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Comprehensive Audit
of the Department of Health

A Report to
the Legislative Assembly
of the Northwest Territories

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AUDITOR GENERAL OF CANADA

VÉRIFICATEUR GÉNÉRAL DU CANADA

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Speaker of the Legislative Assembly
Government of the Northwest Territories
Yellowknife, NWT

I have the honour to transmit herewith my report on the comprehensive audit of the Department of Health, as requested by the Legislative Assembly.

L. Denis Desautels, FCA

OTTAWA, October 1992

INDEX

chapter 1

Executive Summary 1

chapter 2

Organizational Structure 5

2.1 *Introduction* 5
2.2 *Health care system organization* 6
2.3 *The prescribed roles* 6
2.4 *The perceived roles* 7
2.5 *The practised roles* 7
2.6 *What is necessary?* 8
2.7 *Departmental organization* 9
2.8 *Communicating with the boards* 9
2.9 *Communicating with the public* 10
2.10 *Co-ordination with other departments* 11
2.11 *Board members* 11

chapter 3

Planning for the future 13

3.1 *Planning process* 13
3.2 *Human resource planning problems* 15
3.3 *Budget allocation equity* 16
3.4 *Policy harmonization needed* 17

chapter 4

Managing people 19

4.1 *Introduction* 19
4.2 *Employment Equity* 20
4.2.1 *Aboriginal employment equity* 20
4.2.2 *Health bursary program and aboriginals* 20
4.2.3 *Aboriginal employment in boards* 21
4.3 *Boards' hiring efficiency* 21

INDEX (cont'd)

4.4	*Employee orientation*	22
4.5	*Monitoring staff performance*	23
4.6	*Doctors*	24
4.6.1	*Performance standards for doctors*	24
4.6.2	*Conflict of interest*	25
4.7	*Reasons for staff leaving not known*	25
4.8	*Training and Development*	26
4.8.1	*Planning and funding*	26
4.8.2	*Inequitable training budgets*	26
4.9	*Human Resource Management system*	27

chapter 5

Managing Information 29

5.1	*Introduction*	29
5.2	*Information needs*	29
5.2.1	*Research*	29
5.3	*Data processing*	30
5.3.1	*Health Insurance Services (HIS)*	30
5.3.2	*HIS Coding*	31
5.3.3	*Health care registrations*	31
5.3.4	*Reciprocal billings*	32
5.4	*Community Health Management Information System (CHMIS)*	32
5.5	*Information sharing*	33
5.5.1	*Monitoring, evaluating, budgeting*	33
5.5.2	*Information sharing among managers*	33
5.5.3	*Information sharing between boards and the Department*	34
5.5.4	*System interaction*	34
5.6	*Policy and legislation*	35
5.7	*The Boards' accounting systems*	36

chapter 6

Capital assets 39

6.1	*Introduction*	39
6.2	*Policy and planning*	39
6.3	*Asset inventories*	40

INDEX (cont'd)

chapter 7

Financial Issues 41

7.1 *Introduction* 41
7.2 *Allocation of resources at time of devolution* 41
7.3 *Supplementary estimates* 41
7.4 *Medical travel* 43
7.4.1 *Administration and management trail problems* 44
7.4.2 *Escort travel* 44
7.4.3 *Different application of the same policy* 45
7.4.4 *Managing and monitoring medical travel* 45
7.4.5 *Consolidating medical travel programs* 45
7.5 *Receivable from Canada* 46

chapter 8

Management reporting and accountability 47

8.1 *Introduction* 47
8.2 *Management results* 47
8.3 *No board evaluation process* 48

chapter 1

EXECUTIVE SUMMARY

Introduction

At the request of the Legislative Assembly we audited the **Department of Health (Department)** in late 1991 and early 1992. The topic of health in the NWT is contentious, as demands for more services run into the realities of fiscal restraint. At present, health is the single most expensive program in the NWT, and at an annual cost of close to $200 million, it consumes some 16% of the entire government budget. Comparison to other jurisdictions is not meaningful because the services provided are not identical and budgets are not all made up of the same components.

Scope

There has been considerable interest, discussion and sometimes spirited debate about the present state of health care in the Territories and about the future direction it should take. Therefore, we set some simple guidelines for doing this audit. First, we would not duplicate any other work done recently. Second, we would design our report to deal with issues that will be of interest to our client, the Legislative Assembly. We also hoped that our findings would be of interest to the Department and boards.

In scoping our audit we researched extensively the work carried out in recent years. Where appropriate to do so, we make reference to these other studies. We have not attempted to assess the impact of land claims or greater delegation to the community level. Nor have we assessed the impact of the amalgamation of the Departments of Health and Social Services. Similarly, we have not performed any operational audits of hospitals or health centres, although such audits might be of benefit to the system if undertaken with a developed approach and suitable methodology. We did our work in the Department of Health in Yellowknife, and we also visited four boards. We interviewed senior staff in the **Department**, and mailed questionnaires to each of the eight Chief Executive Officers (CEOs). We received 7 replies. We also sent questionnaires to 89 board members, with a poor response rate of 18 percent. The questionnaire asked for comments on policy, legislation and management pertaining to boards, data and information systems, the NWT health care model, and human resources. We followed up on the questionnaires with several telephone interviews with **Board** CEOs.

Where appropriate, the results of this questionnaire are referred to in this report.

We also reviewed documentation and interviewed staff in the Department of Personnel (**Personnel**) on issues pertaining to human resource management.

Several of the documents referred to in this report are relatively old. The **Department** informs us that in some cases the situation has changed, but was not able to produce adequate evidence to substantiate the changes.

The audit covers the period since the health transfer in 1988 with the most current information available used to illustrate the observations.

Our report focuses on those issues that we believe are at the heart of the debate and current problems. Starting with the fundamental organization of the system, we tried to sort out the realities in the vigorous debate between the **Department of Health**, the regional boards, the various intervenor groups and politicians.

Although this report points out many areas where improvements are needed, it should not be construed as suggesting that any individual has received inadequate health care as a result of these issues. Similarly, the report comments on the need for better understanding and cooperation between the **Department** and **boards**, but should not be regarded as advocating the position of one as opposed to the other.

Summary of findings

a. Mandate and organization

The health care system includes many dedicated and energetic people who work hard to provide a good standard of care for NWT residents. Yet they labour under a handicap. The Government has not yet pronounced on what the NWT health care model should be; nevertheless, the Department, boards and professionals are providing ongoing care.

Politicians must take the lead in defining the kind of health care model that is needed or desired by NWT residents. The equitable distribution of health care is as much an issue of political will as of improved departmental and board management. The transfer of health from the federal to the Territorial government was a stepping stone on the road to improving health care delivery to all NWT residents. But our findings have indicated that what is needed now is a consensus, to meet the challenges of taking NWT health care into the 21st century, while accommodating the realities of fiscal restraint. Politicians can assist in this important step by agreeing on a model that meets the needs of their constituents and the **Government's** pocketbook.

As we note in Chapter 2, in the period since devolution, the various parties have been carving out their own positions and the result is unsatisfactory. There is organizational confusion in the system. Control has replaced monitoring and real accountability is diffused. Essentially we found that the organizational structure of the health care system is in disarray. The partners in the process are generally not working together to make things flow smoothly and each has set up protocols and other practices that act as barriers to co-operation. Politicians can initiate this important step.

In many respects, the **Department** and the **boards** are in a holding pattern awaiting directions from the Legislative Assembly on the form and role of the health care model. Once the plan is in place, the **Department** needs to organize and the Legislative Assembly needs to make the necessary legislative and policy changes. These changes should consider the roles and responsibilities of the **Department, boards** and the public, reflecting the partnership in health care delivery that has evolved since the federal health transfer and the new regional structure.

As noted by Geoffrey Weller in *The Devolution of Health Care to Canada's North*, the main advantage of devolution was that "health care services...should be closer to the people served and more likely to be sensitive and responsive to their wishes."

Following any necessary legislative and policy changes, the **Department**, along with the **boards**, must define the systems and processes to administer and deliver health care. If these are developed in a spirit of co-operation and consensus, then the relationship between administrators and care-givers will become a partnership with common goals serving the best interest of the public. The individual partners instead of trying to dominate each other must seek consensus on the principles as well as the nuts and bolts necessary to make the system work.

In particular, in promoting the Healthy Public policy concept, implicitly the Government is encouraging people to work together to identify and promote lifestyle changes. To make sure that the ingredients for overall public health, such as adequate housing, education, employment opportunities, etc. are present, various departments, boards, agencies and professional groups must co-operate effectively. But to consolidate these various efforts requires a change to the existing way of operating. Government must take the lead to break down the bureaucratic barriers that may prevent successful co-operative efforts.

b. Planning for the future

We followed our organizational review with an examination of the systems used to plan for the future and to monitor current developments. What we found was not reassuring. In Chapter 3 we note that planning systems are almost non-existent, and systems for monitoring are deficient and need major overhaul. **Department** managers feel that they have started to deal with the lack of planning by initiating a framework for community based studies. These studies review facilities and services, with those for Fort Smith and Hay River already completed. The remainder are scheduled for completion by the end of 1993. In our view, effective planning needs much more than this, although the framework is a start in the right direction.

c. Managing people

In Chapter 4, we report on our examination of the critical area of human resource management, which is of particular concern in a system where people dealing with people is the single most important factor for success. We found that the many dedicated professionals are not helped by a management system that is cumbersome.

With a high aboriginal population we expected to find progressive programs to help aboriginal people play a meaningful role as employees in the system. Yet the equity programs are not being pursued aggressively and the lack of results is obvious.

When a system has a large number of employees, good hiring and performance tracking capabilities are very important. In particular, with most health care workers coming from the south, it is doubly important to make sure that employees are adaptable to the lifestyle and differing cultural expectations. This reduces expensive turnover and ensures that the people receive the best and most sensitive care. Yet we found that overall Human Resource Management systems were poor or non-existent. There is currently a debate about doctors as employees or fee earning independents. The NWT system has not come to grips with this issue.

Formal management systems need to be improved, and a more equitable training system is overdue.

d. Information systems

Information systems, which should be the lifeblood of a major health care process, need major improvements in order to be effective. Managers do not have the information needed to do a good job, and, as a result, there is a lack of regard for economy and efficiency in operations. We think that some economies can also be made for some system elements.

e. Capital assets

Capital assets are managed with split responsibility between partners. Improvements are needed.

f. Financial issues

Chapter 7 notes some of the critical financial problems facing the system, and highlights the lack of financial accountability and inadequate control over finances.

In particular, we comment on the difficulty in estimating costs, requiring regular requests for Supplementary Estimates, the continuing issue of out-of-Territories patient treatment, and unpredictable and hard to control medical travel costs. But a major problem concerns the inability of the Government to recover some $50 million from the Government of Canada to reimburse the Territories for health care provided to Indians and Inuit. This particular problem has been ongoing for several years and needs an urgent resolution.

g. Management reporting and accountability

Finally, Chapter 8 observes the inadequate processes for measuring management performance.

Many of the problems can be solved with clear vision, leadership, and goodwill on the part of the players.

chapter 2

ORGANIZATIONAL STRUCTURE

2.1 Introduction

When the Government took over responsibility for health care delivery from Canada in 1988, it decided on a unique northern approach to organizing its system. Rather than concentrate decision making in Yellowknife, with all the bureaucratic implications, the Government set up a partnership structure consisting of a central department in Yellowknife, and direct involvement from the communities. The intent was to get the people involved in a meaningful way in the day-to-day decisions affecting their health, and to avoid unnecessary red tape and bureaucracy.

The approach was consistent with the Government's intention of empowering the people through community involvement in many programs. It set up new health and hospital **boards** to both complement those already existing before devolution and ensure all the regions were represented. In all, the Government created eight **boards** to work in concert with the **Department of Health**.

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.

After four years a valid question is "Has the idea worked?" In our view there are many problems that prevent the system from being as effective as it should. The players are confused about their roles and responsibilities and the vested interests are competing for power. 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. Overall Government financial constraints are putting pressure on all the parties and although health care demands are increasing, other government services are competing for the declining resources.

At the root of the problem is the fundamental question of how health care should be delivered in the Territories. The community orientation of the 1988 structure was reinforced by the "*Strength at Two Levels*" report which empha-

1991 population and board funding, by region

Board	1991 population	Allocation 1991–92	Allocation 1990–91
Baffin	11,385	$20,493,433	$17,537,135
Fort Smith	2,480	3,856,829	3,430,902
H.H. Williams	3,206	5,660,614	5,040,303
Inuvik	8,491	14,735,660	14,775,029
Keewatin	5,834	9,173,976	8,157,780
Kitikmeot	4,386	4,985,747	4,858,664
MacKenzie	6,688	9,163,135	7,612,272
Stanton	15,179	22,764,998	17,587,852
Total	***57,649***	***$90,834,391***	***$78,999,937***

sized greater local involvement. The report also reinforced the concept of the NWT Way, which places a strong emphasis on community health centres staffed by nurse practitioners as the front-line professionals serving the people. However, past funding decisions to develop hospitals, particularly Stanton and Baffin, have created public and professional expectations for a level of health care that the NWT Way may not be able to satisfy. Other regions feel they should have similar facilities, even though one of the current dilemmas is how to deal with underutilized hospitals. Increasing the use of nurses in the communities may impact on the roles of doctors.

Finding the right balance among these competing demands is vital. Those affected by policy indecision are becoming restless and, when groups fight rather than co-operate, resources can be wasted and important decisions do not get made. Most importantly, the people can get poor service.

We concluded that the organization structure of health care delivery in the NWT is not working as well as it should. With a population of only 57,000, albeit spread over a large area, there is a surprising amount of discord between the partners. Everywhere we went during our audit, we received complaints about how others were not co-operating to make the system work. Yet little has been done to help solve the problem. The main issue is one of central versus local control. From our assessment of the situation, and the various comments made to us, we reached the conclusion that the problem stems from misunderstood roles and responsibilities dating back to devolution in 1988, and in some cases even earlier.

Basically, the relationship issue is complex. Some health and hospital boards were created before devolution; they have experience and power. In 1988, the Government created new **boards** in the regions, and now these want a greater share of the power. At the same time, the **Department** in Yellowknife appears to want to retain the power centrally.

Is is important that accountability to the Legislative Assembly should not be fragmented. While the **boards** have their conferred responsibilities, the **Department** is at the centre of the system and the Government rightly expects accountability from it. This requires all the parties to work together effectively.

Adding to the difficulties are unclear laws and policies combined with different understandings of roles and responsibilities.

2.2 Health care system organization

One of the most significant issues concerning health care delivery in the NWT is the contrast between the perceived, practised and prescribed roles and responsibilities of the **Department** and the **boards**. The actions of departmental management signal that they perceive **boards** as regional representatives of the **Department**. The staff and members of **boards** perceive themselves as running organizations, separate from the **Department**, with the autonomy of independent entities.

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, as shown in chapters 5 and 8 of this report.

2.3 The prescribed roles

Legislation and policy, specifically the Territorial Hospital Insurance Services (THIS) Act, GNWT transfer policy, and the Financial Administration Act (FAA) should define the role and responsibility of the **Department** and **boards** and the relationship between them.

Ambiguity about the transfer policy, which creates expectations, and the THIS Act, which defines responsibilities, has **boards** and the **Department** competing for power and autonomy. The ambiguity can be traced back to the expectations created at the time of devolution of health care from the federal government.

The Act delegates to the **boards** the responsibility to "manage, operate and control health facilities". In the broadest sense the authority can mean **boards** have an operating mandate that

includes operational and planning responsibility for health care for their region. In its narrowest sense, the authority can mean that each **board's** operating mandate is limited to managing, operating and controlling resources dedicated to its specific health facility only. The "manage, operate and control" authority does not specifically exclude or include any specific activity. The Act generality allows the **Department** and the **boards** to interpret roles and responsibilities as they see fit. This aggravates the ambiguity problem.

Before the transfer of health care to the NWT, Commissioner Agreements were signed by each of the four "old" **boards** (Baffin, Stanton, Fort Smith and the Pentecostal Assemblies of Canada for H. H. Williams) and the **Department**. These agreements do not clarify the "manage, operate and control" responsibility, they do, however, set out responsibility for personnel hiring and firing, property and equipment, service contracts, procurement, and establishing operating policies and procedures. For those **boards** without Commissioner Agreements, the Trustees' Manual is supposed to clarify or define roles and responsibilities. The **Department** is working on an outline for a standardized memorandum of agreement for all **boards**.

Restrictions imposed on **board** operations by the FAA also limit their autonomy. For example, the FAA sets out rules for the **boards** in areas such as borrowing and investments, appointment of auditors and financial statements. The Act gives the Minister of Finance authority to issue directives to **boards** for financial management and financial administration, and provides for the ultimate accountability of **boards** to the Legislative Assembly.

2.4 The perceived roles

The way **board** managers and members perceive their roles comes from the way Government transferred health programs to the **boards** in 1988. In that year, the federal government transferred responsibility for health care delivery to the Government, which in turn delegated responsibility and resources for delivery of health care programs to **boards**. This delegation did not include transfer of legislative or political authority.

The transfer provides for the passing of responsibility and resources for program delivery to local decision makers through community governments or other organizations. This includes local management of buildings, equipment and other assets used in the program.

The Government's objectives and implementation strategy for decentralization does not define the roles and responsibilities of the communities or **boards**. The Minister has authority to decide how much responsibility to transfer to the **boards.** A range of responsibility for assets, employees, and level of support services could be transferred with the approval of the government.

The intent of the transfer of health was to pass more decision-making power to the communities of the NWT. It is the **boards**' contention that the spirit of the transfer has decayed. At the time of transfer, the Government did not state its intentions definitively, and this created high expectations of autonomy. Later the **Department** defined the administrative issues of the transfer, while the **boards** delivered health care based on their own broader interpretation of the responsibilities transferred. The Government has not clarified what it intended the role and responsibility of the **boards** to be.

Since 1988, the disparity among **boards** themselves has become more apparent. Old **boards** are more autonomous because they have more experience and they have Commissioner Agreements. New **boards** have to struggle to define their role, have no Commissioner Agreements, and are closely controlled by the **Department**.

Some of the **Department's** managers believe that they have complete power and control over the **boards**. Many of the **Department's** policies and procedures reinforce this. For instance, the **Department** established policies dealing with budget control, capital fund surpluses, year end audited financial statements, management incentive policy, working capital, deficits and earned interest.

2.5 The practised roles

In practice, the **Department** and **boards** do not function effectively with each other: the **Department** tries to control **boards**, which resist this control by asserting their autonomy. On a day-to-day basis, the **boards** execute their perceived roles with some success. They manage their own staff and facilities, administer programs, set operational policies, negotiate some

contracts, assess health status and health needs of residents, and liaise with other medical organizations. However, the discrepancy amongst the **boards'** perceived, practised and prescribed roles becomes apparent when the **boards** deal with broader issues such as program planning, budgeting and contracting.

The **Department** is responsible for administering, planning, policy making, standard setting and regulating. Some activities, usually those covering all patients, for example Medicare and Extended Health Benefits (EHB), are delivered directly by the **Department**. Other programs are delivered regionally by the **boards**. The **Department** controls **boards** by its power over their budgets, by closely monitoring spending, and by requiring financial and administrative reports on **board** operations.

The **Department** informed us that the tight controls were set up in the early days following transfer when the **boards** had inadequate financial controls. Although things have improved since then, the **Department** still imposes the tight controls because a directive set up before 1988 has not been amended. In light of the improvements, however, it may be time to reduce the strict application of the original directive.

The Department should recognise the improvements made by boards since 1988, and amend the control directive to reflect the needs of the present day.

Management response:
The Department will review financial controls in consultation with the health boards.

2.6 What is necessary?

First, all parties must understand and reaffirm that health care program delivery is a partnership between central government and regions, with accountability to the people through the Legislative Assembly. The **Department** allocates annual resources to the **boards** on behalf of Government, which still retains overall responsibility and accountability to the people. The partners must agree exactly what kind of power "manage, operate and control" gives to **boards**. In turn, the **boards** need to recognize the policy and standard setting role of the **Department**. The **Department** should realize that it adds to the controversy by establishing controls that are neither explained to nor understood by the **boards**, by focusing on trivial issues, and by not involving boards in the broader health care planning issues.

In his article "The Impact of Devolution on Health Services in the Baffin Region, NWT: A Case Study", John D. O'Neil pointed out that conflicts in political perspectives must be resolved to ensure that all parties work toward achieving balance in the evolving health care system.

In addition to the policy and legislation issues discussed above, the **Department** needs to strengthen its program evaluation, planning and communication and information management, at present are suffering from fragmented information systems. The various divisions do not work together as a team with organized information sharing and co-ordinated health care planning.

In paragraph 8.3 we note that the **boards** also have no evaluation process.

For example, the Community Health Division staff planned an evaluation of the Nutrition Program in 1990-91, but the project could not be completed because the delegated staff left and were not replaced. Because the **Department** has no process to evaluate objectively the program performance of itself or the **boards**, such projects have no policy framework to guide them. One consequence is that the **Department** has not completed any full program evaluations.

While there never seems to be enough money to do everything the **boards** and **Department** want to do, both have to deal with fiscal restraint and continue to provide increasing services even where funds will not grow at the same rate in the future. Both parties need to find ways of improving efficiency and making better use of resources.

1. ***The partners in health care should clarify and resolve their respective roles, as well as the ambiguity between the THIS Act and the transfer policy.***

2. ***The Minister, through the Department and the boards, should work with all parties concerned to negotiate a health care model for the NWT.***

Management response:

1. The Department is prepared to participate in the clarification of roles and responsibilities.

2. Agreed.

2.7 Departmental organization

The Government organization policy states that "*...the organizational design of government departments shall be standardized where practical and adhere to the basic principles of organizational design....*" In our review, we identified some areas where pooling of specialized functions could be achieved with potential cost and efficiency savings.

Headquarters has professional, policy and support areas reporting to two Assistant Deputy Ministers. Separate from these areas are Legislation and Finance, which both report directly to the Deputy Minister. We believe the **Department** has an opportunity to save resources by consolidating divisions that do similar things. For example, two operations in the **Department** perform similar functions to finance and administration.

The Health Insurance Services Division administers health insurance benefits which involves paying hospital and doctors billings. It has 22 person years and functions like Finance and Administration, which also pays bills among other things. The division is not involved in a major way in health care planning, management or delivery. There might be savings by merging the division with Finance and Administration to pool the expertise in this type of operation. There could also be benefits in systems improvements where similar processes could take advantage of modern technology. The Government announced recently that this division would be decentralized to Inuvik and Rankin Inlet. Even so, strong functional leadership from Finance could ensure minimum disruption and maximum control and operational effectiveness.

Hospitals & Health Facilities (H&HF) is a ***board*** *monitoring group with a mandate to provide help to the* ***boards*** *in solving financial and administrative problems. This role is also similar to Finance & Administration. The division administers the THIS Act, provides technical and professional consulting services and financial monitoring and direction for board operations. Before H&HF can do any financial or budgetary monitoring, H&HF has to standardize the* ***board's*** *information systems output, a time consuming task. The technical and professional consulting service part of the mandate is not well developed because the division spends more time on detailed control tasks and information conversion. The* ***boards*** *see it as imposing controls and providing little assistance.*

Finance & Administration manages the financial, administration and computer coordination services. It could be beneficial to consolidate all the financial management, systems and monitoring in one group that can pool its expertise.

Strong links need to be forged and maintained among Finance, Administration, Policy and operations.

The Department should review the effectiveness of Headquarters' organizational arrangements to determine if they are the most appropriate for serving the health care system.

Management response:
The Department will review its headquarters' organization structure.

2.8 Communicating with the boards

A decentralized system for health care delivery requires good co-operation and good communication among all staff for efficient and effective service. But we found that bureaucracy and protocol barriers between the **Department's** staff and the **boards** make it difficult to work together towards the best results.

For example, in 1991 there was an outbreak of a deadly strain of E. Coli. This can cause severe diarrhoea and even death if not dealt with quickly. There was a lack of a clear

*understanding about communicable disease reporting between the Chief Medical Officer of Health and the **board** staff. In this case, the **board** staff initially responded on their own while maintaining contact with the **Department**. While the situation was aggravated by the autonomy issue, it required a co–operative effort and rapid intervention without any delays. The resulting communication problems reduced the mutual respect between the **Department** and the **board**. Mutual respect is vital to any working partnership.*

Another example illustrates how the lack of an effective partnership between boards and the Department can lead to a breakdown in communication, misunderstandings and possible monetary loss.

*The Keewatin Regional Health Board provided dental services to the population under a service contract with the University of Manitoba. The contract expired on March 31, 1992. The **Board** was unwilling to renew the contract and negotiated its own arrangements with two NWT dentists.*

*This is a major contract worth some $6.8 million over five years, with clinical services based in Rankin Inlet and itinerant dental services to the other communities. In this region, some 91 percent of the population are Indian and Inuit. Their dental care is the primary responsibility of Medical Services Branch (MSB) of Health and Welfare Canada which reimburses the NWT for costs incurred in providing dental services to these people. The **board** negotiated a new approach providing a blend of per diem and fee–for–service payments. MSB has a preferred type of contract that pays fees for services actually provided.*

*This ensures the best value for money as unproductive time, such as weather delays or equipment set–up are borne by the contract dentist, not by the Governments of the NWT or Canada. Neither MSB nor the **Department** were involved in the negotiations.*

*MSB reimburses the NWT for services provided to Indians and Inuit. In turn the NWT provides initial budgets to the **boards** to enable them to provide the service. In this instance, the **board** owes a duty of care to the **Department** which is an agent of MSB, at least as far as the recoverable portion of dental costs provided under this contract. It would have been reasonable to involve the **Department** in this contract negotiation, particularly as it understands the needs of MSB and has an umbrella responsibility for the whole of GNWT/MSB relationships.*

*The **Department** believes that the **board** may not have understood all the cost ramifications of the new contract.*

*Working together on issues such as these may also pay dividends in other areas. The **Department** has considerable experience in contracting, and it has access to legal services to make sure that the contract terms are appropriate. With the **board** going it alone, it may have demonstrated its independence of the **Department**, but the consequences could be costly, if MSB disagrees with the fee basis.*

These cases each suggest that the working relationship between the Department and the boards needs immediate attention in order to create a climate of co-operation and avoid independent actions where working together will achieve better results.

As a joint exercise, the Department and the boards should review all requirements for board reporting and communication to make sure that all unnecessary barriers are removed, and that tradition does not get in the way of progress.

Management response:
In conjunction with the clarification of roles and responsibilities, reporting and communication requirements will be reviewed.

2.9 Communicating with the public

The Department and boards are responsible for informing the public about the relationship between health care costs and preventive health care. More public understanding of the quality of life, and how poor living habits or practices detract from life expectations, may improve behaviour and reduce needs for health services. This, in turn, will help keep health care costs down.

When the partners have agreed on a health care model, they will need to ensure that all NWT resi-

dents become familiar with all its components, including life-style issues.

The Chief Medical Officer of Health feels that a Departmental publication, EPI North, could be a useful vehicle for this communication. We note, however, that it is published in English only and would need editions in French and all the aboriginal languages for the message to be communicated effectively.

Once a health care model has been agreed upon by all the partners, the Department, in conjunction with the boards, should ensure that the details are communicated effectively to all NWT residents.

Management response:
The Department does, and will, participate in the communication to the public on the health care system in place.

2.10 Co-ordination with other departments

The Government policy, "Healthy Public Policy," is an effort to help residents be as healthy as possible. This requires co-ordination of services from all government departments with planning and commitment at a government-wide level. Health care is still the primary responsibility of the Department of Health, but is affected by factors outside of the management or control of the Department.

An example is shown in the Department's October 1990 publication of the Health and Health Services Report, which contains information on NWT socio–economic conditions such as income, unemployment, education, housing, nutrition, family and community life, alcohol and tobacco, sanitation and contamination of traditional foods. The Report discusses how these socio–economic factors affect the health of the population, and puts into perspective the issues involved in delivering health services in the NWT. If the Department can also find a way to incorporate accountability information, such as what has been spent and achieved, this format will be powerful.

This type of report was a first-time publication for the Department. Management has subsequently produced a further report which was tabled in the Legislative Assembly in June 1992. The second report included useful information on health service operations.

The Report identified operational and strategic issues that on which other departments and agencies need to cooperate. We enquired if there were any interdepartmental exchanges to identify, discuss, and co-ordinate health care delivery.

Senior management of the Department informed us that they liaise and meet regularly with other departments and agencies as well as non-governmental organizations. We have not audited the nature of these meetings nor their achievements, and we understand that agendas and minutes are not prepared. From the information provided to us, the topics covered deal with important issues of the day. With the growing awareness of the need for strategic as well as operational action, these relationships should allow the Department to deal with the longer-term concerns raised in the Health and Health Services Report, and the Healthy Public Policy.

The Government should take steps to form effective alliances at the working level among the departments involved in the Healthy Public Policy. The arrangements should be structured in a practical way to avoid bureaucracy and produce co–operative results .

Management response:
The Department has had numerous working arrangements with other organizations both internal to and external to the Government of the Northwest Territories. It will continue to foster and expand these relations.

2.11 Board members

As part of the health transfers, the Department was to encourage the decentralization of health care to the population served. With the addition of new regional health boards came the need for local membership to fulfil the concept of local involvement and direction. Membership on the boards is intended to provide representation from the various communities and reflect the ethnic mix of the region.

However, many boards members have had no previous experience in this type of role, and what is needed to make them work. If the Government is to make the best use of boards, it must help members feel comfortable with their roles, and provide instruction in the necessary leadership skills. To date, the results of board orientation have been mixed.

There is no comprehensive training plan for board members. The Department has produced a manual which sets out many valuable instructions, but the lack of training makes many members dependent on their CEOs and the Department for real decisions. This goes against the spirit of the boards and concentrates the power in the hands of a few people.

From our various discussions within the Department, the boards, and other departments, we encountered an attitude that showed a lack of respect for board members. They are not viewed as capable of understanding the complex issues involved. Undoubtedly many are inexperienced, but a patronizing view of members' capabilities is really an excuse for doing little to help them improve. At present the board training only occurs if the boards can find the resources from their own funds.

Without an adequate effort to share the power through board training, the suspicion will continue that the Department wants to keep members ineffective so that it can control the overall administration itself. This then perpetuates the myth that boards cannot do what they are supposed to and the Department is justified in maintaining controls. Also, the boards and their CEOs are expected to make informed planning and budgeting decisions regarding health care delivery in their regions. To do so, they need training in how to deal with these complex issues.

At present, boards work in considerable isolation from each other. They do not share information on trends and innovations. During our interviews, Departmental managers informed us that they do not plan to delegate more control to the regions because they want to retain control in headquarters. This, to a large degree, negates the intent of setting up boards.

It is now four years since delegation. Given the comments we received about the boards' effectiveness, it may be appropriate to review their roles and whether the present format is achieving the objectives set out for them.

1. *The Government should arrange for an ongoing independent evaluation of the role of the Department and the boards, against a set of key indicators developed jointly between the Department and the boards. This will establish whether they are meeting their objectives for greater community service and control and if not, what alternative arrangement might better meet the needs of the public. The evaluations would identify training needs and any required changes in the delegation format.*

2. *The Department, in consultation with the boards, and with clear direction from the Legislative Assembly, should plan and budget for a comprehensive and ongoing training program for board members, at a pace that is acceptable to each board.*

Management responses:

1. The Department would support the evaluation of the role of the Departments and the boards.

2. The Department, in conjunction with the boards, will develop and seek approval for training programs for board members.

chapter 3

PLANNING FOR THE FUTURE

3.1 Planning process

The system has not been well planned and organized to deliver health care in the NWT, in light of the changing environment of health care, the escalation of costs, and the recognition that many causes of death in the NWT are preventable.

We observed a 'planning to plan' posture in the **Department**. Part of this can be explained by the recent attention to health care; part by the lack of a formal planning system. Management spends a lot of time on current issues leaving less time for long term planning. For instance, because of escalating health care costs over the last three years, management has been under pressure from the Legislative Assembly, the Standing Committee on Finance, the Financial Management Board, boards, professional medical groups and the public to contain costs without reducing services. Managers have to respond to all the parties consequently their attention is diverted from strategic issues and opportunities, to dealing with emergencies on an ad hoc basis.

Even though four years have passed since the transfer of health care, the **Department** has no comprehensive long-range plan outlining what the government expects health care to be and how it intends to get there. Instead, politicians and the government are still deliberating about how health care delivery should be defined, what principles and framework should be established to guide development of the NWT health care system, and how community consultation could be sought. A consensus is necessary soon. The fundamental question is whether the NWT health care system is to be based on community care or regional referrals, or a combination of both.

In the meantime, the system is not getting the best value for its investment. The utilization of NWT hospitals is generally low. We prepared the following chart using information from the **Department's** 1990 Health Report, which was tabled in the Legislative Assembly on 25 June, **1992**

The current utilization rates make hospitals extremely expensive, thus denying resources to the community-based alternatives which could reduce the need for and shorten the length of hospital stay.

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. All of the concerned parties do not properly understand or accept the model known as the NWT Way. The present system has many

GNWT Hospital Inpatient Utilization Rates

Hospital	# of beds	1990	1989	1988
Baffin	35	62%	65%	68%
Fort Smith	25	9%	8%	11%
H.H. Williams	50	22%	28%	28%
Inuvik	47	30%	37%	35%
Fort Simpson	14	20%	24%	10%
Stanton	99	57%	47%	45%
Overall	***270***	***40%***	***40%***	***38%***

different interests, all trying to protect their own positions.

Part of the problem is the confusion over planning. The present system has not progressed significantly from the old federal system, although circumstances today are different. The **Department** has not developed a strategic plan or clear statements of policy on health resources in the Territories. Senior managers have developed only a broad "guiding principles" document and have not set direction. With the tough financial situation at present and the high costs of health care, the need for such a plan is vital.

Managers gave several reasons for the delay. For example, the Cabinet has directed departments to review the structure, processes and operations of government. The Cabinet set up an Operational Review Committee (ORC) to oversee this. The Committee directed individual departments to conduct functional analyses to review present programs and services and determine what does and does not work. Departments pass the analysis results to ORC, which will assess the organizational structure supporting the programs and services.

The **Department** planned to conduct a functional analysis prior to its merger with Social Services, but at the time of our audit, the analysis had been postponed. At present, the **Department** is doing a highly focused functional analysis of Health Insurance Services, prior to that division's transfer to the regions. The **Department** planned the original analysis to review the administrative side of its activities, not to change people requirements on the care-giving side. In our interviews, management cited the functional analysis as the primary reason for not developing health care plans. Yet it is precisely this kind of analysis that would help health care planning regardless of departmental mergers.

From our **board** visits, we noted that the excessive delays are adding to the frustration of the **board** staff and their distrust of the **Department's** intentions to work in partnership. In the meantime, the **boards** are assessing their needs and developing plans on their own.

The Government, in conjunction with the Department, should complete the review quickly and make sure that it considers all headquarters functions.

Management response:
The Department supports the conduct of a functional review.

We reviewed the Minister's key result areas, the objectives of the Management for Results System (MFRS), and capital and operating plans to understand the corporate plan. We found no planner, no departmental planning policy, and no cohesive system or team approach to collecting information for planning purposes. Among **Department** and **board** personnel there are many ideas about what a corporate health care delivery plan should look like and many agree that a plan is necessary.

We were told that **Departmental** managers attend planning meetings once or twice a year but they keep no agendas or minutes. Management meetings held monthly deal more with the issues of the day than long-term planning.

Management has not established clear priorities. From our discussions with headquarters managers and board personnel, we note an effort to plan for their respective areas. But these individual efforts are not pulled together into an overall health care plan that is well communicated to managers. Often managers change their priorities to deal with new issues, leaving them with no long-term focus.

Recently the **Department** has initiated a framework to review health services and facilities in NWT communities, in response to a request from Cabinet. The details were tabled in the Legislative Assembly on 26 March 1992, including a description of what the **Department** means by the NWT Way. The **Department** sees this as the start of a planning process. To date, community studies have been completed for Fort Smith and Hay River as part of the initial effort to study the Stanton Hospital catchment area. The **Department** informed us on 11 September 1992 that it intends to complete all the community studies by the end of 1993.

Based on our information and interviews, some **boards** appear to have a useful perspective on long- term health care planning and issues, but do not have formal input into the overall health care planning process. They submit annual budgets and monthly financial and administrative reports to the **Department**, but the board's

concerns beyond the one-year time frame do not formally have a place in the process.

> *We reviewed one **board's** planning process with its Chief Executive Officer. The board has a well defined plan that spans several years. It identifies specific areas that the **board** wants to develop including health care programs, capital projects, and administrative systems. The **board** has estimated the resources needed and developed a strategy to achieve the plans. **Board** management explained that it will respond to the **Department's** one year time frame as requested but will try to build an agenda for its own use.*

The **boards**' main point of contact with the **Department** is the Hospitals and Health Facilities division. As already noted, this Division's orientation is control and day-to-day problem solving, not consulting, monitoring and directing in the conventional sense. Although the division director feels that he does consult and monitor, the **board** staff see the division's present role as a control function. Given this relationship, the opportunity for the **boards** to have input into planning is restricted. More importantly, the **Department's** ability to deal with the leading health issues will be hindered until it is able to receive input from the **boards** and maintain priorities.

In summary, there are many problems with the health care delivery organization and the lack of a long-range plan. Until the problems with unclear legislation and ambiguity between legislation and policy are resolved, health care administration and delivery will continue to be out of balance. Without a plan, NWT health care has no clear sense of where it is going or how to get there.

1. *The Department should negotiate a planning process with the boards which sets priorities and allows both parties to participate effectively in planning.*
2. *The Department should develop a long–term plan in consultation with the boards..*

Management response:

1. In clarifying roles and responsibilities, the involvement of boards in the planning process will be included.

2. Agreed.

3.2 Human resource planning problems

According to the Bureau of Statistics, the estimated NWT population distribution is as shown below.

For the **Department** to make the most of limited resources, it needs to analyze causes of illness

1986

Region	Inuit	Dene	Metis	Non–native	Total	1991
Yellowknife	288	1,218	946	11,247	13,699	15,179
Mackenzie	7	4,481	579	756	5,823	6,688
Fort Smith	72	476	919	1,021	2,488	2,480
Hay River	32	313	703	1,844	2,892	3,206
Inuvik	2,665	2,529	745	1,853	7,792	8,491
Total–west	***3,064***	***9,017***	***3,892***	***16,721***	***32,694***	***36,044***
%	***6%***	***17%***	***7%***	***32%***	***62%***	***62%***
Kitikmeot	3,774	12	17	418	4,221	4,386
Keewatin	5,412	20	14	523	5,969	5,834
Baffin	8,558	25	39	1,654	10,276	11,385
Total – east	***17,744***	***57***	***70***	***2,595***	***20,466***	***21,605***
%	***34%***	***0%***	***0%***	***4%***	***38%***	***38%***
Totals	***20,808***	***9,074***	***3,962***	***19,316***	***53,160***	***57,649***
%	***40%***	***17%***	***7%***	***36%***	***100%***	

and death and match the hiring of health care staff accordingly. This requires the development of a territorial-wide strategy that is fair to all of the **boards** and people in the NWT.

With the majority of non-natives located in the western, mostly urban portion of the Territories and the aboriginal people spread throughout the NWT in smaller communities, care must be taken to ensure that health care resources are distributed on a fair basis.

In the regions there is a need for partnership in developing such a strategy. Managers provided numerous examples of differences in staff levels from one community to the next. For example, of the 1,200 staff in the Territories, nurses make up about one third. But most of the nurses are hospital nurses, and 200 out of 360 are in urban centres. Only 160 community health nurses live in the other communities where the majority of the aboriginal people live, and the leading causes of death are magnified. Under the primary health care model, community health nurses are the front-line care-givers. Although hospitals have adequate staff levels to rotate nurses for shift work, community health nurses are required to be on call 24 hours a day, 7 days a week. The distribution can be traced back to the lack of planning. If the model focuses on referral centres then the system may need more nurses in Stanton and Baffin. If the focus is on the communities, people will expect more nurses in the health centres.

The Nursing Services Division has proposed an assessment of nurses' workloads. The Division is trying to determine if it can better assess staff levels and work scheduling, and if it can relieve community health nurses of some administrative duties so they can concentrate more on nursing. But staff shortages in Headquarters have stalled the assessment process. The **boards** question the reasons for the delays and, in the meantime, some nurses suffer from stress and poor morale. In July 1990, based on data from April to September 1989, a Nurse Recruitment and Retention Study showed nursing staff turnover of up to 70 per cent in the NWT. The **Department** has not published a comprehensive analysis of turnover rates in all regions since then, but claims that in some regions, turnover is significantly reduced since the 1990 report. The **Department** is not clear about whether the reduction is systemic or a function of generally poor economic opportunities for nurses across the country.

In contrast, a supplementary estimate relating to Stanton repatriation as a regional referral centre increased the **Department's** staff by three people and the hospital's by 27. Without a firm policy, the other **boards** see Stanton gaining while their concerns are not addressed.

Strategic planning needs good data. As we comment later, managers rely on systems that cannot produce timely and reliable information. We made three requests to obtain summary data through the Community Health Management Information System (CHMIS), but the **Department** could not produce this due to computer retrieval difficulties.

The Department should develop appropriate workload assessment tools and standards as quickly as possible, and apply them to the communities and all the Boards. The standards should consider all variables such as community infrastructure, support network, housing, population, gender, age, health problems, trends, diet, distance, etc.

Management response:
The Department will attempt to develop workload assessment tools or to utilize those developed elsewhere. Although the Department supports the recommendation, it should be noted that the development of appropriate assessment tools is difficult. Most provinces have not been able to develop appropriate workload measurement tools that fit the needs of their own jurisdictions.

3.3 Budget allocation equity

Through interviews and supporting documentation, we were informed that the leading health problems in the NWT are preventable and that such prevention is linked directly to public health initiatives. The Chief Medical Officer of Health noted that if the health care system concentrated its effort on the most important public health issues, this would have a significant impact on reducing health care costs. For example, lung cancer, violent deaths involving alcohol, suicide, sexually transmitted diseases, aboriginal infant deaths, etc., are far higher in the Territories than in the rest of Canada.

In particular, the **Department** recognizes that alcohol abuse has major implications for society

and particularly native society. NWT residents consume 31 percent more alcohol per capita than other Canadians, and this leads to higher medical and social costs. A report to the Standing Committee on Finance indicated these costs to be $87 to $100 million each year. Ironically, the Government earns about $15 million yearly from its Liquor Commission. Based on the 1991-92 main estimates, the Government invests about $2.5 million in programs for alcohol and drug treatment, through **Social Services**.

Suicide is another example. Suicide in the North is five times the Canadian average, and research indicates that the reasons for this are linked to poverty and limited prospects for opportunity and advancement. This is a recurring theme amongst Canada's aboriginal people. Yet, efforts to curb this tragic loss of life are unsuccessful. **Social Services** provides funding to a non-profit society for managing a toll-free crisis line staffed by volunteers on a three-hour evening shift. Problems arise when the majority of volunteers are unable to communicate in the caller's language of choice. In a crisis situation, comfort levels are critical to ensure understanding and reassurance for the individual seeking assistance.

The above examples show where some government programs may not mesh with each other, and emphasize why co-operation between departments is necessary. The **Department** and the Government as a whole need to reexamine Healthy Public Policy initiatives to ensure that they respond to the causes of ill-health and behaviour, instead of just dealing with the symptoms.

Allocating staff and dollars to the regions needs the perception of a "fair shares" policy. In a fair shares policy, some regions may have to give up resources to those which have less than their fair share. The policy needs an initial commitment to the process and participation of all the parties in developing the formula. Pending the finalization of a health care model and any consequent redistribution, there should be a fair shares formula that allocates any new resources in accordance with the scheme.

At present, health care staff and money are not always invested in the areas of greatest health care needs as indicated by the Department's identification of the leading health issues.

In its forthcoming merger with Social Services, the Department of Health should examine its allocation of resources to see if they can be invested in areas more closely associated with the leading health issues, and monitor the results.

Management response:
Both Health and Social Services are conscious of the need to appropriately allocate resources in any merger.

3.4 Policy harmonization needed

In the absence of a master health care plan, policies may be working at cross purposes.

> *For example, since transfer, doctor cutbacks in the Inuvik regional hospital has led to the Inuvik Medical clinic picking up the slack with a complement of five doctors. They work out of a clinic on a fee–for–service basis and are doing some work that could be carried out by nurse practitioners in the region. The costs of supporting the clinic are significantly higher than nurse practitioners. The* ***Department*** *noted no observable health benefit from the Inuvik situation. Also the* ***Department*** *was concerned about damage to the delivery system where the expectation of the population is based on high cost doctor's services when nurse practitioner services would suffice.*

Once the parties have agreed on a health care model, the Department should develop appropriate policies to ensure that private clinics do not result in higher than acceptable payments for health care in accordance with the model.

Management response:
The Department anticipates that the NWT Medical Association and consequently the private clinics will be participants in any new health care model. The Department, as part of its ongoing operations, will continue to monitor the provision of professional services.

chapter 4

MANAGING PEOPLE

4.1 Introduction

The number of persons working in the GNWT health system (2.4 percent of the population) does not differ significantly from the Canadian average.

While most managers are used to managing budgets and administration, many are less comfortable with managing people. In health care, even with increasing technology, people remain at the forefront of dealing with the patients. With a people-dependent system, organizations must help the people they hire to achieve their potential. Human Resource Management (HRM) means that the different parts of an organization have to work together to make the best use of the people hired and to keep them happy and productive. In most organizations, HRM is supported by the systems, people management and support mechanisms.

For human resources to contribute efficiently to health care delivery, management must plan the right mix of staff to meet the health care requirements of the population. In the NWT, Human Resource Management is split between **Personnel**, the **Department** and the **boards**.

The Department of **Personnel** is responsible for serving GNWT departments, boards and agencies in recruiting, developing and retaining people, and ensuring fair and equitable treatment of employees. Specifically, **Personnel** is responsible for job classification, labour relations, equal employment, employee benefits and staffing services.

In 1988, **Personnel** entered into service agreements with each **board** covering both direct and indirect services, such as advertising, recruitment travel, vacation travel assistance, employee removal and medical travel assistance. On July 25, 1991, the Executive Council reduced **Personnel's** direct services to **boards** to employee removals.

To keep the health care system running smoothly, the **Department** and **boards** must be able to determine future staff requirements and the availability of suitable candidates, keep track of how well people work, help people get better at what they do, this information has to be available quickly and accurately. Special care must also be taken to hire staff who are sensitive to the health problems and cultural differences of all the NWT's people.

We interviewed senior managers in the **Department** and **Personnel**, as well as CEOs and managers from four **boards**. Additional input came from various documentation and our survey results. We also interviewed 10 staff members and sampled 50 personnel files from the four **boards** and the **Department** to assess existing HRM practices covering recruitment to resignation.

Systems	People Management	Support Mechanisms
- Planning	- Leading	- Organization
- Hiring	- Organizing	- Policies
- Training	- Two-way communication	- Directives & guidelines
- Performance management	- Involving	- Processes
- Job evaluation	- Empowering	- Information reports
- Compensation	- Motivating	- Control
- Staff relations	- Evaluating	- Performance evaluation and feedback
	- Rewarding	

4.2 Employment equity

4.2.1 Aboriginal employment equity

For a public service to best represent the population it serves, it needs to plan and implement fair and equitable policies. We found that the Department has not significantly increased aboriginal involvement in health care delivery, although this is a policy objective. At present aboriginals make up about 11 percent of the Department's staff compared to 45 percent of the work force.

*Under the primary health care model, community health nurses are seen as front–line care–givers. At present, of the 365 registered nurses, only two are aboriginal. **Arctic College**, in conjunction with the **Department** and **boards**, has planned a Registered Nurse program that will seek to improve access for aboriginal students. A co–ordinator will be hired in the fall of 1992 with an initial task to secure funding as a condition of the RN program going ahead.*

*Another opportunity for aboriginal involvement is in midwifery, which is reaching full accreditation levels in some provinces. One of the Minister's key results areas was to develop a pilot project in Rankin Inlet. The project is scheduled to start in October 1992 and will be further studied by the **Department**. Managers need to study further the financial implications of the expanding role of midwives in the NWT. Midwives would re–introduce traditional aboriginal health practices. The present delay defeats the stated purpose of increasing aboriginal representation in a health profession that would blend both traditional and modern practices.*

*The **Department** has a better track record with Community Health Representatives (CHR) who are para–professionals working in communities. Their job is to provide local health education, disease screening, and health status surveillance for the community.*

*The majority of CHR's are aboriginal, since candidates are selected from the communities where they will eventually work. Except for Yellowknife and Hay River, aboriginal people are the majority in all regions. Past funding arrangements required that a position be vacant before training a replacement. But funding problems are affecting this initiative. On occasion, positions left vacant in the winter remained vacant until the next annual round of training took place in September. Client–group needs remained unfulfilled and there was a risk that candidates identified for training would make alternative plans. To deal with this timing problem, the **Department** has proposed training a pool of candidates. However, several organizations combine to provide CHR training funding, including the federal and Territorial governments. It is possible that aboriginal training may be amalgamated under the Employment and Immigration Commission's PATHWAYS program, a fixed–funding arrangement to ensure dedicated resources for Community Health Representatives training. Such an amalgamation would ensure that dedicated resources are allocated for training CHR. However, this move has still to be confirmed.*

The Department, in pursuing an equitable distribution of training dollars, should address the issue of increasing aboriginal representation in those health vocations that are particularly concerned with delivering health care services to aboriginal people.

Management response:
The Department is concerned about increasing aboriginal representation in health vocations and is pursuing the matter through Health Career Promotion Activities. Unfortunately, the matter is more complex than simply the distribution of training dollars and it requires concerted effort to increase the number of high school graduates in the NWT.

4.2.2 Health bursary program and aboriginals

The Department manages the NWT Health Bursary program, which assists all NWT residents and non-residents who wish to pursue a career in health care. For 1991-1992, $35,000 was committed to the Program. Of the 162 applica-

tions received since 1988, 103 were approved; of these five were aboriginal. According to **departmental** documentation, few aboriginal people apply. Those who do apply are not given bursaries because it has been the practice of the Selection Committee not to duplicate funding for which aboriginal people born and raised in the NWT are eligible under other educational assistance programs.

The Department, in keeping with the philosophy of increasing aboriginal representation in the health care system, should ensure that education assistance funds are available for this purpose. Furthermore, the Department should ensure that eligible applicants are denied funding only if they are able to secure support from other sources, not because they may be eligible for other source funds.

Management response:
The Department of Education already provides extensive funding assistance to aboriginal students. In order to increase the number of students going into health courses, the Department is working with Education on health career education. With respect to the NWT bursary program, the Department has been following the recommendation. Eligible applicants were denied funding assistance only if they had received alternate funding.

4.2.3 *Aboriginal employment in boards*

To increase aboriginal involvement in the health care system requires a dedicated effort to hire, orient, train and develop aboriginal staff to maximize their retention in the system. The philosophy behind employment equity or affirmative action is to develop a public service that represents the population it serves.

We examined the **Department's** and **boards'** affirmative action efforts towards aboriginal representation and noted that the **Department** in Yellowknife submitted its first and only plan in 1989 and has not updated targets since then.

According to **Personnel** officials, the Government target-setting did not cover hiring, orientation and training requirements to promote retention of aboriginal staff. As well, targets were not supported by a workforce analysis and a comprehensive human resource plan. Target setting is difficult because aboriginal students make up only 10 percent of all NWT high school graduates. At the same time, our analysis of statistics indicated that **boards** have been better at increasing aboriginal representation, with about 40 percent. It is lower in the western urban centres, about 12 percent. Although these percentages reflect the local population mix, aboriginal representation in the **Department**, at 11 percent, is much lower than the NWT population.

The Department should revitalize the affirmative action plan to recruit and retain aboriginal employees.

Management response:
The Department is aware of the need for and does encourage the recruitment and retention of aboriginal employees. It is agreed though that the Department's plan does require updating. This will be done and where possible in conjunction with other government entities.

4.3 Boards' hiring efficiency

Hiring staff who are willing and able to work in the remote conditions of the North has always been a challenge for any organization in the Territories. This is particularly so for health care workers who are recruited mainly from the south. In addition, recruitment efforts are complicated if different players are targeting the same market for health care staff.

We found that **Personnel** recruits staff for the **Department** and assists four of the eight **boards** who handle their own recruitment and staffing with help from local **Personnel** staff. The remaining four **boards** do their own hiring without assistance. The **Department** provides recruitment services on an as-needed basis to the **boards**. There can be several players competing for each health care professional. This complicates the task of trying to obtain the right person for the right job at the right time.

Personnel is revising its staffing process for better job matching. **Personnel** managers advised us that they are not sure they will apply the new process consistently in all the regions al-

though the boards must use Personnel policies. The Department hopes to improve personnel practices when it finalizes Memoranda of Agreements with the boards to transfer Personnel staff to the boards.

We reviewed the time taken to staff a position. Regional staff were able to recruit and staff positions in half the time required by Personnel in Yellowknife. We did not audit whether there were any differences in the quality of staff hired. In our view, using turnaround time as a criterion supports the Department's efforts to transfer the personnel function to the boards.

The Department should finalize the transfer of personnel positions to the boards as soon as possible, and develop appropriate co–ordination to ensure that boards are not competing for the same potential employee.

Management response:
The transfer of Personnel positions has been initiated. All boards will have a similar recruitment and staffing capability. The recruitment of nurses is coordinated with the boards.

4.4 Employee orientation

Any organization seeks loyalty and commitment from its employees. This helps to keep staff turnover low, as well as minimizing recruiting and training costs.

There is an added challenge in the North, with its harsh conditions, which can sometimes get the best of even the most dedicated employee. Before hiring a southern based person, it is very important to assess the individual's personal suitability for the North. The hiring process is where this should happen.

We interviewed Department and board administrators and employees to determine how they assess the adaptability of new employees and their families to the working and living conditions in the North. In all cases, our interviewees noted that current recruitment and orientation practices are more concerned with assessing the technical competence of an individual than with whether the person is capable of adapting to life in the North. Management stated that because of Human Rights legislation, recruitment efforts cannot assess the personal suitability of the family unit along with the candidate. With winter in a remote community being long and hard, assessing the adaptability of the family unit is just as important as assessing the adaptability of the candidate. However, even if legislation prevents an assessment of family suitability for life in the North, realistic information packages coupled with the offer of counselling services may offer family units an opportunity to gain needed information before committing to a move. A better job of doing this could help to reduce the high turnover rates.

We also examined rating guides and job descriptions used to match the candidates potential to job requirements. We sampled 50 files and, in all cases, the person doing the hiring used the standard Government rating guide with little if any reference to the personal suitability of the candidates. We also sampled various job descriptions. We noted that all senior staff in the Department and the boards have job descriptions describing in detail the need for sensitivity to the cultural diversity in the North. Yet, less than five percent of job descriptions for subordinate staff made any similar reference, even though these staff are more often in day-to-day contact with aboriginal people in the communities. We found no requirement to train new staff about cultural sensitivities.

We reviewed written materials, such as job advertisements, used in recruitment practices. Personnel and the Department's materials tended to be bland and uninteresting. In comparison, board recruitment materials emphasized the client group in an attempt to increase the incoming professionals' awareness of the unique characteristics of the environment and population of the health centre or hospital concerned.

We also noted that the Department's HRM division does much of the same recruitment work as is done by the boards particularly in advertising for nurses. The division advertises generally and the boards only when they have a specific need. The result is a possible duplication of advertising costs, which could be avoided.

The division does little towards human resource planning, affirmative action or orientation, which are part of the Division's responsibilities.

The Department should consider the desirability of eliminating the recruitment function from the HRM division and redirect recruitment dollars to the development of rating tools that will assist

boards in assessing the personal suitability of candidates to the North. Once hired, staff should be oriented to the requirements of the people and working conditions in the NWT through some form of mandatory in–house cross cultural awareness training.

Management response – Department of Health:
The functionality of the HRM Division will be determined in an overall functional review and in the clarification of roles and accountabilities.

Management response – Department of Personnel:
All new employees in the GNWT will be required to take cross cultural awareness as a part of their orientation. Cross cultural awareness programs are available for existing employees through the Department of Education.

4.5 Monitoring staff performance

Both the Department and the boards need to monitor staff performance critically to assess the quality of health care being provided and to control costs. Without some form of consistent performance evaluation, management cannot know if performance is satisfactory. Management also needs to know an individual's strengths, weaknesses and commitment to the health care system and whether the individual's own needs are being satisfied. An adequate performance evaluation system is important for making sure that employees have an opportunity to state their problems and concerns, as well as receive feedback on their own performance. Performance Review and Planning (PRP) is the management system used in the Government.

Personnel develops broad policy guidelines for performance management. Proposed changes to the guidelines will match the performance review date with the employee's hiring date. To be useful, appraisals must be done regularly. Personnel is responsible for monitoring the completion of performance appraisals. Based on 1991 information from PRP, the Department had completed 43 percent of its appraisals, and the boards averaged 29 percent.

If it is used properly, PRP can be an early warning to the Department of where things are not going well. But PRP must be kept up to date to be useful. For example, Inuvik Regional Hospital has been the site of labour disputes over the last year. In the mid-70s, during the peak of oil exploration, accident levels justified a high number of nurses and doctors at the hospital. Energy companies have since reduced exploration and related medical activity has fallen. With the Department downsizing the hospital, the possibility of staff cutbacks has resulted in tensions with management.

We reviewed three years of overtime in Inuvik and noted high overtime costs. There were inadequate controls and staff scheduled their own overtime at the expense of the budget. Overtime earned by some staff almost equalled their salaries while working in the Territories. Management has since put in controls to prevent this from happening again. This has led to further conflict, with nurses petitioning the Legislative Assembly seeking changes.

Boards and the Department failed to encourage consistent monitoring of employee performance.

Of the 50 files we sampled, less than five percent of job descriptions had objectives that could be considered measurable. Of the employees interviewed, nine out of 10 viewed PRP as a paper exercise with the same indifference for the system as expressed by management.

1. *The Department and the boards should implement a Territorial–wide performance management program and ensure that:*
   a. *all levels of supervision in the boards/HQ are trained in monitoring and controlling employee performance; and*
   b. *they appraise the performance of all employees regularly.*
2. *All managers should be trained to assess the adequacy of performance plan objectives and to ensure that supervisors are not encouraging a paper exercise at the expense of the process.*

Management response:
The Department supports the completion of performance appraisals in collaboration with the Department of Personnel. The Department, in conjunction with the boards will review the performance review process.

4.6 Doctors

Of the 59 doctors residing in the NWT, 37 are fee earning, 21 are salaried GNWT employees and one is on special contract through Manitoba's Northern Medical Unit. The Government registers and licenses doctors, which gives it considerable power to make the system effective.

With increased competition for limited health dollars, more doctors are accepting salaried positions rather than sole-proprietor or partnership practices where their income is fee based. Creating more salaried doctors, or per diem arrangements is a policy decision of the **Department** to better control expenditures. Other jurisdictions are looking at increasing salaried doctors positions as one ingredient of controlling growing health care costs. The move towards salaried positions is not popular with some doctors who consider the employer-employee relationship may be detrimental to their traditional independence. With the move towards more salaried positions comes an increasing demand for the more traditional employee accountability measurements, including employer-set performance standards.

4.6.1 Performance standards for doctors

Traditionally, doctors have been evaluated by their peers through acquired reputations, or in other cases, through malpractice hearings. As more doctors become employees, the question arises whether their performance should be assessed by the employer similar to the assessments made on other salaried professionals. In any event, rising health care costs may force governments to set performance standards for doctors and periodically evaluate performance against the standards. According to **Department** management, they have no standards to assess doctors' performance, although they do have standards to assess nurses. The **Department** has not developed a monitoring process for either salaried or fee-based doctors.

The treatment of salaried doctors is inconsistent. **Boards** have not standardized contract terms and some are more generous than others. We examined contracts of four doctors on salary and noted significant differences in the leave entitlements for two out of the four contracts sampled.

We discussed the contracts with **Departmental** managers, who told us that doctors' contracts in one **board** are unique in the NWT health care system in terms of the rewards.

> *In particular two doctors on salary in one **Board** have unique arrangements for time–off. They are eligible for 16 compensatory days per year for being on call and up to 26 days per year to do paper work. Other salaried doctors do not receive the same time off. Compensatory days off for being on–call are allowed under the contract, but time off to do paperwork is taken out of tradition and is not included in the contract. More important, the contracts have no expiry date and no cancellation clause.*
>
> *Time off for paperwork is a point of contention with **board** management. One of the doctors took 22 days off for paperwork in 1991 and earned a total of 30 on–call compensatory days. The other doctor took no time off for paperwork and earned only 15 compensatory days for on–call work.*
>
> *The lack of clear accountability through performance reviews, and the lack of a sunset clause in these two contracts means the incumbents are virtually secure for as long as they wish to be employed. There is little the **board** can do to change the situation. Without review mechanisms, these contracts are an example of where employees can drive the system without risk to their continued employment.*
>
> *In these contracts, because they lack a cancellation clause, the **Department** and the **board** have no method of dealing with poor performance should it become an issue. In comparison, the other NWT doctors' contracts that we sampled, contain no reference to on–call compensatory or paperwork leave. The other contracts have an expiry date.*

The Department has no process for comparing the billing practices of NWT doctors. But it is trying to develop an annual review, or "calendar review", of individual doctors' billings. The Department will confirm with patients that they visited the doctor on a particular date, and the Departmental staff will visit doctors' offices to review their records. So far the Department has only completed one of these "calendar reviews".

As the Department develops the methodology to conduct these "calendar reviews", it will also need to develop means of comparing billings between various doctors and ways of investigating significant differences.

The Department needs a contract with standard performance criteria to assess the effectiveness of work practices. With rising health care costs, achieving a more economical and efficient use of resources will demand tools to assess and reward good performance.

4.6.2 Conflict of interest

In most organizations, employees or those with contractual relationships to the organization are usually expected to comply with certain codes which prohibit public statements criticizing the organization. If changes are needed, individuals are expected to work from within to get them made. In the NWT there are many players with interests in health care, most of whom derive their livelihoods from public funding. Yet some health care professionals also hold positions in professional organizations which from time to time may put them into conflict with Government.

This raises the question of whether all such relationships with the Government should prescribe remedies in cases where conflicts of interest arise, and all contracts should include both performance appraisal criteria.

Cost effective health care requires a well functioning partnership among all stakeholders, including professionals, patients, Government and administrators. One important stakeholder group is NWT residents who are all patients or prospective patients. With the leading health issues impacting mainly on the aboriginal population, the needs of this group should be considered carefully.

This makes a policy role for health care professionals important, but not more so than the majority stakeholders. While professional groups have their own interests to advance and advocate, these should not drive the entire system. In his publication *The Devolution of Health Care to Canada's North,* Geoffrey Weller comments that the system's small size would make it easier to become controlled by a dominant group such as physicians or administrators. It might then become responsive to their wishes, not those of their clients.

The Department, in concert with the professional associations, should consider developing standard contracts for health care professionals, including performance criteria, to assess work practices, as well as conflict of interest definitions and remedies.

Management response:
The Department will review board contracts with physicians and develop standards where appropriate in conjunction with the boards.

4.7 Reasons for staff leaving not known

To improve people management practices, the system needs better information on the reasons why employees resign. To determine whether an employee leaves because of unfulfilled expectations from the employer requires asking the right questions prior to that employee's departure.

In our sample of files, staff with less than two years on the job accounted for more than 75 percent of the turnover cases examined. Yet, Personnel confirmed that no one holds exit interviews to better assess the reasons for this. At the time of the audit, although the Department, Personnel and some of the boards were planning this type of assessment, no one had a process to determine reasons for leaving and how to better address employee needs.

The Department, in co–operation with the boards, should develop a Territory–wide system of exit interviews to assist boards in assessing the adequacy of their HRM practices.

Management response:
Agreed. Exit interview formats have been developed and are being tested as of August 1992.

4.8 Training and development

How well staff match the job requirements depends on how well the employer has assessed the knowledge and ability of the employee at the time of hiring. Unless the employer has unlimited time to hire or a large number of candidates to select from, it is rare that an employee can be hired who does not require some form of additional training.

4.8.1 Planning and funding

Training and development costs come out of discretionary funds. A department's commitment to a training budget may disappear if it has budget problems in other areas. The **Department** has significant budget problems with cost unpredictability. As a result, with the hiring freeze announced in November 1991, training for the balance of the fiscal year was put on hold. We reviewed training taken in the **Department** in the last three years. It had a heavy emphasis on computer training, with little in the way of management courses taken by key players in the **Department.**

The Government's proposed human resource planning policy will focus on the training needs of employees. Our review of the roles and responsibilities in the **Department's** Human Resources Management Division reveals more time devoted to tracking where dollars were spent than to planning where dollars should be spent. At the time of our audit, the **Department** was developing training guidelines which have been lacking to date.

We noted that **board** training budgets are not planned in co-operation with headquarters. For 1992-1993, **boards** have no fixed budget for training. The **Department** leaves it to the **boards** to locate dollars from within existing budgets. The budget process requires that the **boards** identify all future spending on a line-by-line basis, and that re-allocating dollars to other initiatives such as training is next to impossible without giving up something else.

*Of the 50 files sampled, less than forty percent of the employees had training and development initiatives planned and taken. This is not surprising since this part of the process is usually completed with Performance Review and Planning which is not working well. Of the employees we interviewed, the majority associated training opportunities with conference attendance, on occasion combined with vacation or business travel to maximize limited dollars. In addition, high turnover rates in the **boards** does not provide adequate time frames for employees to use the training in a way that will have a long–term payback for the organization and the employee.*

4.8.2 Inequitable training budgets

For training to address future gaps, it must be planned and aimed in the direction of greatest need. We found that training dollars are not distributed equally between the doctors and other health care staff.

*For example, the **Department** allocates funding for the Advanced Nursing Skills Inservice Program (ANSIP) of approximately $400,000 for 365 nurses. By comparison, a doctor on contract has the benefit of two to three conferences per year which can add up to between $8,000 to $10,000 per doctor for their professional development.*

From our interviews with **Department** management and nurses in the **boards**, this is viewed as a constant source of discontent amongst the community health nurses, who, under the primary health care model, are intended as the front-line care-givers in the NWT.

The **Department** management confirmed that no work has been planned to address static funding levels for ANSIP, and they expect little future change. But national trends in medevac training support the need to fund the development of appropriate ANSIP modules in the near future.

After completing the Human Resources Plan, the Department should develop, in consultation with the boards, a training strategy that assesses staff potential and gaps, organizes training and development programs and distributes resources equitably between the competing demands.

Management response:
Training will be reviewed in consultation with the boards. Financial support for training and development programs will be explored.

4.9 Human resource management system

An organization needs good information to manage its human resources. It must be able to know who is working where, when they were hired or fired, what training they have taken, how much they are being paid, when they will be taking holidays, retiring, etc. An information system is only as good as the data it contains and the information it can provide. The system becomes unreliable if information is outdated and regular updating is neglected.

The Government's human resource information system is the Human Resource System (GHRS). To assess GHRS's planning potential, we questioned senior officers in the **Department** and **Personnel** and surveyed management in the **boards**. Some mentioned that the system is limited due to inadequate staff and dollars to implement it across the Territories. Others confirmed there is no policy to apply the system across the Territories, and as a result, different **boards** have their own processes resulting in multiple hardware, software and service agreements.

Two of the eight **boards** have not implemented the system and the data for human resource planning is incomplete as it lacks data on those two **boards**. In the meantime, the **Department** has a separate LOTUS 123 program to track salaries and positions through the Hospital and Health Facilities division. The Human Resources Management division borrows this information for its own purposes. The HRM division had not been aware that the other division had this information until our audit.

We reviewed the system's capabilities and noted that it is limited to management of leave, position control and providing information on incumbent employees. A printout sample of GHRS information on **Departmental** employees revealed that the system was used mostly for leave management and position control with inconsistent input of employee information. According to **Personnel** officials, although they have plans to incorporate payroll and training components into the system, limited time and money has delayed this.

The GHRS does not link to a payroll system. All of the **boards** continue to use the Manitoba Health Organization (MHO) payroll system. Some provinces, such as Alberta, have developed hospital-based payroll systems that are the equivalent to MHO.

Given the mixture of opinions and systems noted above, it is our observation that the **Department's** implementation of a useful human resource planning tool lacks a clear vision and direction.

The Department, in co–operation with the boards and Personnel, should assess and develop a strategy to have their human resource planning requirements met through GHRS or a comparable system.

Management response: Agreed.

chapter 5

INFORMATION MANAGEMENT

5.1 Introduction

Complex organizations need good information to work properly. Some of the information is formal, such as bookkeeping and computer systems, while some is informal, such as people speaking to each other and sharing information. Rarely is oral communication documented and it is often subject to misinterpretation. For the oral exchanges, such as occur in meetings, we asked for agendas and minutes but these are usually not kept. Our audit focused on the information in more formal systems, such as the various computerized systems and reports that the **Departments** and **boards** use in their everyday work.

Information is both a resource and a tool to make informed decisions. Managers must have information that meets several criteria including usefulness, comparability, accuracy, accessibility and timeliness, as well as being responsive to changing requirements. How managers use the information is equally important.

The way health care is organized affects how information is used by managers. With decentralization of health care delivery, the quality and flow of information between the **Department** and the **boards** becomes even more important to managing and administering health care programs.

In essence, information management involves understanding the kinds of decisions that need to be made, identifying the information needed to make them and then providing it to those who need it.

Overall we have serious concerns about the **Department's** information systems. They do not provide information on leading health issues in the NWT. Nor are they structured for health care planning now or in the future. Information is hard to get, and what is available is not complete or accurate. It is not used consistently to monitor, analyze, or evaluate results. A lot of health care data are unreliable and some information is not accessible, either rapidly or completely, from the systems that are in place. Managers compromise by recycling information and using ad hoc indicators to help them know how well their divisions are performing.

5.2 Information needs

The health care system needs good information to make sure that policies and resource allocation achieve the desired results, as well as for basic control and accountability. Yet the **Department** does not have such a system to collect and process information relevant to planning and monitoring health care in the NWT.

With a concerted effort, some of these needs can be achieved by using existing systems to their full potential and making information accessible to all managers.

5.2.1 Research

As well as requiring day-to-day information for managing its operations, the **Department** also needs information about future issues that may indicate the need for a change of direction, or refocussing people and money on new issues. One way to identify such issues is to use research. But the **Department** has no research resources of its own and research data are poorly managed. The **Department** has no policy governing health research and does not go out and have research carried out in specific areas. The researchers usually initiate health research projects on their own rather than through a management decision process. There is no management process to make sure that research is steered towards program needs.

The **Department** co-ordinates and administers research with the National Health Research and

Development Program (NHRDP) of Health and Welfare Canada. The program funds research projects which are mainly scientific, often with no immediate practical application.

To date, Canada has provided research funding for 21 projects totalling $2,574,600. Seven involved field work and one, evaluating food, nutrients, and contaminants in Fort Good Hope and Colville Lake, is complete. Managers indicated that they have no specific use for the study and do not expect the results will affect policy or programs.

Project monitoring arrangements between Canada and the **Department** are not well established. Researchers provide interim reports to the federal department but do not have to share them with the **Department**. At any point in time the **Department** may not know the status of a project and whether it is progressing consistent with plans. This raises a question about the **Department's** co-ordinating role with the federal government.

The Scientist's Act requires researchers to submit an annual status report on projects to date. For health research, this is not done. The **Department** has no arrangements with the Science Institute to receive health research reports.

At present, it is difficult to see what benefits are coming from NWT health research. An effective research policy should reflect the long-range objectives of health care and should state what kind of research is desired, how it will be used, the responsibility for project monitoring and the kind of monitoring to be performed.

Management should develop a focused research policy and negotiate its implementation with both NHRDP and the Science Institute in conjunction with the boards to ensure participation, relevance to regional needs, and action on results.

Management response: Agreed.

Since 1984, the **Government** received $196,429, of which $58,000 has been received by the **Department** since 1990, in Northern Oil and Gas Action Program funding to collect health status information on NWT communities affected by oil and gas exploration. In 1990 the **Department** modified the project by adding more communities into the scope reflecting new NOGAP program goals and is assembling baseline, or known, information on them. The information is being extracted from existing departmental and external sources. The **Department** informed us that these are data studies and they do not need site visits. To date the project is incomplete and staff attend to it when time permits. This project has the potential to be a cornerstone for preparing health profiles on all NWT communities.

If these data are important for decision making, management should complete the project promptly.

Management response:
The above information refers to two projects of which only one is active. The first project was completed in 1986–87. The second or active project will be completed when an epidemiologist comes on staff later this fall.

5.3 Data Processing

There are two main departmental systems that collect patient and treatment information: Health Insurance Services (HIS) and Community Health Management Information System (CHMIS). We reviewed both of these. We did not review the government-wide Financial Information System (FIS).

5.3.1 Health Insurance Services (HIS)

HIS is a collection of subsystems that process medical claims for extended health benefits (EHB), additional assistance (ADA), Medicare, Territorial Hospital Insurance Services (THIS), medical travel, pharmacare, and registration. The **Department** records nursing station activity in the Community Health Management Information System (CHMIS). All except CHMIS are the responsibility of one director.

HIS functions mainly as a billing process. It is not used for planning because it is not flexible enough for analysis and there is no provision for feeding results back to managers. It contains pertinent data for analysis of health care costs and outputs but it is difficult to obtain this information in a useful format.

The **Department** has no established information processing criteria for HIS. The systems staff responsible for handling non-routine processing of HIS receive many special requests for HIS data analysis from a variety of users. We re-

is not distributed routinely to community nurses. Since community nurses complete the forms for the data that goes into this report, the report should be circulated back to the nurses so that they can see the compiled results of their work. If any data requirements are re–written, the Department and the boards should involve the nurses in the process.

Although the Department has problems with data accuracy, both HIS and CHMIS contain valuable health status data. However, they are two separate systems that cannot merge their data. Diagnostic data are incomplete if taken from one system but not the other. Therefore, to compile diagnostic data, staff must manually combine information from the two systems.

The Department should develop an information strategy to assess system capabilities against information needs. This should include both the Department's and the boards' needs. If the Department intends to use diagnostic and treatment data to evaluate the health status of residents and determine health care delivery, then the two systems should be merged into one complete data base.

Management response: Agreed.

5.5 Information sharing

Information is costly. Like any other resource it needs to be handled economically and efficiently. Many managers do not realize how expensive good information can be. It makes sense to capture it once, process it efficiently and then share it among the people who have a need for it.

We reviewed the processes for program evaluations, policy and legislation and interaction with boards to understand how information is shared for health care delivery, and how other information is shared with those in need.

5.5.1 Monitoring, evaluating, budgeting

The Department's own system reports would be a natural basis for budget information. Yet, HIS reports need improvement to make them more useful for management, monitoring, forecasting and planning of Department program areas, as noted in recent reviews of HIS. The Department and boards recognize that information in CHMIS reports is unreliable or deficient.

For budgeting and Operating Plan purposes, few, if any, system reports are used. Generally, the budget is based on the prior year. We surveyed four managers who explained that their budgeting process involved a combination of historical data, assessing key objective areas, adjusting for known price increases and then allocating the resources. With price and volume data contained in HIS and statistics in CHMIS, planning and budgeting would benefit from better use of the information resources at hand. In other words, the systems have additional information that would be useful, if managers could extract it easily.

We asked managers to describe how they monitor and evaluate their programs. They said they use a variety of indicators to measure program performance: built-in system checks and edits (HIS), staff meetings, audits, variances, achievement of work plans and time schedules. Although these are all useful indicators, there is no creative use of existing system information. Managers do not rely on internal reports such as error listings, efficiency, output and cost/volume analysis. Board managers also indicated that they did not rely on the Department's statistical information because it was either not available when needed or not reliable.

Regular variance analysis reports using key indicators developed by the division managers and approved by the executive are important. Performance reports which allow comparisons with peers are usually treated as important by managers. With the availability of computerized systems, such reports should be available.

5.5.2 Information sharing among managers

We observed that managers do not effectively share information among themselves. Managers hold meetings and they have access to systems reports, albeit the reports are not very good. But few managers appear to know the products or needs of other divisions and use the knowledge for their own or collective purposes.

For example, the Hospitals and Health Facilities Division has a lot of board documents including surveys, insurance policies, job descriptions, bylaws, forms, contracts, financial statements, budgets,

correspondence, etc. In many respects, the information resembles a library occupying at least seven large four–drawer file cabinets. The library may not be complete, but its contents are nevertheless comprehensive and potentially useful to other managers. However, there is no routine sharing of this information with other managers.

The Health Insurance Services division, by comparison, has price and volume data on health services, but again, other division managers do not receive or use reports from HIS for their own needs. This again could be changed if the data could be extracted easily.

5.5.3 Information sharing between Boards and the Department

Based on interviews and a questionnaire, we have concerns about the lack of meaningful information sharing between boards and the Department. The board managers' main complaint is the lateness of information they receive from the Department. They also have concerns about poor quality of information, which they feel is often redundant, not useful and unreliable.

Mostly, information flows from boards to the Department. It is usually financial and administrative data, which adds to the boards' concern that the Department is trying to control all their activities to the lowest level. Reports sent to the Department are monthly financial statements, bank reconciliations, variance reports, accounts payable and accounts receivable reports.

Board managers feel that the Department does not share valid information with them. Operational and strategic information is not compiled for the boards. Board managers indicated that they would like to receive certain information such as utilization reports (ie. medevac), strategic plans, and community disease profiles. Without this shared information, board managers use other sources to meet some of their information needs.

For example, boards do not receive timely and comprehensive reports on their hospital, health centre and nursing station activity from the Department. Instead, they purchase the Hospital Medical Records Institute (HMRI) reports from an external source. This provides information about their hospital services but does not include health centre or nursing station statistics. In spite of this, managers still think the report is useful.

Boards consider the HMRI information more timely and reliable than information available from the Department. They consider the HMRI reports to be well summarized and presented. This report contains statistics on other Canadian hospitals which is useful for comparing size and nature of hospitals.

The Department does not receive the report regularly, but given the popularity of the report in the boards, there may be cost efficiencies to purchasing it centrally and adding this information to the total health care information network.

Some boards collect and process their own statistical data without waiting for the information to be processed and returned by the Department.

The boards also collect information that they do not share with the Department, including quality assurance audits, health needs assessments and regional health trends. In many instances the boards have had to design new systems or hire outside help to get the information that the Department could not provide for them.

The Department should improve the overall quality and timeliness of information and the sharing of pertinent information with all parties on the basis of need. Then it should encourage all managers to become familiar with information from other divisions and boards.

Management response: Agreed.

5.5.4 System Interaction

The three systems used for health care delivery - HIS, CHMIS and board accounting systems - all have a common problem in that collecting and analyzing their data is difficult. Some of the systems can be programmed to generate analytical information, others cannot. Using important statistics for health care planning requires specialists to analyze and interpret the data. The Department cannot do this because it has been unable to staff positions for an epidemiologist and health statistician. To get analytical data or compile information, managers use personal computer software as their analytical tool. The

viewed the special requests for a recent 12-month period and noted that a significant number of these were met, but few resulted in programming changes to the HIS system. There is no assessment of the requests to determine if users' needs are being met. Many requests needed a special extraction program written.

Management does not monitor the HIS system routinely. It does not review or spot-check the validity of input data, relying instead on soft indicators such as complaints and staff meetings to indicate problems. Although such indicators can be reliable, more routine and tangible monitoring would give management continuous information about claims processing.

The problems with the HIS are not new to the **Department**, which completed its own internal review of the system in September 1991. In February 1992 the **Department** also received an external review called the Tamarack Report. This study noted an urgent need for information to assist the managing, monitoring, and cost forecasting of programs. We agree with the general recommendations of the studies.

The Department should take action to improve the flexibility and usefulness of the HIS system.

Management response: Agreed.

5.3.2 HIS coding

There are two different kinds of codes used to record and process health care claims for Medicare: international medical diagnostic codes (ICD-9), and fee codes. There are no treatment codes. The **Department** receives Medicare claims from hospitals or physicians using ICD-9 codes which detail the diagnosis. The Government has set up its own fee codes which are used to record the cost of the patient's treatment and process its payment.

We found that codes are not used effectively and that there is a misuse of codes, indicating that the accuracy of health statistics is questionable.

People filling in the claim forms often use general rather than specific ICD-9 codes. The coding does not permit analysis or evaluation because HIS cannot match the diagnosis codes to the relevant costs thereof.

Too many people use codes that are too general, which limits the usefulness of HIS data for analysis or cost monitoring. We sampled four claims and noted that codes varied for the same condition and were frequently not specific.

> *For example, one patient was initially diagnosed with an "unspecified open wound". Another code for service performed on the same date for the same patient indicated treatment for "open wound - forehead". The claim code used for the charter flight on the same date indicated an "open wound unspecified site". Subsequent claims used codes indicating treatment for "unspecified open wound of scalp", "unspecified open wound of head", "open wound structure mouth (gum)", finally ending with claims for treatment of "depressive disorder not elsewhere classified".*

The ICD-9 coding system contains enough detail coding to describe exact medical diagnosis, but because users do not code things accurately, this limits the value of information.

The Department should ensure that claim forms are completed more accurately and more thoroughly and that compatible codes are utilized.

Management response:
In respect to reviewing overall system needs, consideration will be given to the accuracy of the data captured.

5.3.3 Health Care Registrations

Health care for NWT residents is free, but some other provinces charge a fee, making it desirable for ex-NWT residents to keep their membership. Even if residents move out of the NWT, they may try to use their NWT health care membership so that they get free benefits of NWT coverage.

There is inadequate monitoring of health care registrations under the HIS. The only way the **Department** can know if an NWT resident is living out of the Territory is if it receives notification from the individual or another province. Every two years the **Department** issues new registration cards. In March 1992 the **Department** reissued new 1992-94 health care cards. In an effort to eliminate ex-residents from NWT health care registration, the **Department** set a policy that any cards mailed from outside of the NWT for re-registration will not be renewed.

In a sample of 28 Medicare claims, claims for 9 patients originated consistently outside the NWT. None of the 9 patients had incurred medical travel expenses and none was registered as a student. In fact, 8 registrations were cancelled and 4 of them were cancelled because the patient lived in British Columbia. But the claims had been paid and were not recovered.

The Department should improve its registration tracking process to ensure that as people leave the Territories their eligibility ceases.

Management response:
The Department will examine means of strengthening its registration system. Certain provinces are working on the problem now, but they are at a test stage only.

5.3.4 Reciprocal Billings

These are claims for Medicare and hospital services performed on NWT residents in other provinces.

We requested copies of all interprovincial hospital agreements but the Department could not locate them. Management told us that all the agreements are the same. We did receive some amended agreements to the hospital in-patient agreements and noted that these were made between the province concerned and the Territorial Hospital Insurance Services Board (THB). Since the THB has been disbanded and replaced by the Minister of Health, the agreements should be corrected at the next renewal.

The Department should update all agreements and ensure copies are on file.

Management response: Agreed.

The practice between territories and provinces is to pay reciprocal billings on receipt of invoice before claims are input into HIS. The agreement between the Government and provinces states that payment be made in 30 days.

The agreements require the territories to pay the full amount billed, even if it includes billing problems. Common types of problems are lapses or terminations of a patient's registration. The Department does not attempt to recover these overpayments which we estimate at approximately $84,000 per annum.

The agreements do not allow the Department to recover from the province concerned. This limits the Department's recovery actions to the individual.

We reviewed the January 92 claim from B.C. and found several instances where a patient's claims were billed against the NWT, although B.C. indicated that the patient was registered under B.C. health care. The Department has now terminated the patient's NWT coverage. Other typical problems involved patient's claims made under a non–valid Health Care Plan number.

The Department should verify all billings and try to recover any payment where the Territories' liability is not clearly demonstrated.

Management response:
The Department will review its procedures to recover funds as appropriate according to interprovincial agreements and the federal/provincial working arrangement on portability of services.

5.4 Community Health Management Information System (CHMIS)

CHMIS is separate from HIS. CHMIS compiles and processes nursing service data sent in by nurses working in the community health centres. Services are recorded using ICD-9 codes. Our testing concludes that CHMIS information is outdated and unreliable. An analysis indicates a significant error factor in input data.

We tested one week's inputs and found an average processing time of 130 days; the clerks have to correct input data errors on 70 percent of documents. The primary diagnosis description is typically brief, incomplete or difficult to decipher.

The final product of the CHMIS information processing exercise has limited circulation and low user interest. The CHMIS output report is distributed to regional boards but it

result is a variety of customized systems exclusive to a manager or division with overlap or duplication.

CHMIS, Cancer Registry and Notifiable Diseases Registry

In the Medical Directorate division there are three separate systems collecting the same kind of information: CHMIS, Cancer Registry and Notifiable Disease Registry. The same data are also collected in HIS but in a payment processing format. CHMIS, Vital Statistics and Notifiable Disease databases collect information solely for information purposes – there is no billing involved. CHMIS is not capable of data manipulation or analysis – its output is formatted and inflexible.

Cancer and certain diseases have to be registered promptly. For this reason, cancer and notifiable disease statistics are kept in separate databases by the Medical Directorate. Data for the cancer and notifiable disease registry are obtained partly from CHMIS and other sources such as special forms completed by the community nurse or out–of–territory claims. The Department considers CHMIS and HIS as inadequate sources for these special registries because of the inaccuracy or untimeliness of their data. Therefore, these special registries are reprocessing information and partially duplicating the CHMIS data collection process.

Vital Statistics

Safety and Public Services (S and PS) register all NWT Vital Statistics. S and PS staff make photocopies of birth and death registrations and send them to the Medical Directorate in the Department of Health. The Medical Directorate re–inputs information from the certificates to its own Vital Statistics database. The Health Insurance Services division also collects births and deaths information to update health registrations.

Budget Analysis

The Director of Finance converts some HIS information into Lotus 123 or PowerPlay for easier budget trend analysis. This is not available directly from HIS.

1. *The Department should consider updating its entire system. Present–day technology, including relational data based systems, may help to improve significantly the information available for managers.*
2. *The Department should seek efficiencies through data sharing wherever possible.*
3. *The Department should negotiate with Safety and Public Services to seek agreement that only one will collect the information, and will develop appropriate methods to collect, process and share the data on a timely basis.*

Management response:

1 & 2. Agreed.

3. The Department will review this recommendation with Safety and Public Services and seek a resolution.

5.6 Policy and legislation

The Department's Policy and Legislation Division reports directly to the Deputy Minister in a staff support role. The policy and legislation making process reacts to changing needs. No new departmental policies have been established in five years. Of the six departmental policies that exist, the most recent was established in 1987. Four of the policies are for health programs, one is the Department's establishment policy, and the sixth is the smoke-free workplace policy. None of the policies in place deals with current medical and health issues in the NWT. The Department has no new policies under development at this time, but updates to the existing ones have been done recently.

The Department develops new legislation less frequently than new policies. The latest legislation was the Disease Registries Act in 1989. Changes to legislation are also infrequent but the Department plans to propose changes to seven acts between 1992 and 1994. The changes are to resolve technical deficiencies, reflect changes in the Charter of Rights, conform with legislation in other Canadian jurisdictions, or introduce stronger regulatory procedures. The THIS Act was changed recently but the regulations have not been updated since December 1980.

With all the major challenges facing health care in the Territories, the **Department** is not making good use of the Policy and Legislation Division. It could play a valuable front-line role in developing new policy initiatives with other departments towards the Healthy Public Policy initiative and other emerging health care issues. Yet we have seen no proactive work being done to investigate and develop common inter-departmental approaches to solving the common problems. This Division could also be a good place to co-ordinate all longer-range planning.

Boards can establish their own unique policies under the THIS Act for operations or administration. These are not shared with other **boards.**

1. *The Department should consider a new mandate for the Policy and Legislation Division so that it can become proactive in developing new initiatives in consultation with the boards and other government departments and entities. The Department should consider making tactical and strategic planning a responsibility of this group.*
2. *Boards should consider sharing their internal policies.*

Management response:

1. The functionality and mandate of the Policy and Legislation Division will be determined in an overall functional review and the clarification of roles and accountabilities.

2. The Department will set up a mechanism with the boards to share policies.

5.7 The Boards' accounting systems

There are three different accounting systems and two different accounting methods in use by the **boards**, with different financial coding structures. None of the **boards'** systems are used or directly accessed by the **Department**.

The older boards use the MHO system and the newer ones use HBIS. MHO was designed for health organizations, as was HBIS, although the latter is derived from the Government's own FIS. The Government directed the new boards to use HBIS, although no analysis of the board's needs has been done by either the **Department** or **Finance**. The MHO system is a cash and accrual accounting system and HBIS allows for recording commitments. We have not reviewed either system in depth.

The Department of **Finance** has a group of three persons assigned to technical support of HBIS and absorbs the costs of this support internally. Senior managers from the Department of Finance feel that HBIS is better than the other systems, but some managers in the Department of Health support MHO. Some **boards** complain about the complexity of HBIS, and others are comfortable using MHO.

Presently, because of the different systems in use, both the **Department** and the **boards** find it necessary to reprocess information into a useful format. The **Department** has designed a standardized chart of accounts for all **boards** but this has been put on hold. Realistically, the Departments of Health and Finance should pool their resources and prepare an analysis of accounting needs including the the **boards**, the **Department** and the central agencies. Following that, they should analyse the available systems including

Board	Accounting System	Financial Coding
Baffin	MHO	MIS
Fort Smith	MHO	CHAM
H.H.Williams	Accpac	CHAM
Inuvik	HBIS	FIS converted to MIS
Keewatin	HBIS	FIS converted to MIS
Kitikmeot	HBIS downloaded to Lotus	FIS converted to MIS
Mackenzie	HBIS	FIS converted to MIS
Stanton	MHO	MIS

HBIS – GNWT Health Board Information System
MHO – Manitoba Health Organization

both MHO and HBIS, as well as other potential systems, to see if one best suits the overall needs.

> *The Hospital and Health Facilities Division receives **board** interim financial reports. Since the **boards** do not use the same accounting system, the **Department** has to re–input the financial information into its own LOTUS 123 software so that it can work with standardized data. This is time consuming. We estimate that converting the information takes at least one person– month each year. In another case, one **board** re–enters its financial information from MHO into Accpac so that it is easier to work with.*

Part of the problem and a possible solution lies within the Hospital and Health Facilities Division. It puts a lot of pressure on the **boards** with detailed control tasks rather then looking for ways to improve its services and support to the **boards**.

Detailed control, reprocessing information, and different accounting systems are all inefficient and add to costs. Management recognizes the problems with this situation but at the time of our audit, there were no plans to standardize the **board's** accounting systems.

1. *The Department and the boards should decide whether to standardize the board accounting systems, and if so, which system to use. It should also provide appropriate training for board staff to make sure that they can operate the system effectively.*
2. *The chart of accounts should reflect the allocation of authority to act and spend to the specific positions in the Department and boards.*

Management response:
Agreed. The Department is currently working on this in cooperation with the boards.

chapter 6

CAPITAL ASSETS

6.1 Introduction

The Legislative Assembly appropriates funds to the **Department**, which then buys capital assets on behalf of the **boards**. It is involved in planning for capital asset purchases, and thereafter, for their efficient control and use. Capital planning and expenditure is the responsibility of the **Department**. Operation and maintenance is the responsibility of **boards** which receive funds in their budgets for this. From 1987 to 1991, the Government spent over $55 million on capital assets for the health system. These are distributed throughout the various communities.

The Government has established procedures for capital asset purchases in health care and professional acts as well as the Capital Projects Process Manual. This manual has not been amended since 1982 and is not often used by the **Department** because it is out of date.

Boards are the custodians of Government assets and use them in their everyday activities. They are involved in capital planning with the **Department**. They identify their needs and negotiate capital spending plans with the **Department**. Capital assets remain the property of the government under the **Department's** control.

6.2 Policy and planning

Managing capital assets is a complex task. It is made more difficult by financial constraints, and by requests from **boards** for facilities and equipment that may not meet the Government's particular policy preferences. For example, because the big issue has not yet been settled, some regions do not accept the concept of hospital referral centres for the Territories, and would prefer their own hospitals. Yet the practical implications of this are beyond the resources of the Government. Thus, the **Department** has to juggle the interests of all parties including the Government, **boards**, regional planning committees, and other interest groups, as well as community interest. It also tries to keep in mind that all capital assets carry a down-the-road price-tag in terms of operation and maintenance costs and ultimate replacement.

Realistic capital planning needs good information which is at present lacking. Information cannot be extracted in a useful way to help make future planning decisions.

The **Department** has no policies or procedures for health facility and equipment management, including acquisition, replacement, disposal, maintenance or renovation. Control and maintenance requirements for health facilities and equipment have special needs, such as sanitation, that other government property may not have. Therefore, broad government standards for facilities and equipment are not specific enough for the **Department**.

Also, the **Department** needs to improve project management follow-up after completing construction projects. We reviewed five completed projects and noted that it does not regularly do follow up reviews. After-the-fact follow-up reviews are useful for identifying where future improvements or corrections may be necessary.

Because the **Department** has not set any criteria for defining needs, the assessments were not consistent. Without such criteria, the **Department** cannot be sure that all important elements have been considered, and that capital demands are comparable on a region-to-region basis. Defining needs is the first step in a capital assets plan. We noted that needs were defined by consultants.

The Department should:

- *specify the criteria that should be used in defining and assessing capital needs;*
- *establish policies for facilities and equipment maintenance; and*
- *ensure that project follow–up inspections are carried out for all capital projects using standard criteria.*

Management response: Agreed.

6.3 Asset inventories

The Government has developed rules for departmental inventory systems. The **Department** does not have this system operating yet for **board** assets. It maintains an inventory of buildings and land but it does not meet all the rules outlined by the Government. The **Department** does not keep an inventory of equipment or maintenance records. But it is responsible for record keeping of assets under Section 61 of the FAA. Based on our observations, the **Department** needs to develop its capital asset inventory system. Effective planning for capital assets cannot be done without information about the identity, value, quantity, condition, location and maintenance requirements of assets.

The **boards** prepare their inventories and send them to the **Department**, but because there are no guidelines showing the **boards** how to set up and manage an equipment inventory, they are not standardized. The **Department** started drafting a capital equipment and biomedical maintenance manual last year, but, because it has a low priority, staff work on it only when they have spare time.

The **Department** and **Government Services** discussed ways to modify the standard GNWT Controllable Assets System. From these discussions, the departments determined that **Government Services** could not provide the **Department** with what it needed, so the **Department** has issued a request for proposals for external consulting help.

The **Department's** present asset inventory system is too incomplete to be useful. Some assets are recorded, others are not. The **Department** has no detailed record of investment in facilities or equipment. We asked for the cost of the equipment and facilities but the **Department** could not compile this. Managers gave us the insured values from the Government's policy.

The Department should set up an inventory system for its capital assets, to be maintained according to rules set out by the Government.

Management response:
The Department is actively pursuing the establishment of a standardized controllable asset tracking system for health boards.

chapter 7

FINANCIAL ISSUES

7.1 Introduction

Everywhere, health care budgets appear to be out of control, causing governments to consider radical changes to what they will fund, and how. In the NWT, the Government faces the same problem. As resources shrink, demand increases and policy makers are confronted with having to make tough decisions. Yet after four years of experience, the people still await critical policy decisions.

Another major concern is the continued inability of the **Department** to predict budgetary needs accurately, requiring an annual pilgrimage back to the Legislative Assembly for more funds to complete its plan. The **Department** cites difficulties with predicting some elements of cost, among them medical travel, control over which needs improvement.

The annual pilgrimage is symptomatic of the lack of accountability, the unclear definition of co-operative arrangements, and the need for more effective information management. This is typical of the situation where those responsible for service delivery do not feel that the budget is their responsibility, and the consequence is that they spend based on perceived service needs; improved efficiency is not a motivator. Unless savings from efficiency gains are dealt with fairly, this system encourages people to believe that any savings from their efficiency will be taken back to the centre and reallocated to the less efficient. Also, overspending will result in bigger budgets with no consequence other than concerns from headquarters. Budgets based on previous year's allocations compound the problem, as they do not reflect changing circumstances.

7.2 Allocation of resources at time of devolution

We discussed program transfer with Federal Program Transfer officials. They confirmed that federal policy dealing with the devolution of programs to other levels of government does not consider the adequacy of resources in relation to long-term need. As a result, when health care programs were transferred to the Government, it was up to the negotiating teams to either accept or reject the terms and conditions of the transfer. By contrast, the federal government to Indian Band transfer policy requires that a needs assessment be completed as part of the negotiation process. This is to ensure that the receiving Band is capable of meeting health needs on the reserve and that it is capable of assessing on a continuing basis whether that need is being met.

In the course of interviews, management acknowledged the inequitable distribution of resources between east and west. The west has 62 percent of the population but five out of six hospitals, 86 percent of the doctors and 70 percent of the nurses. There may be other useful comparisons to be made.

These are significant differences in the distribution of health personnel and facility types compared to the share of population. To balance the service levels, the central region of the NWT is served out of the Baffin region, or through arrangements with the Northern Medical Unit, out of Manitoba.

7.3 Supplementary estimates

Since devolution the **Department's** budget has doubled and supplementary funding has increased substantially from year to year. Medicare, hospitals and medical transportation are the highest cost increases.

The **Department** spends about two thirds of its budget on **boards**, eight percent on Medicare, 11 percent on medical transportation and the rest on administration. During the last four years the **Department's** operations budget has increased

from $141 million to $188 million, a four-year growth of 33 percent. But the last four years shows another disturbing pattern. The **Department** starts each year without enough money to deliver its programs and has to be bailed out by increasing amounts of supplementary funding. Supplementary estimates have increased by six percent over budget for 1989-90, 10 percent for 1990-91 and 12 percent for 1991-92.

The Operational Plan is the first step in budget preparation. It leads into the Main Estimates production. The OpPlan exercise finishes in August and the Main Estimates production follows immediately. The final Main Estimates figures are agreed to by the Financial Management Board which makes some adjustments to the figures supplied by the **Department**. The FMB has noted inadequate substantiation by the **Department** in some areas of budget preparation. For 1990-91 and 1991-92 there are significant differences between the OpPlan and Main Estimates figures. The **Department** informed us that its supplementary estimates includes price increases and inflationary adjustments. At the time OpPlans are produced, the process does not allow departments to include estimated cost increases for inflation and price increases, although it does allow for known price increases.

The **Department** spends about $20 million each year on medical treatment for NWT residents outside the Territories, exclusive of medical travel. Most of this is in Alberta with over $13 million. When health care costs rise in other provinces this affects the **Department's** costs.

The **Department** argues that out-of-Territory costs cannot be controlled. But it should be able to predict the trends and come up with reasonable budgetary estimates. The **Department** needs trend information and prediction models showing estimated price and use of these provincial facilities. Without this, it is difficult to budget for hospitals, Medicare and medical travel. The **Department** does not have a system to analyze and predict cost and use of out-of-Territory facilities. As mentioned earlier, the HIS system cannot produce useful trend information.

The **Department's** 1990 Health report contains data on the daily cost of NWT residents treated outside the NWT as inpatients. These average $596 per day and range from a high of $723 to a low of $480 for 1990. We were not able to determine whether there is any significant changes in patient referrals to Stanton from the south, and whether there are any consequential savings in costs.

Three activities consistently receive most supplementary funding: hospitals, medicare and medical transportation. These are most affected by changes in price and the number of patients. The Financial Management Board (FMB) recommended that the **Department** develop cost prediction models but we have not seen any. During the last two years, management has made efforts to support requests for budget increases using trend information, but supplementary funding still remains a problem.

Budgets are usually a financial view of annual operating plans. The **Department's** budgets are based on prior year levels and adjusted for known changes. Supporting the Main Estimates is an Operating Plan (OpPlan) which goes to the FMB and should provide the analyst with sufficient information to support the summarized estimates. We reviewed OpPlans and supplementary funding documentation for three years to 1991/92. We note that budget support for the OpPlan is narrative, even for those programs that are volume based. We also noted that price and volume increases are not well supported. For example:

Department of Health Budget, $ 000's

	1991–92	1990–91	1989–90
Budgeted (Op N. Plan)	$ 163,205	$ 147,142	$ 150,738
Main Estimates	168,008	150,550	145,827
Supplementary Estimates	20,446	15,506	8,887
Total	***188,454***	***166,056***	***154,714***
Actual Spending	**188,000**	**165,430**	**153,601**

The 1991–92 OpPlan forecast for Out–of–Territories Hospital Care was $21.7 million, based on a simple cost x volume formula. There is a written description explaining how cost and volume were calculated, but no schedules showing the cost per day, matched with the estimated number of patient days in a particular hospital. The remaining support was a narrative, primarily explaining the calculation itself. There were no additional numbers or supporting evidence.

The Department could provide better trend analysis using its own numbers, letters from suppliers, fee schedules, etc. But the systems cannot easily produce this statistical information. By analyzing costs only, management cannot isolate whether cost increases are due to price and volume increases or to trends in the health status of residents requiring different treatment.

Spending against budgets must be measured. The Department uses a quarterly variance report in which managers explain OpPlan variances and send the report to senior management. These reports contain brief explanations of variances but lack documented support. We reviewed the 1990-91 second and third quarter variance reports and found there was no documented evidence of senior management review. We asked for the fourth quarter variance report for 1990-91 but staff could not locate it. The variance reporting process appears to be a paper process instead of being used as a management tool for control and accountability. The reports deal with dollars only and do not provide a full account of what the manager is doing. The variance reporting process is not co-ordinated with the Management For Results System (MFRS) process.

Overall, there is room for improvement in providing costing information and support for budgets; the Department needs a budget system that can compile and analyze health care statistics and costs for budget purposes. This would also help determine whether budgets were reflecting operating requirements.

1. *The Department and the boards should establish a better method of developing budgets and then reporting expenditures against them. The reporting process should allow and require corrective action during the fiscal year.*
2. *The Department should set up a clear accountability for reporting and corrective action, and should make periodic reports to the FMB.*
3. *Departmental managers should monitor and analyze the costs of supporting budget requests.*

Management response:
The Department will review existing operations in respect of the recommendations being made.

7.4 Medical travel

There are two separate medical travel programs in the Government. Personnel administers a regional Medical Travel Assistance (MTA) program for government employees and their dependents. Health has a centrally managed medical travel program for NWT residents, other than government employees and their dependents. In 1991-92, Health spent approximately $22 million on medical travel and Personnel spent approximately $3.8 million. Health has needed supplementary funding for its medical travel program in each of the last three years, amounting to 4.8 percent, 20.8 percent and 17 percent respectively, of the main estimate amount.

Personnel revised its employee Medical Travel Policy in August 1991 to clarify and specify the administrative and management procedures for employee medical travel assistance. Health issued an Administrative Directive in July 1991 to clarify the medical travel benefits policy for services received outside the NWT.

Medical Travel programs are difficult to administer. When people get sick the government should treat them compassionately but be aware of opportunities for cost savings. In critical cases, care and compassion usually prevail over concern for cost.

We reviewed the medical travel programs for the period April 1990 to March 1992. We noted improvements since the medical travel policy changes, but there are some outstanding problems. The Department lacks quality controls in claim processing and does not monitor and manage medical travel. The Department does not

collect information to evaluate the new medical travel policy in terms of how it has affected medical referrals to Stanton Hospital. Stanton Hospital is also unable to extract information to determine the change in the pattern of medical referrals.

In January 1992 the Department released its Medical Travel Study 1990-91 on non-employee medical travel. This was to assess the variables in patient referrals which may impact on the escalating costs of its Medical Travel Program to establish an ongoing monitoring process. This report did not quantify the impact of the new Medical Travel Administrative Directive and presented no forecasting formulae for medical travel costs or volume.

7.4.1 Administration and management trail problems

Doctors or nurses make the final decision on whether a patient requires medical travel. For non-employee medical travel, the Department pays the bills and can query the claim after the fact. For employee medical travel, Personnel processes and pays the bills. Once medical travel is authorized, the process of documenting the claim begins.

We examined 40 employee medical travel claims, and 30 non-employee claims. Based on our testing of processed claims, we found a poor trail of documentation. ICD-9 coding records the reason for medical travel, but is often too general and does not show the true reason for medical travel. Written diagnoses are often vague also, and do not provide enough information for review and evaluation.

Accountability for medical travel costs is divided, because authorization and payment responsibility rests with two separate people at two different times in different locations. To improve accountability the Department should provide boards and nursing stations with detailed information on the medical travel incurred in the regions. More importantly, a good budget system with later variance reports would be even more valuable.

Incomplete forms and management trail problems make it difficult to link all payments for one medical travel claim. This problem is worse with employee MTA because it has more payments for a single case than non-employee MTA. For example:

An employee from the western Arctic claimed MTA to attend an out-patient clinic in Edmonton for approximately four weeks. The employee claimed airfare and meals, but no accommodation. The travel claim does not cross-reference to an accommodation warrant, so we cannot tell if one was used. The description of the clinic suggests that the patient's time commitment was only four hours per week. There is no record showing that the patient attended the clinic.

In another case, an employee travelled to British Columbia for a rehabilitation course. The employee claimed meals while on the course, again not indicating whether meals, transportation or accommodation were covered in the course. The medical travel claim does not cross-reference to an accommodation warrant or course claim.

7.4.2 Escort travel

There are two kinds of escorts allowed to travel with a patient: medical escorts and non-medical escorts. Medical escorts are doctors or nurses. Non-medical escorts include a language escort to provide translation, an escort for a child, an escort to receive patient care training, or an escort to provide compassionate support.

Personnel's new employee MTA Policy makes it clear that assistance will not be provided for compassionate escorts. In comparison, the Department's Medical Travel Policy does not disallow medical escorts, but managers informed us that they do not approve escort travel.

Information on the travel form is not clear enough to determine the reason for escort travel. In our testing we found no cases where travel for a medical escort was rejected.

In one case a doctor recommended a compassionate escort for an employee and the claim was rejected initially by Personnel. The employee wrote a letter to the Deputy Minister of Personnel and the claim for the escort was subsequently allowed.

7.4.3 *Different application of the same policy*

Both medical travel policies provide transportation to the nearest point where treatment is available.

We tested medical travel claims arising after the medical travel policy clarifications in August 1991 to see if any were for destinations beyond the nearest point for treatment. None were.

> *But we noted a case where an employee was paid MTA for a dependent's medical travel to Vancouver for treatment. The nearest point of treatment was Edmonton. The payment was based on a doctor's referral to Vancouver for compassionate reasons.*

We did not find any examples in our sample of non-employee medical travel where nearest centre rule was not applied, but we did find instances where the employee medical travel policy was applied differently.

> *An employee from Yellowknife sought treatment in Toronto. The physician approved the referral to Toronto but* **Personnel** *only reimbursed for travel to Edmonton, the nearest centre for treatment.*

> *One employee combined medical, personal and business travel in a June 1990 trip. As a result, the employee benefitted by having a personal portion of the travel paid by the Government. The employee received a medical travel warrant for a full economy fare to Montreal return. This allowed the employee to convert the ticket into a trip from home to Sydney, Nova Scotia via Halifax. Sydney was the personal destination of the trip, and Halifax was the medical destination. The employee finished the trip by travelling from Halifax to Yellowknife for a conference, returning home afterwards. Halifax is not the nearest treatment centre for this patient.*

The Departments should ensure that all medical travel claims agree with policy and that the reasons for all medical travel are set out on the travel form.

Management response – Department of Personnel:
The Department of Personnel revised its Medical Travel Assistance guidelines and forms in September 1992 to address the need for additional information to ensure compliance with policies. The Department now requires medical practioners to identify the closest centre where treatment is available. Medical Travel Assistance expenses are limited to the closer of the point of departure or the nearest centre.

7.4.4 *Managing and monitoring medical travel*

The Department needs to improve control and administration of the Medical Travel program. For example, at present there are no quality control reviews, desk audit procedures are not documented, and HIS billings are not linked to Medical Travel. Also, there is no requirement that non-employees on medical travel provide proof of attendance for treatment. In contrast, Personnel requires employee patients to obtain confirmation of attendance directly on their MTA application form. There is no formal appeal processes for rejected claims. Appeals are dealt with by the employee's supervisor, who assesses each appeal individually against the claimant's concerns.

The Department should require proof of attendance for all medical travellers.

Management response:
Agreed. The Department will examine means to verify attendance at medical appointments.

7.4.5 *Consolidating medical travel programs*

Employee and non-employee medical travel programs are administered separately by Personnel and the Department respectively. To know the full cost of medical travel, the two programs must be added together, but for reporting purposes this is not done. The result is an incomplete picture of medical travel, making it more difficult to understand overall health care issues.

With the exception of differing allowances for accommodation and meals in the Union Agreements, the two medical travel programs have few notable differences.

The Department should discuss with Personnel whether they can save resources by consolidating the two medical travel programs. .

Management response – Department of Health:
The Department has discussed this with Personnel and will be following up.

Management response – Department of Personnel:
The Department of Personnel agrees with this recommendation.

7.5 Receivable from Canada

Funding of health care in the NWT is complicated because Canada still retains responsibility for Indians and Inuit. Under an agreement between the two governments, the NWT delivers this health care to Indians and Inuit and recovers the costs from the federal Department of Indian Affairs (DIAND). There is an ongoing dispute between the Government and DIAND dating back to the transfer of health care in 1988. Canada is questioning the Government's billings and the unpaid claims in dispute are approaching $50 million. The Government continues to provide health care to Indians and Inuit pending a resolution of the dispute, but the withheld funding is putting significant fiscal pressure on overall Government finances, and health care delivery in particular. The costs for 1991, as an example, amount to some 22 percent of the Department's budget.

chapter 8

Management Reporting and Accountability

8.1 Introduction

One important question for all Government activities is how managers measure their achievements and report them in a meaningful way. This Government has been trying to come to grips with this issue, and has developed a Management for Results System (MFRS). This is a government-wide management reporting system used by all departments, including the Department of Health, but not by the **boards.**

8.2 Management results

MFRS is supposed to measure how well a program is performing. It has four parts: broad program or activity objectives; year-specific goals and targets; indicators to measure achievements; and finally, a results report. Each manager in the **Department** reports each quarter.

A common problem with performance measurement systems is that they measure what people do, not what they achieve. While measuring activity, or what people do, can be important for assessing efficiency, it does not answer the questions about what the program has achieved, or whether it has met its goals. For example, in health care, the program exists to prevent illnesses, or treat them where prevention does not work. The basic issue is what kinds of questions need to be answered to show if managers are meeting the **Department's** goals. Results that show how much time people have spent on a particular problem may be interesting, but, unless the results show whether the problem has been solved or, if not, why not, then the process does not answer the key questions.

> *For example, Dental Services has four objectives. One of them is "to monitor the dental health of the residents of the NWT." The objective is not broken down into any sub–objectives or into ethnic groups. Yet the indicator on how this is being achieved, shown in the 1991–92 3rd Quarter Report is "Comparison of the dental health of Status Indian and Inuit children in the NWT with children on Indian reservations across Canada by participation in the survey: 'Oral Health of Canada's Native People'.".*
>
> *Status Indian and Inuit in the NWT make up some 57 percent of the population according to the Bureau of Statistics 1986 estimated population distribution. More current information is not yet available. The children of this group undoubtedly have serious dental problems as revealed by the survey, but using this comparison is not meaningful to explain how the* ***Department*** *monitors the dental health of all NWT residents. In any event, other group data will only provide a base of comparison against which future information can be compared. We feel that this indicator is unsuitable for measuring the stated objective.*

The **Department** does not use the system to its fullest potential. The objectives and goals are not clearly stated and its indicators are poor, and there is inconsistency in the quality of reports produced by managers. Managers need to be involved in developing indicators for their divisions, if they are to be committed to using them.

All departments have a responsibility to set clear goals and targets for what they are trying to achieve. This often means that individual programs must set their own specific objectives and be prepared to later report how they are meeting them. Yet we found that many of the program objectives were not set out clearly, few had specific targets and many had inadequate measurements on what they had achieved. In many

cases, MFRS reports to senior managers said little that could be used to explain to the Legislative Assembly what had resulted from operations.

For example, one division has as an objective increasing the number of qualified health care personnel, and increasing the number of native health care personnel advancing through the system. Without a target, no one can be held responsible for the results. The division has no meaningful response, only that the process is "ongoing." This report does not provide any meaningful information on progress.

Some objectives have no obvious indicators, either quantitative or qualitative.

For example, one division uses "...timely responses..." as its indicator but does not define what time is acceptable. It is difficult to know if the indicator is a good measure of the goal or if any of the results are in fact timely.

Another indicator is "...productivity of dental therapists as indicated by statistics." With the objective stating that productivity would be demonstrated by statistics, one would expect to see some. Yet the current status is shown as "visits and treatment planning have been provided in Snowdrift...", with no numbers.

These unclear objectives and targets, combined with poor indicators, are of limited use in showing what management has achieved with the resources invested.

Reporting progress towards results is also uninformative.

In two cases, current year activity reports merely reported what stage work was at, instead of showing progress toward the objective. For example, one division reported the status of most objectives as "ongoing" and no indicators of activity or results.

We sampled the MFRS reports of seven divisions for the first three quarters of 1991-92. None defined quantified yearly indicators: numbers, dates, or standards were not used. This sample included processing-type divisions which could measure their performance by volume.

Only one division in our sample, Community Health, quantified its reported results. For the third quarter of 1991/92 this division submitted a 12-page summary of its results, which included some statistics on number and type of pamphlets distributed, meetings or workshops attended, and contacts made with **boards**. But these results still show what the branch did, not what it achieved.

These unclear objectives and targets, combined with poor indicators, are of limited use in showing what management has achieved with the resources invested.

1. *In order to make the most effective use of the MFRS system, senior management should give basic guidelines and then encourage division managers to develop the achievement criteria. These should include clear MFRS objectives and targets, along with appropriate indicators. Executive managers should ensure that division managers use and report the MFRS system properly.*

2. *Whether or nor division managers use and report the MFRS properly should be a key indicator for measuring their performance.*

Management response:
The Department will review its use of the MFRS system and address deficiencies as appropriate.

8.3 No board evaluation process

Given that **boards** manage and deliver health care, they are responsible for meeting regional goals and objectives and NWT-wide standards. The **Department** must be able to satisfy itself and the Legislative Assembly that standards are being met in a cost-efficient way. This requires an evaluation process, acceptable to all the parties, which is performed regularly.

However, we noted that **board** performance has not been evaluated.

As for the **boards**, evaluation methods to assess progress towards achieving regional goals and objectives are varied. The NWT Board Trustee Handbook provides the **boards** with a self-evaluation process but, of the four we visited, none had an ongoing evaluation process that assessed progress towards achieving regional objectives.

As we reported in paragraph 2.6, the Department similarly needs to strengthen its program evaluation.

The Department should work with the boards in assessing client needs and developing evaluation tools to ensure that goals and objectives are achieved through a spirit of co–operation and consensus. They will also need mechanisms for co–operation and consensus if the spirit is to thrive.

Management response: Agreed.