital boards in the Northwest Territories. The Standing Committee also considered whether it was in the best interests of the health system to have board members appointed by the Minister or elected by communities or regions.

THE STRUCTURE OF HEALTH AND HOSPITAL BOARDS

The Standing Committee is of the opinion that it must be recognized that the various regions served by health and hospital boards differ considerably in population, community development and health needs. Accordingly, the Standing Committee felt that the structure of health and hospital boards should reflect the regional character of the people they represent.

During November consultation sessions, the Standing Committee was informed that a number of boards have undertaken very specific initiatives aimed at reorganizing themselves for better representation and efficiency. This is resulting in a situation where somewhat different structures are emerging for different boards.

In the Inuvik Region, for instance, there has been a concern by board members that representation from each community and aboriginal organization has resulted in a very large and rather cumbersome board structure. Current efforts have been aimed at developing a proposed framework to carry out regular board activities through a streamlined executive committee, with the full board meeting once each year.

On the other hand, with the wider geographic area covered by the Baffin Regional Health Board, the need for representatives of all communities in the catchment area to meet regularly has been given a different, and higher, priority.

A Health Advisory Committee could also serve a very useful function in assisting the Minister of Health and the Territorial Government to devise a joint strategy for dealing with the the federal government's serious erosion of non-insured health services in the Northwest Territories and elsewhere in Canada.

The matter of non-insured services has been raised as a concern by Members of the Legislative Assembly. The Standing Committee on Agencies, Boards and Commissions believes that a coordinated political strategy should be developed by the Minister of Health, the health and hospital boards, and Territorial and national aboriginal organizations, whose members have a direct stake in this issue. A Territorial Health Advisory Committee is a vehicle through which this strategic planning could take place.

The Standing Committee on Agencies, Boards and Commissions is of the opinion that there should be no further delay in the establishment of a Territorial Health Advisory Committee.

Recommendation #7

Therefore, this Committee recommends:

THAT THE MINISTER OF HEALTH ESTABLISH AND REGULARLY CONSULT WITH A TERRITORIAL HEALTH ADVISORY COMMITTEE COMPRISED OF REPRESENTATIVES FROM ABORIGINAL ORGANIZATIONS AND THE CHAIRPERSONS OF EACH REGIONAL HEALTH BOARD AND HOSPITAL BOARD IN THE NORTHWEST TERRITORIES.

The following motion was then introduced and carried by the Eleventh Assembly:

> **THAT THE MINISTER OF HEALTH IMMEDIATELY ESTABLISH A TERRITORIAL HEALTH ADVISORY COMMITTEE COMPRISED OF REPRESENTATIVES FROM ABORIGINAL ORGANIZATIONS AND THE CHAIRPERSONS OF EACH REGIONAL HEALTH BOARD IN THE NORTHWEST TERRITORIES.**

Although some twenty months has gone by since this motion was passed, no action has apparently been taken to establish the Advisory Committee.

The Standing Committee on Agencies, Boards and Commissions finds this to be a source of serious concern. Clear direction was provided by the Eleventh Assembly that regional and aboriginal input into senior policy formulation should be safeguarded. While there is little question that the Territorial Hospital Insurance Services Board had become ineffective and somewhat unrepresentative, the importance of a direct link to the Minister was given a high priority by the Eleventh Assembly ... *and is just as important today.*

The Standing Committee on Agencies, Boards and Commissions fully realizes that direction to a previous Minister is not binding on the current administration. However, the Standing Committee believes that an Advisory Committee, reporting to the Minister and comprised of regional and aboriginal stakeholders will still form an important function in representing regional needs and interests. Further, the Standing Committee believes that an Adivisory Committee would foster information exchange and improve communication within the health care community.

The evidence brought before the Standing Committee over the course of its current review of health and hospital boards strongly indicated that such an advisory body is badly needed. It will provide health and hospital boards with a direct channel for communicating input to senior decision-making in the Minister's Office. It will also ensure that aboriginal organizations are able to represent health care needs and recommendations directly to the Minister.

TERRITORIAL HEALTH ADVISORY COMMITTEE

During the Eleventh Legislative Assembly, the previous Standing Committee on Agencies, Boards and Commissions tabled a report which recommended, among other things, the dissolution of a central advisory body, known as the Territorial Hospital Insurance Services Board.

The former Minister (Hon. Nellie Cournoyea) responded by introducing a bill to amend the *Territorial Hospital Insurance Services Act* during the Eighth Session of the Eleventh Assembly. These amendments dissolved the central board and transferred its duties to the Minister. This bill was Assented to on July 7, 1991.

The current Standing Committee on Agencies, Boards and Commissions is of the opinion that the Eleventh Assembly took an important step when dissolving the central Territorial Hospital Insurance Services Board. However, a very valid concern was raised at the time the bill was under consideration by the Eleventh Assembly.

On July 4, 1991 the Eleventh Assembly's Standing Committee on Legislation reported on its review of the bill which eliminated the central board. The chairperson commented that:

> **There was some concern expressed in both the survey input we received and also during committee discussions that the health system must reflect input from aboriginal organizations or aboriginal people and must involve aboriginal people in the development of standards, policies and financial decisions at the senior level.**
>
> **Further, the Standing Committee on Legislation was mindful of the fact that, if authority for the health system is to lie with the Minister of Health, regional health boards feel strongly that they should have direct access to her for communications and policy input. They did not want to see a process developed where the department is a filter between the Minister and the regional health boards.**

BARRIERS TO EFFECTIVE INPUT INTO HEALTH POLICY

The Standing Committee on Agencies, Boards and Commissions also reviewed the process through which community interests are represented in the formulation of health policy.

INPUT INTO HEALTH POLICY BY HEALTH AND HOSPITAL BOARDS

Generally, health and hospital boards expressed a concern that the Department of Health is not taking their suggestions and recommendations seriously. During the November consultation sessions, several boards described situations in which important recommendations had been forwarded to senior officials in the department, without any formal response or action.

This should not be happening. Health and hospital boards have a unique perspective on the needs of their facilities and of the people served by them. It is important to ensure that these perspectives are taken into consideration when Territorial health policy is being developed.

The Standing Committee on Agencies, Boards and Commissions takes the position that health and hospital boards report to the Minister of Health and not to her department. Accordingly, procedures need to be developed through which the boards can have direct input to the Minister's Office without having to negotiate a series of bureaucratic channels. When health and hospital boards bring forward specific suggestions for policy input, they should be able to expect a timely and complete response.

Clearly, what is needed is a process through which any health or hospital board can issue a formal recommendation to the Minister on a matter of policy. Standards should be set within the Minister's Office and the Department of Health which allow for the timely response to formal recommendations, and there should be a system for reporting the status of recommendations to the Legislative Assembly.

Recommendation #6

Therefore, this Committee recommends:

THAT THE MINISTER PREPARE AMENDMENTS TO THE *TERRITORIAL HOSPITAL INSURANCE SERVICES ACT* TO ESTABLISH A REQUIREMENT THAT ORIENTATION AND ONGOING TRAINING BE PROVIDED TO MEMBERS OF EACH BOARD OF MANAGEMENT ESTABLISHED UNDER SUBSECTION 10.(1);

AND FURTHER, THAT THE CONTENT OF MANDATORY TRAINING SHOULD BE ESTABLISHED BY REGULATIONS DEVELOPED THROUGH CONSULTATION WITH HEALTH AND HOSPITAL BOARDS;

AND FURTHER, THAT THE MINISTER BRING THE NECESSARY PROPOSED AMENDMENTS AND DRAFT REGULATIONS BEFORE THE LEGISLATIVE ASSEMBLY BY THE FALL SESSION IN 1993.

During the January 1992 public hearings in Fort Smith, it was noted that there could be a role for the Northwest Territories Health Care Association to play with respect to developing a framework for board members' orientation and training.

There may be merits to this approach. The Health Care Association represents each of the health and hospital boards in the Northwest Territories and, through its affiliation with its national organization, is in a position to take advantage of work that has been already completed in other jurisdictions.

However, it should be recognized that, while the Association may have a role to play in coordinating and delivering orientation or training, it is the responsibility of the Minister and her department to ensure that the job gets done. This should involve direct supervision of the allocation of funding and of the administration of any contractual arrangements with the Health Care Association. This will require setting a high priority on orientation, training and support for board members.

A review of the amount of training and support provided to boards by the Department of Health since the 1988 transfer agreement has not inspired much confidence that the will exists within the Department of Health to recognize board orientation and training as a priority.

Accordingly, the Standing Committee on Agencies, Boards and Commissions is of the opinion that training and orientation of board members should become a formal statutory duty imposed upon the Minister by the *Territorial Hospital Insurance Services Act.*