# Standing Committee on Public Accounts

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**STANDING COMMITTEE ON PUBLIC ACCOUNTS**
**2001**

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The committee met at 09:00

**The Chair**: — Good morning everyone. Thank you for your attendance this morning. We have an agenda, a proposed agenda before you that is, I hope, lengthy but also will enable us to go through a number of items.

The first department that we'll be looking at is Health, and we've tentatively assigned the time till 11 o'clock this morning to deal with the chapters on Health. Which again, there are many recommendations in the Health chapter, so we'll have to see how that time allotment goes.

And then for the balance of the morning, if we're successful in completing Health by 11:30, we will then move to Social Services.

Are there any questions about the agenda? Okay, then that's the way we will proceed.

First of all, as far as members, I think the government members are the committee members without anyone standing in for any of the members, but on the opposition side June Draude and Brenda Bakken are replacements for Carl Kwiatkowski and Mr. Lyle Stewart.

With that I'd welcome Fred Wendel from the auditor's office this morning and ask him to introduce the new faces that we see around the room this morning.

**Mr. Wendel**: — Thank you, Mr. Chair. We have a lot of individuals here this morning. We do a lot of work in the Health area and they'll be making . . . different people will be making different presentations as we go through. And Mike will be leading us through all this, so that Mike Heffernan is sitting next to me here. He leads our work in Health.

Mark Anderson from our office; and over on the other side, Jeff Kress; Loyd Orrange; Jane Knox; Rosemarie Volk; and Rodd Jersak, who comes to all our meetings, works closely with the committee; and behind the Health officials, Brian Atkinson, my assistant, who also comes to all the meetings.

**The Chair**: — Thank you very much, Fred. And also from the Health department, Steven Pillar is going to be handling, I believe, the presentations this morning. And I'd ask Steven to introduce the people that are with you.

**Mr. Pillar**: — Thank you very much, Mr. Chairman. I'm Steven Pillar. I'm the associate deputy minister of Health. Our deputy minister, Glenda Yeates, is unavoidably out of the province today and sends her regrets at not being able to be here. But, however, I think with the officials we hope to be able to answer your questions this morning.

On my left is Bert Linklater, who is the executive director of our district support services branch. He deals with all of the 32 districts in the province, and he is the senior official, department official, in that capacity. To my immediate right is Rod Wiley, who is executive director of our finance and management services division or branch. Rod's also the department's chief financial officer. And to his right is Leslie Parker, who is the director of our capital facilities and management unit within the department.

**The Chair**: — Thank you very much,

**Mr. Pillar**: — We have one other official, I'm sorry, behind me, Chuck McDonald who is from our finance branch as well.

## Public Hearing: Health

**The Chair**: — Thank you very much, Steven, and welcome to all of the officials from Health. Okay. Let's get right into the chapters that we're going to be dealing with. As you see they're from various reports — three of them to be exact — the '99 Fall Report, the 2000 Spring, and the 2000 Fall Report, Volume 3. And I guess we'll begin with chapter 1 and probably, Mike, your first presentation on chapter 1.

**Mr. Heffernan**: — Good morning, Mr. Chair, members. Our audit reports on the Department of Health for 1999 and 2000 cover a lot of material. Our office, as Fred says, expends a great deal of resources in examining the Department of Health and districts because of the size and importance of the health system. Health is the largest government program, spending over $2 billion.

I've given you a list or a handout describing the order that we want to do the . . . to cover the chapters this morning. It's a one-page handout. We've decided to do the presentations by presenter rather than in any particular order, otherwise we'll have the presenters getting up and down. And we think this is probably the most efficient way of doing this.

I suggest that we pause at the end of each presentation so the members can ask questions of our office and the department, and that way the committee can deal with the recommendations as they come up.

So the order we'll make the presentations are, I will do parts A and C, which is Health and the district health boards of our 2000 Fall Report, chapter 2. So parts A and C. And after that I'll do part C of our 1999 Fall Report, on Toward 2000.

Then Mark Anderson will do part D, chapter 1 of our 1999 Fall Report on board development, a health district case study. And Mark will also do part D, chapter 2 of our 2000 Fall Report, health district board information for financial decisions.

Then Jane Knox will do part E of our 1999 Fall Report, Department of Health resource allocation among districts based on health needs. She will also include in her presentation part E of our 2000 Fall Report, which deals with the follow-up on our district health board resource allocation work. And then she'll do part D of our 2000 Fall Report, accountability for capital construction.

And finally, Jeff Kress will cover chapter 11 of our 2000 Spring Report on the Uranium City hospital.

Okay. So I'll start into parts A and C of our 2000 Fall Report. These chapters contain several recommendations that the Public Accounts Committee has agreed to in its January 1999

meetings. In front of you, you have a schedule that shows which recommendations are new and which ones the committee has already agreed with. And you can see from the handout that there's only two new recommendations.

This should help us to focus on what's new in the report, in the chapters.

Part A starts on page 83, and the table on page 85 shows the total revenues to the health system by source, and total cost by program. Health revenues and costs were over 2.1 billion in 2000.

While I'm going to focus the committee's attention on new recommendations, I want to mention a couple of matters relating to the section on the department's annual report, which starts on page 86.

If I can draw your attention to that section, and in particular on page 88, we describe the first ministers' September 2000 communiqué describing how each jurisdiction in Canada will start to report publicly on the health system's performance starting in September 2002.

We have offered to work with the department to ensure it has sound reports and reliable information systems to prepare those reports. We are also working with all other legislative auditors in Canada to develop a process to provide independent assurance on those reports.

Another matter I want to raise regarding the department's annual report starts on page 89. Here we set out some possible financial measures for the health system. We hope to encourage the department to report on the financial condition of the health system through a number of financial measures. It's important to note that these measures do not help to assess performance on population of health status, health outcomes, or effectiveness of health services. These are financial measures only.

We describe six possible financial measures showing trends from 1995 to 2000. In the interest of time I'll only discuss three of these indicators. All of the indicators relate to the sustainability of health spending.

The first performance measure on page 90 involves analyzing total health spending as a percentage of the province's gross domestic product or GDP. The GDP reflects the size of the provincial economy. If health spending grows faster than the GDP, the economy may not be able to support that level of health spending in the long run, unless spending on other health . . . on other government programs is reduced or taxes increased.

The graph on page 91 shows that from 1995 to 1997 health spending decreased or declined as a percentage of GDP. But since 1997, health spending is increasing as a percentage of GDP. If the upper trend since 1997 continues into the future, this would suggest a decrease in sustainability because health care spending will be placing more demands on the economy.

The second performance measure involves analyzing the total government health spending, as a percentage of the government's total spending. This measure shows the impact that health spending has on spending to deliver other government programs. The ability to spend a greater percentage on health each year may not be sustainable because of the need to provide other necessary government services.

The graph on page 92 shows the trend in the government's health spending as a percentage of the government's total spending. The graph shows that from 1995 to 2000 health spending has increased only slightly, from 20.1 per cent to 21.7 per cent of the government's total spending.

The slight upward trend in this graph might suggest a small decrease in sustainability due to more demands for health care spending being placed on the government's total spending, but a longer trend would have to be seen first.

The third performance measure of sustainability involves analyzing the change in health spending compared to the change in the consumer price index or CPI, and the GDP.

Comparing the change in health spending to the change in CPI indicates whether health spending has kept pace with, is less than, or exceeds inflation. If, for example, health spending increases are higher than inflation, this would indicate an unsustainable trend.

The graph on page 93 shows health spending grew faster than CPI and the rate of our provincial economy. If this trend continues, the government's ability to meet program and service commitments may be weakened.

In the interests of time I won't discuss the remaining indicators, but I would be pleased to answer any questions at the end of my presentation.

The first new recommendation in this chapter is on page 98. We think the department needs an agreement with the Canadian Blood Services agency to ensure the agency meets the department's objectives. In broad terms the department's objectives are to ensure that only safe blood products are provided to Saskatchewan residents.

On page 98 we set out the key elements of such an agreement between the department and the agency. We recommend that the department make a service agreement with the CBS (Canadian Blood Services) to ensure it achieves the department's objectives.

The next new recommendation is on page 101. We think the department needs to improve its capital project agreements with health districts. Without sound agreements, the department cannot ensure that capital projects managed by the agreements meet the department's objectives.

We recommend that the department's capital construction agreements require health districts to provide the department with adequate and timely performance information on capital construction projects and describe the department's processes for verifying performance information.

Our final new recommendation is on page 105. The Saskatchewan Health Information Network is a Crown corporation that receives money from the department to acquire

and operate the Saskatchewan Health Information Network. In our view the corporation did not follow rigorous accounting rules in preparing this 2000 annual financial statement.

MLAs (Member of the Legislative Assembly) and the public need government organizations to follow rigorous accounting rules that report their performance in consistent and comparable manners. When government organizations do not follow rigorous accounting rules, they increase the risk that their financial statements may misstate their annual performance. Incorrect financial statements increase the risk that MLAs and the public will form incorrect conclusions about the organization's financial performance.

In our opinion, the corporation's 2000 financial statements understate the corporation's liabilities and overstate its accumulated surplus by 1.4 million. Also the financial statements understate the corporation's revenues and overstate its deficit by 2.4 million.

The corporation receives money from the department to develop and acquire capital assets. The corporation records this money as revenue at the time it receives the money. We think the corporation should not record the money as revenue until the corporation incurs the cost of developing and acquiring the related assets. Until those costs are incurred, the department should record the money received from the department as a liability due to the department.

On page 105 we recommend that the corporation record the money received from Saskatchewan Health for the acquisition of capital assets as a debt until the corporation acquires the related assets. We also recommend that the corporation amend its 2000 financial statements and table the revised financial statements in the Assembly.

That concludes my remarks on chapter 2A. I would be pleased to answer any questions.

**The Chair**: — Good. Thank you very much, Mike. I think the first reaction I will ask for is from the Department of Health on this particular chapter and then we'll open it up to questions from the members. Go ahead.

**Mr. Pillar**: — Thank you, Mr. Chairman. I will be brief and in the interest of brevity I won't speak to all of the recommendations in the chapter in the sense that we're in agreement with most of them and support the recommendations of the auditor's office. And Mike hasn't gone through all of those as well. And I don't intend to follow each one. We're certainly prepared to answer questions on any of the recommendations but I'll, in the interest of brevity, stick with some of the new items and more controversial issues.

With respect to the performance issues that Mike started off his presentation on and the first ministers' communiqué around performance issues prior to the increasing of CHST (Canada Health and Social Transfer) funds last year. We in the department, as Mike indicated, along with the Provincial Auditor's office have done a fair amount of work in the last year, both in terms of our strategic plan the department has been working on.

We've also worked a lot with the HSURC, the Health Services Utilization and Research Commission here in the province, in developing performance measures that we know we need to spend a great deal of time on.

The Fyke report also outlined the fact that we in this province and elsewhere in the country have a large gap in terms of our ability to assess performance in the health system, and there's a need to move on that front. We're making every effort to do that.

The financial measures that Mike outlined, three of the six that are outlined in the report, we think are very useful. This is, I think, I believe the second year that they've been reported. We track those measures as well as several other financial measures and use those arguments in support of our presentations to Treasury Board and cabinet for additional resources usually. The Provincial Auditor's report's been useful for us from that perspective as well. But we think that is a useful feature and we continue to monitor those measures.

With respect to specific recommendations, the new ones, the CBS service agreement, we would agree there is a significant contribution that we are now making up from what was provided by the government and the Department of Health three years ago to CBS — very significant increase in our contributions — and we're in the process of working through service agreement with CBS.

The capital agreement recommendations, again we're supportive of those capital agreement recommendations, and the capital agreement recommendations have a bit of a history in the sense that there were many recommendations coming out of the Toward 2000 report that I understand that we'll get to later.

That, in turn, went into a broader review of the capital processes in the department. The Provincial Auditor was involved in that and there's a separate report on that one as well. And we're working and have agreed to work in partnership with the Provincial Auditor's office on refining those processes.

The last new item that Mike raised was with respect to the SHIN (Saskatchewan Health Information Network) financial statements, and I'll pass that item to our chief financial officer, Rod Wiley, to speak to briefly.

**Mr. Wiley**: — Thank you, Mr. Chair. This is one recommendation that the department does not agree with the Provincial Auditor with respect to. And I'll just cover in fairly short order our points with relation to that and if desired, the Department of Finance officials may wish to speak to it as well.

The matter that the auditor has reported on is in relation to accounting policy. I want to begin by saying that the auditor's office is not in any way suggesting that SHIN is spending funding inappropriately, and in fact their audit report states that SHIN has complied with the authorities governing its activities in relation to financial reporting, safeguarding of assets, raising revenue, spending, borrowing, and investing.

It also . . . The auditor has also indicated that SHIN has adequate rules and procedures to safeguard its assets. What the

auditor believes is that SHIN should record the funds that it receives from the General Revenue Fund for capital assets as debt until those assets have been acquired.

Like all government agencies, SHIN records the funding it receives from the General Revenue Fund as revenue. It remains recorded as revenue even if it isn't spent in the intended time frame. Both SHIN and Saskatchewan Finance believe that the grants to the corporation carry no restrictions by legal agreement or legislation, and therefore are of the opinion that the corporation complies with CIC (Crown Investments Corporation of Saskatchewan) recommendations in regard to the booking.

What the impact of this is, is a timing difference in the recognition of revenue between accounting periods.

And I'll pass it to the Department of Finance officials if they would like to add anything.

**The Chair**: — Mr. Paton, comments?

**Mr. Paton**: — Yes, Mr. Chairman, I can add a little bit to this discussion. As Rod indicated, this is an area that we believe is properly accounted for. It's one where there's a difference of opinion between our office and the Provincial Auditor's office of how to apply some of the accounting standards that the Canadian Institute of Chartered Accountants do prescribe.

It's an area that has caused problems in other areas. We've got other entities that do account for this in a similar fashion as what SHIN does and the auditors raised concerns on that as well. This issue really isn't straightforward. It's been raised with the Institute of Chartered Accountants and it's actually forming the basis of a task force because there is confusion in the area.

So Rod's correct, it's a difference as to when this revenue gets recorded; it's not that it's being hidden or not recorded. We believe it's revenue of SHIN when they receive the grant. The auditor believes part of that should be deferred until the capital expense is actually made.

So we can get into some of the discussion around the specific accounting rules, but I think we're not going to get very far there. We actually disagree on the application of the rules, and hopefully the Institute of Chartered Accountants will be providing some clear direction in the future so that we can apply these rules consistently.

**The Chair**: — Thank you, Mr. Paton. Okay, I think we can open the floor to questions or comments on the overall chapter 2A.

**Mr. Gantefoer**: — Thank you very much, Mr. Chairman. And to Mr. Pillar and all your officials, thank you for being here.

Briefly, and I don't want to go into the details, but there were a large number of recommendations that the auditor noted as that Public Accounts had agreed with in the past. And I just want an overview in terms of progress on those past recommendations from the auditor.

First of all, are these things largely being complied with? I heard from Mr. Pillar that the department's, in large, in agreement. Where are we at with those agreements in general that have been agreed to in the past by Public Accounts in terms of their implementation?

**Mr. Heffernan**: — Thank you, Mr. Chair. Unfortunately those observations are based on our last audit. We're in the process of auditing the department now for the year ended March 31, 2001, and we're just sort of in the middle of that process. So we really can't report to the committee on the progress at this point.

**Mr. Gantefoer**: — To Mr. Pillar, then. From your point of view, in general, are you making progress on all fronts or would you indicate that some are hopefully going to be completed in the auditor's current work?

**Mr. Pillar**: — I'm just reviewing all of the recommendations briefly now. I believe that in most instances we are making progress on these recommendations. And as I indicated earlier, we've supported them in previous years as well. So I focus my comments on ones where we may not be in agreement or may have a difference of opinion.

The progress that we make may not always be as swift as the Provincial Auditor would like, or that we would like, but we're certainly attempting to make progress in those areas that we've agreed to in the past.

**Mr. Gantefoer**: — Thank you. And we will await the report of your work to see what progress is being made. And I know that, as past, you have noted where progress is being made and things of that nature.

To the new recommendations on the Canadian Blood Services, again I didn't hear any disagreement, and I would ask Mr. Pillar, how are you coming in terms of putting together the components of an agreement with the Canadian Blood Services?

**Mr. Pillar**: — This issue has become more critical, I believe, as I mentioned in my earlier comments, in the last two years, as our contributions to the Canadian Blood Service have increased. Our contributions to formerly the Red Cross were far less level than they are currently. And our contributions have increased by at least 40 per cent in the last two years in recognition of the increased security attempts being made to protect the blood supply and this activity of the CBS.

So our contributions have increased significantly, and as they have, we are in agreement with the fact that a service agreement for that level of contribution — we're over $20 million a year now — is likely a requirement. So we're entering into discussions with the Canadian Blood Service.

The issue is complicated by the fact that with our interest in proceeding with a service agreement, the Blood Service is cognizant that this might cause all other jurisdictions who have similar arrangements with the Canadian Blood Service to require the same kind of arrangement. So that the progress is a little bit slow in the sense that they're not just dealing with Saskatchewan. They're thinking this is something that could be a model for the rest of the country.

**Mr. Gantefoer**: — In terms of how it's determined, there must be some kind of a framework or agreement between the various departments of Health and the Canadian Blood Service that determines the level of your contribution and what services you would expect from that.

How is it determined that your contributions have gone up by 40 per cent in the last two years, for example?

**Mr. Pillar**: — It's a formula based on population, as many of these federal/provincial arrangements are with respect to the population of the province. So it's a formula . . . Our financial commitment is based on a formula that applies right across the country, in terms of Saskatchewan's population. So our increase in funding has gone up commensurate and proportionally with the rest of the country. It's not just that ours in Saskatchewan has gone up and the rest of the country hasn't.

The agreements that we have to date relate more to our financial contribution, our financial commitment, as opposed to the actual services that are provided for that financial commitment. So we do have agreements around our financial responsibility and commitment, but that does not extend very far into the service component.

**Mr. Gantefoer**: — So the model that is being suggested, coming out of the auditor's report in Saskatchewan, potentially is going to be a model for service agreements right across the country which do not exist in any jurisdiction, from your comments.

**Mr. Pillar**: — I'm not aware of there being a jurisdiction that has an agreement similar to what's being proposed by the Provincial Auditor.

**Mr. Gantefoer**: — Okay. Thank you. And I certainly don't hear any problems there.

I'd like to move on to the capital recommendation. Currently can you describe how the capital tracking occurs? And what I'm thinking of is, for example, a project goes through the approval process, then there is the approval of construction to proceed. The construction then proceeds in phases and disbursements for those capital portions are disbursed.

And generally I would suspect that this process occurs over a multi-year timeline. It would be highly unlikely that it would go from approval to disbursement of funds to completion of project within one calendar year.

So could you describe for me how the department manages its capital budget, if you like, in terms . . . There must be some almost rolling funds that are drawn on, or once the commitment is made, that allocation or provision for those resources are made. And as the actual projects come on stream and disbursements occur, there has to be some provision.

And I would like you to describe how that process works for the committee, please.

**Mr. Pillar**: — Mr. Chairman, I'll turn this question to the director of our capital facilities branch, Leslie Parker, who's in a much better position to answer this question in detail.

**Ms. Parker**: — Mr. Chair, thank you. Once the capital appropriation has been approved through Finance in the legislature, the capital projects and the costs of capital projects, once they've been identified for priority, are determined through a process that as projects are developed and the costs of the work is known, the refinement on the total cost is calculated, and on the budget we make those refinements on a regular basis.

Once we come to agreement on the final cost of the work, it's known and communicated to the districts, and it's on that basis that we proceed to tender.

If projects come over, we do an aggressive attempt at bringing those costs in line, and for the most part we're successful.

And the disbursements are made largely once we're in construction where the majority of the dollars are incurred after a capital agreement has been signed between the province and the district itself.

So I'm not sure if I've answered your question, but that's the general process.

**Mr. Gantefoer**: — Well I was looking for . . . You obviously have more than one project underway at any given time, and all of these projects would be at different stages of the project. Some would be in planning, some would be approved, some would be in various stages of actual progress payments and disbursements being made, and that that would occur over calendar years or budget years.

So how does the department . . . I note in this year, I think it was something like $45 million or something, in the year under review. It wouldn't necessarily follow that the $45 million would . . . Or does it follow that the $45 million is what's actually disbursed in the year rather than what's approved in the year.

So what I'm getting at is how do you manage multiple-year projects and how do you carry over the calendar or the fiscal year?

**Ms. Parker**: — The caps agreements, for the most part, secure the commitment by government on the capital project in that fiscal year. So in the year we have $45 million we might have 30 projects. That $45 million is secured in capital agreements on projects that we are far enough along where we understand very well what the scope and cost of the work will be.

If the project for whatever reason — whether construction is slow or the planning process is slower — we then carry over a payable into the next fiscal year. So the actual payment on that agreement, it can be made the following year, and as you say, over a multi-year process.

**Mr. Gantefoer**: — So that for the department's budgeting purpose when the project is anticipated to largely occur, that's the year that it's budgeted in its entirety, and then there would be a payable or a liability that actually occurs into the following year as the project gets completed.

**Ms. Parker**: — We certainly try to do that. When projects are

identified through the valuation process that you referenced earlier, those projects are already forecasted on our budget that is updated every month. As those costs are known, they're refined on a monthly basis. And when we get to, as I say, an agreement on what it's going to cost us, those dollars are frozen, if you will, in a capital agreement and payments are made as work is complete for the most part.

**Mr. Gantefoer**: — Thank you. There are various funding ratios depending on the project and its importance to the province as a whole. Could you outline briefly . . . I believe there are different arrangements in the major tertiary centres in terms of some of the capital projects and they move down to other projects in terms of the funding ratios. Could you outline in general the basis on what the various funding ratios are set up as?

**Ms. Parker**: — I can. The standard funding formula for health capital is 65 provincial contribution and 35 local.

As you've stated, there are differences. Where we have provincial programs tied to a project — and for the most part that's in larger centres — that work is funded by the province at 100 per cent. That would also be the case . . . Because of difficulty with the tax base, northern projects are also funded by the province at 100 per cent.

We do have instances where, in the urban centres — Regina and Saskatoon — where some projects, where they're not provincial programs, they too have been funded at 65/35, consistent with the broader funding formula.

**Mr. Gantefoer**: — Okay, thank you. In terms of . . . Does the department have — I don't know what the right word is — an inventory of capital requirements, if you like, where you're looking forward and saying that in the next decade we are going to anticipate that we need X number of long-term care beds, we're going to need refurbishment of acute care facilities, we're going to need these sorts of things? So that there is an anticipation, if you like, a looking forward anticipation, of what capital projects are going to be needed throughout the province in the different categories — acute care, long-term care, or whatever. And does the department try to meet this long-term need on an annual basis when you set aside or you make your requests for capital budgets?

**Ms. Parker**: — The projects are identified . . . Well in a fiscal year where we have funds that we can proceed with a capital valuation process, capital project proposals are presented to the department by districts themselves.

Districts do ongoing planning with their needs assessment, aligning it to their program needs as you commented on, and its impact in terms of facility requirements — whether that's new or renovation. Those proposals are submitted; they're priorized by their districts independently, and they're presented to the department for a broad provincial review.

We have what we call a technical evaluation process that supports health reform and some of the principles in terms of where the health system is headed into the future. And that evaluation process sets a priority of all of the submissions that are presented to the department. And there is a formal ranking or rating that's presented or identified for each project.

Once that priority listing is identified, that is a public document that's shared. So districts understand very well where their proposal came in, in that review process. And depending on the availability of capital funds, the allocation is made on the top priorities.

**Mr. Gantefoer**: — Is there more of an anticipation . . . What I'm thinking of, that the department would look at the demographics for example in a 15- or 20-year looking-forward way. And saying that, you know, those of us who are going to require long-term care facilities in the next 15 or 20 years are going to create a bulge, if you like, in our demographics and that this added demographic reality is going to occur across the province or localized in major centres or those kinds of things, to try to anticipate and match up capital projects to meet this anticipated demographic change or reality.

Does the department engage in that kind of forward-looking vision and then use that as at least a portion of its criteria for allocating capital resources?

**Ms. Parker**: — I believe we do. On the program side there is an understanding of demographics and what it means for long-term care in particular, in certain areas of the province.

We have some understanding of what the age and what the infrastructure is doing itself. Much of the infrastructure is on the average, 30 years old in some communities.

So we are identifying the pressures on the infrastructure, that is true. If projects are not submitted through the evaluation process, albeit that we work with districts through their planning process, needs assessment, and try to get those priorities and proposals to the table, those submissions are first presented from districts themselves.

**Mr. Gantefoer**: — Thank you. Finally, on the final recommendation, the new recommendation, it sounds to me that we could sit here and listen to accountants argue the virtues of listing things as a capital asset, a liability, or whatever till we all have our eyes glaze over.

I heard that there is some work being done by the Institute of Chartered Accountants on some recommendations on this, and I wonder if the auditor could comment. Is indeed this work anticipated and may this have some influence on your recommendation?

**Mr. Wendel**: — Yes, I noticed something the other day. The Institute of Chartered Accountants have stated that they are going to be looking at transfer payments, and that this would be one of those kind of transfer payments between General Revenue Fund and SHIN. So there may be more guidance come out of that, we'll have to wait and see.

**Mr. Gantefoer**: — Thank you, Mr. Chair.

**Ms. Jones**: — Many of my questions have been covered, but I wanted to ask about recommendation no. 2 on page 98 concerning the Canadian Blood Services. And I noted that you indicated that our contribution had increased 40 per cent to $20 million annually, and that's very significant. But I'm wondering what percentage of the total amount of money that the Canadian

Blood Services gets does that amount represent?

**Mr. Pillar**: — Our share of the operating funds of CBS is about three and a half per cent. And that again is based on our population in Saskatchewan vis-à-vis the rest of the country and their contributions to the CBS.

**Ms. Jones**: — So although it's a significant contribution for us, it's almost an insignificant percentage-wise in terms of their total funding, and I'm wondering in light of that, how difficult it would be for us to actually encourage them into a service agreement considering the percentage of total funding that we contribute?

**Mr. Pillar**: — I think as I mentioned earlier, if it was just Saskatchewan that was interested in doing this, it might be something that they wouldn't view as a high priority. But my understanding is that other jurisdictions are interested in proceeding this way as well, given their significant increase contributions over the last two years. So as a national exercise with all provinces involved, it has a better cost benefit.

**Ms. Jones**: — Thank you. So if it was a national objective, would each jurisdiction likely negotiate on their own, or would you, as a perhaps provincial health ministers or provincial departments of Health, try to negotiate a national agreement as opposed to a provincial agreement.

**Mr. Pillar**: — That is why this is taking a little longer than ordinarily it would because I think there's attempts to look at a template, if you would, or a model agreement for all jurisdictions to be involved in.

**Ms. Jones**: — Thank you very much; I think that will help me consider the auditor's recommendation.

**Ms. Draude**: — Thank you, Mr. Chair, and welcome everyone. I have a number of questions but maybe I'll just cut them down to one.

First of all on the capital projects, we've talked about the costing. What happens if during . . . once a project is approved, there's a cost overrun that's significant. And I would imagine that probably happens. And when you have a set amount of money set aside for capital projects, how is that figured into determining . . . is somebody going to lose their project next year or halfway through a project or how is that worked in?

**Ms. Parker**: — I might just make reference to an earlier comment that I made, that once projects are all identified and costs are known, on a regular basis we're updating the projects to ensure we can . . . that we can manage the capital budget and their current allocation.

So where that occurs, we work with districts, their consultants, and the contractors, if tender costs come in higher, to reduce the scope of the work to bring them in line. And I would say that we're successful in that on probably 90 per cent of our projects.

Where there are some cost overruns that are as a result of recent market fluctuations if . . . we've had incidences in a year where steel costs have gone high, or wood cost, that there's virtually nothing that you can do to bring those costs down.

We have made some adjustments in our cash flow for our projects as a result of it. There is a confirmed recommitment, if indeed there is a slight increase in a project cost, that commitment is confirmed at that level and so is the provincial funds.

What it does in terms of managing the balance of the projects, we for the most part cash flow our projects as tightly as we can, and most certainly consistent with the schedules that districts and their consultants are sharing with us.

So there is some movement of dollars in a fiscal year to see that all the work proceeds, and most certainly as timely as possible. So that . . . I mean there is some fluctuations to some extent when that occurs on project costs.

**Ms. Draude**: — So if the cost overrun happens and you can't take it out of this year's budget in Health, then can you go to the government . . . do you go to the government for extra funding for that year because of the overrun?

**Ms. Parker**: — The majority of our projects we manage within our . . . in the allocation that we have, and what we expect our allocation to be in the following year is a multi-year, sort of, process.

You know the incidences like Project '98, indeed, there was a resubmission through the budgetary process for the increase of those project costs. But that is very unusual.

**Ms. Draude**: — I think I have this question on me to ask Department of Finance. I understand that if a capital project isn't finished in the time frame that was suggested, the money is held over and paid the next year.

Now that must be a different way of handling than you do, say, in Municipal Government where with the infrastructure program if you don't pay . . . if a project isn't completed in one year, then they lose the funding and they can't get it back the next year. Is it different departments work different ways?

**Mr. Payton**: — Mr. Chairman, I can't speak specifically to the infrastructure program. It could be a different nature of a program. The one that Health is operating is where they're providing grants to these various entities to undertake capital. The infrastructure might be a cost-sharing type of program where, as they incur costs, they're reimbursed by the provincial government or the federal government. But I'm just . . . I'm guessing as to how that operates.

**Mr. Harper**: — Thank you, Mr. Chair. Just a brief question on the Canadian Blood Services agreement. Once a new agreement is reached, do you anticipate that there'd be any change in the level of service that Saskatchewan would receive from the Canadian Blood Services?

**Mr. Pillar**: — No, sir.

**Mr. Harper**: — You indicated that the funding is based on a, basically on a formula based on population. In a case of a, say, a disaster anywhere, would that play any role at all in the renegotiating of funding levels in the future? For example, if there was a disaster in the services of the blood . . . Canadian

Blood Services was of greater use than normal in any one province, would that affect it in the future?

**Mr. Pillar**: — No, not to my knowledge. The agreement is a long-term agreement and it's based on population. And there are no provisions for other arrangements.

**Mr. Harper**: — So it's just based on population; it's not based on services required and so on and so forth.

**Mr. Pillar**: — That's correct.

**The Chair**: — Thank you, Mr. Harper. Any further questions? Ms. Bakken.

**Ms. Bakken**: — Thank you. I just had a question on the capital funding. You indicated that there were provincial programs that were approved in Regina, Saskatoon, so were cost at 100 per cent.

How do you determine which are provincial programs, and could you give us an example of a cost sharing arrangement in either Regina or Saskatoon where actually the cost is split 65/35?

**Ms. Parker**: — The renal or hemo dialysis projects are a good example of what we consider provincial programs. And those are programs that are in place in various centres, both Regina, Saskatoon, Yorkton, Swift Current. There are others. Those projects were all funded at 100 per cent.

An example of where projects have been funded in Regina at 65/35 would be the mental health consolidation. There is currently one in planning at William Booth. It's scheduled to be funded at 65/35. The mental health project that's currently in planning in Saskatoon is also scheduled at 65/35.

**Ms. Bakken**: — Another question to do with capital funding. When you are approving capital funding, do you take into consideration sustainability of the operating funding that will have to be tied to that, and is that considered when you're approving projects and what they're asking for within their new facilities?

**Ms. Parker**: — It absolutely is, through the functional program process where the marriage, if you will, between the needs assessment around their programs and what their facility needs are and how the future operations of service delivery at that site will be. Operating costs and staffing costs are most certainly considered in terms of its sustainability and affordability for the district in the long term.

**Ms. Bakken**: — Following up on that then, you know, there are cases within the province where certainly this is happening, where it's built to provide certain services and those services then are not provided because the funding is not available to carry on the operation of them.

To who is that mistake contributed to then? I mean, who takes responsibility for that happening? Because the capital costs are being put into it, but then there isn't funding to operate them and the service is never provided in some cases.

**Ms. Parker**: — It's a good question. The kind of planning that occurs, an investigation of operating costs of the functional program is earlier on in the process. That's true.

Once facilities are up and running and service is delivered from that site, there are inflationary costs; there are facility costs. There are things that as to the best of everybody's ability to see the sustainability over the long term, there are some adjustments and changes that do occur. Nonetheless the districts are responsible for managing within . . . in their operating resources.

**Ms. Jones**: — It seems like in the presentations the new recommendations were highlighted and we've asked questions about them. But I note the recommendation on page 103 and it has been previously dealt with by Public Accounts Committee, and it's the recommendation that the department provide the Legislative Assembly with a list of persons who receive money from the Saskatchewan prescription drug plan.

And there was PAC's (Public Accounts Committee) recommendation at that time in the second session of the twenty-third legislature, and I wondered did we have a report on the current status of that recommendation which was to report back on the implication of adopting the recommendation?

**Mr. Wendel**: — That report was to come from the Department of Health back to this committee as to how they plan to handle that.

**Ms. Jones**: — I should ask the Department of Health.

**Mr. Pillar**: — This has been a long-standing concern expressed by the Provincial Auditor's office, and our difficulty relates to section 37 of The Saskatchewan Medical Care Insurance Act which prohibits payments to physicians from being disclosed publicly. And we have taken the position that payments to individuals through the prescription drug plan should be addressed similarly, as they're somewhat analogous situations.

We are considering, and government has considered, repealing or amending section 37 of the medical care insurance Act so as to provide the public with disclosure on payments to physicians. And if that was the case, then we would feel comfortable providing the request with respect to prescription drugs as well. But that is a decision that is still under consideration by government.

**Ms. Jones**: — But if you provided a list to the Legislative Assembly of individuals who had received payment under the prescription drug plan, would that not be somehow exposing or disclosing private health information of individuals?

**Mr. Pillar**: — With respect to individuals, it would. The issue I think is more profound with respect to payment to pharmacists actually, the payment to pharmacists from the prescription drug plan on behalf of individuals. Certainly the individuals' names would not be appropriate. But I think the concern, if I understand the Provincial Auditor's concern, relates more to the payment to pharmacies and individual pharmacists.

**Ms. Jones**: — Could you describe to me what public purpose disclosing that would serve, or should that better be asked of the

auditor?

**Mr. Pillar**: — Well I can I guess respond generally in that I think in public policy throughout — not just in health care sector — I think governments and public sector organizations are trying to be as transparent as possible and provide as much public information as possible. And certainly we provide a lot more than we did say 10 years ago.

But that needs to be balanced on the other hand with protection of information for individuals. And it's that balancing act that from time to time moves, you know, in one direction and from time to time in the other direction.

**Ms. Jones**: — Thank you. I would like to ask the same question of the Provincial Auditor.

**Mr. Wendel**: — Our recommendation comes from this committee. This committee said it wanted to see certain information on payments that are made by government. And it listed, I think it's $20,000 for any payments to suppliers, and payments to staff is a certain amount, and transfer payments are another amount.

So when organizations haven't disclosed that kind of information, we advise you of that. And we're advising you they haven't disclosed that information for payments to pharmacists. That's not been done. Now as to whether the committee wants that information, that's for the committee to decide. At the moment there's no law prohibiting it as far as we can see.

Now possibly to the payments to the individuals, there's a very good case to be made that you wouldn't show the payments for those prescriptions to the individuals. But that amount is a very small amount of money that's paid out. I think it's $85 million that's paid to pharmacies, and $270,000 is paid directly to individuals. So the largest amount is paid directly to pharmacies.

Now you have to decide whether you want that information. And we have a chapter in Executive Council that provides a process for you to go through and you make your decision as to whether you want that information or don't, and that's acceptable to me.

**Ms. Jones**: — Thank you.

**The Chair**: — Mr. Paton, if I could ask for your comment, please?

**Mr. Paton**: — Yes, Mr. Chairman, this issue of providing a list of payments is one that not only covers the Department of Health, but other departments. And I believe in 1998 this committee asked my office to look at the issue of how these payments should be disclosed, and when they should or shouldn't be disclosed.

We tabled a report with this committee last spring — actually June 22, 2000 — and I've got one copy here. But it was a process that we recommended that this committee adopt on how to deal with disclosure of issues such as this one.

Speaking to this issue quite specifically, it's my office's opinion that these are being dealt with on a consistent basis within government. The policy that we've adopted for public accounts disclosure states that, details that . . . details are not provided for high-volume programs of a universal nature, or income security or other programs of a confidential nature and personal nature.

So that's the type of thing that we recommend not be disclosed and you'll find Social Services payments and other similar ones that fall into that category.

The issue that's being debated specifically here is the fact that these payments are being made to pharmacists on behalf of individuals. We review . . . Or we view those as payments that are being made in respect of the individual. And whether I choose to shop at Wal-Mart or some other pharmacist and they provide the drugs on my behalf, they're receiving the payment that really the individual qualifies for. So there's a potential that seeing where the payments are going to, people could assume who's getting assistance of some nature in terms of this program.

So quite specifically if you were to go through our, I guess our recommendation on how to deal with this, we believe what the department is recommending is consistent — that these are personal nature payments and should not be disclosed in the public accounts or in any other reports.

**Mr. Wakefield**: — Thank you, Mr. Chair. I wanted to just go back briefly to a quick question on the capital program.

Some health districts wish to pursue a particular capital project. It may not be a priority under the, the view of the department but they feel it's an important aspect to their community and the community development. I'm thinking of a long-term care facility. And they're prepared to raise a very substantial amount of money in capital for this, maybe almost all of it if they had the permission to go ahead. How do you handle those situations?

**Ms. Parker**: — Carefully. And I say that respectfully because you know, the ongoing planning for a district-needs assessment for services where there . . . you know in . . . and to use your example for long-term care, and its . . . and the district's ability to provide appropriate service, you know, within their resources, is always balanced against a community's interest for an upgrade for . . . in a facility for a long-term care project. And those are difficult processes.

From the department's perspective, we work with the communities and the districts through those issues. If the district feels it's a priority, we have . . . in the past there has been some . . . some approval has been given, although very, very little, for projects to proceed with the majority and in one case 100 per cent funding. I would say that's a number of years ago. More recently that has not occurred because of the sustainability issue, because of inter-district planning around services, what the infrastructure is doing, and more recently around what the commission might be telling us.

**Mr. Wakefield**: — So if . . . from what I understand then, if all the needs assessment has been done and still doesn't fit within the priorities of the department, the project will not go ahead

even though the health board . . . local health board decides that it needs to go for, I guess, the vital continuation of community interest.

**Ms. Parker**: — I think the key piece is around the sustainability and the operating costs and a district's ability to provide long-term care services in the most appropriate way and hopefully in the right communities. But certainly the operating would dictate a number . . . the majority of our support for districts in communities to proceed with a project, whether it's funded by the province or not.

**Mr. Wakefield**: — I have another question, Mr. Chair, if I could, and that . . . that really talks about the plans, and I'm looking at specifically an item on page 99 under the heading, department needs to approve district plans on time. It indicates here that The Health Districts Act requires the district to submit annual health plans to the department for approval. I think that's pretty straightforward.

And then it says . . . it goes on to say that in a lot of cases these plans are delayed or incomplete and so on. And this I think has been addressed maybe earlier but my question would be, why are these delays from the health districts delayed? What are the circumstances? Do they not want to comply or is it other circumstances, maybe information that is not given to them, or other kind of restrictions? Why is that?

**Mr. Pillar**: — The difficulty that we have . . . and I might add that we certainly agree that district budgets should be submitted as soon as possible and we certainly agree with the intent of the Provincial Auditor's recommendation that as early in the fiscal year as possible districts have approved budgets, that they know that they have to work within throughout the course of the year.

So we agree with the intent of the recommendation. The difficulty in complying with the precise letter of the recommendation relates to government budgeting cycle and delivery of provincial budgets. As you will be aware, provincial budget information and provincial budgets typically are brought down towards the end of March. So health districts don't know what their budget is actually going to be until the provincial budget is brought down.

For health districts to . . . I think this year it was March 30 the budget came down, so for health districts to comply with a budget submission on April 1 would have been physically impossible. They need to find out what the revenue source from their grant is going to be. They need to conduct their discussions within the district, with their publics, and then have the board approve the proposed budget and then they submit it to us.

So it's a matter of timing. It's a matter of government process with respect to the provincial budget and when all third parties, not just health districts, find out about what is in the budget for them specifically.

**Mr. Wakefield**: — I think it was my understanding that the health districts were required to put forward a budget that was sustainable in a way that is not running a deficit because of the trend lines that were in place, and were required not to consult with their people. I find that really an awkward situation to place elected and appointed board members in. And I know that there was a lot of calls coming about the unfairness of that particular action or that particular demand on them.

**Mr. Pillar**: — I think you're referring to one cycle ago — not this last budget cycle but the previous budget cycle — when there were some requests made of districts not to consult broadly with their publics on potential budget scenarios until the department and government had a good look at what the implications were.

That's not the process we've followed this year. We've changed the process. I think we've learned some lessons from that process a year ago.

The intent of that of course was to ensure that the public was not . . . concern was not developed in the public prematurely or without foundation in terms of what final budgets would look like, and a desire not to have that occur until final numbers were known, again, a year ago.

This year we've conducted the process a little bit differently. And we think, based on the reaction we've had from health districts anyway, that they're more receptive to the process this year.

**(Due to a problem with the microphone system some verbatim was not recorded.)**

**The committee recessed for a period of time.**

**The Chair**: — Okay, we'll reconvene and we believe that everything is functioning. Just maybe a connection problem that left us with power but didn't enable the controller to control the microphones. So we think we're on, and back to you, Mr. Wakefield, for your final questions.

**Mr. Wakefield**: — Thank you, Mr. Chair. I'll have to try and think about what the question was.

The question I had was referring to the second paragraph on page 100 under the heading, department needs better reports from the district. It said several districts did not submit their quarterly financial reports to the department on time.

And I guess that triggered a thought that if the departments requiring these financial reports to come from the districts, and particularly when they're trying to plan ahead, they need to get a . . . they need to have the vision of a year, two years, three years and that goes back to the recommendation that was agreed on page 99.

But there was a statement in this page that was sent out saying that it was agreed in 99 and recommended that the department should to the best of its ability, provide the districts with an indication of their funding levels for the next two to three years. The department has not done this, and I wondered why?

**Mr. Pillar**: — Can I take the fifth on that one?

**The Chair**: — Wrong country.

**Mr. Pillar**: — Wrong country. Okay, I'll plod on then. We, two

years ago, commenced a process with districts in developing three-year strategic plans. And it was an attempt to address the issue that you've raised, an attempt to get around the problem we have annually with waiting until the budget comes down before we give districts an indication of their funding level.

Those strategic plan processes I think worked well and districts participated in them enthusiastically. The area that we fell down on, quite frankly, was in being able to give them accurate projections of what funding would be like into the future. So the financial component of those strategic plans was where we had difficulty.

And quite frankly the issue is not being in a position to either, you know, have the wisdom or the intuition or the nerve to predict what the government was going to allocate to the Department of Health for health districts on their allocations. We have not been able to give them any indication now.

We're hopeful this year, with the report of the Fyke Commission and the review that is going on both now legislatively and within the department on the Fyke Commission and its recommendations as it takes the system into the future, that we will be able to, and that the government will announce sometime in the fall a plan that will be able to be a broader longer term plan than just the annual cycle that we are confined to each year.

So the short answer is we haven't been able to do that because we can't breach budget security nor have we been able to get Finance to give us those projections into the future and understand why. But we hope to be able with the response to the Fyke Commission to perhaps address that issue.

**The Chair**: — Thank you very much. Any further questions? One more? Okay, Ms. Bakken, one more.

**Ms. Bakken**: — This is to do with capital funding. When you were asked the question by Mr. Wakefield about who you consulted with to determine priorities and so on in capital funding, you listed several things that you consult . . . people or groups that you consulted with, and one that you said was the commission. Who is the commission?

**Ms. Parker**: — I think I need to be . . . Well the commission would have been the Fyke in terms of the planning and anticipation for where we were headed and where the commission might go. I mean, in terms of the actual statement that I made, if the reference is to funding, if that's where you're going . . .

**Ms. Bakken**: — On prioritizing projects and so on, you said the one thing that you took in . . . and I'm just paraphrasing. I don't know exactly. That was the commission.

**Ms. Parker**: — The reference that I was trying to share with you is that the technical process for prioritizing those projects includes the health reform principles and also the sustainability, and more recently in terms of working with districts and on capital projects over the last year with anticipating the Fyke Commission. So there was no direct consultation with the Fyke Commission on priority setting.

**Mr. Pillar**: — If I could just add to that. Certainly into the future the Fyke Commission and the government's response to the Fyke Commission will very significantly impact on our capital and all service delivery of all programs.

So I think that was the reference that Leslie was making that in the past we've had a number of factors influence our planning. We know Fyke, or the reaction or the response to Fyke, will clearly affect our planning into the future.

**Ms. Bakken**: — And fair enough. My question is and I'm wondering, is that being taken into consideration now? Seeing how Fyke was a commission but has not been adopted, are his recommendations in fact being used by your department now?

**Mr. Pillar**: — They are being reviewed, evaluated, but no decisions have been made on the basis of Fyke's recommendations. We have, as you know, a legislative process in place to respond to Fyke. We in the department have put together a fairly elaborate process involving stakeholders and health professionals in helping us evaluate all of the recommendations of the Fyke Commission.

That process is going on as well, but we're in the review stage at this point, the review and analysis stage.

**The Chair**: — Thank you. Members of the committee, I'd like to deal with the recommendations in chapter 2A. And after talking with Mr. Wendel here, the recommendation that was numbered as number 1, on page 88, really is a recommendation that has been dealt with before by PAC and it probably should have been left as being not bold, in bold print and not numbered, because it is like the recommendations on page 97 or page 99 or on and on and on.

Those are recommendations that were dealt with previously and PAC has considered them. So I think as far as new recommendations, as we have in the summary, we are dealing with recommendations 2, 3, 4, and 5 as new recommendations.

And the first recommendation, no. 2, is on page 98 and that is the recommendation regarding blood services.

**Mr. Gantefoer**: — Concur and note progress.

**The Chair**: — A motion that we concur and note progress, I think, is the consensus of what questions were asked and responses.

Any further discussion on that motion? All in favour? Carried.

Recommendation no. 3 is on page 101, and that's regarding the department's capital construction agreements with the two bullets that appear on the top of page 102.

Is there any further questions or any decision that is ready?

**Mr. Wartman**: — Concur.

**The Chair**: — Concur. Any questions?

Motion that the PAC Committee concur with recommendation no. 3. All those in favour? Opposed? Carried.

Recommendation no. 4 is on page 105. And we've heard comments from both the auditor's office and the department's officials regarding SHIN and how it's working. We've also heard from Mr. Paton regarding not only Health, but other departments.

Any further comments or questions?

**Ms. Jones**: — Not a comment, but it appears to me, in terms of the recommendation, that there's a difference of opinion that's being worked on and considered. So I would recommend that the auditor's office and the Department of Finance continue working towards reconciling their accounting policies.

**The Chair**: — And I think we've heard from the auditor's office regarding the Institute of Chartered Accountants, that they were looking at putting forth some recommendations.

So I believe that that's a new motion that would . . . it's not concurrence. It's not rejection. It's that there be continued work done between the auditor's office and the Department of Health on building something that is acceptable.

**Ms. Jones**: — Finance.

**The Chair**: — Or Department of Finance. I'm sorry.

Mr. Gantefoer, did you have a comment?

**Mr. Gantefoer**: — Yes. I think that what we can do is note the positions as stated by the auditor's department and the Department of Finance and await the report from the Institute of Chartered Accountants and the fact that it may shed some light on the issue.

**The Chair**: — Okay. And that's what you're prepared to move, Ms. Jones?

**Ms. Jones**: — Yes.

**The Chair**: — Yes. Okay. New motion that would indicate the circumstances and that we await the decision. Any questions? All in favour? Agreed.

No. 5. I think it goes together so do we have the same resolution? Mr. Gantefoer moves the same resolution as was for no. 4. Any questions? All those in favour? Opposed? Carried.

Okay that took care of chapter 2A and I believe, Mr. Heffernan, you're still going to be on the agenda right now with chapter 2C. Chapter 2C which begins on page 121. Mr. Heffernan.

**Mr. Heffernan**: — Thank you, Mr. Chair. Page 123 shows the total revenues and expenses, assets and liabilities of health districts. Districts spent 1.5 billion in the year 2000 and held assets of 1.1 billion.

We followed our risk-based approach to auditing. We've determined that health districts have similar risks and as a result we don't audit all districts every year. We limit our audits to 10 districts. Each year we audit the two largest districts, Regina and Saskatoon, two of the four medium-sized districts, and six smaller districts.

Exhibit 1 on page 125 shows the districts we audited in 2000 and the districts we are currently auditing in 2001. This chapter shows our audit conclusions and findings for each of the 10 districts. There are no new recommendations in this chapter. The Public Accounts Committee has agreed with all our recommendations in its January 1999 meeting. The reason we bolded the recommendations was that there are new . . . Since we do 10 districts, it's different names of districts in each year but the recommendations are the same.

That concludes my remarks.

**The Chair**: — And, Mr. Pillar, I guess I would ask you to comment on the recommendations since there are no new ones as such in progress.

**Mr. Pillar**: — And certainly, Mr. Chairman, I think we have no quarrel with the auditor's comments here. I think we would note that — and they would agree — that the number of occurrences, as health districts mature, are diminishing in number and we continue to work with health districts and of course are following up with the recommendation . . . have followed up on these specific recommendations.

**The Chair**: — Are there questions or comments from members of either the auditor's office or the Health officials?

Okay, seeing none, the fact that there are no new recommendations in chapter 2C will allow us to . . . (inaudible interjection) . . . Yes. Sorry, Ms. Jones.

**Ms. Jones**: — I have some comments on recommendation no. 4, page 132, and it talks about the Regina Health District ensuring "its operating agreements require affiliated organizations to establish" systems and etc. And I'm wondering how we can ensure that and what the progress is on that recommendation? I mean there's nothing new in the auditor's recommendation as I understand it.

**The Chair**: — Well I think we can ask the departmental officials to comment on that please?

**Mr. Wiley**: — I'll respond on behalf of that one. Again essentially, the Department of Health and the Provincial Auditor have the same expectations with respect to service agreements or agreements with affiliates needing to provide a certain level of adequacy and ability to manage.

There is one fairly minor disagreement with respect to the way that the auditor believes the agreement should be structured. The auditor believes that in order for the agreements to be effective, there's a requirement that districts get an audit opinion as to the adequacy of the affiliate's financial, operational, and compliance objectives.

It's, in our view, a judgment decision as to whether you want to spend additional dollars on an external audit opinion that gives you additional level of assurance about how the affiliate operates. In this case, we would agree that you would get an additional level of assurance. What we don't believe is that there's a cost benefit of spending that additional level of funding.

So it really comes down to a matter of developing your level of assurance around the affiliates through either means, and districts largely take that on the basis that the affiliate statements are audited and receive audit approval. And generally, unless there's any issues that require more in-depth review, that's taken as an adequate level.

So it's a question of economics. There's some value in asking for the additional assurance. It's our view that the money is best spent on front-line services rather than audits, and we don't think that there's significant control issues that result from that.

**Ms. Jones**: — So it's a matter of cost versus benefit. And in their opinion, they can adequately ensure service from the affiliate without requiring an audit.

**Mr. Wiley**: — There are audits done. It's the question of how much assurance you ask the auditor for. The auditors already provide an opinion with respect to the accuracy of the financial statements. The question is, should the auditors also provide an opinion with respect to the controls and processes that are in behind the statements.

So if you think about it, whenever you establish an audit, you can always review deeper in order to feel comfortable that the audit . . . that the results are adequate. And what the affiliates do now is what typically is done. What the auditor is suggesting is that you could get additional assurance by going a little further. And we would agree that going further, in terms of providing auditing assurance, would provide some additional support; however, you pay for that additional, and we don't see a lot of value.

Also we would acknowledge that you would get a better review, but we don't think you get a lot of additional value for the extra cost.

And again, we'd rather just see those dollars flow to front-line services rather than to pay for additional external audit opinions.

**Ms. Jones**: — Mr. Chairman, in light of that response, I'd like to propose an amendment.

**Mr. Heffernan**: — I don't think we're as far apart with the department as the department thinks. If you look at the second last paragraph on page 131, it talks about the model that the department and districts agreed to prepare the operating agreements.

And the second sentence says that the agreement provides for the affiliates' auditors to report on a district's adequacy of financial controls in compliance with authorities. And it goes on to say that the model agreement also states that the district and the affiliates will jointly assess the effectiveness and quality of services provided by the affiliates.

That last part there, in our minds, complies with what we're looking for in the districts, or the affiliates reporting on their effectiveness of their operations. Having the district and the affiliates work together to do that assessment is fine with us. It's only the Regina district that doesn't have these reports coming from their auditors.

**The Chair**: — The situation that will occur this fall in the fall report will be the auditor's analysis of the year just past on March 31. And I think, as Mr. Heffernan has indicated, they may make the comment that the agreements that are in place are adequate to achieve what was asked for in recommendation no. 4.

So until we see the reaction, I guess, of the auditor's office to what has been asked for and the agreements that have been put in place, we may be dealing with a topic that won't even be before us.

**Ms. Jones**: — Perhaps though if PAC makes a recommendation, you can weigh the results against that recommendation when the new report comes in.

**The Chair**: — That's true too. So I guess . . . Do you want to place an amendment before this PAC committee, or do you want to wait until we see a fall report.

**Ms. Jones**: — Let's put it before this committee so that I don't lose track of it at the next report.

**The Chair**: — Okay. Could we hear your amendment please.

**Ms. Jones**: — I would suggest:

> PAC recommends health districts develop agreements that help ensure affiliates effectively deliver health services.

**The Chair**: — Okay. So you're not specifically stating Regina Health District; you're stating districts.

Could you forward that to us in writing, or can you get . . .

**Ms. Jones**: — If you give me a piece of paper I can. You can't have my notes.

**Mr. Wakefield**: — If I could just add a question of clarification while the motion or the amendment is being written.

To Mr. Wendel: the name, affiliates, I see here on page 131 is associated with special care homes. Is that the extent of what is meant by affiliates?

**Mr. Wendel**: — In the case of what we're reporting in this chapter, I think . . . it's special care homes, but the recommendation that was made by this committee in the past also applied to acute care facilities, larger organizations. So some of the districts would have large service agreements with an acute care hospital and it would be more significant to them than it would be to others that just have smaller numbers of affiliates.

So the recommendation . . . I'm not sure if . . . I haven't seen it yet, but I'm not sure if the committee's recommendation is on a broader basis or just applicable to Regina.

**Mr. Wakefield**: — I guess the reason I was asking, Mr. Chair, is some health districts have operating businesses associated with it. The one I'm thinking of in particular is the Saskatoon Health District has a physiotherapy operating business actually set up in Lloydminster on the Alberta side. And I wondered if

that is considered part of this associate label, or what?

**Mr. Pillar**: — Yes, an affiliate, we define affiliates.

**Mr. Wakefield**: — Okay.

**The Chair**: — Now, Ms. Jones, just for clarification, your suggestion that this be an amendment. Are you then suggesting that the full recommendation, no. 4, be replaced by this, or that this be in conjunction with what's already there? I just need some . . .

**Ms. Jones**: — Recommend it be replaced by that.

**The Chair**: — You recommend that motion no. 4 be replaced by this? Okay, I'll read it again. Moved by Ms. Jones:

> That the PAC recommends health districts develop agreements that will help ensure affiliates affectively deliver health services.

Are there any comments about that? Mr. Heffernan, do you have a comment?

**Mr. Heffernan**: — I think the model agreement covers that already. As you can see in the last paragraph on page 131:

> The model agreement also states that districts and affiliates will jointly "assess the effectiveness and quality of services . . ."

So I guess the committee could recommend that the districts follow the model agreement that's already been prepared. That would probably be the simpler recommendation. There is already a model out there for them to follow.

**Ms. Jones**: — My purpose is really in wanting to ensure that the affiliates provide the necessary and desired services without unnecessarily tying up valuable resources in reporting procedures that seem to be in duplication. But certainly our desire is that they provide the needed services.

So that was the purpose of my motion, that you develop agreements. And if you have a model agreement, fine. But the model agreement can be changed into another agreement, I'm sure. And my motion, I believe, would see into future and other agreements as well, and would still provide the same protection that we're hoping for.

So I mean a model agreement is a model agreement, but it can change.

**The Chair**: — And I'd ask Mr. Pillar . . . I mean we've noted from the auditor's office that there's concern with the Regina district, and I think there's been comments about other districts and affiliates. Is this of concern to other health districts?

Is this already being followed, the model agreement that was suggested by Mr. Heffernan? Is it in place with other districts, and how do you see the recommendation put forward by Ms. Jones as being able to be complied with, or does it cause a problem?

**Mr. Pillar**: — Mr. Chairman, I'll let Mr. Wiley answer that question.

**Mr. Wiley**: — Thank you. Certainly the amendment put forward is a broader statement to the issue than the specific recommendation that's in the auditor's report at this time.

I think that, as I understood Mr. Heffernan, that this recommendation may in fact . . . there may not be much difference in opinion between themselves and ours. I would suggest that it again becomes a fairly finite point as to when adequacy has been achieved in terms of establishing systems that control financial, operational, and compliance objectives.

The broader statement simply allows us to say with clarity that the model agreement satisfies that. If, as Mr. Heffernan has indicated, the model agreement would satisfy their recommendation, there doesn't seem to be a lot of difference from our point of view at this point.

**The Chair**: — Okay. Ready for the question?

**Mr. Wakefield**: — Point of clarification. This is a motion that would supersede this recommendation no. 4. No. 4 has already been agreed upon in the past — is that correct?

**The Chair**: — Yes.

**Mr. Wakefield**: — So would no. 4 then have to . . . would there be a motion to rescind no. 4?

**The Chair**: — No, I don't think so. And I need some guidance here, but I would suggest that the motion no. 4 has been dealt with by a previous PAC Committee and it was agreed upon.

Now the reaction by this committee to recommendation no. 4 is the putting forward of a new recommendation. It will be up to the Department of Health and the auditor's office to determine whether or not that recommendation is being met by the model agreement, met by other circumstances and the like. So we can't undo what the PAC Committee has done before.

Now we can propose something different, which I think is Ms. Jones's intent. And that recommendation is an additional one to what's there, because there are no new recommendations in this chapter. So we're creating a separate motion which is what we can do — not as an alternative, but in addition to.

So the use of the word amendment I think is incorrect, and that's maybe where we should have clarified it at the very beginning. It's in addition to, because we're not amending this motion because it's not for us to amend.

I will read the motion again. And it's moved by Ms. Jones, and it says:

> That PAC recommends health districts develop agreements that help ensure affiliates effectively deliver health services.

**Mr. Wartman**: — Just a question that we were talking about here that I'd put out for consideration with regard to this motion, and that is would it be helpful to reference the model

agreement as well in this motion so that it might read . . . And I would like to hear some wisdom before I consider making a recommendation. I don't think it's a big issue, but we may want to say PAC recommends health districts develop agreements or use model agreements that help ensure affiliates effectively deliver.

Any wisdom on that, that . . .

**The Chair**: — Well I think there is . . . there is I think consensus from the auditor's office and from the Department of Health officials that the model agreements that have been suggested may already meet that, and I don't know that we have to specifically reference it. I think it's understood by the committee that that's what we're referring to, that they may already exist, but it's for the two groups to ensure that those kind of agreements are in place.

**Mr. Wartman**: — There's no need to reference it if it's understood. I'm quite prepared to just . . .

**The Chair**: — Is that acceptable? And that's just my opinion. Is it acceptable?

Okay. Let's move to the question then of the motion and I will . . . will you take it as read? All those in favour? Opposed? Carried.

That concludes the chapter 2C.

And still dealing with the report by Mr. Heffernan, we're now going to look at part C of chapter 1 of the '99 Fall Report, which you will see begins on pages numbered 53 and onwards, quite further on in your package. Page 53 of "Toward 2000" which is the chapter of the '99 Fall Report.

**Mr. Heffernan**: — Thank you, Mr. Chair. Toward 2000, also referred to as Project '98, was a five-year construction project in the Regina Health District. The government, through the Department of Health and the Regina District Health Board, initiated Toward 2000 to help improve health care and to help control health care costs.

Begun in 1993, Toward 2000 had three general objectives. First, to close the Plains Health Centre; second, to maintain and improve services at the other two hospitals in Regina, while reducing hospital beds; and to attract health care professionals.

Originally the department and the district expected the costs of Toward 2000 to be 83 million. The department planned to finance the construction through grants of 83 million from the General Revenue Fund. At the date of this report, Toward 2000 was nearly complete. The actual cost was 133 million.

This cost was financed through grants of 91.8 million from the GRF (General Revenue Fund) and through debt. In its summary financial statements the government has recorded the 133 million as health costs and has recorded the related debt.

For some time legislators and the public had expressed uncertainty about the actual costs of Toward 2000 compared to the original plan costs. As a result, we decided to examine this complex project.

We found once again confusion about costs and approvals for costs. This confusion stems from the government managers focusing on the costs recorded in the GRF. The government has not recorded the full cost of the 133 million for Toward 2000 in the GRF. In addition, the government has not recorded the related debt in the GRF. In the GRF the government has recorded only 91.8 million of the cost of Toward 2000 and has recorded none of the debt.

We're concerned that the government continues to encourage managers to make decisions based on incomplete cost and debt information contained in the GRF. Making decisions based on incomplete information led to confusion about planned costs, actual costs, and what costs had been approved. Decisions should be based on the more complete information contained in the government's summary financial statements.

Our examination addressed three objectives. First, we determined the actual costs of Toward 2000 compared to the original planned cost. Second, we determined whether the district received prior approval for the planned and actual construction performance and the financing for Toward 2000, and whether the district complied with governing laws and related authorities. Third, we determined whether the district's board, the department, and the public, received adequate and timely performance information on Toward 2000.

In our opinion the actual cost of Toward 2000 was 133.4 million, compared to the original planned cost of 83.2 million. The Regina Health District did receive a prior approval from the Department of Health for the construction and financing of Toward 2000, and complied with governing laws and related authorities, except for two months in 1997.

During those two months the district signed contracts for construction totalling $8 million before it obtained a decision from the department on how the construction should be financed, i.e., from the GRF or through debt.

The district's board and the department and the public did not receive adequate and timely performance information on Toward 2000.

We make the following recommendations on page 63. We recommend that the Department of Health and health districts make public, timely performance information on major capital construction projects, including the full cost of construction projects compared to original planned costs, the nature of any significant changes to such projects, and the extent that the expected project benefits are achieved.

We also recommend that the Department of Health ensure its capital project agreements with health districts describe the process of verifying expected performance, ensure requests, and receive adequate and timely information on capital construction projects, and assure it determines whether such performance information is reliable.

That concludes my remarks. I'd be happy to answer any questions.

**The Chair**: — Before we do that, Ms. Parker, are you going to be making any comments on this, or . . .

**Mr. Pillar**: — Mr. Chairman, I can just make a couple of very brief comments. Certainly this issue has been discussed in public, and in fact the disagreement that the department and the Regina Health District have with the Provincial Auditor over the conclusion of this audit with respect to cost is well-known and has been debated publicly.

We don't disagree with the total cost of the project that was identified. We do disagree in terms of what the project was composed of. Our view being there was a Project '98 that came in over budget, but not at 133 million. And then there were a number of other projects that were undertaken by the Regina Health District, coincidental or subsequent to that project, both at Regina Health District . . . or at the Regina General Hospital and the Pasqua Hospital.

So I think that debate has been held fully in public.

We do however agree with the auditor on some of the process recommendations that have been made in the audit. Those process recommendations were carried through into the audit that was undertaken by the auditor's office on capital projects. A number of our capital projects were audited subsequently and I imagine we will get to that particular audit later in our discussions.

A number of the recommendations made initially here found their way into those recommendations based on a review of other capital projects. We are in agreement with those and are incorporating them into our process. So perhaps I'll just leave it there.

**The Chair**: — Okay. Thank you very much. Questions of Mr. Heffernan or Mr. Pillar on these two recommendations that you see on page 63?

**Mr. Gantefoer**: — Thank you, Mr. Chair. I hear in the auditor's report you know that there were some serious concerns about the way this project was managed. It was arguably a complex and multi-faceted project involving, you know, almost three concurrent sites. And I understand that went on.

From what I heard from Mr. Pillar he's not arguing with the total numbers but the categorization by the auditor's office that this was all one project, I didn't quite understand that. The totals . . . you were in agreement of the totals at I guess 133.4 but in the original planning of 83.2 there were added on components that came to the total or at least partly added on components; there was some overrun I think you said that you acknowledged.

From what I understand the auditor to say, because this was multi-faceted and it all had to do with the provision of services and, you know, as a global project his point is it should be considered as one project and therefore there was indeed a cost overrun. Is that a summary of . . . you know, a cost overrun of the magnitude of the full amount rather than some of it.

And I guess that again gets down to a point where we can agree or disagree on the interpretation of the details but the numbers are not in dispute — is that correct?

**Mr. Pillar**: — I believe that to be the case. The total number we are in agreement with. Just to provide more specific numbers, while we would agree the initial Project '98 budget was 83.2 million, our evaluation is that the cost overrun went to $96 million on that part of the project, i.e., moving the Plains to the General.

The other $37 million that would come up to the 133 million then, would be other projects that were undertaken to enhance services at the Regina General and the Pasqua.

**Mr. Gantefoer**: — And I also then understand from the auditor's remarks — just to make sure that we're in agreement — that about $92 million was recorded as General Revenue Fund expense of the 133. The balance between that and the 133, is that recorded as Regina Health District debt, or where is that?

**Mr. Pillar**: — I'll let Mr. Wiley speak to that issue on the GRF.

**Mr. Wiley**: — Right. In terms of the broader GRF, the funds that would have flowed from the department as grant funding would be reported in the GRF. So the funding for Project '98 was fully funded and so would have been reported through Project . . . or through the GRF.

In terms of the other construction projects that Mr. Pillar referenced, there was a total of $37 million in additional projects. Of that, 21 million were funded via grant process to the Regina Health District so would have been recorded through the GRF. Beyond that, the additional funding would have been largely via debt, and they would not be flowed through the General Revenue Fund but would be recorded in the summary financial statements of government.

**Mr. Gantefoer**: — Well I'm looking on page 54 of the executive summary, and trying to understand it. And it says in the second last paragraph:

> The Government has not recorded the full cost of $133.4 . . . in the GRF. In addition, the Government has not recorded the related debt in the GRF. In the GRF, the Government has recorded only $91.8 million of the cost of Toward 2000 and has recorded none of the related debt.

Is that accurate?

**Mr. Wiley**: — I believe that it may be accurate within the reporting period that this chapter reports on. But there may have been . . . what I'm looking at is, I think, a later statement that would have recorded grant payments with respect to this, subsequent. So certainly I'm not intending to put forward numbers that we could not readily reconcile with, with the auditor.

I think it's likely a timing difference that accounts for the numbers that I'm speaking to as opposed to the ones recorded here.

**Mr. Gantefoer**: — Okay, thank you. And to the auditor then, will that show up in your current review then, if that subsequent changes to the recording or in a subsequent period would show up then?

**Mr. Heffernan**: — Yes, we would look at that. I wasn't aware of any further capital funding, unless we're talking about operating funds that were given to the district that they're using. I'm not sure.

**Mr. Gantefoer**: — Yes, thank you, Mr. Chair. What I'm trying to do is to get from the statement that I see on page 54 and reconcile that to the statement that we just heard from Mr. Wiley.

**Mr. Wiley**: — I'm sorry?

**Mr. Gantefoer**: — Like how do we get from the statement I see on page 54 to the statement that you made that reconciles the general terms of that discrepancy?

**Mr. Wiley**: — I'm just looking at additional information here. There was a total then of . . . Beyond the original 83.2 million that was provided as grant payments to the Regina Health District for Project '98, additional funding of 12.8 million was provided for that project.

**Mr. Gantefoer**: — Where does that get us to? What number is that?

**Mr. Wiley**: — That brings us to the 96 million.

**Mr. Gantefoer**: — So there's 96 million has been recorded?

**Mr. Wiley**: — Relating to Project '98 as grant funding to the district.

**Mr. Gantefoer**: — Okay.

**Mr. Wiley**: — Beyond that there's an additional 11.1 million that was provided on other projects that were funded by a grant funding — 8.45 million was provided for an Aboriginal healing centre, satellite laboratories and therapies, a cardiac cath lab, a new burn unit, and new space for a CT (computerized tomography) scanner, and a new dialysis area. An additional 2.2 million was provided for women's and children's health. And about 500,000 was for renovated space to accommodate the district's finance and materials management staff.

So in total, beyond the original 83 million, there was an additional 24 million that was subsequently funded in capital grant funding to Regina.

And again I believe that the difference between what's reported in the auditor's report right now and the material that I have in front of me is a timing issue, as to what year it was forwarded . . . or provided as grant funding.

**Mr. Gantefoer**: — So from your recollection . . . Or from the figures you've just used, of the original expended cost of 83 plus 24 — which gives us what? — 107 of the 133. You know, because you listed a bunch of projects here, are they all part of that 133 that we agreed was the total cost?

**Mr. Wiley**: — Yes, they are.

**Mr. Gantefoer**: — So is the difference . . . How much is then carried as debt to the district?

**Mr. Wiley**: — I believe that the total amount that was carried as debt to the districts right now is about $12 million. There are other projects that were paid for via grant funding; I believe two that I didn't mention in the first pass. There was 2.3 million provided for MRI (magnetic resonance imaging) space and a mental health consolidation project at 6 million.

In total there's about $12 million then in debt. I just have to redo my math here but . . . and a lot of that relates to projects that are actually expected to have a payback as a result of the projects. For example, there was some space that was developed that the district would be able to rent in the future and so they have an assured source of funding that will pay that back, that debt, over time.

**Mr. Gantefoer**: — And they're all part of that 133 total figure?

**Mr. Wiley**: — They are all part of that 133, yes.

**Mr. Gantefoer**: — Okay, thank you. In the auditor's report as well . . . and I recognize that, you know, putting aside the arguments about the projects being included or not included in the Toward 2000 and the total still is not in dispute in terms of the 133 million, but I also hear in the auditor's report that there were concerns about the actual implementation and planning and how the project was managed I guess.

What was the management team that was put in place? Was it done by the district? Did the district have a project manager? How was that structured in order to minimize the exposure that, I guess in hindsight, did occur to a significant extent, but also perhaps arguably could have been much worse? What was the management structure that was put in place by the health district? And was there any involvement of the department in order to manage this project?

**Ms. Parker**: — Mr. Chair, early on in the development of Project '98/Toward 2000 in 1993-4 and in 1995 in the front end, I believe — if my recollection is correct — there was a project manager retained specifically for the purposes of managing the capital project. And that individual was hired and worked for the health district. Following him leaving, there was an individual at the district itself that managed the balance of the project on an ongoing basis.

We as a department were involved early on in the process in terms of the preliminary planning pieces insofar as overseeing the integration of Project '98 or the closure of the Plains. There were other elements that the district was interested in pursuing around some of the other enhancements as well.

**Mr. Gantefoer**: — Who was that manager? Do you recall?

**Ms. Parker**: — I don't have that individual's name here with me today. I probably could find it for you, sir. I don't have it . . .

**A Member**: — The manager of the district?

**Mr. Gantefoer**: — The project manager.

**Ms. Parker**: — Currently, or earlier on?

**Mr. Gantefoer**: — No. You mentioned the manager that was there as the project . . .

**Ms. Parker**: — To start with, yes.

**Mr. Gantefoer**: — . . . was being constructed and then left, and then someone within the district then took over that responsibility.

**Ms. Parker**: — Keith Blakely.

**Mr. Linklater**: — The first . . . Keith Blakely was one. There was also a Jim Morris, who was a district employee who oversaw facilities planning for the whole district.

**Mr. Gantefoer**: — And they had the credentials and experience to manage a project of this complexity?

**Ms. Parker**: — They had previous project management experience, yes.

**Mr. Gantefoer**: — Okay, thank you. You know, from the department's perspective, you know, it may well be that it is unlikely that there has been any projects of this complexity since, and may not be any anticipated into the future. But has the department put in place some thoughts or some guidelines or management structures in place to guard against this kind of project sort of getting to a fairly significant extent off the rails?

And I'm particularly wondering this in light of the fact that it is at least conceivable, following Fyke, that there could be some capital significance to whatever happens out of the Fyke report that may not reach this complexity, but could reach some complexity.

**Ms. Parker**: — We certainly have spent an extraordinary amount of time looking at the recommendations that came out of this and subsequent audits by the Provincial Auditor around making improvements to our program. The implementation and expansion of the capital planning process is getting more detailed. We're implementing a new risk-management process throughout the development of a project.

We're also looking at the options for retaining a project manager, the credentials that are required. All of those elements are being worked through at this point. We are hoping to work with the Provincial Auditor's office in finance and districts as well, in terms of making sure this works, as well as the industry itself in terms of the consultants and its appropriateness and due diligence.

**Mr. Gantefoer**: — Thank you, Mr. Chair.

**The Chair**: — Any other members with questions or comments?

Let's turn to the recommendations on page 63 then, as put forward in the '99 Fall Report. Recommendation no. 1, moved by Mr. Harper for concurrence. Any questions on the motion? All in favour? Opposed? Carried.

Recommendation no. 2, with the three bullets as indicated on 63 and 64. Concurrence by Mr. Wartman. Any discussion? All in favour? Opposed? Carried.

That brings to a conclusion the sections that were going to be dealt with by Mr. Heffernan. And I guess I can see him moving, so I must be correct.

So we'll now turn to Mr. Anderson. We've got to 12. It's part D only, part D. So is there a possibility we can cover the presentation and questions by 12 o'clock, with 15 minutes? Yes. Okay, let's proceed.

Okay, we're going to be dealing with two part Ds if you are following. Hopefully, you're not as confused as I am. We're going to be dealing with part D of chapter 1, which is the '99 Fall Report. And that, I think, is numbered page 81 in your volumes. And part D of the 2000 Fall Report is numbered page 135. Go ahead, Mr. Anderson.

**Mr. Anderson**: — Good morning. I'm going to very briefly describe two projects that our office did that are about how you equip public sector boards to do their job.

Now the context for these two projects is the health system and the boards that we examined and wrote about are district health boards, but the concepts and ideas are definitely applicable to other public sector boards.

Now the first project concerns board development, that is how you can take a group of individuals and improve their collective ability to govern. The second project that I'll spend a little more time on is about the information that you should put in the hands of board members to enable them to make good financial decisions.

Now the project on board development is reported in 1999 Fall Report Volume 2, Chapter 1D. And our objective there was to describe best practices for developing a board to govern in all of its key responsibility areas.

I'd like to mention the approach we used, which is CoCo, which stands for criteria of control. That comes out of the Canadian Institute of Chartered Accountants and really what that is is that it's a framework for effectiveness. So we looked at board development, how a board can improve its ability to govern through CoCo. Everyone see that all right?

So the first component is that a board has to understand its purpose in order to carry it out. And part of understanding its purpose involves both receiving information on responsibility areas, which is clearly a starting point but not enough, but going further and considering the implications of those responsibility areas.

Finally, and this is a crucial step, is that a board that's following best practices for developing itself to govern effectively will map its responsibility areas to its strategic direction.

Now all of that, by doing those steps, that helps promote the board's understanding of its purpose. But even if a board understands its purpose, it requires board commitment in order to carry it out.

Now at our office we tend to use the word accountability a lot

— as this committee will know — and we think, as you've heard, that knowing to whom you're accountable and for what helps build commitment.

Also part of building commitment is that the board should, and I have here, endorse a mission and vision. That doesn't quite describe it because really what's important is that the board build a consensus around the table about what its mission and vision is. And by building that consensus, the board builds its commitment.

Finally the board should decide the values that are important to it and ideally go back and use those values when it makes hard decisions.

That's purpose and commitment. We're now looking at capability. There's a cliché here: foster culture of continuous learning. But it's one that holds real value because our study found that where you have a group of people and there's a strong mutual expectation around the table that they will always be learning, that board will be stronger.

A crucial point, often missed, often neglected, is that because the board's so important, you're going to have to allocate resources to it. Not just money, but time. And of course, you've got to identify gaps and then fill them, between where the board is and where you want it to be.

And I'll just mention here that there's a role for individual board members, and a leadership role for a board Chair.

The last part of the CoCo framework is monitoring learning adjusting. We think it's important that boards set objectives for developing themselves. We don't think it's done very often.

Boards should evaluate their progress in meeting their objectives for where they want to be. And this is a touchy subject for individual board members who aren't often evaluated, but boards, at least collectively, are increasingly using some self-evaluation processes. We thinks that's valuable.

And finally the board has to be receptive to change, and look at how it's doing, and make changes to govern more effectively.

Now that in a very quick nutshell, is our board development project.

The second project that I'm going to describe is from our 2000 Fall Report, Volume 3, and it's about the information that boards should have in order to make good financial decisions.

Our objective was to assess whether selected health district . . . district health boards received adequate information for making financial decisions.

Now just pause for a moment here to consider who is responsible for the quality of the information that the board gets. And while the board has to rely on management for information, it's the board who is ultimately responsible for setting out its information requirements. They have to tell management what they need.

Now the best way, actually, that a board can do that is by being clear about what its priorities are. That helps management put the right information on the table.

So what's adequate information for making financial decisions? Information should be relevant. It should be timely both in terms of being available shortly after the relevant period end, and it should be in the hands of board members long enough before a meeting that they can use it.

It should be goal related. That means it should tell the board how it's doing towards its objectives and goals. And finally it should be forward oriented. It should help the board look ahead.

Good information for financial decisions has to be reliable, it has to be accurate, complete. It needs to be fair and it should be verifiable.

Finally, good information for making financial decisions should be understandable. It should have enough detail to be useful but not so much that important things get lost. It should provide some context, it should provide comparisons, and finally it should be communicated in such a way that the information's useful.

We ended up finding that three of the six boards that we looked at received adequate information. So what needs improvement? And our recommendations are found on page 140.

Our first recommendation is that boards of health districts should improve the relevance of the financial and program information they receive by requesting timely reports. That means available within 30 days after the end of the period, and also available at least a week before the meeting so that they can use it.

We came across actually some boards that received very important information only verbally. So what I'm not saying here, but it's part of our chapter as well, is that the information has to be in writing. So the information should be timely.

The report should show progress towards the goals and objectives of the organization. What our recommendation is, is that the board should concentrate on defining a limited number of key measures that reflect the board's priorities.

Finally, the report should help the board look ahead. That is they should include forecasts and projections, and they should identify risks.

Now we say the boards should also improve the reliability of the information they receive, both financial and program information, operational information. They should do this by ensuring that the reports include significant affiliates. Where there are projections or forecasts the report should disclose the assumptions that underlie those projections or forecasts.

Finally we recommend the districts should . . . or that the board should ensure that the districts standardize the way they collect and safeguard information.

Now, Mr. Chair, if there's any questions I'd be happy to try and answer them.

**The Chair**: — We'll follow the same format. And I'd like, first of all, the Health officials to make any comments if they wish at this time.

**Mr. Pillar**: — Very briefly, Mr. Chairman, the board development audit, the first presentation that Mr. Anderson made, used of course the Moose Jaw-Thunder Creek Health District as its model or the district that it went into to review. That district was very complimentary of the Provincial Auditor's office in terms of the assistance that that audit provided. As was the auditor complimentary, I believe, of the practices in place in the Moose Jaw-Thunder Creek Health District. So it was a good arrangement.

I think though that the significance of that audit is that it has been, it has been widely circulated among boards throughout the province as a model that other boards should be looking at in terms of their operating procedures. So that very brief comment on that item.

With respect to the financial, the information of financial decisions, the second presentation Mr. Anderson made, we concur with all of the recommendations in that, in that audit.

And in fact anecdotally, we — in a meeting Mr. Wiley and I had with the Provincial Auditor and his staff yesterday — we've agreed that that audit in fact could form the basis of an in-service or a staff development/board development program; that we jointly would pursue the Department of Health, the Provincial Auditor, and the Saskatchewan Association of Health Organizations and take it out to the field. So we're highly supportive of that one as well.

**The Chair**: — Mr. Pillar, I have Ms. Junor on.

**Ms. Junor**: — More an item of curiosity, when the boards were developing I remember a lot of talk about the Carver model of governance and that isn't referenced in any of your material. Is that what they're functioning on for the most part? Is that what they're using and you're building on that? Or how does that actually fit into your audit?

**Mr. Anderson**: — We definitely had to consider how the Carver model affected governance because it's had quite an impact on governance in the province. But we did try to also take care not to tie ourselves too closely to that model. And I think actually that you would find few boards that say that they follow a classical Carver approach.

So we had to be cognizant of it when we did our procedures. And we were. But we did not try and tie ourselves . . . and we took steps, care to not tie ourselves too closely to the model.

**Ms. Junor**: — So am I correct in saying that most boards that we have now are using the Carver model?

**Mr. Anderson**: — I would say that most boards that I have come across in our work have been influenced considerably by the Carver model. I would say that in reality the Carver model has been applied, but not fully.

**Ms. Junor**: — Thank you.

**Ms. Jones**: — Sounds like Health concurs with the auditor, so I would move concurrence.

**The Chair**: — I haven't checked if we've had any more questions.

**Ms. Jones**: — Oh more questions.

**The Chair**: — Are there any other questions or comments?

**A Member**: — I had a comment.

**The Chair**: — Yes, Mr. Wartman.

**Mr. Wartman**: — Thank you. I just couldn't help reflecting in terms of the wisdom of the board development, the kind of work that goes on, on the amount of committee development that we had in preparing us for dealing adequately with public accounts. It was an interesting reflection during the presentation. That's all I want to say. Thank you.

**The Chair**: — Thank you, Mr. Wartman. No further comments? Ms. Jones, recommendation no. 1.

**Ms. Jones**: — Move concurrence.

**The Chair**: — Move concurrence. Any discussion of the motion? All those in favour? Opposed? Carried.

Recommendation no. 2 on page 141. Mr. Harper moves concurrence. Any questions of the motion? All those in favour? Opposed? Carried.

That brings us to the end of part D of both chapters 1 and 2.

And that takes us to 12 noon. So we will adjourn at this time and indicate that next Wednesday which was . . . a tentative agenda had been put forward, we, upon consultation with Mr. Harper, we will amend that agenda and we will begin with parts E and B, which will be, of course, Ms. Knox and Mr. Kress on Wednesday next. And then we will add what we believe will be the appropriate sections to cover for that three hours, beyond completing Health.

Thank you very much to all the officials and all the people from the auditor's office for being present and helping. And of course thank you to all the members.

The meeting stands adjourned.

The committee adjourned at 12:00.