The Chairperson: — I would ask members to turn their attention to the meeting and bring to your attention the number of things that I think we need to visit about before we begin, or as we begin. And I have three documents that I want the Clerk's staff to hand out, and they deal with three separate items.

First there is an update on the report by the Provincial Auditor to the Standing Committee on Public Accounts on matters included in our 1992 annual report. And we will be handing them out — or they may have been handed out already. That's this item here.

And then there is a letter to myself from the auditor regarding how the capital property of governments is evaluated, and that's in a letter like that.

And the third item that we'd like to have you take a look at and view is a draft report of our meeting in October, and I will leave that with you just to have for reference so that you can decide what you're going to do. We won't deal with that today, but it will be a part of what we have to do probably in January or at the beginning of the session, one of those two days. So that's kind of the preliminary things that we have to deal with.

I thought I would present to you what I had perceived to be the agenda for today. And the agenda would be that the Department of Health would provide for us some information as it relates to the questions we asked in Public Accounts Committee last time, and they had to do with the role that the Department of Health perceived the audit function to be within the framework of the health boards in the province of Saskatchewan.

And then we wanted to have the auditor's overview of his perception of what they should be and could be. And I've asked the comptroller to also give us an overview from his office, what the roles and where he perceives the controls within the framework of the department should be and how they should be emphasized. And I have asked each of them to contribute. And after that I would like to have the questions from the members to the agencies that are going to be discussing their various aspects of that question, among other things.

But I would follow your direction. I've indicated to these individuals that that's the process we'll be following. Is there a disagreement or is there agreement? And then we'll move along in that fashion.

The Department of Health and the auditor have been visiting about how to make the presentation to the committee on various issues and they are broader than the issue that I explained, and I explained that to Mr. Adams as well. I think that we're here to take a look at whatever function is required within the framework of the Health departments — no, the health boards — to make sure that they function in a fashion that will exercise their accountability to the Department of Health and to the public of Saskatchewan in a fiscal management, in relationships of other things as it relates to how they manage their people, how they manage their time, how they allocate that to various groups within the framework of their board.

So I give the department a lot of latitude in the presentation and I will give the auditor the same latitude and the comptroller and also the members in asking questions. But I would like to have them do their presentations and store your questions till the end and then we'll do that in a general discussion fashion, if you don't mind.

Taking no discontent here, I'll assume that that's the way we're going to go, and I'll ask the deputy minister of Health, Mr. Duane Adams, to introduce his staff and then proceed, please.

Mr. Adams: — Thank you very much, Mr. Chairman. I'd like to introduce to my right, Neil Gardner, who is the executive director of our corporate information and technology branch. And to my right . . . (inaudible) . . . To my left is Kathy Langlois, the acting executive director of our management support services branch of the fully integrated, new division of the department that I'll speak about in a few moments. And to her left is Rick Kilarski, our acting executive director of finance and administration.

The reason that they're acting is this, is our director, that you know from the finance and administration, and I've seconded her to help us in another part of the department. And Rick has gone down to fill in for her for four months while Kathy is helping us on organization in the field.

I must say that I wasn't exactly certain what you wanted to hear from us this morning when we began to prepare for this, so we prepared both broadly and narrowly. And I think what I've heard the chair say is that you're interest is focusing on a number of very specific issues. And I think as I go through this, I'm going to adjust a little bit what we were going to offer you.

I thought that we might share with you some information broadly for your private study as well as an overview. And then I know that you're interested in a number of very specific questions having to deal with accountability, which we're prepared to talk to today, and that relates to things like service agreements and funding formulas of the department.

One area that's of, I think, real interest to all of us in the health field is some very innovative and world-class work in the field of information and technology which the department has advanced in the past year and a half. And Neil Gardner is prepared to make a short presentation to your committee to show how that integrated and unified information system would work for us in Saskatchewan and all the districts and health partners.

If you're interested in seeing that short presentation, we'll schedule that into your work this morning.

I think that the questions that are of some note for us this morning have to do with the essence of standards and accountability in the roles of the department and the district boards and other players in that balance.

To begin with — just so you've got some materials since they were prepared for you anyway — we'll table with you right now some documents which you can take away. And as I said, I wasn't quite sure what you were getting at today, so I want to make sure that nobody felt that we were being disrespectful in tabling materials for you.

Ms. Crofford: — You know how to get even, don't you?

Mr. Adams: — There are 20 copies here, as you usually request, and that is not quite as overwhelming as it looks. While you're standing, folks, table the SAHO (Saskatchewan Association of Health Organizations) documents and the *Contact* document, and I'll explain these documents before we begin.

Some of you may have . . . Yes, I'll explain the *Contact* one first perhaps. All right, Mr. Chair, I'm not trying to advance this photo of myself in this thing called *Contact*, but even I was a little surprised that that one existed.

But the reason I'm giving you this is that I will . . . if you turn to the first page inside, page 2 and 3, the department has reorganized and is in a continual state of evolution to support the districts and a lot of changes are occurring. The most recent material on how we're organizing in the department is contained in this little article by Dianne Koepke which appears on page 2 and 3, and this was just published yesterday. I think it encapsulates some material that may be of interest to some of you and this is the easiest way to present it, so I don't talk at you for a hour about this. That's why I'm handing that to you; that's the beginning briefing on departmental organization.

If you'll turn to the thick book first, the health reform is a very complex reform. I have recently met with my colleagues in England and elsewhere in Canada and we have compared notes across the OECD (Organization for Economic Co-operation and Development) countries and the Commonwealth countries as well as Canada. Very clearly the directions that have been selected in Saskatchewan are the compilation of the advice that governments across the Commonwealth and the OECD countries are getting, and we're working on leading-edge material.

We have been invited to be twinned in Saskatchewan with parts of England; they have come to us for that. In New Zealand and Australia they have also made contacts here so that we can share our information and their experience with us so that we can continue to measure and develop things like emerging standards and new ways of evaluating health and health structures. We can do that and compare notes across the country, across the world actually.

The World Health Organization is now linked with us as is the Pan American Health Association where we have been invited to participate in their various planning meetings. And they have invited us to make presentations to them and they're using our materials, many of which or some of which are tabled here. And as a consequence, I want to make sure you have those materials which are being circulated across the world at the request of these other countries.

Because it's complicated, all the answers are not yet known and they're evolving and that's one of the reasons we've chosen this developmental approach in Saskatchewan where a lot of consultation goes on and the answers often emerge from the community groups we talked to.

In this briefing book that I've given you — could you give me one that is mine — just to flip through the pages here, the first chart is *Saskatchewan Vision for Health* which is the framework for change. It has been tabled in the legislature, but it's put together for you in here and outlines the main objectives of the reform, and those directions have remained consistent from the time that we published this document a year ago.

In respect of district development in chart 2, you will see the district development guide, which the districts are using to begin to get themselves formed into districts, which is now completed.

And as you flip through the next one, you can see the first piece on helping the districts get some idea of what to look for in terms of strategic planning.

If you flip to the next, this is the guide to districts on helping them begin. It's not the detailed methodology, but it's to begin the needs assessment which is one of the very first things that each district is doing and will of course affect how they determine their priorities, and as a consequence, the resource allocations that will be required there and how they will redirect some of their resources. The idea, of course, is to take the available dollars we have, and within the standards of the province, then begin to put the resources behind the highest priority needs found in each of the districts.

The listing of core services is the next chart, and people wanted to know what we felt were essential and to be provided in all parts of the province and to begin to understand what some of those services mean. We have issued that guide and explained the core services that need to be provided throughout the province.

There is a great deal of interest in the next group on community health centres. There's a widely different understanding of what a health centre is because there are different kinds of health centres, different kinds of services, different kinds of governing structures. We have experience with those in Saskatchewan and

elsewhere in Canada. So that to help districts look at the various models and the kind of services that could be included in health centres, we published this little guide or handbook, and at the back of it we selected specific examples of health centres that have been functioning in Saskatchewan for many years. One of them is kind of interesting, on page 20 of this, with respect to Mainprize Manor, in that there has recently been some local reporting on that centre to bring people up to date. I saw something in the paper just a few days ago or I think maybe last night.

If you flip to the next one, what we've done for you here, so that any of you who are not familiar with The Health Districts Act or need to explain this to any people who come to you, we have given you a text of what's in it, in shorter form — the actual Bill — so you've got that readily at hand.

And then, of course, legislative language often is confounding, and there is an awful lot that people don't understand by reading the legislation. So we took all of that and converted it into a user's guide, a user-friendly guide, as to what that Act says, along with questions and answers. And that's contained in the next document. All of that was available to the districts before they formed.

The next piece of the book has to do with the amalgamation process. As you know, we are now in the process of taking public corporations, and in the case of union hospitals and ambulance boards, they are being amalgamated with the district boards this coming month and early January. And there are others. There is information and guides on that issue.

Labour has been of great importance to us, and there are of course phenomenal changes affecting labour in this reform. And to assist the labourers to adjust in this reform, a labour adjustment strategy was worked out with them. And the highlights of that and some of the details we have in this next briefing document for you, which of course is also a public document.

The next chart has to do with some examples that were given to the districts about job descriptions of CEOs (chief executive officers). As you can imagine, we had 400, if you can believe it, nearly 400 corporations governing health in Saskatchewan for less than a million people. And what is happening is, those corporations are being contracted and amalgamated. And in the course of all that, there is an infrastructure of administration that is falling out. But what each board needs to do is appoint a CEO. And these have been examples that have been used by various corporations in recruiting a CEO.

There is a lot to be said about what we have done with we and the Saskatchewan association of health-care organizations, known as SAHO. It's the successor organization of SHA (Saskatchewan Health-Care Association). They have been working with boards to orient them and get materials to them which would be helpful as they begin to set up. I'll give you some of their documents as well. But in our orientation of boards, we have been listing some of the things that each should be doing, and the next group of documents here is some of the basic material that each board has to have, including things like the compensation for boards and other materials which you can flip through in there.

Each board has been required to deal with the conflict of interest by-law or regulation. And we have outlined for them a sample or a minimum that each board is expected to have a look at. They may add to this or tailor it if they've got some specific features that don't fit well here. But in any case, all boards have conflict of interest by-laws and our guide is here, if you wish to look at that.

The next section has to do with freedom of information. These boards will come under the freedom of information Act I believe on January 1. Is that right? Oh, we're not sure when it will be proclaimed but we think it'll be very shortly. The boards are already more accountable because they're required to have public meetings. We have given them information on the freedom of information and will give them in-depth briefing on it as they will be certainly involved in a much more transparent accountability than former boards were.

We have listed for everyone in the next segment here a list of existing health organizations, professional groups, and helping organizations and their addresses so that if you want to get in touch with any one of these — for example, the interns and residents association, or the Metis society, or the Mental Health Association, or the Catholic Health Council — all of those are listed. So for ready reference for the board, all of these groups are quite prepared to meet and help boards in whatever way they can.

Now in addition to those materials which the boards have, the Saskatchewan Association of Health Care Organizations, SAHO, has been putting out materials and then taking them out and orienting the boards with these as well.

So you have these in loose form here. These were published, as I pointed out, by SAHO. Their first document is: understanding roles and responsibilities for the board, and they go into a great many of the concepts that boards of trustees need to know about.

Then in terms of the development of the boards, since all of the boards will require training — and it's not a one-shot event; it's ongoing training — and each board needs to have the same kinds of attention in terms of development as new employees would in a department, so that SAHO has put out documents that will lead to a program of development for the boards and the trustees as their needs are expressed.

Of particular interest to the boards is the hiring of a chief executive officer. All of them are in the process of that. I think over half of them now are appointed. But they issued a guide on how to go about that and the kind of credentials and experiences they should be considering when hiring a chief executive officer.

And then most of the boards had asked SAHO to give them some information with respect to communications. All of us are aware that the kind of technique for communicating that we used in the '70s and '80s is not up to the requirements of today, not just in health reform but across all kind of public processes; that the public is asking for a great deal more information. The public is more interested in being informed, to make decisions for themselves or contributing to information, and they are very demanding of the reasons for decisions that are taken in the public interests.

That kind of more open communication process is required of district boards as it is required of governments. SAHO began the process of helping the boards to understand how to approach that more openly and a lot more attention will be given to communication and tools of communication that are available to us today when they were not available to us perhaps some years ago.

That is an overview of materials that you can take with you. And that aside from that, I'm going to make a few additional, brief remarks which I was going to do in a slide format but I'm not going to now; I think you don't need to review that, unless you want me to come back and talk to you in greater depth about the overall steps that have been achieved in the health reform in the past year and a half.

What I want to do though, to set the context for everything we're doing here, is to remind you about why we started this reform. And we have a lot of additional research information that would back up what I'm going to say in short form here — actually I think it's something like two or three feet of it, from around the world — and we'd be glad to table that for the committee if anybody has the interest in reviewing all or some of that.

The point that is important . . . Pardon me?

Mr. Cline: — I just want to make this point, Mr. Adams. We all appreciate the material we've been provided with and it's helpful and I think it sets the backdrop against which we have to examine the health boards, but we're primarily concerned with the question of accountability in terms of fiscal management, accountability of the boards to the Department of Health, and the role of the Provincial Auditor, I think. And I wonder if the presentation should be focused on that question.

Mr. Adams: — I'd be glad to do that, Mr. Chairman.

The Chairperson: — If you're laying the groundwork for that to come, then I think we'll proceed if I . . . I was leaving that latitude open for you to do that, Mr. Deputy Minister.

Mr. Adams: — That's fine. I'm glad you would like to focus right on that. The reason I gave you this other material is essentially to set a context for the expanded role of district boards and the fact that they are more accountable because we are contracting a plethora of individual corporations into 30 quite accountable institutions, and that there will be an easier accountability there in the future than there has been in the past. That's one point to be made.

And I was asked whether — at least I was asked by the Provincial Auditor — whether these boards had been trained to be able to carry out the responsibilities. So I want to make sure that you know that there's an intense effort going onto make sure that they can carry out their responsibilities.

Now with respect to the accountability question. There is no less responsibility held in the Ministry of Health for health services than there was in the past. The key to our accountability is provincial law, the standards that are enmeshed in several pieces of legislation and regulations and policy, in our financing obligations, and in our standards enforcement. And through those documents I have given you, also the assurance that core services are provided and maintained.

Now one of the current questions is whether or not the ministry's responsibility for standards is in some way given over to the districts and we are relinquishing our responsibility there. And the answer to that is absolutely not. The health districts are delivery agents; they function within the provincial law. In the respective standards that existed last year or exist today, there have been no changes in those standards at all or who's responsible to see that they're ensured and they're enforced.

The districts can supplement services beyond the core services that are universally mandated for the whole province, but they cannot subtract from the base of services that are mandated for all people. In addition to that, what is happening in the way that we're dealing with the districts is then to arrange service agreements with them which will . . . through the department, and the service agreements will spell out the services that are expected to be delivered in each of the districts, will tie to that the funding that is going to be given by the province to pay for those services, and tied to that, the outcome measures that can be developed to look at what they've achieved with the resources.

The specifics of the service agreements are being worked out with the districts and we will use them in the upcoming fiscal year. They will focus on outcome as opposed to an item of service. We're more concerned with assuring that for a dollar spent, or a hundred million dollars spent, that there is a positive health outcome as opposed to simply ensuring that services which have historically been provided will be provided in the same way in the future. We actually want to try and get benefit out of this, and that's your interest as well.

Now in the case of outcome measures, there are some that are reliable, and have been, and we will adopt; in others they have to be in fact created. There is no place in the world yet that has a complete set of outcome measures for health. And so we are in a

developmental mode with respect to outcome measures.

We have also the financing, the financing requirement, and our approach to that is to globalize . . . will be to globalize budgets for the districts. So we will, in working out the service agreement, attempt also to provide funding on the basis of need as opposed to what has been done in the past, which is to take a measure of what happened in the past and just forecast it into the future. Currently money is allocated on the basis of past experience. We would like to begin to move — begin, and I emphasize begin — begin to move to allocate money on the basis of health need and what services need to be provided in the future and how much they're going to cost.

So that areas of high need like services for long-term care and the elderly, services for teenagers, services in the field of crisis intervention — these are examples — services in the home or near the home, these are services that don't have in many cases the level of attention that some of the needs studies are showing. And then in other areas we seem to have historically locked in money where it can be better spent — locked in money on infrastructure, of administration, locked in money in other kinds of things like that. And you've heard much about that.

So our approach on funding that we are working through is to turn to a funding formula that looks more at need, more at outcome, is adjusted by age, sex, and a few other factors like geography, and to begin to provide a more equitable allocation of resources to districts. What we will do is tie the total dollars to the specific services for which we're contracting, and then the boards have to report back to the department routinely on the performance of those contract provisions.

Now in being able to do that requires a fairly sophisticated information system. That's something that is being developed now. You may not want to get into that this morning but we're prepared to show you some of the integrated information that is being put together.

With respect to accountability, the boards are accountable directly to the department for those contracts, and also because they're an instrument of legislation which is reportable to the Minister of Health. The boards are also responsible to their public within the district. The law requires that they have a minimum of two public meetings and that they also will share in one of those public meetings their needs assessments and estimates and expectations with the public before the minister then is . . . those estimates are tabled with the minister for her review. The boards also are expected to be elected, and you're well aware of the provisions of that. So that is another form of public accountability there.

The view of the department is that in respect of accountability to parliament, the minister is accountable for those district boards and also the specifics of it are accountable through the service contracts, which I would expect the auditor to be examining relative to the district performance, and for the money that is spent through those service contracts and the outcome measures that are laid down to assess their performance.

Therefore in terms of Public Accounts and that process, we would be expected to answer for the district boards. I don't believe that the boards are ultimately expected to answer directly to the committee of the legislature. That's our view. In the near term, until they are elected, there is the question about whether or not you want or need to talk to them directly. But that I think is, in our view, a transitional kind of arrangement.

Beyond that, in respect of . . . Maybe I should turn it back it to you for questions here now in terms of accountability. I'm just emphasizing that there is a law which makes them accountable, standards which are already in place in some cases, and will be expanded to touch all the core service areas I've tabled with you; the financing formula which we are accountable for and the outcome measures which are driven into the service contracts that the boards will have with us as a condition of receiving any money.

Now on top of that the entire department, with the exception of a bit of corporate structure, is being refocused and directed specifically at the district. That is we have coordinators and developers out there every day now. They are assigned very specifically to districts, and all of the field staff that we currently employ for mental health, public health, and addictions are being . . . the intervening administrative structures are being taken down so that they work directly with specific districts.

And we have made it known publicly for quite a long time that as the districts are ready to absorb that staff as a part of their district staff, we will transfer the staff so that they become . . . The direct service is going to be provided by the districts. The department is responsible for standards, financing, evaluation, overall leadership of this, and accountability for those universal standards, and money.

Any further questions on that?

The Chairperson: — We will hold the questions because the questions may have answers in the presentations by the auditor and the comptroller. And so we'll hold the questions. And if you have some further comments that you would like to make at the conclusion of their remarks, I will allow you to do that and also I will allow the auditor to do that, and Gerry Kraus. We're not running a very disciplined, structural kind of meeting here, but I want you to have the freedom to do that.

Mr. Adams: — That's fine. Thank you.

The Chairperson: — Okay, to you, Mr. Auditor.

Mr. Strelioff: — Thank you, Mr. Chair, and members. Our discussion today will describe how we're moving

forward, our audit plans, and some of the issues that we face in helping the Assembly and this committee assess and understand what's going on in the health care industry. And also to help them hold the department and the government in general accountable for the administration of public money.

With me today is Mike Heffernan, and Mike is our executive director in our office. He's in charge of our health portfolio and he's going to review with you some of the issues that we have on the table and how we're trying to move forward some of the accountability relationships that need to be established and ensure that those issues are moved forward in as reasonably rigorous way as possible.

So Mike, can you . . .

The Clerk right now is handing out the overheads for Mike's presentation so you're able to follow it a little bit more easily.

Mr. Heffernan: — Okay. We've been working with Saskatchewan Health over the past month or so to prepare a guide — an accountability guide — for the health boards to help them in their accountability requirements. And my presentation this morning, which will last 10 or 15 minutes, covers the suggestions that we've made to the department on what should be in this guide. The department may have other requirements they want to add to this. This is not necessarily complete, but it's the things that we think should be in the guide.

The topics I'm going to cover is: the reporting and auditing requirements that should occur in the districts, the appointment of auditors in the health districts, information systems that the health districts should be working towards, and the role of the Provincial Auditor.

Now the guide that will be issued to health boards should include certain reports, including first of all a report on financial statements. And we're suggesting that in the guide a common format or model be put in for the health boards so that they're all preparing a consistent financial statement so that comparisons can be made readily.

We think that the accounting principles that are followed should be those set by the Canadian Institute of Chartered Accountants. And one of the accounting principles that's going to have a very significant impact on the health boards is the fact that they've each got a number of separate facilities or entities — as Duane mentioned, I think there's about 400 of them; that as they gain control of these, as they amalgamate with the hospitals, long-term care homes and so on, they're going to have to bring those facilities into their combined financial statements.

And that's going to start right away in the first year. And so that complicates matters somewhat for them. But it is important that their financial statements include all their operations of their health agencies so that the reader gets a full picture of the financial position and results of operations.

Now we think that the audit reports that the boards should be having prepared and then issuing to the minister and to the public would be the three reports that the Legislative Assembly receives. And those are audit reports on financial statements that ensure that the financial statements are reliable that management prepares, that management of the health boards have prepared, have internal controls in place to help safeguard and control their assets, and that the management of the health boards is complying with laws and also with the agreements that they have with the department.

As Duane mentioned, there's going to be service agreements and funding agreements. It would be very helpful, I think, to the department, if an independent auditor was . . . (inaudible) . . .

Finally, we have a couple of other reports that The Health Districts Act requires and one is that the health boards are going to have to work towards reporting on the cost of their services and activities.

The current financial information systems and financial reporting that's done by health districts don't really give specific costs. For example, the cost of a particular operation, the cost of certain types of services, the overall costs, are just not known because the information generally hasn't been compiled that way. The health boards are going to have to start working towards this now, and I think the department is helping them with preparing the kinds of information systems they're going to need to do that.

The health boards also are going to have to report on their effectiveness, and that's . . . Duane was talking about that they're going to have to be able to assess their outcomes. So given the amount of money they're spending, can they show that the outcomes are worth the amount of money that they're spending?

There is a purpose to this overhead which may not be apparent when you first see it, but . . . and we're not trying to necessarily show the accountability relationships here so much as I'm going to talk about the auditing implications of having 30 health boards and about 400 institutions that will be controlled by the health boards.

This could be a very complicated situation for auditors, for health boards and their auditors, to have to deal with. And what we're suggesting is something that we've tried in the Saskatoon Health Board, which we audit, which can simplify this I think quite a bit for the auditors and for the health boards and also keep . . . sort of keep the current auditing structure in place for a little while so there isn't a huge disruption in having maybe a hundred or so auditors being put out of work immediately.

What we're suggesting is that the health board appoint one auditor, a primary auditor, who is responsible to audit the health board's financial statements, which would be the combined financial statements, and to

issue their reports on compliance and internal controls. And that where there are health agencies in the district, and these will be hospitals and so on, even though they're amalgamated and no longer exist as legal entities, they still are likely to be running on their own systems, their own internal controls and accounting records, because there won't have been time yet for the health board to integrate those systems.

So what we think should happen is that the health board should keep the current auditors of these health agencies in place. Okay? They're the ones that are most knowledgeable about the audits, and it's probably the most efficient way to do it and it allows the health board to have to deal with just one auditor, their own primary auditor.

We're suggesting that the primary auditor actually hire the auditors that are in place, the secondary auditors in each agency, to do the work that he would have to do otherwise. So that rather than the primary auditor having to audit over an expanse of a hundred or so or several hundred square miles in dealing with maybe 20 agencies, that he would instead just have to deal with the auditors of those agencies.

And so he would set out the audit plan for each of the health agencies, he would review the work of the secondary auditors, and he would then form his overall opinions for the health board. If the Department of Health continues to want some audited financial information from each agency, this will work well for that too.

So what we're suggesting that is in this health guide that a fair amount of guidance be put in place for both the chief financial officer of the health district and the appointed auditor. What we've offered to do to help the primary auditor is we're willing to prepare some detailed audit procedures for them. Some of these auditors won't have had much experience with internal control and compliance auditing, and so what we would do is prepare a set of audit procedures and with . . . through the Department of Health issue these audit procedures to the primary auditor.

I think the guide should indicate to the health boards that it's important that they integrate the information systems that they have with all the various agencies that they're dealing with — hospitals, ambulance boards, and so on — so that they've got one integrated management system that they can work with. Without that kind of information system it's going to be very difficult for them to coordinate and integrate their programs. So it's important that they work on that right away.

It'll also help them to . . . it'll just be more cost effective to have one system. It'll be easier and cheaper to audit. And we understand that the Department of Health is working with three boards specifically on an integrated information system that will be common for all health boards once it's developed.

Saskatchewan Health, as Duane mentioned — and I'm not sure if Neil is going to talk about this — is working too on a province-wide system that will have uniform information on everything that goes on in the health care system, and I understand would be able to be accessed by any health board or any other important user of the health systems such as the department or the various commissions that are set up to assist the department in health care.

Okay, finally we come to the role of the Provincial Auditor. The health boards initially are being appointed by cabinet. And under The Provincial Auditor Act, in that situation they are deemed Crown agencies, and as such are subject to an audit by the Provincial Auditor.

However at the current time we don't have the resources to audit the 30 boards. So what we're suggesting is that we audit six. And we've been doing Regina and Saskatoon and Prince Albert since their inception, and we're suggesting that we do three others. And I've listed four possibilities there. Those are four that sort of seem to meet some of the criteria that we're considering.

We're looking at, first of all, I guess, significant dollar expenditures. And I guess Moose Jaw would certainly fit in with that. Working with the department on a common information systems. And I understand that Prince Albert, Greenhead, and Twin Rivers, I believe — I can correct it if I'm wrong on that — are working with the department on that. So they would be pretty interesting candidates.

We're also interested in various other things such as if they have . . . for example, diverse operations are going to be a little more complicated, rural settings, many facilities, and geographical coverage as well.

Pipestone is an interesting area that's east of here, I guess, in the Indian Head-Montmartre area. It's quite a large district. It's got something like 20 institutions in it. It is close for us to travel, so we may pick that one ultimately too. But we are having discussions with the Department of Health on selecting these three boards, and we hope to have that settled in the near future.

Our audit plans may change as a result of advice we receive from the Legislative Assembly, or if the government doesn't move forward on its plans to have elected boards. But in the meantime, if the government plans to have elected boards by next fall, then this is only a small term where the boards are Crown agencies, and so we will back off at that point.

I guess for the 24 boards that we're not auditing, we are available through the Department of Health to provide them with some advice. So they can get some advice through the Department of Health and our discussions with them.

As boards become elected, as they move through that transition, we will no longer audit individual boards. But we would like to do some cross-board issues that are significant. And an example could be roles and responsibilities of the boards, which we are currently

doing in Crown Corporations.

Okay, so in conclusion, we think it is important that an accountability guide be issued to help boards in that regard, and that it be done on a timely basis, so that it is in place soon enough for the boards to prepare their reports and so on for the March 31, 1994 deadline. I think that's all.

Mr. Strelioff: — Thank you very much, Mike. The purpose of that presentation was to explain to you what are the key accountability documents that we're moving forward. And they relate to the financial statements and the reports on internal control and written reports on compliance with legislative authorities, particularly compliance with the service agreements that are going to be put in place.

The assumption in our audit plan which, as Mike mentioned, is going to focus on six organizations, and the assumptions are that as announced, we will be moving to elected boards in October. And as a result, in terms of the best use, the most effective use of the resources in our office, we thought we should focus on the larger ones, and also a sample of smaller boards to try to identify opinion leaders and also best practices that other smaller boards could look to.

And Mike mentioned some of the criteria that we would be looking at are the dollars, those boards who are going to be involved in pilots to create the integrated information systems, and also those boards that have a fairly diverse practice.

We are going to be going to the Board of Internal Economy some time in the next month or so to discuss with the board this audit plan, and particularly their concerns or wishes, and our involvement with the other 24 smaller boards, which the intent is to move some guidance through the Department of Health, and have the Department of Health prepare accountability advice and guidance for the individual reports, including just how to get the financial statement reporting models together and the audit plans and tendering audits out to make sure that each board can get up and running as smoothly as possible.

It's going to be important to get going as soon as possible on this. Our experience in Saskatoon, Regina, and Prince Albert is that this is complex. Bringing together the number of institutions into one organization is not going to be easy and it's going to be important to move forward very quickly. We plan to contact the three smaller boards that we're going to examine more directly during the week of December 6.

The draft guide that Mike refer to, we've provided it to the Department of Health for their advice and discussion and we've had . . . we've met to discuss the guide.

It'll be particularly important for the boards and their auditors to have examinations of internal control and compliance with service agreements. Those will be particularly useful to the department and will assure, I think, the Assembly that those things are being handled right.

The experience out in the various regions . . . there won't be that much experience in auditing these kinds of issues, but our office will be providing advice, be available, and also we will be trying to help the department in moving that forward.

The bigger issues in the future, as Duane and Mike mentioned, are related to the outcomes and costs of services. How much does it actually cost to provide similar services in the various different boards and what are the comparisons of outcomes? What are the costs achieving? And the information structures in architecture that's being put in place throughout the province are going to be very important in that area.

And in the past that's never been done, and it's not very easy, as Duane mentioned. This kind of information really doesn't exist anywhere in a very focused way, although my understanding is that groups across the country and elsewhere are focusing a lot of effort on trying to determine performance indicators or rigorous measures of outcome and trying to relate that to cost so that decision-makers can have a basis to make important decisions.

Another part that you'll be particularly interested in in the future is the content of the annual report of the Department of Health. Last meetings we talked about ensuring that the annual reports of departments and other agencies when they get tabled in the Assembly get referred to this committee and provide you a basis for understanding and assessing the role of the department and how well they're managing the health system. That's going to be particularly important in terms of what was planned and the results, both in a financial sense and a non-financial sense.

And then as the . . . again, we're assuming that the boards are going to be moving to an elected basis. As they move to an elected basis, our shift in focus is going to be towards cross-board issues and how well those issues are being managed. And it could be the roles, responsibilities of boards, the content of annual reports that are provided to the department and the cost of services and outcomes achieved as well as the standards and service agreements that are going to be put in place and whether those service agreements are being adhered to.

So there's a basic outline of where we're moving in terms of the transition to health boards. Again, I think it's very important to get going as soon as possible. And we're trying to make that happen. Thank you.

Mr. Kraus: — I don't think I have a lot to add to that, Mr. Chairman. The department has the accountability issues well identified and while they obviously have a ways to go, they know where they're going. I think they have an excellent plan.

I suppose it seems like a relatively minor issue, but one thing a decision has to be made on is while we're in this transition period should the financial statements

of these individual 30 health districts be bundled up and included in that compendium of financial statements that you get each year along with the *Public Accounts?*

And we know that in the longer run and certainly as contemplated by the legislation as now it exists — I think it's section 35 — annual reports and financial statements will be presented to the minister by these health boards but the health boards are also accountable back to their electorate. And so a decision is going to have to be made though in this transition period — is it really worthwhile providing these things to the legislature? I guess I could give you my opinion, but I won't.

But, you know, obviously the intention is that these health boards are accountable to an electorate, the same as an RM (rural municipality) or a town or a city or a school board and their financial statements, for example, don't find their way up to the legislature through the *Public Accounts* or something; so you can tell which way we'd likely be hoping that this would go.

But I think that's all my comments to that.

The Chairperson: — Okay. Mr. Adams, would you like to . . .

Mr. Adams: — Thank you, Mr. Chair. I have appreciated the help of the auditor in setting down some guidelines for the new districts and we welcome all the help we can get there. We agree with being very clear very quickly to the boards what is going to be required by way of auditing process as well as requirements. And indeed I'm going to discuss the beginning of this with the districts when the minister meets all the districts next week.

The idea this year of auditing six is agreed with the department. Which six you find most useful to audit is the criteria that has been outlined, seems pretty good to me and we don't have any difficulty with that. I would appreciate being able to offer to the six the no-cost service of the Provincial Auditor to these districts so that they'll receive an immeasurable benefit, not only cost-wise but talent-wise. I haven't been offered that deal yet but I'm sure that the Provincial Auditor will come round in due course.

With that, a couple of — I see he doesn't find that amusing — a couple of points I want to draw to your attention. With regard to cross-auditing, I think that that's probably a useful thing to keep in mind in the future, that cross-auditing will get at common issues which we're all interested in looking at, and especially program issues.

I wanted to tell you also though, with regard to the information systems and the information base, we're not going to pursue that discussion, unless you wish, in detail today. But you see, the former boards were audited and their accounting systems based on a site specific. We granted money to a facility or a site and that's the form of their books. What we're trying to move to is get to a program, to begin to account or to measure effectiveness by program.

So an example of that would be, rather than saying what happened in the Regina General Hospital and what did their books look like there — that's not terribly relevant — it is to break their programs for the Regina area down by . . . For example, what happened in palliative care? How much money did they get? What benefits did they get? What are the outcomes? Or renal dialysis, for example. Those are the kinds of program standards we're trying to be able to get the database to accommodate and reveal information on this which is useful.

You will of course know that there is some auditing experience in the field in that there are 400 corporations out there that have had auditors for years. What they haven't had experience with in very many cases is a large, integrated structure as we're putting together. And that's where the attention of expert auditing attention needs to be focused in order to give them some ground rules and some process assistance to know how to go at that, especially in the transition when we're putting together a variety of different types of reporting arrangements until we get to the new system.

And I want to confirm that the department is in fact, with the cooperation of three of the districts intimately working with us and the others participating as a client interest organization, developing a common data system for use of all districts and related health facilities. So that there won't be a lot of incompatible systems out there and they're not going to all go out and build their own systems.

We'll do it once, do it together, make sure it's compatible, have the same information, the same definitions of information, and have it put in a network that can speak across the province to parts of the organization, that is to say, speak with . . . the system from one district can speak to another and to the department, and that everybody should get their information needs out of the same system.

With regard to auditing requirements, you know that the Act requires each board to appoint an auditor. I believe many of them have done it. There'll be a corporate auditor. And I support what the Provincial Auditor is saying in respect to how to work that arrangement in the interim as well as in the longer term.

The annual report — the question has been raised — is something you want to look at carefully. If you require the reports to be aggregated, keep in mind that the districts may have to report twice, or create two reports. Because they have to table financial and program information with their public meetings. And the public isn't going to wait for the legislature to have received the report first if you're not sitting. So that they will have to have financial data readily available there.

And in terms of the aggregation or the combination of

all financial statements, keep in mind the difference between an amalgamated corporation and an affiliated corporation. An affiliated corporation is not subsumed by the health district. They are a separate corporation working under contract to the district. And while the financial statements should show the grant or the contract between the health district and the affiliated agency and what it buys for that contract, I don't believe that you can go and subsume the financial statements of the affiliated agency in total — the example being, for example, a denominationally owned nursing home or hospital.

We have to account for the grant that's going in there but they have other sources of revenue and expenditures, in some cases. And that doesn't immediately fall under the purview of the district board. It's only the amount the board is paying to that contracted affiliated agency which is of immediate concern. Beyond that I appreciate the time we spent with you today and your tolerance for letting me smother you with some documents that may be of help on another occasion.

The Chairperson: — The first question we have from Mr. Van Mulligen.

Mr. Van Mulligen: — Yes, two issues I want to deal with. One is the question of the interim until such a time as we have elected boards and . . .

Mr. Adams: — Mr. Van Mulligen, I didn't clearly hear the question. I'm sorry.

Mr. Van Mulligen: — I'm sorry. Two sort of areas I want to touch on. One is the question of the interim until we have elected boards. Can I just get that clarified, at what point we're going to be having elected boards, first? And then I want to ask some questions about that.

And then also, I have some questions about the issue of accounting and accountability post-election, in the long term. So but first if I could just get it clarified as to when the elections . . .

Mr. Adams: — Yes, I heard the Provincial Auditor indicate that there had been an announcement about elected boards for October. Actually, that's not correct. The government has made no announcement about elected boards in October. What they have said, what the minister has said, is there will be elected boards — that is in the legislation — and that it is preferable to have them tied in with general municipal elections. And the earliest date that that could occur would be October, 1994.

With regard to an announced date for elections, the government has not decided that matter yet, but will need to do so shortly . . . (inaudible) . . . I'm sorry. Does that . . .

Mr. Van Mulligen: — I just wanted to get that clear in my own mind. I agree with what the auditor is proposing, like in terms of the interim period that you continue to do the work in Regina, Saskatoon, and P.A. (Prince Albert) and sort of pick three other, you know, districts that you would continue to monitor.

My question I guess on that is one of resources. I don't quite see that . . . it seems to me, like one of the issues that you identified in your report this year was one of resources and being able to do your work because you've got additional demands being imposed upon you by virtue of the fact you feel you're responsible to audit health boards.

For me then I guess I'd like to get some clarification as to the process for the coming year or years as to your involvement. And it seems to me to be logical that if all health boards have budgets to undertake, you know, to have auditing done, that there should be some process for those health boards which the auditor does, for that auditing fee to go back to the General Revenue Fund and then be credited to his office so that his office is not out money or resources.

It doesn't seem appropriate that you would have district A that would have a budget of 30 or $40,000 or whatever it is, to be able to spend on a private firm to do its annual report and its audited financial statement, but if you do district B, that your office is expected to come up with the additional resources to do that but isn't compensated in any way for doing that.

So I guess I'd like to get that clarified. And that's Duane's comment that he'd really appreciate . . . something along the lines that he'd really appreciate the . . . or the Department of Health would really appreciate the auditor doing these audits for — I forget the term that you used — essentially for free. So that's one issue I'd like to get clarified about the interim.

And also an issue I'd like to explore — and I'm not really clear on, and maybe it's not an issue — but it was a comment made to me by someone from some small community about how that small community has done fund-raising in the past, the objective which was to support health facilities in that community. That is they were saving up some money to improve the local health facility. And a feeling now that unless they take specific action — I guess they're examining this — those funds could be assumed by the district health board, yet it's the local community that raised those funds for some specific purpose within the local community. And that's not to say that the objections to that couldn't be altered somewhat for the local community, but nevertheless there's a . . . I sense a bit of a tug of war going on here with respect to some of these local funds.

And I'm not quite clear nor can I remember what this person said about how they might try and set up some local trust fund or some local non-profit corporation that might take those funds that were specifically . . . or which were raised locally and specifically earmarked for local facilities, and take them into some non-profit corporation or trust fund to be held for, I'm not sure, I guess some future health need down the road.

And it raises for me a question, that I don't know how

widespread that is, but it raises for me some concerns about some hundreds of thousands of dollars — and perhaps more, I don't know — being diverted into little funds here and there. Without dealing with the question of whether or not it's appropriate, it raises for me the question of accountability. And it just seems to me that the more little funds that you have out there without any clear idea as to who the trustees of those funds are accountable to, it risks for me anyway, well it creates risks about misappropriation of funds. And so I'd like to get some discussion on that topic as well. I don't know how that's resolved. Maybe all the money is going to go to the health board, right or wrong, and so there isn't an issue. But I'd like to get some understanding of that one.

The Chairperson: — Can I just hold it there and then let the response come so that we don't get this too disjointed.

Mr. Van Mulligen: — Okay. Yes, I can deal with the other points I've got on the longer term . . .

The Chairperson: — Yes. We'll deal with them right after this. I'd like to have Mr. Adams and Mr. Strelioff answer, and then we'll take a short break and then we'll come back.

Mr. Van Mulligen: Or we could take a break now.

The Chairperson: We'll answer this question and then we'll have the break and then when we come back, you can be on the order again.

Mr. Adams: — Thank you, Mr. Chair. The first question having to do with who's paying for the audits and whether the Provincial Auditor's costs might be recovered in some way or other, keep in mind that while each of the current facilities or corporations have got a budget now for auditing, and I'm thinking of the 400, that the issue of consolidated statements area new cost and are not budgeted uniquely. And up until this year we haven't had to be concerned about the cost of the consolidated statements because it's been handled in part by the Provincial Auditor.

Our view is that auditing services are like any other management service, subject to efficiencies and subject also to rationalization, and that we have no intention of adding new money into the budgets for overall auditing purposes of the corporations so that as they surely can . . . first of all there will be fewer corporations to audit in the future, and that the total amount of money that's in the system for auditing purposes will deal with the consolidated statements as well as any other specific auditing work.

I think that I will leave to later questioning or debate whether or not the Provincial Auditor ought to recover his costs in the transition, from existing boards. That's an interesting question. If there is a move to do that, I think that there will be a debate with some of the districts as to whether they will use their own auditor then for the consolidated statements, whether they can get that cheaper, or whether they go to tender or whether they do something else. Because in the case of the Provincial Auditor they're not given an option. That's not a disrespectful remark but merely to say that we've selected . . . well three are locked in and three more will be selected and basically invited, with a little pressure, to accept this approach to auditing through the transition. So that some may have already appointed a consolidated auditor and may have views about whether they want to change that arrangement.

With regard to the question of privately raised money that Mr. Van Mulligen has raised, there are a set of very clear rules and understandings about this. And unfortunately the message has been confused by some folk and maybe I need to send some of our people back again to explain this more widely. Let me explain how it works.

There are various ways for let's say a former local union hospital to have raised money. They may have gotten money directly from the provincial government as a grant; they may have levied on the municipalities and raised money for one or two different purposes; they may have levied for the purpose of capital reserves or development; they may have levied for a supplemental operating cost. But in any case, it's municipal money raised by the municipalities involved in the union hospital district.

Third form of money is bequests. Like somebody dies and wills a farm or some money to the particular institution. There may be non-liquid kinds of assets out there too. Some people have willed artworks; they've willed equipment; they've willed beds or they have donated beds. in one case it's a series of handcrafted blankets and things like that that have been given to the institution, and in other cases, things like community-centred bingos and lotteries . . . not lotteries, bingos and other fund-raising activities centred on a particular community.

In the case of any provincial money, any provincial grant money, it is required that that money will be turned over . . . any reserves of that money will be turned over to the district board, so that money cannot be disputed. It can't be hived off.

In the case of municipal levies for capital or supplementary operating costs, the biggest part of that is money raised for the purpose of future capital. So it's a capital reserve.

Since it's publicly raised, there are two or three possibilities . . . two possibilities. It can be returned to the municipalities if the Saskatchewan Municipal Board agrees and then returns the money, or the money can go to the new district board.

And in going to the new district board, one way to protect its use for the municipalities that raise the money is to work out the limits of what it can be used for in a preamalgamation agreement. So that the communities involved work through — and that's what they're doing now —they work through with the district board what would be the future allocations of that money and what would be the limits of its purpose.

So at that point for that money in the preamalgamation agreement, the minister has to approve those agreements and the district board is responsible for the honouring of the conditions, but it takes the money into their reserve accounts and protects it in some way or other. And then at a future date when the agreed purpose arrives, or purposes, then the money can be allocated according to the agreement. And the minister is accountable in the end to see that the agreements are met.

At this point there isn't too much dispute about those two sources. It's the third source. And I want to remind the committee that there are a large number of health foundations already in place. You hear about them all the time. In Regina here they raised money for equipment in one or other of the hospitals. The foundations are set in place as adjuncts to the facility. And often community-spirited people then organize one event or another to raise money for the foundation, and then through the foundation, donate to a specific set of purposes.

In my discussions with the representatives from the foundations in Saskatchewan, I have some months ago suggested to them that they should begin to think about moving their foundations to align up with the district, as opposed to line up with a particular institution. And in fact that is happening in Regina. The foundation in Regina is for all of the facilities here. It doesn't line up with the specific. And in the case of Saskatoon, they haven't got that far yet, so it lines up with specifics. And there was a lot of competition. You either contribute to City Hospital foundation or to Royal U or to St. Paul's, but not all three at the same time.

Throughout Saskatchewan there are other foundations around, but they are not very well known. And they line up again, as I say, with certain institutions or with denominational facilities. Where there is privately . . . has been privately donated money, if a community chooses to move that philanthropic . . . those gifts into a foundation trust, there is nothing wrong with that. The law does not prevent it. We did think about it in advance and our intention was from the outset . . . is to leave in the community monies that were specifically bequested or raised by that community for the good of that community.

What we are trying to do is make sure that the purposes for the use of those foundations are more clearly prescribed so that some . . . as has happened in Regina or Saskatoon, that the foundation doesn't go out and convince the public to invest a million dollars in some piece of equipment when nobody has asked the question, who is going to pay for the operating cost.

And in our discussions with the foundations, I am trying to encourage them to tie their foundation money-raising ideas with the priorities of the district board, and that they should also feel that there is value in providing sustaining support to some kind of services as opposed to feeling it has to be in a hard asset, like a piece of equipment. There is no reason why they can't turn their attention to certain ongoing activities of certain high-risk groups, for example, and give sustaining grants to that.

Now that may be a long explanation, but this is in fact a complicated piece in some communities. So the discussion then that has gone on in some communities is, if we can create the foundation, then who are the trustees? And that there can be two different kinds of trustees. They could give the foundation, with a prescription for its purposes laid down, to the district board to administer on their behalf. So the trustees could be the district board. They also have the right to set in place their own local trustees.

Now in different communities the answers are coming through in different ways at this point. There are different choices. What the department is encouraging, but it hasn't got the power to command on this, or demand, the department is encouraging the communities to let the district board become the trustee for the foundations. it doesn't mean . . . now I'm not sure what that means in terms of auditing of the foundations, but what it does mean is that there is a better linkage between the two sources of funding. But if the communities say no, we don't want that, that is perfectly, perfectly okay. They can set up or they can expand existing foundations and designate that money for the use of that particular community. I don't think it is a particularly big problem in the longer term, so long as it is understood that the tax money can't be shunted off into foundations.

Now I'm aware of two communities who are thinking of that, may have gone so far as to attempt to do it, and a little message was sent out that they can't do it. It's illegal and there are penalties in the various pieces of law for any board of directors who take public money and does that. So they better make sure the money does not drift in that way and there is a full auditing at the point of transfer of all monies, where they came from and where they're going to.

The Chairperson: — Duane, do want to take a break and come back and answer the question, because I've got a number of questions on this topic as well and I wondered if we could finish it kind of off and then go to your next question, Mr. Van Mulligen. Then we'd have some continuity as to the questions. Let's take a 10-minute break and then come back and then we'll lead off with Mr. Strelioff.

The committee recessed for a period of time.

The Chairperson: — I'd like to ask the auditor to respond to the questions, the two items. One is the payments for the audits and the other one is what I would generally call a non-government organization contributing to funding for health care in some frame of reference at one point in time or another. And then I have a couple of questions on that issue myself and Mr. McPherson has asked to have some questions on that, and then we'll go back to you to deal with some

of the other questions you may have on this issue or others.

Mr. Van Mulligen: — Why don't you deal with the first issue and get that one out of the way and then . . . (inaudible) . . . trust funds and so on.

The Chairperson: — Yes. Mr. Auditor will do that.

Mr. Strelioff: — Thank you, Mr. Chair, members. The first question relates to our audit costs or the audit costs of examining all the 30 health boards. I think as we all know, the funding for those costs comes from the General Revenue Fund, whether it's directly to our office or whether it goes from the General Revenue Fund to the department to a health board and then to our office or to another public accounting firm.

So it all comes from the same place and it also gets approved, appropriated by the Legislative Assembly, so we're talking about the sequence — how many different routes does it go or does it come directly?

Now the starting point is that by law we're responsible for examining all 30. And the proposal that we have on the table is that within our existing resources we're developing an audit plan to focus on six, and the costs of those six vary from institution to institution. For example, for the Regina Health Board we've been examining all the hospitals that make up that board and that funding has come through to our appropriation directly from the Legislative Assembly and we discontinue to do it that way. We didn't bill the Regina Health Board for any of our costs; we just used our existing funding to pay for those costs.

Saskatoon, a little bit different. We used our existing funding to audit the University Hospital, the Parkridge hospital, and as they come together in a total organization, the total financial statements and reports. We then used the auditors of individual organizations that are in there. For example, the auditor of City Hospital and the auditor of Sherbrooke, we developed agency agreements with them and paid their costs and billed the Saskatoon Health Board for those costs. So the money moved through in that way.

For Prince Albert, what we're planning to do in Prince Albert is this past year for '93, March 31, '93, the Prince Albert Health Board was just a small board. They hadn't had their agreements with the individual organizations, individual institutions that now make it up, and we used our existing funding to audit that small board. What we're planning to do with Prince Albert is to approach them and ask them to hire a primary auditor or an overall auditor and ask that auditor to form agreements or agency agreements with the auditors of the individual institutions for this transition period. And we'll just review what they do and provide them as much information and advice as we can.

For the three smaller boards, what we are planning to do is again, within existing resources, we're planning to be the central auditor, much like the Saskatoon model . . . be the central auditor for say Pipestone, if that's one of the ones that we end up doing, and have agency agreements with the auditors of the individual institutions that are coming together to form Pipestone and bill the health board for the costs of those individual auditors — those costs exist right now anyway — and just bill them and pay the costs for those individual auditors for the three.

So our proposal right now is, for the work within our existing resources, we don't plan to charge the health boards for the work that our staff do in a direct way. It doesn't mean that there is a free cost to it. I mean, the cost is just coming in a different direction. The cost is coming from the General Revenue Fund straight to our office versus coming from the General Revenue Fund to the health boards . . . or to the Department of Health, to the health boards, and then to our office. But we plan to, within our existing resources, examine . . . do our work with these six boards. But as I've explained, it also involves agreements and contacts with other auditors that will be out there, public accounting firms right across the province. So that's in terms of the funding.

Now if the Board of Internal Economy wants us to do something different, whether they think that more of the costs of the six or the 24 should come straight from the General Revenue Fund, straight from an appropriation to our office, or whether they want us to bill more of our costs to the board, the health boards, I mean those are options that I assume the Board of Internal Economy will provide us . . . will give us some direction on. But what we've done today is explained within our existing resources, here is what we plan to do and the system that we hopefully will set up.

The second part of the question, which I think of as retention of existing reserves, so when . . . Stop it? Okay.

Mr. Van Mulligen: — The question of who pays for what is an intriguing one for me because it seems to me that for a period of time that you'll be taking on additional responsibilities or duties with respect to some of these health boards, in addition to the ones that you have already taken on for Regina and Saskatoon, because they were Crown corporations and so on, and you started to do that last year.

A Member: — And Prince Albert.

Mr. Van Mulligen: — Prince Albert. You are now taking on three others, and I agree that you should do that. But it's a question again of the payment, because at one point you evince concerns about not having the resources to do your role properly and at one point say that you have decided to no longer examine every government organization each year.

It seems to me then, especially on something that's of an interim nature such as this, that the funding, in my mind, the funding that would otherwise go to a private auditor should go back to the General Revenue Fund and be credited to your office to recognize your additional expenses as opposed to, you know, the people that fund your office, the Board of Internal

Economy sitting back and saying, well what do you need this year. But someone else is getting a credit in the system by virtue of the fact you're doing the work, quote, free for them. And I guess I'd like to see some discussion between yourself and the controller in Health, I guess in this case, as to what are the options here that the Board of Internal Economy can look at.

Because I get concerned that you say that I don't have the resources to do my job adequately and then point in part to health boards as part of the reason that I'm not able to do that. And therefore you say you're not going to do other kinds of things which are probably, you know . . . which the government may, by virtue of law, have to have done and it may have to contract other . . . or provide additional resources to make sure that's done. But someone else is getting a credit in the system somewhere.

And I guess I'd like to see a better understanding of, you know, if there is cost for accounting then that gets properly credited to your office as opposed to this system that I don't quite understand. I guess it will be helpful for me if you and the controller in the Health department got together and had some understanding as to how this . . . what the options are for the Board of Internal Economy, I guess.

Also that we better understand, so that we have a better understanding because this is also an issue that comes to our attention in your report. And I wonder if there's any comment from any of the parties that I've named on that.

Mr. Kraus: — Well I could make a few comments on that. This thing gets very confusing because there are certain principles I've always thought should be adhered to. And yet what you're saying, Mr. Van Mulligen, isn't necessarily in line with that principle — the principle being that there are some audits that I would argue have always been paid for by the legislature.

And if monies have been appropriated to the Provincial Auditor for that . . . and certainly it was all departmental audits and I think the majority of Treasury Board agencies, perhaps not always some of the Crown corporations, perhaps. Although in the past, in the past, I would say that if the — and you can correct me if I'm wrong — even if the Provincial Auditor billed SaskPower Corporation, let's say . . . We'll go back 10, 12 years. We won't worry about just recent history. If he billed them that in that time, even though I collect the $25,000 or whatever it was he was getting from SPC (Saskatchewan Power Corporation), they would pass that on to us at some point during the year and it would just go into the General Revenue Fund. So he was still getting his full bill covered for by an appropriation, and that's the way I still continue to think of it.

Now there has been some change, some direction given by the Board of Internal Economy that it may be okay for the auditor to go and bill some of the Crowns and use it to supplement his resources. I don't know whether I agree with that but someone has decided that should be considered.

Mr. Van Mulligen: — Whether it's directly or go through the General Revenue Fund, is it, you know . . . I mean that's . . .

Mr. Kraus: — Yes, right. The idea was, we thought that the Provincial Auditor's office in someway should be treated like a department. You know what the cost of his operation is; you can see it right in the appropriations. No netting.

However, I don't know what these particular agencies are. You know we've got this transition period. They're certainly not Treasury Board agencies, I don't think, and they're not Crown corporations. They're Crown agencies, I guess, or something in between. And so I suppose I would still think that if he's going to be . . . if the auditor's going to do some audit work, my preference would be that the monies are appropriated for that work.

The problem with that is — and I'm sorry, I'm just going to have to talk about this for a while — the problem is we've then not only . . . the legislature hasn't only appropriated some money towards him in his budget, they've also through the Health budget appropriated some monies that in turn find their way down to these individual districts.

My preference would probably still be that if you're not going to have a double accounting for that cost, that you would be billing the district, getting the money back from them, and depositing in the General Revenue Fund and at least we'd only sort of incur one expenditure.

If we provided monies to them for audit work, and you, and they didn't have to pay you, they get something for nothing; they get to keep the money. And I know that isn't what's intended, by the way; Health would probably say that isn't what's intended.

So I'm just not sure where I'm leading on this thing, but certainly you don't want to provide the money twice, unless you're going to get it back at least once.

The Chairperson: — Mr. McPherson, did you have a question that was related to this, or the second question?

Mr. McPherson: — Second question.

The Chairperson: — Okay. I have an observation that I'd like to make in relation to this as well.

This is going to be a concern that is going to be raised more often now than it was before because of, let's say, a billion dollars going into the health care area, where in two years or three years we will have very little control of what is spent. And yet we're going to be required to ask for the taxes from the people of the province of Saskatchewan to deliver that source of funding to those health district boards. And that is a concern that I have in relation to this.

And when that happens, should the responsibility of this Public Accounts Committee be responsible for that money as a part of an overall reporting back to the Assembly, whether it was adequately and appropriately spent in the way that it was said that it was going to be. And that's a part of, I believe, our Public Accounts responsibility. And if we don't have anyone providing us with an overall general viewpoint of it and we have to go to details within the public health — or not public health — in the health district boards, and say we want to meet with that auditor, is that effective and efficient use of funds.

And I raise that as questions that I think have to be addressed. And I think Harry's raised a good question here. Is it then our responsibility as a Public Accounts Committee to inform the Board of Internal Economy that there are issues that we need to deal with, and that need to be dealt with from the public accounts perspective, that the Board of Internal Economy is going to have to deal with, and Mr. Kraus raised them, is does the auditor have the right to keep the funds that have been allocated for an audit? Is he responsible to pay it back, and does he have to pay it back? I think all those things need to be dealt with.

But I wonder if it's our responsibility as a Public Accounts Committee to provide a directive to the Board of Internal Economy that would assist them at least in getting the discussion going and giving a perspective of our committee in relation to that.

I raise that for the committee's direction later on some time. And maybe today's the time to do it, but maybe later on is the time to do it as well. I just put that out before the committee.

Mr. Van Mulligen: — The reason I raise it is that because the auditor has raised it.

The Chairperson: — Right.

Mr. Van Mulligen: — In his report. That in part he is unable to do the things that he would like to be able to do because of these additional responsibilities, and therefore leading him to decide to no longer examine every government organization each year.

I'm not sure whether that then means on the one hand that the government then has to put additional resources into the system to make sure that the government organizations that are required to be reported on are, in fact, reported on. I don't whether that's done through you or engaging some other auditors; I don't know. But it seems to me that what you have is a system that allocates money for audits. And if the Provincial Auditor doesn't do it, the money flows to private auditing firms.

But the auditor does it, then they no longer have to then spend that money or that system no longer has to spend the money on the auditing firms. But the auditor has incurred additional expense in doing that, and there may not be any appropriate recognition back from the General Revenue Fund for having done that work. And so the auditor says, well I'm not going to do some other things which may need to be done. And then the issue is, well where do we get the money? How come we're not auditing these other functions? Well the reason we're not is because someone else is getting a credit here in the system.

And I guess I'd like to see a better understanding on these interim kinds of measures, as to how they're going to be paid for, to put it bluntly. Like, Mr. Kraus, you know, I think there are traditional roles and undertakings that are expected of you, departments, and Treasury Board Crowns, and so on. But when you get into some additional responsibilities which weren't budgeted for, you know, how do we properly account for those things?

And I guess I would like to see some discussion between — not necessarily here today — but between you and Mr. Kraus and probably the Health department as to how do we pay for these audits in the health care system on this interim basis. And how do we make sure that you get the adequate resources in your office to be able to do that, and how that gets accounted for.

And so I . . . rather than the committee, at this point, making some recommendation to someone, I guess I'd feel better if there was some discussion between you and Mr. Kraus and the Health department as to how that's going to be handled. And if that then means a recommendation back to us to take to the Board of Internal Economy or, you know . . . I suspect rather not. I mean if there's an understanding between the three as to how it's going to be dealt with, then the Board of Internal Economy is probably prepared to go along with that.

But I'd like to see some . . . I raise the issue because I'd like to see some resolution of that so that when you go out to do those health boards, that it's clear in your mind that the resources that are there within the system to pay for that are in fact being . . . find their way back to your office for that purpose, through the General Revenue Fund, I'm sure, because you wouldn't want to set up additional funds, but through the General Revenue Fund, so that your office clearly has the resources allocated to be able to do that, as opposed to at some point saying look, we got a shortage in the resources for my office and therefore I'm not going to do some other things.

Well, you know, that's not the issue that . . . I mean that's not the way I'd like to see these things dealt with. I mean if you're taking on additional work, you should get the resources to be able to do that, to do that additional work.

I just wanted to raise one other little question, Mr. Chairman, that you raised, and that is the question of accountability. And it's in a sense a different question about . . . you mention a figure of a billion dollars going out there in the health care system and people making decisions about that and raising the question of accountability within the legislature, etc., etc. I'm not sure what has changed from . . . well just to go back here, you've had monies go from the provincial

government to elected hospital boards, but we haven't called these boards before us. And the same billion has been going out there.

Now you're going to have elected district boards. I'm not sure how the relationship with the Legislative Assembly would necessarily change very greatly from what it was before. You know what I mean, you had money going to the home care boards which were elected somehow, you had money going to hospital boards which were elected somehow, you know, and those people were responsible to and accountable to whoever elected those boards and so on.

So I'm not quite sure that now that the money is going through district health boards that it of necessity changes the fundamental relationship between how health care dollars are expended by those elected external boards, that is external from the government, as opposed to those boards, hospital boards and so on, that were expending money. So I'm not quite sure, you know, that there is a fundamental shift in responsibilities and accountabilities taking place here.

But that's not the issue I was raising, and I'd be glad to get into that one too, but I did want to make that point in response to what . . .

Mr. Strelioff: — Thank you, Mr. Chair, members. The issue of audit costs. I concur with Mr. Kraus that in general all our audit costs should come from the General Revenue Fund, be appropriated. And that if that means that audit costs that were normally moved through the department no longer are required, then there should be a quid pro quo there. Where we are in this transition with the health boards, there are 400 or thereabouts individual institutions with individual audits that were decided upon by the individual institutions.

Right now it's probably hard to determine what the total audit costs are which is . . . I mean I shouldn't say that because that shouldn't be the case, but it probably is. And so the quid pro quo would be difficult to determine.

But in general I think that our total costs should be straight from an appropriation from the Assembly and that our ability to bill and retain fees should really be used when there's something happening during a particular year, that something new has happened and therefore instead of going through a fairly elaborate process of special warrants and Board of Internal Economy meetings, it makes sense just to have a specific agreement for the interim year and then come back the next year to the Assembly and say, here's the total costs.

So that's in general where I would like to see it move, and that makes sure that I am accountable to the Assembly in the direct fashion that I should be for the total fees, and that the Assembly gets to decide what resources we have and what we should audit, not the government decide what resources we should have and what we should audit. Because if we have to bill individual government organizations, it's up to the government then to determine whether we can carry out that work.

And the other part of your question, in terms of shortages of money, therefore not doing all the work that we're required to do, a good example is what we just were discussing. I'm putting on the table a proposal that sees us examine six organizations. Well there's 24 that I'm not going to be looking at, assuming the existing resources of our office are maintained and no new resources are provided.

And I'm putting that on the table because I want to make sure you know what the implications are. In thinking through the proposal, it seemed reasonable in the sense that the boards are going to move to an elected situation soon. Now I heard Mr. Adams say this morning that exactly when that's going to be is still in the air; I was thinking that it would probably happen in the fall but I guess I'm not sure about that now.

But in terms of ensuring that the Assembly knows the implications of what we're doing with our existing resources and what we're not doing; what we're not doing, what we're planning not to do, is the 24 health boards. But again, to be going back to what I said at the beginning, I think that our appropriation should reflect the total costs of our audit work plan and that if there's costs already going through the department to the health boards that are no longer required, then there should be a way of making sure that that's not happening.

Mr. Van Mulligen: — Again I have just a concern that you've decided that you want to take on these additional health boards and take on these additional responsibilities but at the end of the year you say, well I've decided not to do some other things and therefore you can't . . . I mean, where does that leave the government or where does that leave the legislature when you say, well I've decided not to audit some other organizations and that's your problem now because I've decided it's more important for me to do this than it is to do the things that I traditionally do.

I guess if there's savings in the Health department then I'd like to see some clear understanding that that money is then available for the auditor's office for those specific projects, you know, on an interim basis. And that, you know, in the long term there's no questions in terms of departments and all those kinds of things, that the money should come straight from the General Revenue Fund to your office to be able to carry out those responsibilities. But if there's . . . on an interim basis if you're doing something, I'd like to see some better understanding that there is money available to do that and where it comes from and that it need not implicate other work that you do.

Mr. Adams: — Yes, thank you. I don't know what your problems are beyond the health field in respect to this auditing requirement, but in respect of the health field I'm hearing that a fairly significant issue is being made of what . . . and I don't understand what the significant

issue is. Let me explain,

As a principle within the field of health, we don't want to pay more money totally for auditing across the piece than we've paid in the past. We don't see, totally, a need to audit more. We think that you may audit different, differently.

The new work in the piece has to do with some front-end developmental work where we are expecting some guidelines from the Provincial Auditor which we can universally use. That is some new work. And in . . . then there is an issue of some consolidated statements — consolidated, not individual site audits.

We are also talking about a transition here. This transition could be as short as a year; it could be a little longer. But this is not a long-term event. So in something in terms of a transition, when I'm urging you not to lay on requirements that totally cost us more money to audit when we're already auditing, through one route or another, 400 corporations . . . It's not that this is an unaudited field. The debate around this table is who's going to do it?

I want to draw a distinction also between, in your thoughts, about the costs of audits and then how they are funded, because I think those are different issues. And part of the discussion here about how the Provincial Auditor is . . . how the money is raised to fund his office is a separate issue from what it is going to cost to do the audits.

Now in respect of what's going to happen with these new audits in the health system, we're talking about three more that the Provincial Auditor is proposing be done. As I understand our discussions in preparation for this meeting, is all of these individual sites or facilities already have auditors. And all of the districts were required to appoint auditors as one of their early responsibilities anyway. Now some have done it, and some haven't because of the newness of their organizations. But there is already that function there.

So in respect of these three sites, my understanding was the Provincial Auditor's role was to provide a consolidated statement in the corporate headquarter office and that they intended to use the existing auditors for all the site audits and give them guidance, get some commonality, bring them in, and all the existing auditors out there that have been in place for, in many cases, quite a few years would be continued . . . would continue to be used and their work consolidated under some general guidelines. And the costs of all those other auditors were to be billed to the districts, so that the cost that we're talking about here is the consolidation cost in the centre, for three centres, three additional sites.

Now in exchange . . . I have not talked about this next point with the Provincial Auditor, so excuse me, but it's relevant now. Depending on which sites are chosen, which districts are chosen, the auditor may not do some work that he has been doing in the past in certain other districts. The audits of the regional centres in Swift Current, Melfort, and Weyburn are significant audits. They are big regional centres.

I don't know exactly how much time is spent on each one of those audits, but at this point I'm presuming that if he is switching his direction to deal with consolidated audits in three districts where there are not three regional centres, then the district boards will have to employ site auditors for those regional centres and they have to absorb that cost, which frees up some of his time to do the consolidated work in the three new sites.

It is possible, though, that the auditor said, well no, I will work as a subauditor for those three regional sites, in which case the boards don't have to pick up that new cost, in which case he doesn't have . . . he doesn't even need new time, I suppose, for the consolidated statements. That's a bit of a trade-off here as to who is actually going to do those audits, but I can't see that this is an enormously big resourcing question. It's a question of deciding where he puts his time and what he is not then going to do in the health system; and where he doesn't do it, we will have to employ other auditors and the boards will have to pay for it.

I want to get it through my head clearly, and I hope share this with you, that when somebody says they are not doing audits for 24 districts, that doesn't mean they aren't being audited. My understanding was that the general guidelines that the auditor will lay down as requirements for the audit purposes, will be laid on all the districts and that the auditors employed by the districts will have to conform to those requirements, and the results of their work will have to be in some way viewed or reviewed either by the department or some other arrangement we put in place.

You will in fact have more accountability and more integrated accountability in the new system than you had in the old. And in the transition all the sites that existed before are still going to be audited. It is only a question of putting the pieces together at the consolidated level.

Now I say all that to you not to make your lives more difficult, but to come back to my first point which is, I do hope that in the whole process of auditing, it doesn't cost us more governmentally in the end than it already does. Because I don't see that there is a need for that. My view is that we want to redirect time and to apportion responsibilities in the interests of the legislature.

Thank you on that point.

The Chairperson: — I'm going to raise one point, and I'm going to ask you, Mr. Adams, this, and I jotted it down earlier. Are you comfortable with the way the reporting will have to be done to the Department of Health in relation to the expenditures that you're going to make? They may be made differently now, which they're going to be made to the board rather than to the individual site.

And are you going to be satisfied that the program

performance and the services rendered and the finances in each of those areas have done what the auditor has said should be . . . two things that he said here is cost of services and activities. Are they going to be effective, in your estimation, in relation to your own control within your own department?

And that's, I guess, the question that you have to be comfortable with so that when the auditor comes and does your department, that he doesn't go down into health district X and find some things that have been done inappropriately and then you are responsible for that action. So that's, I guess in a pointed way, what we're in Public Accounts asking — maybe I'm putting words in Harry's mouth; I'll take them myself — but I'm asking you that question.

Mr. Adams: — I'm comfortable that in terms of costs and financial controls that they will be even tighter than we've had in the past. And we could get into a lengthy discussion of why, but that's the short answer.

In terms of effectiveness measures, I can tell you that I don't believe that we have perfect measures for that yet. No place in North America or the western world has got that done yet. The auditor didn't say that thou shalt have those effective measures on April 1; he said the department is working on those measures. And we're trying to change our accountability process to move away from site-specific, detailed activity accounting into program accounting, and our information system is designed with that in mind.

The beginning steps of moving off site and on to program are taking place with the key boards. We will have more program-specific measures in our requirements for 1994-5 than ever in our history, and we will continue to work away to improve those. So that I think this is an evolving and a developing field and I'm comfortable that we will be able to account better in the future than we ever have been in the past at two levels — to the legislature through the minister for the things which are important, that is program outcome and not the minute detail of financial expenditure; and then at the other end the public will be far more informed and the health districts more accountable because they are required to report to the citizenry directly. And they will have very pointed questions to answer there as well. So they will need data systems or information systems, and they will need to be able to account for program information in a way that they have not been required to in the past because all of the boards that we've been talking about have in the past not required to have open meetings or public meetings. They have all been able to do their business behind closed doors.

The Chairperson: — Are you going to require that they publish public accounts for their health district board?

Mr. Adams: — Yes, as a part of the requirements for . . . One of the two required are legislated meetings. They are required to table their program information and their proposed estimates, their report on activities, and their financial statements in a public meeting. And that has to be done in advance of the minister receiving their estimates.

The Chairperson: — You didn't answer the question. Are they going to take a public accounts perspective like the urban municipalities and rural municipalities and school boards are now required to do? Are they going to be required to give a public accounts statement the same way they are?

Mr. Adams: — Perhaps that I don't fully understand what's required in the other systems. What they will be required to do is table financial statements and audited statements and program explanations and statements. I don't know whether they are going to fit with this other model you've described or not, and I'm not sure that I've been briefed on whether that's the intention or . . . I haven't been briefed on whether that's the intention or not.

The Chairperson: — That is something that probably should be taken a serious look at because the requirements by urban municipalities to say so-and-so received payments and that's the kind of thing . . . and I haven't got my Public Accounts books here with me, but you know what the Department of Health has for public accounts. And that's the same criteria that I think the public would perceive to be good in relation to getting back to show where the benefits accrued in more than just a program.

Mr. Adams: — I hear you. We'll have a look at that.

The Chairperson: — Okay. Are we finished with this discussion then? Do we want to go to the second question on . . .

Mr. Van Mulligen: — I'd like to ask Mr. Kraus something.

The Chairperson: — Just before you do that, we have the second part of that question dealing with trust funds.

Mr. Van Mulligen: — No, just on this first.

The Chairperson: — Go ahead and ask them.

Mr. Van Mulligen: — Is it possible that you might sort of get together with the parties to arrange for some proper credits and so on?

Mr. Kraus: — Sure, I would undertake that although I think it's part of . . . what you're raising is an issue that might come up from time to time when there is something different has happened. As the auditor has said, in the normal course of events, it's preferable that the legislature provide him with his full budget. But should there be a mechanism to deal with situations like this that arise, and I know what you're talking about. It's really leading to some kind of maybe a net budgeting option that he might argue he has now but we would argue he doesn't because the law isn't specific in that. But yes, we'd get together and talk about that.

The Chairperson: — Mr. Van Mulligen, would the interests of this committee be served by having a discussion with the Board of Internal Economy in relation to what they provide, and/or at the time of the discussion where the vice-chairman and myself be a part of that discussion to present the Public Accounts' perspective of that view? And that's something for you to think about for the future. I just raise that.

I'm prepared to go to the second part, and Mr. Strelioff has not answered the question on the second part. I'll give him the floor to do that now.

Mr. Strelioff: — Thank you, Mr. Chair, members. My understanding of the question of the second part is when a health board is created, there'll be say 10 institutions surrounding it and each institution will perhaps bring in a beginning surplus within a reserve account somewhere. And who gets that surplus once the board is formed as a whole and how do they decide? In terms of financial reporting, the surplus gets in with the whole, so that no one, I don't think, will lose track of the monies.

What the board decides in terms of where if one institution comes in with a million dollars reserve funds, whether that million dollars will be used by the board to do something within a specific program within that institution, I assume would be something that the board has to decide and they would negotiate with the individual institutions coming in. And no doubt those discussions and negotiations are probably pretty difficult, but I don't assume that the monies will disappear somewhere. The monies will come in and it'll be reflected in the financial reports of the board. The difficult part will be deciding how to use those surpluses or deficits as they come in.

Mr. Van Mulligen: — If I could just follow up here. My concern is not necessarily with any monies that are administered by boards, whether directly or in trust; my concern is with the little trust funds that are set up that are not administered by boards but by groups of well-intentioned people who want to make sure that there's some . . . the money that was raised for a specific community facility is going to be there for some future community facility.

And my concern relates to any number of little special accounts. Probably the best example is when the Department of Justice, shall we say . . . where people have, I mean you got these little accounts and you have people looking after them and the increased incidence of risk, shall I say, that that seems to have incurred in that department. So my concern is about these little funds out there being administered by groups of citizens — not by municipalities, not by elected health boards, but by citizens. Just what are the conditions that are attached to that? I mean, what are the conditions of accountability attached to that? That's my concern — that money doesn't sort of end up walking away somewhere.

Mr. Strelioff: — Mr. Chair, members, the board would not be setting up trust funds on its own. I guess you're thinking of foundations, fund-raising foundations that exist right now outside of the board activities and that have fund-raising activities and provide monies to the board from time to time on their fund-raising activities.

Mr. Van Mulligen: — Even more so foundations that are going to be set up that didn't exist because the money went to the local hospital board or whatever, but now they want to withdraw it because they don't want the monies going to the district board. They want it to stay in their community and they're going to set up their own little foundation within the community. What are the guidelines for those and how do we account for those, and what requirements are there for accountability? Because under the local hospital boards there were some clear guidelines as to how money is, you know, accounted and statements have to be published and audited, financial statements that have to be produced, etc., etc. But what about these other little foundations that are going to spring up? That's my concern.

I don't know. Like it was raised to me about one community — and I can't even remember who raised it and the community in question — but it begs the question of other little foundations. And I don't know the extent of it, but I am concerned enough that I want to get it clarified that Health and your office is aware of these little developments taking place in that there is a question here of money being raised for a specific purpose, which was within the system and therefore is subject to the accounting and accountability standards within that system, now being drawn out, and who is accounting for it? What accountability is there and who's looking after that?

Mr. Adams: — Well I've spoken at some length about it so I won't repeat what I said about it. I think . . .

Mr. Van Mulligen: — Very thorough if not encyclopedic.

Mr. Adams: — Thank you. I do know exactly what problem you're talking about. And in terms of the accountability at this moment, as I'm speaking to you, the accountability flows through the type of incorporating documents that created the foundation. Most of them will be non-profit corporations and they'll be governed . . . they're required to have auditors, but these will be private auditors. These do not come under the purview of the Health department or the Public Accounts Committee. These are separate issues.

And there may be other kinds of specific arrangements that have to be honoured by boards as they go through the sorting out of assets having to do with bequests that they've received historically. I don't know of all of those.

But what I can tell you is the department isn't ignoring this issue. We are going to have to give some further guidance to the existing corporations about this because just what I said to you earlier about sorting out where the money came from is not something that is entirely clear to some of the folk who are involved in

this, and that all of this has to be regularized at the point of transferring the assets.

I think that in respect of the foundation arrangements or the bequests that are limited to a particular site, the department has very limited powers over those funds. And it would take . . . I've actually asked for some legal advice on this, and I think if we were to take more powers than we currently have, which are very few in respect to them, it would require legislation to do it. And that what we will do — though there are very few places that I'm aware of that are trying to abscond with money. What they're trying to do is sort out the original intent of the money and place it in that kind of a cubicle, if you like — so that what we would do is issue some suggestions or guidance, use the full range of whatever persuasive or legal powers we have, which I say are limited, and then determine whether there's really a problem there.

But at the moment, unless my department is going to correct me at this point, a foundation is not subject to the department's rules or auditing or anything else. That is a private, non-profit corporation that raises money for a purpose which is health related in many cases, but we can only persuade the use of the money or how it's handled. We have no legal right to interfere with it.

So in terms of looking at all the surpluses and reserves, capital and operating, and who raised the money, tax money or non-tax money, this is the smallest component of the problem. But it is certainly one that in a few areas is anxious for the community; it's an anxious point.

Mr. Van Mulligen: — I guess my concern is that I don't get very good feelings about monies which at one point were accounted for within, you know, an elected system or an accountable system, i.e., local government, or through the Department of Health in some fashion, now going to some non-profit corporation, the requirements of which you've got to send in a financial statement.

But I mean there's no requirements in terms of that some auditor's got to sign off and that. I mean there's no . . . you can get any local person to do the audit, no qualifications required; money sitting there that no one's particularly going to look at for some years, you know. Who's really looking at those things? And that's my concern.

I don't think that you've got any legal framework for that either. I'm not sure.

Mr. Kraus: — It would seem to me that if these monies had been given to a local hospital or something and there were conditions attached to it, that the monies would have to flow in accordance with those conditions. And if that hospital, for example, was disappearing from the area and one of the conditions was that the monies be spent in that hospital, it would seem to me that the hospital, when these monies were transferred, you would have to live up to these original conditions. And that might very well prevent the money from moving on to the bigger district unless everybody agreed. And it may very well lead then to those monies moving back out into a trust that's properly managed.

But I would think that the auditors, the management and the auditors involved in that process, would have to make sure that the conditions are adhered to. And it might very well lead to those monies coming right back out into a properly managed trust that would be audited again in a private manner.

I mean that's just one example I could think of where you just couldn't take that money and push it on to the bigger district. You'd have to follow the conditions, if there are any. Now if it's unconditional, perhaps it could move on to the bigger district. But wouldn't you have to look at each one individually?

Mr. Adams: — Yes, absolutely. Every single bequest or arrangement has to be looked at as a part of the amalgamation. And the monies have to be sorted out, the conditions have to be examined, and the best arrangement for honouring the . . . either the bequest or the conditions of raising the money have to be met.

Mr. Kraus: — And I would think that the auditors — management and auditors both — of these institutions that exist now, or agencies that exist, have to be signing off. When they're signing off the audit reports or whatever, I think they have to be sure those monies are moving in the proper way, or they shouldn't be signing off. At least it would seem to me they'd be handled properly because of those kinds of things. And because of the direction that Health is giving, it doesn't mean people aren't going to argue over whether or not that was the original intent. But I would think it would sort itself out.

Mr. Strelioff: — Just a question of trying to understand the issue. So when one institution comes into the board and they have maybe some surplus monies and also some designated bequests, some of those institutions are choosing to move that surplus money or those bequests out into a separate foundation that is perhaps created by private people, and then the use of those monies and bequests would be decided by the foundation rather than the board. Is that what is happening, or is it just the bequests that are moving out, or something completely different?

Mr. Adams: — As I said before, there are three sources of money going into the corporations that are being amalgamated: provincial tax dollars; locally raised tax dollars off the property through the levies, which can go into one of two types of accounts — a capital reserve account or an operating supplement to the provincial grant; and a third type of money is out there, or resource is out there. It may be bequests, which may or may not be tied to a particular site or facility. So these are all the possibilities. It may be non-liquid assets. It could be long-time endowments. It could be physical assets that have been tied to a particular site.

There is no problem with the first two types of

resources. All provincial money transfers to the district. All money raised off the property tax base is either transferred to the district, if nobody has any particular concern about tying the money to a site, or it is tied into a preamalgamation agreement by the municipalities who were taxed to raise the money. And they can work out with the district in advance of the amalgamation how the money in the future would be used in the benefit of the communities who actually raised the taxes. That agreement is in the hands of the district. It is subject to audit. The minister must approve of the arrangements. And once again, that is not . . . there is no separate actors involved in that. It is all administered by the district.

The third type of money is philanthropic contributions, basically. They've come from a variety of different sources. Some of them are tied to very specific causes. And you should remember that many of the health institutions today have foundations or trusts attached to the general corporation. Lots of them are out there, both in the field of acute care and in the field of long-term care. There are even some foundations for home care. These have separate boards of directors and they have separate, local fund-raising arrangements. And the boards of directors of the foundations are usually local citizens who are in some way involved in the fund-raising.

They are set up under non-profit corporations usually, although you could do it by way of the society, and they have their own audit requirements. They have all of the arrangements of the self-standing corporation. They then, when they raise some of this money, may make some bequests to a health purpose or an institution from time to time. That's at the discretion of the trustees of the foundation.

Now some of those already exist. For the ones that exist there is no problem. I mean it's just carry on as usual, although we would like to make sure that the money, when it's allocated from the foundation, is used within the priorities established by the district board, so that we've got two financial sources working as a complement.

Where Mr. Van Mulligen has a concern and an interest — and a valid one — is where a philanthropic bequest was given over to an existing corporation, like a union hospital board, with terms and conditions originally attached to it that limit what can be done with the money and especially require that the money be used to the benefit of a particular community or facility that has the money currently, not necessarily the district as a whole.

And where there are some of those kinds of tied or limited fund-raising initiatives or bequests, the question is, how are the existing boards planning to deal with that? One of the ways that they have looked at, and in some cases used, is to move that kind of money under the auspices of an existing foundation in that area, which moves the bequest to the trust of the trustees of the foundation.

The other approach that has been used is to create a foundation. The third is to give it, to put it in a foundation, but leave it to the administration of the district to honour the conditions of the money that's in there or the assets that are in there. That's the third approach.

Mr. Van Mulligen's concern is that if it doesn't fall to the administration of a district board, but rather falls to the administration of local trustees who are not publicly accountable and where originally the money didn't go into the foundation, it went into a conditioned reserve account, is there some fault here in either the accountability or do we run some risk that that particular asset is now either unprotected or falls to the hands of some people who are not serving in the general public interest.

And my answer to his questions about that were to give him everything we have by way of information at the moment; that our main powers as a department on the assumption that the board in placing these assets in the right pigeon hole have done things legally and correctly and examined the terms and conditions of any of the bequests, if that much has been done, the department has few other tools at the moment. We do not have legislative or legal power to move in on the foundations. And that beyond that it doesn't make some of the members of the committee feel yet very comfortable about how it's being handled.

And I've taken the issue closely to heart because we want to be able to make sure that the kind of worry that's been expressed here is not a worry for very many people, or it can be in some way dealt with.

Our strongest route to deal with this is persuasion of existing boards to place as many of the assets as possible in trust to the district. That is the best armament we've got. But we cannot compel it if everything else has been done legally and the terms of the bequests or the donations have been honoured. And Mr. Kraus has added that in . . . is there a single answer to this whole issue. And the answer is no, there is not. Each specific arrangement and bequest or philanthropic gift has to be examined specifically and uniquely.

And that at the point of moving all the assets and agreements through, obviously the department has to inspect along with every . . . with a number of other agents all of the terms and conditions of the allocation of the assets and the obligations, the liabilities, and the amalgamation agreements. It's a very complicated and very detailed appraisal.

And if we can do anything more to tighten up the conditions under which the foundations can be created or used, or the trust responsibilities for assets that may fall into that category as a result of this division, then we will do that. We will do everything within our own powers because we, ourselves, have a great interest in this and are concerned. But it is not, in our view at this point, a really rampant rip-off of resources.

The Chairperson: — I think I'm going to interrupt here

for a couple of reasons. There is a couple of other people that want to get on the floor on this issue too — Ms. Crofford and Mr. McPherson; and we're going to close for lunch and then come back at 1:30 to deal with that. And then I'll let you back in after that.

Mr. Van Mulligen: — I'm going to do a quick follow-up and you can answer it later, and that is . . .

The Chairperson: — Could I interrupt?

Mr. Van Mulligen: — Well anyway I'll ask . . .

The Chairperson: — No, no, you go ahead and do it if . . .

Mr. Van Mulligen: — Is it possible that given the laws that you have that the primary auditors are going to do the consolidated statements for the boards now, and the boards themselves, that when these trust . . . when these new foundations are being set up or that any monies that are hived-off and put in separate cubicles from the district health board, or for that matter within the district health board, that they do some public reporting within the communities to say, now this money was put in trust, or was part of the health board and is now hived-off to this foundation, those directors, and that's the amount, and there you are, publicly you know it now.

Because if there's some public knowledge of that, hopefully there'll be greater interest in the future too as to what's happening with that money and where's it going.

Mr. Strelioff: — One mechanism could be . . .

Mr. Adams: — A quick answer to that, if I can, is yes. A requirement that we've laid on the districts with regard to the preamalgamation agreements is to make them public, and in those agreements they'll spell out the allocation of assets.

One area that I'll raise, but I don't want to get into at length right now, is one has to be careful about whether the foundations can be taken into the general purview of the district board accounting or publication. And that where the foundation is dealing with a foundation associated with a former union hospital district, one might see that is something like a public foundation.

But let me give you another example, that I don't think that the foundation of . . . associated with the St. Paul's Hospital in Saskatoon, mandatorily has to be published and inspected by the auditor of the district. It turns out that there have been some understandings reached up there which allow a more full revelation of financial resources of the entire district, including St. Paul's Hospital, but the foundation, I'm sure, is a private corporation and doesn't have to be made public.

Mr. Van Mulligen: — My concern is that any funds that . . . where some group says, look, this is a philanthropic bequest, that the union hospital board had it, we don't want the district to take it, we want to set up our own little foundation here, so we want that money transferred from the board to this organization, that at that point the board says, fine, we'll do that but we're going to publish it and here it's publicly for that community the knowledge as what money was transferred to which group and who's got control of it.

Mr. Adams: — It's being required.

The Chairperson: — Thank you. We'll break for lunch, 1:30 back in.

Mr. Adams: — Mr. Chair, could I make one remark first, that I don't appear to insult the committee here. I have to meet with the federal government, the new federal government, early this afternoon. It's expected at 2 o'clock. Now my associate deputy, Dan Perrins, is here and I would like to come back and do what I can to answer questions directly but I feel this first meeting with the federal people is fairly urgent that I attend. Now how would you like to handle this? I'll come back for as long as I can, but can you deal with my associate deputy?

The Chairperson: — Yes, we'll deal with him. I've dealt with him before so I am fairly confident that he can . . .

Mr. Adams: — That's bad news, is it?

The Chairperson: — No, no.

The committee recessed for a period of time.

The Chairperson: — I believe we have quorum and we will begin our discussion here again. I think that, Ms. Crofford, you had some observations you wanted to make on this issue of funding and auditing for special interest groups or were you going to go . . .

Ms. Crofford: — No, it was part of that. I do have other questions but I'll wait for my turn.

The Chairperson: — Yes, I've got you on the list for that.

Ms. Crofford: — I was just going to hearken back to the fact that for several years now the kind of concern we are talking about, this kind of NGO (non-governmental organizations) trust fund or whatever, I've had that same concern about NGOs overall because a huge part of government or indirectly government money is spent out in the NGO community and the current legislation governing non-profit organizations and the ability to monitor and/or enforce or do any work with that is virtually nil. And all that this discussion here has raised is a need somewhere down the line to take a look at those kinds of things, because I agree very much with what Harry was saying and then Duane's explanation that you do have a substantial amount of money being spun off into these separate and independent groups that have their own boards and what not, and how do you create any accountability for that. So I'm just wanting to reinforce that I think that's an exercise that we need

to go further into at some time in the future but not necessarily right now, because apparently you've covered it off from your point of view by making a requirement that they report on those trusts within your regular structure, right?

Mr. Perrins: — In the preamalgamation, it is. That's right.

Ms. Crofford: — Yes, so it's been covered off in this particular situation but there's many other situations not related to health where it hasn't been covered off at all, and it might be something that you might want to look at in the future.

The Chairperson: — Okay, I have a couple of questions on this one that I want to ask, and they have to deal with those areas of facilities where facilities have been built by organizations like maybe the Knights of Columbus or the Grey Nuns or . . . and I just speak on behalf of the people that I've been connected with and the Mennonites in Rosthern, Waldheim, Saskatoon, Herbert, all through that area. They've built nursing homes and different kinds of facilities like that. How does this relate to how you're going to be handling that in relation to the accountability of the sinking funds in those places and also the service contracts that you've got with them to deliver, and if they have surplus in that and the facilities side, which is somewhat the same as the sinking fund?

Mr. Perrins: — Well initially, Mr. Chair, the intent, the direction of discussions with health boards and communities is with respect to acute care facilities and ambulance services. So they're subject to amalgamation and that's what's underway now; and the 120 days has begun, so that at the end of that 120 days should preamalgamation agreements not be in place, the district board will assume responsibility. For home care and long-term care facilities, the approach being taken there is affiliation agreements. So the preamalgamation agreements that I have been referred to earlier relate directly to hospitals, and in effect, ambulance boards, but that's not been a particular issue at this date.

So the outcome of that will be, as I understand it, that the . . . while we may still end up with amalgamation, that's still left open and the individual, like St Paul's Hospital, to give you an example, will still exist as an entity and that we have contract for service with the district health board. So the building will . . . and the sisters will retain ownership, for example, of the building. And there's discussions under way about medical staff and their own staff, but the actual entity I think will be owned by the religious order itself or the . . . (inaudible interjection) . . . Yes, the funding for the operating will go to the health board itself. But the building would be retained by the organization.

The Chairperson: — Then when you're dealing with how the funds get allocated, is there compensation made to the fact that the general public has not financed certain portions of that facility? And then will there be allowances made for that funding to take place and then I go back and say, how is it going to be audited?

In reference to the context of that, it's almost like the auditor moving and doing work and not getting paid for it because he's got to deliver it through the Consolidated Fund, yet he's got more work to do. And that's the kind of . . . it's almost the same scenario.

Mr. Perrins: — I think there really oughtn't to be any cost because my understanding is the auditor is continuing, for example, to work with St Paul's on that. I mean the funds, all the funds are going to still go, the funds themselves will go to the health board, so the flow of the monies for operating is quite different than who actually owns the physical plant itself.

In home care we have yet another issue because there isn't the same . . . there isn't a building, there's just a program. So that the flow of the dollar, I think, shouldn't be any different if you're talking about tracking the initial dollars.

The Chairperson: — Well I'm thinking about the funds that would have to be there to put into place to pay for capital costs of University Hospital, for example, which is borne by the taxpayer. Those facilities where the capital cost has been borne by another agency, that is what I would call a charitable organization, where that agency has or is or should they be receiving funds in lieu of the rent on the facility, if you want to call it that. And then, is there a payment made to a sinking fund so that restoration of the facility can take place? And how do you manage . . . Does the health board manage that fund or does the particular charitable organization handle that fund?

Mr. Perrins: — Okay, well I think, if you step back a little, the point of the district and the district board is to really allow for, rather than a vertical approach to health care and the program surrounding it, a horizontal one. So the board should really be looking at the overall needs in a district.

The funding will follow that same kind of approach, that there will be a capital fund for a district that will come through the Department of Health, I think, as there are community . . . as there is now. If there are funds that are generated from the community, I think that's sort of the point of where — we were talking about that prior to lunch — how do you identify those and how do they become part of the overall picture?

On the acute . . . that's the difference between, I think, between the amalgamation and the affiliation. Because on the amalgamated approach, there is no difference any more, in that sense. It will be publicly clear. With the affiliated facilities, there still is a separateness, I suppose you could say, to them.

But the capital plan for long-term care should be vetted . . . should come through the district board. So that I think the public funds should be clearly identified through the capital fund itself. And in terms of how . . . I'm not sure myself how we'll maintain . . .

what will happen when some blending happens, but it should be in the context of an overall plan for long-term care.

The Chairperson: — Is there, in your mind or the department's mind, a difference between the allocation of funds, and I'll use Coronach as an example, where they have a debenture outstanding in relation to the construction of their facility, and Cabri, which has paid for theirs, and is completely paid off? So is the responsibility, first of all, going to be assumed by the health district board to pay off that debenture for that facility in Coronach and then deliver a tax across the board to all of that area that would in fact relay the responsibilities of that hospital for the debenture that's there against the taxpayers in that community?

Mr. Perrins: — Yes, the debenture wouldn't be taken over by the health board . . .

The Chairperson: — They will be?

Mr. Perrins: — They wouldn't be. They will stay home, I think is the way it has been expressed.

The Chairperson: — So that the other areas of that health district would not be required to assume that responsibility?

Mr. Perrins: — That's correct.

The Chairperson: — Is that money put in a separate fund to be delivered to that health board over the period of that debenture?

Mr. Perrins: — It's the municipality that has the debenture and they'll just continue to levy for that.

The Chairperson: — Okay. The reason I asked the question is there's other areas that have thought about building and have put debentures on and have subsequently given that back to the municipalities because there's been a decision to close various hospitals. Is that going to beheld by the department or is that going to be allowed to go back to the municipalities that collected it in the first place?

Mr. Perrins: — That will go back. It will go back to the municipality that collected it.

The Chairperson: — Okay. And they're not doing anything wrong by having done that?

Mr. Perrins: — No. That again, that's part of the preamalgamation process itself.

The Chairperson: — And when the agreement comes in, you could have a different agreement with hospital A versus hospital B and C and they would have different amalgamation agreements.

Mr. Perrins: — That's right. In fact, some of that's already happened. And because they're going to be public and shared with each other, I'm looking forward to some of my next trips to some of those communities.

The Chairperson: — I bet you are.

Well I think on that subject, that's all the questions that I had. We'll go back to the original speaking order, and Harry was up. Do you have some more questions? Okay. Then go to Ms. Crofford.

Ms. Crofford: — Okay. I just wanted to mention, I am interested in your data system presentation but I don't know if it's appropriate to what we're discussing today. But if I had another opportunity to see that, that would be good.

Mr. Perrins: — Well it is, in the sense that it gives you the program. It gives you a good description of the districts, the programs, and I think another kind of auditing so . . . But I put everything in terms of time.

Ms. Crofford: — I don't know if we'll have time or not, but I just wanted to register that I am still interested in that.

The other thing is the part I don't understand in this piece in terms of accountability is the municipal part, because municipalities have money going into this process. They're not necessarily represented on the boards with the new structure and I'm just not sure, in terms of the auditing and accounting, where the accountability comes for the municipal people with their chunk of the money that's in there.

Mr. Perrins: — At this stage it's really just mandatory; there isn't anything beyond that. I think the thinking has been to look at it, as the health care structure is changing, to look at the resulting changes that in fact may occur with the municipal structure itself as well. But at this point it's really built in to the . . .

Ms. Crofford: — An unfinished piece . . .

Mr. Perrins: — Yes.

Ms. Crofford: — Okay. The other thing I just wanted to mention is I think it's good that whenever the elections take place that they're being thought of as being concurrent with municipal elections because I think people are just about at their limit electoral-wise. Hardly a week goes by that you're not voting on something. The cost of that is also a huge drain. So I just agree a great deal with the idea of having them concurrent with the municipal. Thanks, Mr. Chair.

Mr. Serby: — Thank you, Mr. Chairman, just a couple of comments and a question.

First, this morning I heard us in the presentations a number of times indicating that this process that we're moving into in terms of accountability is going to be significantly stronger than what we've had in the past. And I concur — I think it will. And by some of the information that was put together that we have in front of us today and the involvement with the Provincial Auditor certainly, I think, reflects that in the long run,

we'll have a much stronger accounting system, particularly for program.

But I also heard us say that some of the accounting hasn't been that strong in the past, and I want to say that having been involved with third-party funding for a number of years and having sat around this table now for two and a half years, it seems to me that the public accounting process for third-party funding has been far greater than it has, I would suggest, even in government. Because I think some of that is reflected in the fact that you need to not only report to government as third party, but you also need to report to the electorate, because the majority of the third-party funded agencies or organizations were served by elected people.

And so I see some real importance here to moving this process along the way so that we too have elected folks whom these boards would be responsible to in terms of accounting.

One of the issues that I have, and it's in relationship to the transition process, I hear us talking about sometime early in January is when the preamalgamations agreements will have been completed and I'm wondering if at that time, the existing organizations, agencies, are having to wind down in their operations and do a public accounting for their organizations after nine months of operations. And if that's the case, do they then assume that cost — I would expect they would — out of their operating budgets?

Then what happens effective the transition or the turnover of those responsibilities for those agencies to the district boards? Do they then have to provide an audit of the next three months on those organizations, or do they roll them into a 15-month calendar year? How does that work? I guess I'd be interested in having response to that.

I think thirdly, by way of comment again, in the presentation that was made earlier today in respect to primary auditors and secondary auditors, I think part of this whole process of the amalgamations, in my opinion, is to do with not only enriching the health care system in the province, but at the same time trying to address some of the costs that are there within the infrastructure. And I see by adding a secondary audit system, even for a transitionary period of time, doesn't escape from the district boards that particular cost.

And so I concern myself a bit with the implementation of that kind of process. Because there are, at least in my experience, a number of auditing firms across the province who are not just comfortable but certainly knowledgeable in doing consolidated types of accounting which encompass a variety of different services, programs, departments, and so have some issue I think with the ideology of having a two-tiered audit system trying to provide that accounting process for the district health care boards by way of comment. Thank you, Mr. Chairman.

Mr. Perrins: — The last point is I think why it's important that the Provincial Auditor be involved to give his advice on that consolidation. I think on the first two questions, yes, the individual facilities will be doing an accounting as of the nine-month period, and the 12-month audit in that sense will be rolled into the districts. So they'll do the accounting at the preamalgamation point of the audit. Then we're expecting the year-end report from the districts that would include speaking to the individual facility.

Mr. Serby: — Just for my . . . (inaudible) . . . Conceivably on the 15th or the 12th day of January or the second day of January, as an operator . . . or as a board member of a hospital board, we would expect to provide an accounting as the hospital board that's moving out. For the period January 12 till March 31, the district board would then provide another accounting of that three-month period?

Mr. Perrins: — That's right.

Mr. Serby: — All right. Who then assumes the cost on the 30 days . . . on the 90 days from January till the end of March?

Mr. Perrins: — The board.

Mr. Serby: — The district board. And that would come out of the . . . Would that be new resources then or would that be resources that would be part of the allocation for the year?

Mr. Perrins: — No, it's all part of the current allocation.

Mr. Serby: — Okay. Thank you.

Mr. McPherson: — Thank you, Mr. Chairman. I don't have any more questions on the trust accounts.

The Chairperson: — Yes. You can go to the . . .

Mr. McPherson: — I can have some latitude here?

The Chairperson: — Yes.

Mr. McPherson: — I do have questions on the creation, funding, and expenditures of the district boards. Individual facilities under The Union Hospital Act receive their funding based on beds and other criteria. I'm just wondering what the new funding formula will be. Mr. Adams had mentioned it's based on age and sex and geography. I would like to have some example.

Mr. Perrins: — The previous funding, I think to generalize a little, which is always a bit dangerous, but it was really based on utilization. And so what's being developed now is a new approach that's being done in consultation with experts around the country in terms of sharing our work with them and they, in turn, giving their response to us, primarily from McMaster University at this point, who have some people locally assisting us.

And it's to look at the population at large. And I think when you see the . . . if we could see the information piece that Mr. Gardner has, I think that would go a long way to help and clarify just how . . . (inaudible) . . . because we've broken it down by district, to look at the population in a particular district, to look at the age, the gender, mortality, morbidity rates, and begin to break it down in terms of . . . and patterns and relationships and then begin to cost it accordingly so that we really move away from a site-specific or facility-specific or a program-specific funding, to start looking at health.

And at the end of the day, what would be intended with it is then to start talking about health outcomes so that you would be able to then really determine whether the expenditures of the dollars were improving the health care of the population in that district.

So at this stage, we're not quite at the point where we can say, here's what the dollar allocation will be. But some of the work that's been done shows that you would really be looking at some shifts too, because it talks . . . it looks at where do people get their services from, as an example, okay, their physician services, etc.

Mr. McPherson: — For operational funding then, we're going to see something later, are we?

Mr. Perrins: — Well it gives you a sense of how you would . . . what the profile of a district looks like that we're basing the funding on.

Mr. McPherson: — What about the funding formula used to arrive at transitional funding for affected communities?

Mr. Perrins: — Okay, that was really using some of the — I think, if I could call it that — our previously existing technology, you know, which was utilization. I mean it was really based on, in terms of the affected facilities, you know, it looked at those facilities that were under acute care number of eight and that it was the cost of a bed, and essentially translated, you know, the number of beds used, the number of beds used times the cost of a bed, that average cost of a bed.

Mr. McPherson: — So all of the affected communities are basically under one formula.

Mr. Perrins: — They will be, that's right.

Mr. McPherson: — For transitional funding.

Mr. Perrins: — Yes, they were under the same, essentially the same formula for the transitional funding.

Mr. McPherson: — Is the population taken into consideration?

Mr. Perrins: — Not so much in terms of the funding formula itself. Are you talking about the transitional funding for the acute care facilities? No, I mean the population of the district wasn't taken into account. No, the population of the union hospital area was a consideration, but usually there is a relation between use and population in those areas throughout the province so that, by and large, the smaller the population in an area, the lower the utilization.

Mr. McPherson: — Were severance packages calculated into these funding arrangements? Or who will pay the severance packages?

Mr. Perrins: — Yes, severance packages were part . . . or funding for severance was provided for.

Mr. McPherson: — You don't happen to have a breakdown of that severance, the severance total?

Mr. Perrins: — No, not with me. We can certainly provide you with that, but I didn't bring it with me. I knew I should have brought that book. I was going to bring that book. It had all that in it, but . . .

Mr. McPherson: — Now, is there a difference between funding arrangements for urban district boards versus rural district boards, for remuneration?

Mr. Perrins: — For board remuneration? In fact there is, and having consulted with a lot of the districts, we have been asked to revisit the difference. I don't have the rates with me. I think the binder has the rural rates in it. But currently, you are talking about the current rates? I don't actually have the rates.

Mr. McPherson: — I do have a copy of them. I'm just wondering, for Regina and Saskatoon, where chair per diem is 525 per day; rural areas it is 235 per day. The chair retainer for Regina and Saskatoon is 10,000 versus 5,000 in the rural districts. And the member per them is 300 versus 155. Why is there such a difference? What role is it? It is administration, right?

Mr. Perrins: — I think, first, I should mention we have been asked to look at the rationalization of the two, so that's something we've initiated. We have been asked to look at how we might come back with something that strikes a different balance. But in speaking to the current rates, they were really set based on people's sense of the level of responsibility and size and the management of a large corporation compared to a smaller corporation, in effect. And I think that that was at the heart of the difference, and the time that was seen to be required for the larger one compared to the smaller one.

Mr. McPherson: — But that's being revisited?

Mr. Perrins: — Yes, it is.

Mr. McPherson: — Could we get the actual expenditures for closure and conversion versus budgetary savings for the creation of the districts? You don't have that?

Mr. **Perrins**: — You are talking about the actual . . . the difference between establishing the new health care districts and all that . . .

Mr. McPherson: — Versus budgetary savings to the affected communities — the costs of the closure and/or conversion versus the budgetary savings that you're expecting.

Mr. Perrins: — Just for the affected communities, not the overall, okay.

We don't have the details with us but we have talked about an annualized saving of 20 million. Essentially it would come from the conversions themselves. But that doesn't speak . . . that doesn't address all of the savings in terms of the related reductions in other areas.

Mr. McPherson: — So it's not the 20 million over three years where . . .

Mr. Perrins: — Yes, over the three years.

Mr. McPherson: — For the creation and implementation costs to the district health board, could we get that, and I guess the personnel that were from the Department of Health, who was involved?

Mr. Perrins: — I think one of the . . . that's probably why it's important to be discussing this today. Because when we're looking at the creation, the implementation and the savings, it's not that I'm . . . I mean the changes happened October 1, some are going to happen December 1, districts came into being in August, the board chairs are just in place now, and we're just in the process of engaging CEOs.

So I think it's very early for us to . . . we don't have any information as yet to draw on to give you some kind of roll-up on consolidation, but we can certainly provide you with what we have and what projections were. Because I say it's still early even with the conversions. We can give you the dollars that were intended and we can talk about what's actually been reduced in the system and what the savings will be over the next two years. But I think on the actual implementation cost, I think it's going to take us a little while yet to be able to give you some solid numbers there.

Mr. McPherson: — What about the cost of any studies done in 1993 with regards to the district boards and the wellness concept? You don't have those with you?

Mr. Perrins: — No.

Mr. McPherson: — Were there any studies with labour relations implications for the creation of health districts?

Mr. Perrins: — Do you mean was there any analysis done of what the labour relations impact would be? I think the . . . it's now SAHO, Saskatchewan Association of Health Organizations, did review the implications to the institutional side of things in terms of the proposed changes, yes, but I'm not aware of any sort of private or consultant studies.

Mr. McPherson: — You would have the costs. Was it funded indirectly or directly?

Mr. Perrins: — SAHO is a non-government organization so in that sense it's an indirect funding. There wasn't a direct . . .

Mr. McPherson: — Department of Health funded?

Mr. Perrins: — Yes, the provincial government funds SAHO, yes. They provide a range of other services. They're the management, in many respects, the management representative in the labour negotiations piece with health care professionals.

Mr. McPherson: — And you have the conclusions to a study of that?

Mr. Perrins: — Yes, I don't know if you'd call it a study as information that they were providing about implications of changes to acute care facilities, but yes we can share those numbers with you.

Mr. McPherson: — Were there any grants to district health boards regarding labour relations?

Mr. Perrins: — No, because in the beginnings of this there weren't any health boards; by the beginnings of it, I mean the conversions were initiated prior to the establishment of the district health boards.

Mr. McPherson: — What about monies that were provided to private nursing homes or private operators like Extendicare or Chantelle Management?

Mr. Perrins: — I'm not aware of any.

Mr. McPherson: — So there's no monies provided to district boards to indirectly go to any private care homes?

Mr. Perrins: — Maybe I'm not following the question, but there are monies that go to health boards for special care homes for their, as I was saying earlier, for their management of them. But were you meaning separate from that around the sort of creation or work done around the creation of districts? The operating dollars would flow through the district or will . . . For some, Saskatoon being an example, some dollars do go through the health board to special care homes, but for the provision of special care home services.

Mr. McPherson: — Can we get the total grant dollars to Saskatchewan health care organization or Saskatchewan Association of Special Care Homes for 1993?

Mr. Perrins: — Okay, prior to SAHO there were three non-government organizations. Was that your earlier question? Sorry, I thought you mean actual service of special care itself, you know, the NGOs themselves. Okay, yes, we can provide you with that.

Mr. McPherson: — As far as any studies on that labour relations, you will provide us with the conclusions on whatever statements we're . . .

Mr. Perrins: — Yes.

Mr. McPherson: — Were there any consultant costs to the Department of Health as far as labour relations?

Mr. Perrins: — None that I'm aware of, but if there are we will certainly provide you with those.

Mr. McPherson: — I guess the total, the cost for advertising expenditures, public forums, all consultation as far as the creation of the district boards and wellness.

Mr. Perrins: — Are we meaning this fiscal year or just a roll-up?

Mr. McPherson: — A roll-up.

Mr. Perrins: — A roll-up. Okay. Because there being the wellness pieces and discussions preceded a lot of the work on districts and district formation.

Mr. McPherson: — Right. Being that we have two ministers in charge of the Department of Health, Associate Ministers Calvert and Simard, which minister is overseeing wellness and the creation of districts?

Mr. Perrins: — Well my understanding of that is it's Minister Simard.

Mr. McPherson: — Okay. Can Minister Calvert act independently of her?

Mr. Perrins: — I'm not sure I'm the one that can answer that.

Mr. McPherson: — Okay.

Mr. Perrins: — If I say he can, I don't know if it means he can, because I'm not sure. I mean there is a division of responsibility as I've seen it from my role. And essentially the broad direction comes from Minister Simard around wellness and districts, and some of the program directions around mental health and SADAC (Saskatchewan Alcohol and Drug Abuse Commission) and labour relations come from Mr. Calvert. That's the working . . . from my point of view, that's the working relationship between the two.

Mr. McPherson: — Also the cost of the extensions for operating the small hospitals after September 30, that's ongoing? There are more extensions being given?

Mr. Perrins: — I don't think there's any more being given, but the ones that have been given, I think we'd indicated were continuing — Climax, Eston, Loon Lake. I'm not sure if I have all of them.

Mr. McPherson: — Indefinitely?

Mr. Perrins: — No, up until the fiscal year. We've actually been reviewing them ongoing. Each one has a different reason for the extension.

Mr. McPherson: — So until March 31 ?

Mr. Perrins: — Well that would be the outside limit, but maybe sooner, depending on the reason for it.

Mr. McPherson: — The losses from changing from The Union Hospital Act to The Hospital Revenue Act and the changing of the mill rate now to a flat two mills would have a significant loss of funding from the federal government grant in lieu of taxes. Is there some considerations of ways of making those monies back? Has there been any discussion with the federal government?

Mr. Perrins: — We have had discussions with the Department of Finance in that regard because it's actually a responsibility that they assume overall for the provincial government in terms of taking up the loss. It's a role that the Department of Finance plays for us. But yes, we have discussed the . . . (inaudible interjection) . . . I guess I got it wrong. Well maybe we should back up on the whole revenue side itself because I think we're probably disagreeing a little.

Health has been dealing with the revenue . . . with the loss itself with the Department of Finance. And at this point I think it's fair to say that we anticipated it was going to be in the neighbourhood of $4 million that there would be lost revenue.

Mr. McPherson: — From grants in lieu of taxes?

Mr. Perrins: — No, that's in total.

Mr. McPherson: — Total $4 million?

Mr. Perrins: — Yes. We know that there's some differences about the amount of, you know, how that dollar's arrived at.

Mr. McPherson: — Right.

Mr. Perrins: — But that's our understanding of what it would be.

Mr. McPherson: — Could you give me a breakdown as to how you arrived at the $4 million?

Mr. Perrins: — Yes. Why don't you just tell him.

Ms. Langlois: — Basically how we get at 4 million is the average levy from union hospitals this year was 3.6 mills; so when you take 3.6 going to 2, it's a value of about $4 million.

Mr. McPherson: — To arrive at that average levy, are you including any of the cities where there was already a flat 2 mills?

Ms. Langlois: — Well they would have been within the average of the two; yes, their count is an average of 3.6 mills counting everybody.

Mr. McPherson: — Right. So then . . .

Ms. Langlois: — No, no, let me clarify; I should clarify. It's just the union hospital levies. The cities are

in agreements under The Hospital Revenue Act, which is separate and apart from the union hospital levies. So this is just outside of the cities where there are union hospitals.

Mr. McPherson: — And it's a 3.6 average?

Ms. Langlois: — In 1992 it averaged around 4 mills; and in 1993, the average fell to 3.6 mills.

Mr. Perrins: — That's the difference when you look at it provincially.

Mr. McPherson: — Provincially, right.

Mr. Perrins: — Because I understand . . . if your question . . .

Mr. McPherson: — Well I guess we've discussed this before.

Mr. Perrins: — We have talked to the same person who has a different view and we are communicating some of that information to him as well.

Ms. Langlois: — Are we speaking about the Southwest district?

Mr. Perrins: — Yes.

Ms. Langlois: — I believe their levy would have been in the neighbourhood of around 8 mills.

Mr. McPherson: — How much?

Ms. Langlois: — 8 mills.

Mr. Perrins: — Eight.

Mr. McPherson: — For which district? I missed that.

Ms. Langlois: — Seven to 8 mills — Southwest.

Mr. Perrins: — Southwest. And if you take that as the average, you come up with obviously significantly different numbers.

Mr. McPherson: — Well if then we will just use the Southwest as the example. If we're going to look at a hospital such as Shaunavon where, I'm not sure what their mill rate was — 10, 11 mills — now to a flat 2 mills, and I know that all of the surrounding municipalities, just from out-of-province assessments, there's 55, 60 per cent of the total assessment is from out of province. That's quite a loss to that facility.

Not only are we looking at the funding cut in the upcoming budget, but the loss in the mill rate.

Ms. Langlois: — The estimate of 50 per cent is in fact an estimate, and we are unable to confirm or deny whether that would be accurate. Because in talking with SAMA (Saskatchewan Assessment Management Agency), who should know the sources, they don't keep their data on that basis. So it's really quite a rough estimate to say that half of that levy would be from out of province.

Mr. McPherson: — Oh, I've done all that work myself, so it's not roughly.

Ms. Langlois: — Oh.

Mr. McPherson: — But thank you.

Ms. Langlois: — Okay. So you're right. It would have to be done on a detailed basis, looking at every individual who would pay, to come to that assessment. So on a province-wide basis we . . . Do you have that information on a province-wide basis?

Mr. McPherson: — Right. So now just dealing with the Southwest again, what can those hospitals that are affected in this way — Shaunavon I guess being the one — what can they expect? Any increase in funding or any means to have that from the province if they're not receiving it from the municipalities? Has there been consideration of it?

Mr. Perrins: — Yes. I mean that's part of, as we're striking our budget, that's in fact the very discussions that we're involved in now, because it is disproportionate. If you're looking at the health care need itself, what can be done to offset some of that. That's the discussion that, as we're doing the budgets right now, is under way. That's why we're trying to make . . . It is, looking at it provincially, we're looking at it by district as well because we have to . . . we're now looking at the budget from a district point of view, not just the individual facilities.

Mr. McPherson: — Well I guess I'm putting you at a disadvantage because I'm looking at the Southwest in particular, not at the province as a whole. But then it's also that area of the province that have the large community pastures, federal pastures, grants in lieu of taxes, and a lot of pipeline, oil and gas. So the loss to those facilities is significant and it's . . . But if it is in the considerations of the upcoming budget, you're saying, or being discussed at that point?

Mr. Perrins: — Yes, it is.

Mr. McPherson: — Mr. Chairman, that will be all for now.

The Chairperson: — Okay. I have some questions and then Mr. Boyd's turn and then I have no more on the speaking list, but I will entertain that. I have a number of questions.

Relating to some of the observations that two individuals have made, one is Mr. McPherson — I'll deal with that first. We've had questions and answers given on a very complex transition period, I'll put it that way. And what we will have is complexities because you'll have to treat different health district boards with different kinds of criteria because your amalgamation agreements are different. Your criteria within the department will stay legitimately the same, but the agreements that you reach on amalgamation with different ones will have a slightly different

emphasis. Maybe I'm being generous and maybe I'm not being generous, but it will have differences.

My question to you is this: how are you going to give an audit report from the department to the Provincial Auditor so that those complexities are all identified, or are you going to put a page of conditions that exist or qualifications to those audits as they transpire and they're given over? And that's part of the reason why I believe that we're sitting here discussing this, because we want to have you understand, we as legislators will want to understand, and I think the auditor needs to understand — perhaps he does more than we do — the complexity of the issue.

And I'd like to have some response to that. And that's why, Mr. Deputy Minister, I asked you the question earlier about the confidence you had in this going about, and you gave me a firm answer and I'm not sure that all of the issues that have been raised will deliver that.

Mr. Adams: — Well I want to, as I said before lunch break today, I apologize for not being able to be with you at 1:30 with this federal meeting I had to attend. But let me pick up what I understand has just happened here, to say two things.

In respect of the differences amongst districts, when you consider the full range and dollars value of services that have to be delivered, the differences proportionally aren't that great because there's a foundation of core programs and established services and infrastructure that has to be delivered, and that is all contained in service agreements. So what we're trying to say to you is that certainly there are some specific differences to take into account, local needs that have been assessed as being somewhat different and conditions which are somewhat different. But as a percentage of the total budget, this is not a phenomenal range of differences across the province. That's one thing.

But secondly, where we have differences in programs, those are going to have to be recognized as a part of the service agreements. So when you ask how we account to you, it will be the same way as we account . . . or that the boards will be accounting to us. What it is that they are going to do for a year — we are working on one-year concepts right now — will be contained in service agreements. So they'll be accountable for that. And they're reporting to us and our monitoring of their activities will relate to that particular set of agreements and to the fulfilment of their foundation obligations, which are the universality of our programs.

So I don't think that that presents a particularly complex set of reporting requirements because if you think now, over our many programs there are differences now. I mean what happens in the Wascana Rehab Centre is quite different from what happens in Royal University Hospital. Those are different institutions and different program purposes. And that is different from a home care program somewhere.

When we spoke this morning of our ability to track some of these outcomes and effectiveness issues, I spoke to you about our building a data system that would allow us to, first of all, capture cost data in a manner and with a precision that hasn't been possible ever before, and in a uniform way for the whole province, and to capture . . . to begin to build a data system that allows us to report on outcomes.

I didn't tell you that it was all finished and ready to go. I told you that we have some measures that are thought to be useful and effective, and that that will be an evolving set of outcome measures, and we will build it into the service contracts and into the data system as they are made ready.

I think that gives you more information than ever you've had before, and I expect that you're auditing us against those service agreements. That's what I expect is going to happen. So that beyond that, I'm not quite sure what your requirements are beyond that. Am I answering the question that you have in mind?

The Chairperson: — Yes, you are. I'm just going to go on from that, and then say that . . . is there a time in the process of the department when the complexity of the audit functions in each of those areas that the health boards will be taking over and delivering, that the Provincial Auditor should be involved? Because we are not dealing only with a one-year program; we are going to be dealing with this for the next 20 years. And what we establish now is a beginning to what we want to build in the province.

And so is there a time in the beginning when we establish the criteria for what the framework of the audit should be for those, as the auditor said, the secondary auditors and the primary auditors, and then himself as perhaps the overall auditor? Are we building that framework in a good enough fashion so that we will be able to deliver it to the public — an audited financial statement that is going to have relevance, and that's going to have fiscal accountability by the health boards and agencies within the health board, and also the Department of Health?

Mr. Adams: — Well I've been on the assumption that that's what we are doing right now, and that the first round of that is the document that you have and we have from the auditor. It's a first set of requirements, and these will be refined; and as experience shows us that we may have to refine that together, I'm expecting that that will be done. So in terms of timing, I think the requirements should be laid down, I'm saying, now. I don't mean next month; I mean now.

As I said this morning, the first discussion of this collectively will take place with all of the district board chairs and presidents next week, and that I had indicated to the Provincial Auditor I would take up some of these questions with them and that is exactly what I intend to do.

Now I don't think that all of the needs of your

committee or the Provincial Auditor are yet defined or known. I think a first attempt has been made. We're assuming that your needs will be transmitted to us and that we'll work this through with the auditor and with the boards so that we give them the best set of guidelines and the clarity that gets them started this year.

We also have had ongoing discussions with the Provincial Auditor's office and I would expect that a standing working arrangement with the department would exist where as the data systems are enlarged and brought into full operation that they're a part of that; they know what data they can count on and that they are as involved in the effectiveness measures as we are.

Now I believe it's our job to make sure that they're enforced out there and in many cases we have some staff who can actually develop them, but I don't think that we're alone; it's not a one-agency effort to try and find better measures of outcome. So that we're quite anxious to have the input of the auditor on that.

The Chairperson: — There's another question that I have from the discussion about the audit component of third-party grants to, well, various organizations that I've been involved with and their governance, school trustees and urban municipalities and various agencies like that.

They have a closer distance from the electorate to the board than what the health district boards are going to be and that raises a concern with me when you say that the health district boards are going to be monitored by the electorate and by the department and by whoever is doing the audit. And I agree that they're all there; however, the distance from the electorate to the health board is significantly different than it was from the electorate to the health board . . . or the hospital board, I'm sorry. And that is the concern I have.

And the greater that distance, the less accountability that is required. And that's why I would seriously have you consider giving to the public, or giving to us, how you're going to tell the boards or suggest to the boards how to deliver that accountability measure back to them, back through more than just one public meeting. One public meeting doesn't do that any good, and I've been in RM business long enough to know how many people go to that annual meeting.

There are some other requirements that they have to provide each ratepayer with a detailed assessment of the financial statement and also where the monies were spent. It's similar to a public accounts, but it needs to be more because the greater the distance from the electorate the more you have to put back out there. And I wonder if you've provided some funding or you're going to provide some funding to the district boards to deliver that back, or they're going to have to find that from within themselves.

Mr. Adams: — Well you raise several quite important questions. I did say this morning that the requirements for public meetings at the very minimum are two, not one, but at one of those meetings for sure the accounts have to be delivered.

When I talk about accountability at the district level, I'm not simply meaning ratepayers. But there are a number of audiences that they will have to be accountable to, and those bodies will demand accountability. It may be interest groups who have a particular concern about the mental health . . . about health programs like the mental health groups, for example. Or a particular . . . in Regina a group that's very, very much interested in services changes is the palliative care association, for example.

We are aware that employee groups are wanting a part of the decision-making process and wanting to have more information and wanting to have some accountability of the boards to them as well. There are provider groups — physicians, nurses, and others who are also asking for the same kind of accountability.

So the boards have to create a variety of vehicles to hear from and talk to some of these interest groups, and they're not solely vested-interest groups, but these interest groups. And then they have broader obligations as well to talk to the citizen at large.

In the case of Saskatoon, for example, recently what they've done in order to be able to talk to all of the communities that are in their district is to create what I think they call is a constituent assembly where, as an advisory group to the board, they have somebody representing each community of their whole district and they're brought together routinely for detailed briefings from the board itself and from the administration. And also they have a chance at that time to make some of their concerns and interests specifically known. So it's a supplementary process to the formal, legislated hearings of the board before the public.

Now with regard to a variety of ways of reporting back, the old ways, I think you're implying that the district boards are going to be more remote than the current set of boards. I would challenge that. In the case of union hospitals, union hospitals, if they want to tax the ratepayer, they are fairly accountable because they've got to go to the municipalities and either requisition funds or justify themselves or arrange a voluntary agreement. So there's a fairly close relationship between municipalities or municipal councils and the union hospital boards.

But for most of the rest of the corporations in the health system, they don't really have to go to anybody. They may have a requirement to meet once a year if they're a society, but unless they're raising money . . . asking for money from municipalities or asking for something from a constituent group, they don't have to report back there at all. And they certainly don't have to reveal much information to get it.

In the new districts, they are required to be more fully . . . more open with respect to a greater variety of

information and they're required to appear before not a particular interest group, but a constituent or a group of citizens. Anybody can come.

Now I think that you're asking for levels of definition of what they will be required to do to report and I think we've told you what we can today. And it's not an end issue — we haven't fully developed this at all. We have some experience with what's gone on in boards that have been established for over a year and that the boards themselves are finding the need to find new ways to relate to their interest groups and to the public at large. And as they find these ways or find these needs, new things are being built in to the system.

I want to try to leave with you the impression that nothing is entrenched at this point, and the whole system and how it will look in the future is evolving as the real needs of the public and the providers and the employees and the government and others, as that becomes more clear and focused, then steps are being put in place to accommodate and to meet those requirements.

With regard to money, are we specifically budgeting new money to hold public meetings or to do something new in respect to reporting? And the answer to that is no, we're not budgeting new money for that.

We have a small amount of resource that we can make available to emerging districts to get them started and in some cases pay a few things that, where there's a large amount of transportation involved, we've, I think, allowed . . . to get people together. We've given them a small budget. We're talking very, very small dollars.

But there is enough money in the entire system put together to be able to pay for these things. It doesn't normally cost a lot of money to hold a town hall meeting and invite people to come. Sometimes you might have to rent a hall and buy the coffee but that's not a huge expense and can well be absorbed within the overall funding in the health system.

Beyond that we haven't contemplated that there would be major new needs in terms of communication. They all have to produce annual reports anyway. That's funding that's already in the system.

If we see something that's important for public accountability that can't be funded, then we'll have to take that to government and see whether we can get some money for it.

The Chairperson: — Okay, I have a couple more questions on some of the observations that were made by the auditor's office.

You're going to measure costs of services which is . . . you know, that's reason to say that I can measure this because it costs X amount of dollars. How are you going to measure, and are you setting up ways of measuring, the effectiveness of programs? You are going to move from site delivery of your program to a program delivery of the health care system.

So have you set up measures for example to measure the effectiveness of home care? Have you set up effectiveness criteria as it relates to acute care, level 4, heavy level 4, all of those? And are they the same or are they all different? I'd like to have you respond to that.

Mr. Adams: — Well I respond in a couple of ways. I thought I had mentioned a bit earlier today that only some effectiveness measures or outcome measures are available anywhere in the western world. Those that we know are available to us and are reliable, we're using. They'll be built into the system. The measures that we use will be universally applied, so we'll not have one set of measures for one community and a different set for somebody else.

There are some measures that we can use which are clinical standards. And we have some of those, and you've actually seen some I'm sure reported publicly. Let's take the issue of clinical standards against, say, certain kind of laboratory testing. The utilization commission has shown us recently that unless you do tests in a certain order, you're just wasting your time doing any of the tests, because the result of test A affects test B affects test C. And if you skip A, B, and C, go to C, B, and A, the whole thing's invalid. Things like that we know now and can apply.

That had to do with thyroid testing, and I think the department just in getting that bit of information saved, if I'm not mistaken, over a million dollars just by insisting that proper clinical standards be applied to the calling for and the undertaking of thyroid testing. That's an illustration in a clinical field.

Where those kind of things are known, we're working with the medical association and the College of Physicians and Surgeons, who have a major responsibility I might say for quality measurement and assessment in the system. This is not simply a Department of Health responsibility.

So where we've got those measures we'll use them. In the fields of other hospital standards, we'll still continue to use what we have in The Hospital Standards Act, and they'll be updated.

In fields of human services in the area of mental health, some conditions have outcome measures. You do A, B, and C, and it should have an impact within X number of treatments in a certain way. Well insofar as we've got those, that's fine; we'll use them.

When you get down to issues though of measuring stress, just on the issue of stress, we have some clinical information about stress. And for example we are going to take the work that is undertaken by the centre over at the University of Regina, the Paul Schwann Centre, where they measure stress, for example, and monitor health conditions. We're going to take that example and they are going to take their capacities there and make it available to many parts of

Saskatchewan via mobile sites.

So when you get down to measurement, say a person who currently isn't measured for stress now at all, say a farm stress person could access through one of the Paul Schwann mobile centres a site that can test for stress, test for other things, and then that program can monitor that person.

Now when you begin to build a data base up on some of those kind of cases, one could, when you get an update, be able to show that by identifying the stress and taking some steps to reduce that, it will have an effect on (a), health, but (b), costs of health care, because these are the kind of cases that will end up with cardiac conditions and a few other things if interventions don't take place.

So when I'm talking about effectiveness measures, it's a good deal more complex than to say that A causes B and it's equal to this, either cost saving or outcome over here, and it can be done in a one-year time frame. Some things can be done that way; other things have to be built up from a good data base and changes in interventions and behaviour in order to prove over a period of years that something better has happened for health.

What we're trying to get to is a situation where we start with baseline data on the health of the population, and it's going to do actual testing of people, know what their general health status is by age, by sex, by location, and then as some of these new interventions or assistance take place, measure the change on people's health to the population over a period of time. And if we're not seeing concrete improvements in health status and quality of life by whatever measures we can adopt, then we have got to change our resource mix again or our intervention mix. So it is a period of high innovation and testing and development.

And what we're trying to do, we know we can't do this all alone in Saskatchewan. And the ministers of Canada, the ministers of Health in Canada and the deputy ministers of Health are creating now a networking of research consortiums across Canada and the research utilization mechanisms across Canada and the research capacities of the various Health departments, to link their efforts together, aimed at getting these measures across Canada and aimed at improved quality of services in order that each of us would take a piece of the action and work very thoroughly at that piece and then share it with the rest of the country. And if the whole country doesn't network on this kind of work, then no one province, including a big one like Ontario, could produce all the results.

So that I think . . . I realize that you've triggered a very long answer to what was a very short question. This isn't a simple answer. I can simply say to you — and I'll repeat again — that I can guarantee that we are doing more now and will do more in every successive year to move towards better measures of effectiveness and outcome monitoring than has ever happened in our history in Canada, not just Saskatchewan, because the entire country is moving in this direction of how we want to measure health and how we want to try and begin to make judgements about our resource allocations.

The Chairperson: — I appreciate your answer. I raised it from the area of concern because if you're asking an accountant, a chartered accountant to do an evaluation on effectiveness in a health care field, you're not going to get the measurement unless you have criteria established. And you've given me an answer that I think . . . a reasonable one to be considered in how you're going to work towards that.

But I would say that you need to begin to establish those criteria and not look for an end result, in saying that some day in five years we are going to have a beginning. We need to do that now. And that's why I asked the question.

Mr. Adams: — Could I just pursue one point about that though? I think we are talking the same kind of language at the moment. But I don't think a chartered accountant can handle the measurement of effectiveness, in the way we've described it, alone.

The Chairperson: — Right, I agree.

Mr. Adams: — And that I don't think that it is solely . . . I think how you decide as a committee what you want by way of . . . I think what you want by way of accountability and how you are going to get it is a very important question, and I don't think there is a very easy answer to provide either. One might like to turn towards program outcome measurements and that type of thing. But what is the vehicle by which you are going to get that information, and can our society deliver the results — in the near term at least? So that there is this blending of program expertise that is needed to be put together with financial expertise to be able to come at your general objective.

And when you start thinking about auditing in that context, auditing, I think, then requires interdisciplinary teams. And certainly, I would . . . you have got to have some health experts in any team that's auditing in the field of health, if you are looking at program outcomes, to be able to even interpret the results of what we've got there. So how you do your auditing and what you're expecting I think is a terribly important concept. And I think the answer is very complex and it may require some testing of new models here, because I don't think there is any other part of the country that's worked this one through yet.

The Chairperson: — That goes to the next question I was asking. How do you measure compliance then, in relation to effectiveness, when you are not placing . . . when you're putting it in a subjective perspective? You can be objective, but you have to be subjective in relation to the measure of compliance. And that's where the difficulty comes in for . . . and you mentioned this as well, that the compliance measured by a person who has gone in and done a hospital board audit, for example, is maybe not sophisticated

enough, even though he may be competent in a compliance mode as it relates to an internal audit and whether the dollars were spent for what they were designated to be spent for. But compliance on effectiveness in a subjective observation, that takes a whole lot . . . a different kind of analysis. And that's, I guess, where I see us having to begin to work to develop that. And if you've got some observations of that, I would be interested in knowing them.

Mr. Adams: — I do. I have been around the health system a long time, and many of you around this table have been around as long. And you know that in the field of health there are some objective things and some subjective things. And the effectiveness measures we've been talking about for most of the day have fallen on the objective side. It's something that can be measured; you have a fair confidence in the measures, and there are some criteria that have been tested. Often they are clinical in nature, and we do the best we can. The rest of how valuable is seen . . . the investment in health is a subjective issue. The debate in the whole world is how valuable is this investment and can you relate it simply to the health industry as a measure of value of this investment.

So you find that places like Japan spend several points less than we do of GNP (gross national product) and yet their health status is better than ours. And the Americans spend a good deal more and theirs is, health-status-wise on every indicator, is a good deal worse than ours. On quality of life, on measures of years of life, on all indices of health, the American population is not in as good a shape as the Canadian population.

So what does it all mean and how do we measure that? Well you know probably better than I do how you measure the subjective part. Sometimes it is consumer comment, sometimes it is polling. Hopefully the polling is random samples so you get accurate measures of consumer satisfaction. Sometimes one relates the investment to a thing beyond the health service as a value or a proxy for a value.

A big part of the health system has to do with industrial needs and employment needs so that a society can judge the health system in relation to some of those other factors if one wishes. And above all we've got to keep in mind that in a society as open as ours, that the subjective part of it is annually questioned in considerable detail on the floor of the legislature, and even through Public Accounts and other vehicles like that.

What we're trying to do in the health system in Saskatchewan, and I think in several parts of Canada they're talking the same way and in some cases doing it, is to expand the arena of objectivity in terms of resource allocation and decision making and narrow a little bit the area of subjectivity. And I think we're not talking of all one or the other; it's a question of better balancing this.

When we didn't have the technology or the data systems or the microcomputers and all of that kind of thing, the number of things you could objectively measure were very few. We had millions of dollars in Canada spent collecting data which meant nothing and then having so much data you couldn't analyse it anyway, and having very little information about that investment available to anybody. And so we just continued to plough money back into the same kinds of services doing the same things on the basis of historic experience.

If we did it last year and we paid for it, we'll do it again next year and add several percentage points without really knowing whether we were doing the right thing or the wrong thing. But what the age of technology has brought to us is the capacity to take huge amounts of data, make it intelligible, and to be able to interpret it in a good deal more refined way than ever before and therefore make more refined judgements.

So we don't have to do so much guessing and we can provide to the average citizen a good deal more information than ever before in an intelligible way if we make the effort to do that — not everything a citizen wants, but a lot more. And so it allows much more consumer intelligent input into decision makings about their own health, about the health system in general, and allows for a much more intelligent dialogue which puts then governors of health — administrators and bureaucrats and elected folk — more in a position of having to have good information for their judgements and their decisions, and also to open up the process of public debate and accountability in a way that was never required before.

So what I say to you about this is we're doing everything we can, not just here in Saskatchewan but across Canada, to expand the objectivity and narrow the subjectivity, just to get a better balance. And in the end, in a democratic society, the subjective part is going to be measured at the polls as the ultimate test.

The Chairperson: — Okay. My last question has to deal with compliance on agreements. Will you be making all of that information available to auditors as they come in for your primary and secondary auditing? They will be able to deal with all of those issues as it relates to compliance with different agreements you have with some health care providers and the different health care providers? You're going to put that all in a framework so that the audit can in fact see whether there's compliance within the framework of those agreements and the laws as it relates to the Act that you have to follow?

Mr. Adams: — Yes, of course. We couldn't ask for a proper audit if they didn't have the service agreements with the department, and indeed all the other preamalgamation and supporting documents that go along with any kind of arrangements that have been made between the amalgamating parties and the district board, and I think probably also the affiliation agreements and the subservice contracts. So we have no interest, the department has absolutely no interest, in withholding information.

The Chairperson: — Well I wasn't saying from the department because the department has the agreement between two . . . Let's give you an example. Between two health boards there's an agreement to provide services to the other health board. And those agreements may be made — well I know they are being made — and that's what you have to have. It's not the difference between you and the board; it's the difference between boards that have to have the compliance in agreements to register it as well.

Mr. Adams: — Yes, Mr. Chair. I think one of the more interesting complexities is this issue of the cross-agency or cross-boundary arrangements and accounting, and that the analogy is how we account between provinces for health expenditures so that our citizens are somewhere else and we have arrangements made to pay, say, Alberta or Manitoba for the expenses of Saskatchewan citizens when they get service in those provinces and vice versa.

So it's the boundaries issue which you need some special arrangements on. So when you audit us, you audit what goes on in Saskatchewan; you're not auditing what happens in Manitoba even though we're paying some money to Manitoba for services rendered to Saskatchewan people.

Now we are quite conscious that since there is no limitation on a Saskatchewan citizen on where they can get service in Saskatchewan — the fact that there are districts does not mean that you have to obtain your service in that district — that there will be a lot of crossovers at the margin here for where you actually get service. And in some cases, you know, a smaller district may contract with, as you've suggested, a larger district to provide, say, the public health nursing person or service. Or you get specialized psychology consultants out of a larger centre and they're contracted for three days a week or two days a week to come to the smaller centre.

So it seems to me that this is where we want to work very closely with the Provincial Auditor in working out how the cross-district issues will be looked at and accounted for. Now if we can come up with a fairly simple system of accounting for expenditures that are made outside the boundaries of a district and there's a charge-back system, then it's fairly straightforward.

In any event, there's still other crossover issues. And in the presentation this morning by the auditor's staff, they said — without getting into detail — that they were interested in pursuing cross-agency or cross-border issues, and this is an illustration of one of those. There may be contracts there; it may be a cost accounting system; it may be some other measures. So it's an important point.

Mr. Boyd: — Thank you, Mr. Chairman. Mr. Adams, earlier this morning there was concern raised about foundation trusts or less structured funds being set up to provide additional funding for various health-care-providing institutions. As you may be aware, in a number of communities in rural Saskatchewan where hospitals are closing, very well-meaning people have started fund-raising projects to supplement the funding to their healthcare facility. Mr. Van Mulligen expressed some concern about the funds being subject to risk.

In speaking with the people in these community fund-raisers, the risk as they see it is not that money will be spent inappropriately, but that the government may at some point step in and demand that these funds will go to the larger health care board rather than be directed to a facility or operating expense or capital project or whatever that the funds were initially set up to do, to set up for. And I'm wondering if you can give those people some kind of assurance that the government hasn't designs on that sort of thing.

Mr. Adams: — Well as you know, I've talked at some length this morning about the different forms of local money, the provincial tax money, the property tax levies, and then the philanthropic gifts and local fund-raising initiatives, and the forms of protection for those three types of money.

I've made it very clear that the province does not have the power to take or to direct to the district the philanthropic funds and the bequests given to any of those local institutions without the consent of either the institution or in violation of any of the bequest conditions. We don't have the power to do it.

The other thing that I'd say to you is, taken as a whole, the amount of money is not huge. I don't want to minimize millions of dollars; I'm not trying to do that. But keep in mind that when the health system is costing one and a half billion dollars a year and that the fund-raising in total at the local level is a very, very small percentage of that, so that there is not a need to see that money as a major contributor in any way to operating.

And these communities tend to raise monies for a couple or three things. For capital, so that they raise either an advance for capital equipment or capital renovation; and also for a piece of equipment. Or sometimes just for improving the conditions in one of their buildings — that is improving say the furniture in a waiting-room, or sometimes some of the artwork or other kinds of things in the facility.

Now to go back on that, the minister has repeatedly said that money that has been locally raised or locally bequested, they want it to be used in those communities where it was raised or bequested. So there is no interest in taking that money into some larger fold.

The point raised this morning by one of the members of your committee had to do with the concern that money that is already in the system, that was bequested, might find itself in the hands of individuals in a private trust, who have no obligation to account for this publicly or to act in the interests of the community as a whole.

And the question was put to us, what are you in the department going to do about that? And I gave as much information about that as I could. That's the other side of the very point you're making.

Our interest is in seeing that the money is used in the community's interest, according to the terms and conditions of its acquisition, and the legal arrangements that have been put in place for it. And people should not worry that there is going to be a great big money grab by either the ministry or by the districts. We can't legally do it, and frankly there is enough need in most of these communities that the money can be appropriately utilized in years to come for good things, if that's what the community wants.

Now the other part about this is a lot of the money had to do with . . . most of the money is in there for capital. And I haven't noticed at the moment any policy that encouraged me to think we were into a major investment in new hospitals. So that some of this money would be quite valuable, though, if the communities wanted it to. And they've come to see us about it, using the money to build a health centre, or to renovate some existing facility into a better long-term care facility, or into a health centre coupled with a long-term care facility.

So that even money, when people say, well we've raised a million dollars for a new hospital and we are not going to have one, that doesn't mean that it's all wasted at all. There are good reasons to see that even capital reserves can wisely be used in the future.

So did I miss any of the points that you were raising with me?

Mr. Boyd: — No, I don't think so. The only subsequent question would be — you mainly touched on capital-type projects — would the same go for ongoing operational expenses of a hospital that's slated for closure or conversion?

Mr. Adams: — I'm not quite sure what you mean by that.

Mr. Boyd: — Well I'll clarify that for you then. Supposing there was a fund-raising initiative in a small community to fund the ongoing operation of a hospital that's being at the current time slated to close. Would the government have any problem with that?

Mr. Adams: — Well communities can raise money whenever they want for local purposes. We aren't physically closing any doors. It has to do with converting in-patient beds to other purposes. So no, if they raise local money, it's their local money. There's not going to be any change on that.

Keep in mind that across rural Saskatchewan, some communities tax themselves over and above capital and over and above the 2 mills. They tax themselves to supplement the operation of some of the hospital facilities and that was both by voluntary agreement with some of the Catholic facilities and then for the union hospitals.

As of January of this year, when the union hospitals are folded into the health districts and the health districts have no taxing powers, that any of those special levies for operating purposes will simply evaporate. And the maximum levy under The Hospital Revenue Act then is 2 mills. So that there is an issue there which will be of some interest to the municipalities, and we're having a fair chat with their representatives now about the whole issue of municipal taxation, property taxation, for the health system in the next year and for the coming few years. And just how that resolves in a policy sense will probably be known fairly shortly because they need to have the answer for their requisitions at the end of December.

Mr. Boyd: — Well thank you. I'm sure that will provide some relief for people who, in some of these smaller communities, are of the opinion that if the government isn't going to fund them that perhaps they will.

There is, in a number of communities that I'm familiar with, exactly that kind of discussion is taking place; that while their hospital is not necessarily closing, it's being converted to something less than what it was is their view.

And so I'm happy to hear that the department wouldn't have any particular problem with an initiative in a small community, we'll say, to provide additional funding to that facility to upgrade it to what they once had.

Mr. Adams: — No, you didn't hear me very carefully, You asked me . . .

Mr. Boyd: — Well I got it close . . .

Mr. Adams: — You asked me the question: can they locally fund-raise and would the government take that money? And I said that communities can locally fund-raise whenever they want to. And when this is locally generated, non-tax dollars, that the department has no interest in taking that money into general coffers or into the district financial arena.

In the past some communities have raised money to supplement their own small hospital operating costs. The power to designate a facility as a hospital and a program as a hospital or not rests with the Minister of Health. So you may raise money in whatever manner is legal and is preferred by the community, but whether or not a facility is a hospital or not is something that is determined in the end by the minister being prepared to declare it and designate it as a hospital or not. And it also depends on what the board of the district is prepared to devote by way of operating money to the facilities that are in question.

So I just want to make sure that it's clear: you can raise money and that's different than declaring yourself a particular health service.

Mr. Boyd: — Well I guess there's something to be said for that. Okay, we'll say then that they've decided to

raise — through a non-tax initiative — they have decided to raise community funding somehow through a non-taxation method and they've decided to raise the standard of their health care converted facility to something — I don't know what name you want to have applied to it other than a hospital — but they want to provide a level of care similar to what they used to have, the department wouldn't have a problem with it?

Meaning open after 5 o'clock and on weekends.

Mr. Adams: — Yes, I think one has to be careful about what you mean by what they had before.

Mr. Boyd: — A full-service hospital.

Mr. Adams: — Well yes, if in fact . . . if you're talking about extending hours of a clinic or you're adding some kind of additional, supplementary service in that the district board either doesn't have the money to pay for or doesn't want to invest in, local communities can supplement services in the health clinics in that way, and the only area where it might become a problem is where the differences became so great across the province that there was any reality to the possibility of creating a two-tiered health system which will never be permitted by this government as a matter of policy.

So that you can have some differences to account for different needs. But you cannot create a system that enables any possibility of a two-tiered system on the core services.

Now come to the other point that you're making. I know where you're coming from and I hope you understand where the minister and the law in Saskatchewan is coming from. And I'll just repeat it again.

When you're talking about a hospital, whether something is or isn't a hospital is a question of it meeting certain standards and the minister determining that she will designate it as a hospital. Because when you have agreed that a facility and its program is a hospital, you're agreeing to some standards that are going on within it and you're agreeing to some presumptions about the service that can be delivered there And you're agreeing to something about paying for its operating cost because hospital services are an insured service in this province.

So you're making a number of statements and commitments when you agree that a place will be designated as a hospital. That's the first thing.

The second thing that I want to try and urge the community to remember is we want more and more of the health programs to reflect the needs as assessed by the districts so that districts will have to be a part of this process too. And that if a community decided that they were prepared to supplement the expenditures in some area and they had the support of the district to do that and also that there was a perceived and proven need for what that service was, I then can expect that the minister would listen pretty hard to that.

Mr. Boyd: — Thank you. So as I read what you're saying, essentially they can raise money if they want, but there are certain criteria that would limit them as to the amount of involvement that they could have as far as designating that money to a hospital. A more specific example . . .

Mr. Adams: — No. They can aim it. You're on a point which is . . . The reason I want to be very, very careful about what I'm saying here is I realize that we're talking about future policy and I recognize that every word I say is being transcribed here and will be, you know, is a public record. So I want . . . if I hear something from you that I am not agreeing to, I want to stop and correct it.

You can raise money however you want locally if it's in a philanthropic way. You can even designate it that it will be used for hospital purposes. It does not mean, however, that the authority to run hospital services will use it or can use it or that you even have a hospital to use it for.

Mr. Boyd: — Yes, I understand that.

Mr. Adams: — Okay. Okay, that's fine then.

Mr. Boyd: — A more specific example of what I'm getting at might be something like, in some of the communities that I'm aware of the hours of operation of their health care facility now are being cut back to something, oh, in some cases eight hours, in some cases longer, whatever. The people of those communities in some cases feel that that isn't adequate in their judgement. Now it's not necessarily up to me to decide. They've made that judgement that that, in their view, isn't adequate.

So they have decided — and I'm aware of a number of communities that find themselves in this circumstance — they have decided that they are going to, through non-taxation methods, raise voluntarily in their community, funding for that — whatever you want to call it — facility. I know that you can't designate it a hospital without the ministerial approval, but they've decided to extend the hours of that facility, nursing station, whatever you want to call it. They've decided that they feel 24 hour . . . a facility with 24-hour nursing provisions is what they think is required for their facility. Will the department allow them to do that?

Mr. Adams: — The general answer to that is, with some qualifications, is yes.

Now let's get down to some of the qualifications. There are two . . . You're talking about health centres for the most part, so we're not talking in-patient beds which lead to the designation of hospitals. And you are . . . There are two kinds of health centres that have somewhat different circumstances. One will be the health centres owned by denominational . . . a facility like a Catholic church. And those are somewhat different than the facilities owned by the district

board. Remember that any of the union hospital facilities by the middle of January will be owned by the district. And so if a local community wants to supplement in either of those cases, the district really should be involved in that decision.

But the general answer is yes, they can supplement. And that's not a problem. And it doesn't require the department to rule on that because it doesn't require us to do anything about the designation of the facility. This is something else.

And the only way that we would get into . . . at least the only way I can think at the moment that we would become terribly concerned about it is if, as a generality, it really was creating a two-tiered system. If you were taking a whole new facility in one of those districts and said this is now a privately run hospital and is available only for American citizens to come up here and buy the service and nobody else can get in, then you've got a second system as an illustration. And we would certainly have an interest in that kind of thing.

Mr. Boyd: — Well I don't think the reality of that is very strong. But what the reality I believe is a possibility is I think you might be surprised at the resourcefulness of people when it comes to this sort of thing. In communities that I'm aware of, they take this as a very, very extremely serious issue, seeing their facility being cut back to a level that they don't deem as adequate. And I think that they're going to go in some cases to rather extreme lengths to maintain the facility as they have today, or had in the last few months at least.

So I'm raising it, I guess, from that perspective, that people want to have some kind of assurance that voluntary fund-raising can take place and it can go without there being any demands on it from the larger unit or from government to direct that money to the larger unit.

Mr. Adams: — Well I've told you the answer to that, and I remind you though that in publicly owned facilities, publicly owned, they will be owned by the district and the district has some say and responsibility for that.

I don't think anybody is going to turn down the enhancement of hours of service or hours of care so long as you're not taking a program and turning it into something which is quite different from what was currently intended. I mean if this is a way of expanding the hours of health centre opening, that's an entirely different issue from trying to take a former small hospital that handled two acute patients and say we're reopening and trying to make a two-person institution into an acute general hospital. That's an entirely different issue.

Dan is reminding me here that what we're relying on very, very extensively is a district to complete its needs assessment, to find out what the real priorities of the whole district are. And while it may be a particular interest group in a particular community wants one thing, another interest group may want something else. So I mean it's not . . . you can raise the money through that route, I'm not saying you can't, but go easy about creating conflicts within the community when the community's choice of priorities is not perhaps well defined.

Mr. Boyd: — Well they'll define it themselves, I presume.

Mr. Adams: — Yes, with the district.

Mr. Boyd: — Yes. I just wanted your thoughts in conclusion here, your thoughts on the other concern that has been expressed to me that — I guess these are fairly hypothetical situations but nevertheless I envision that there's a possibility of this one happening — where a community has decided through non-taxation methods to raise some money to supplement the operations of their health care facility, now their concern is that the . . . not only is their concern about the money having to go into the larger unit — and you've clarified that, I think, to my satisfaction; I think probably to theirs as well — but their concern is that as a result of their initiative to raise additional monies to supplement their hospital or health care facility, sorry, that the larger unit may look at it and say, well maybe we could cut back on the amount of funding that we are providing to that health care facility because you people are doing it in your own, in another fashion. And I'm just wondering what your thoughts on that might be.

Mr. Adams: — Well my thoughts on that are that the community in question here should be in really close communication with the . . . the community that's in question, whatever this hypothetical community is, should be in very close connection and relationship to its district board, that the assurance of levels of service, levels of funding now and into the future comes through the development of that close working relationship where there is a predictability to the future and that there are no surprises in the piece. That's what we're trying to get down, is a greater degree of predictability and a greater degree of equitability in the system on funding now and in the future, and the allocation of resources.

I'm sure that there are all kinds of worries that can creep up about, you know, being penalized for helping yourself more. I heard a deputy minister recently who had been penalizing the Treasury Board for having made a very good suggestion and offering up some money from his department to do a good thing, say that all good deeds will be punished. And I suppose the same worry might apply to some of those communities who are in a greater self-help mode.

No one wants to punish good-spirited people. And I simply can't say to you as a department that we have the responsibility or the power to go in and beat up on a district board that makes a local decision on how to allocate some of these dollars. Our responsibility is to allocate fairly through a set of service criteria that are defined in contracts and where our money can equitably apply to each of the districts, and to ensure

that that happens. But how the district decides to best provide for services for all of its people is largely left to the district, so long as they meet provincial standards.

Mr. Boyd: — So their concern in that area you don't think would be justified?

Mr. Adams: — I don't think that I would be overly concerned about that. But, on the other hand, it's possible.

Mr. Boyd: — I mean what they're saying to me is that . . . they're saying, we think there's potential to raise 50 to $100,000 in this community on an ongoing basis. Is 50 to $100,000 simply going to be deducted from the larger health board to our community because we have started this initiative?

Mr. Adams: — No, what we're trying to do is ensure that our policies allow for equitable distribution of that money to that predetermined set of needs that have been worked out within the districts, and that I can . . . I understand what the worry might be.

I would be more concerned, frankly, as the deputy of this department, not with the issue you've raised, but that the community says we will raise $100,000; they claim it, some resources are hired or some program mounted or equipment purchased, and after one year then the community says, well forget that, we really didn't need it after all. And they bow out, leaving you with either an equipment overload or a public expectation that the district board is then hung with or somebody else is.

That sounds like the old loss leader trick the federal government used to use on us. Dangle a few bucks for two years' start-up money and then pull out and leave you stuck with the operating costs. So that if communities are going to do that, I would urge both the communities and the districts to clearly understand one another about ongoing responsibility and probably have the deal in writing and make sure that there is no secret deals right on top of the table.

Mr. Boyd: — Well I think that's probably good advice. However, I don't think that the communities are looking at — the ones that I'm thinking about anyway — I don't think they're looking at capital expenditures or buying equipment. I think they're simply looking at staffing requirements, ongoing operational expenses of their facility rather than building anything new. I don't think they're looking at that at all. I think that they're hoping to retain what they've got, let alone add anything in addition to it.

Mr. Adams: — Well I hear you on that. And many communities have been putting in some dollars into supplementing local initiatives and they've been doing that since the '40s or earlier, probably all of this century. And I would expect that that will continue in some areas, but it'll be done on a voluntary basis.

Mr. Boyd: — Thank you.

Mr. Sonntag: — Thank you very much, Mr. Chairman.

I can appreciate your difficulty, Mr. Adams, in answering some of the questions with respect to how communities deal with the different situations. Just before I made my comment, it reminds me of last spring when I was in one of my communities, St. Walburg, where I was at a meeting. And if I'd have had to make a quick evaluation of the crowd that was there, I suspect three-quarters of them may have wanted to draw and quarter me, I'm not sure, but that would have been my evaluation.

But from a recent news release that I saw there, where there was a profile done of that community, many of those same people with that ill thought, shall I say, on their mind were interviewed and suggested that they now have many, many more services than they did before. So I think it's the willingness of the community to deal with the reality that they are currently faced with and look forward to better solutions to deal with the situation they're in.

I want to just speak though secondly on the second point and very briefly to speak to the accountability of the new district and new district board members versus the old hospital boards and the distance or the lack thereof from the electorate. Correct me if I'm wrong, but in the past membership to hospital boards was by appointment through RM boards and town councils and soon many of these boards will be elected directly from the general public.

So that was a point that I guess that you didn't make and I'd just like confirmation on that. And I think that . . . to me I would see that as being more accountable to the general public than less accountable. That's the only remarks I wanted to make.

Mr. Adams: — That's correct. I'm confirming that, with the exception of Crown-owned hospitals where the Crown directly appointed those boards, and there weren't very many Crown-owned facilities.

Mr. Sonntag: — Okay. Thank you.

The Chairperson: — I have no more members wishing to speak on the subject. Are you prepared to deal with the stuff you have on profile of the health district board or whatever you were going to do with that machine that we moved around here earlier? How long . . .

Mr. Adams: — Well maybe I should offer to give you a break. I mean you had a long day already. What Mr. Gardner has, if you want to see it today or you might want to see it on another occasion, is a relatively short presentation on the new information system, the integrated information system that we've been putting together. And I think we'll probably be able to show you some of the illustrations of how . . . Can you show them illustrations of how it actually works? You've got it all plugged in?

The Chairperson: — Well we've heard his bells and whistles; now we want to see the real thing.

Mr. Adams: — Is this plugged into the main computer? Okay. So you could actually see, I guess, a

live, working model here. If you want to see that for 15 minutes or so, that would be just fine. I would get out of here and not talk at you any longer if you'd like to do that and leave this to Mr. Gardner, if that's okay. Or you may prefer to have us come back on another occasion and do this.

The Chairperson: — No, that's fine. We had scheduled the meeting till 4:30. So if we have the guys ready to go, I think it would be a good idea to do that right now and then we've got it completed.

A Member: — May I suggest a five-minute break?

A Member: — Sure.

The committee recessed for a period of time.

The Chairperson: — If I could have all of your attention directed to the other end of the table, I'd appreciate that. And we'll entertain ourselves for a few minutes with how we're going to run the health care program.

Mr. Gardner: — Okay, I recognize this is going to strain your eyesight a little bit. I apologize for that. What I'm using here is a computer though, not foil.

Let me back up a little bit, I guess. When we first began a lot of the work around health reform we realized at a very early stage the importance that information would play in moving towards more of a population-health-based perspective.

As well, the past history of both the department and the health system itself was, we tended to develop information systems primarily for administrative purposes, for individual programs. When you start looking at overall health issues, you quickly realize those compartments of information become barriers. We collected information in different ways and rarely was it comparable. Particularly there was interest by the discussion around effectiveness and outcomes, because our information largely counted the numbers of services we provided.

So with that shift in focus to both looking more at the population needs of this health area and the whole question of looking at the individual and being able to link information, we needed some new ways of doing things. I guess the good news as well is that technology has evolved in a way that really facilitates being able to do things using data bases so that you can look at all these different relationships.

We've begun a process of developing what's called an architecture and it's like a framework for information. Basically it consists of a common data model, so that across the health system, we will record information in consistent ways no matter where it's collected. We would connect the various health points with a common network so that information could be accessed at different points.

And we're in the process then of beginning to work with the districts in developing common systems so that we're not re-inventing the wheel over and over and over again. And in fact using the technology now, you can largely build components and then use those components in different areas. So we've begun that process. We began meeting with districts as they were being formed. We have quite an active committee now with the districts.

We are currently working intensively with staff from three of the districts in working through the same kind of process we did in the department. And it's very much an information-driven process. So we're getting groups of nurses together across the different types of programs within these districts and talking first and foremost about how do you see delivering services in future, and then what are your information needs.

All too often in the past it's been somebody had some technology and they wanted to apply it. Very much the focus of this process is to look at information needs. I say "information needs" from the perspective of delivering much more integrated and coordinated services at the front-line point, through to providing information that enables us to effectively manage and coordinate services at a district level, through to some of the provincial needs we have for information so that we can do longitudinal health research and outcomes.

So we're basically looking at developing . . . a long ways down the road to developing a common information model and collecting that information with a view that it's going to be used for all of those different purposes.

What this system does is enables us to use our existing information more effectively while we're designing some of these new systems. So what we've done is we've taken information to help the districts and ourselves do planning. We've taken information from roughly 20 to 25 different systems that the department had, converted the data into one format. This is running on a $1,500 computer . . . That our plan is, in December then we will give this information to the districts so they can begin to use it directly.

Now I'll just, in the interests of time, I'll just go through, give you sort of a sample of what information is in here. There's quite a bit. Certainly our intention is to add more information, but what we want to do is get this out to the districts so that they can begin to work with it and identify indicators that have meaning to them; so we can sort of collectively then build the system.

Basically think of it like a microscope. It allows you to look at information at a provincial level, at a district level, and then within a district you can look at municipality or right down to an individual village. So that it really helps you to look both at a macro and a more micro perspective.

So I'm going to just go in at a district level. Think of it like a microscope thing where you've got four lenses and can zoom in and out.

The first thing you're presented with is a list of the districts. So I'll just select the Midwest district. You then have the information broken down into chapters. And I will go into the demographics. Basically this takes the population data and gives you different alternatives in terms of what age groupings you want to use. It provides you with — I realize you can't see some of this that well — three years of data broken down by age group and male/female for the Midwest Health District.

And if we wanted to . . . There's also a key that gives you . . . These are the numbers of people in the population. You could also then go in and look at the percentage of people. If you're interested in making comparisons of your district versus another, we often . . . Every district, frankly, thinks they have the oldest population in the world. And it's interesting. This will really help districts begin to communicate with each other.

You can also then zoom in, if you want to see what this district is made up of, this presents you then with a list of all the RMs in the district, and then we can go in and just . . . in fact I'll select Arm River, and it will give me the population information at Arm River. I can look at the page breakdowns and so on.

I'll just show you a few more. We've taken a lot of data from census. Now certainly as we begin to look at health we realize the importance of the socio-economic characteristics in terms of determining health needs versus just looking at past numbers of services. So using the '86 census data, we've taken this data and totally remassaged it so you can look at it by district. So if you want to look at the size of this district physically, you can go in and look at that information.

One of the factors that was talked about earlier, geography, is just the population density, will be a factor in looking at the cost of health services and hence funding. So here's a source of information. I should mention this same data base that's being used for the development of the funding system is being used for some of the geographic mapping we're doing in the province. It's the whole concept of bringing information together, making it accessible, and then using it for a number of purposes.

We can go in and, for instance, look at characteristics of families. I imagine you probably have difficulty seeing the detail here? What we have down here is the number of husband-and-wife families with no children, and then with one child, two children, and so on; single parent families with male heads by family size, female, etc. For certain health programs, single parent families are . . . that's important information to have. There's a lot of information in the census — occupational breakdowns, mother tongue, etc. — and we basically developed a way to take that data and link it and build into one resource.

Health status indicators. This is an area of course where we need to do a great deal of work, and we're involved nationally in looking at different types of indicators. At the moment, basically we have mortality rates so we can tell you what people died from — hardly a dynamic health indicator. But actually some research shows that if you standardize mortality rates, it is actually a fairly powerful indicator. We'll be adding information on birth rates and other characteristics. We're looking at accident data and other kinds of things. So we can see by age group numbers of deaths, and by heart, neoplasm, cerebral, vascular, accidents, etc.

Then we can look at the current utilization of services. So for hospitals you can go in, for example, and look at the number of hospital admissions. Now keep in mind this is the number of admissions by people who live in that area, no matter where they went within the province. And similarly we could look at a breakdown then in terms of . . . if we want the breakdown, this gives broad age groupings but we can also request and it will give us a breakdown by five-year age groupings if we want more detail.

It will also allow us to look at those if we want to do comparisons; we can get a program that will be able to have age- sex-adjusted comparisons and so on. You can look at the rates per thousand in terms of . . . to see the wide difference in terms of the 85-plus age group being roughly a thousand admissions per thousand people, as opposed to some of the younger age groups.

And if you're looking at the utilization of services, it's something to know just overall what it is, but then you want to start looking, are there certain age groupings that are using more or less services than others?

We also have the capacity to be able then to compare easily with other districts. So if you want to compare to another district, you can press this button, and so if we wanted to compare this to, say Moose Jaw, it will basically go to the same data for the Moose Jaw Health District and allow us to . . . it's really to facilitate people beginning to utilize the information, make comparisons. This will lead to obviously a number of interesting questions about what the differences are in research and so on.

One of the major advantages we see too is that as we're beginning then to build the new information system model, because people are using the data for new purposes, we'll get that kind of thinking reflected in terms of their ideas around the information that should be collected. You really only get to collect the information well once, and that's at the point of service. And so we want to think about collecting that information with all of the uses in mind.

I'll just show you a couple more. We actually have far more home care data in here than hospital. There's lots more hospital data we can put in here but we want people to tell us which things are of interest. Similarly, you can go in in home care and look at the use of services according to the marital status or the living arrangement. Was the person living alone, or with family? Because these things are significant determinants of their probability of being admitted for

long-term care.

We can also then go in and actually look at individual services within homecare. So we can look at a district and say, how much home care nursing services are they using? Which age groupings? How many people? And then the intensity of service in terms of . . . This shows across the numbers of individuals and then down this way it shows the amount of service in terms of hours of nursing care they've received.

I'll just then go in . . . We have ambulance services where you can look at the numbers of calls, what the reason for the call was. Was it a heart attack? Was it an accident? How many of them were . . . was the person picked up from their home versus an accident scene at a highway, or whatever? All of these things are very useful in terms of planning services and looking at current utilization.

We can also go in, for example, and look at drug utilization. Now districts aren't responsible for the delivery of drugs, but it's certainly a key issue as they're looking at the broader population of health in their area. And so we're taking provincial information and making it available to them in terms of . . . Excuse me, it doesn't display the titles but I can make it do that.

Basically this gives you about 20 different drug categories and allows you to look by age group — this is anti-infective agents, antibiotics — allows you to look at the numbers of prescriptions by age group and by geographic area. Because keep in mind we can zoom in and look at an individual RM.

We haven't as yet done this but our plan next is to begin building in information on what service points exist in that geographic area; what are the characteristics of those service points in terms of the numbers of staff, the funding, the services they provide. Where do the people come from that come to those service points, so that they get an idea of the sort of area of coverage.

We've also built in the ability to actually create a district, or look at if there were changes in your district, what would it look like. Or you can take your district and look at, if you have a feeling that maybe one part of the district is somewhat different in a certain respect than another, you can break your district into two parts and look at the two parts collectively.

There's also the ability then to look at . . . all of this information is designed in a way that you can print out reports that actually show you comparisons of your district compared to the province and so on. And there's roughly 40 different reports that you can print out and use and analyse.

So basically this is almost . . . we're creating sort of a new mechanism for allowing people to use information with this system. We've done it deliberately on a personal computer so that it's something that small districts — it's not a big investment — they can use it on equipment they have.

We're also creating a larger database with actually all of the detailed information. This is summarized by five-year age and sex groups that will facilitate then the work of the Health Services Utilization and Research Commission, work within the department, and by external researchers in terms of doing some of the multi-factor types of studies where you can look at and group together utilization of services, for example, for individual types of people in terms of disability or disease type, etc., and follow them through time. Right now it's a very expensive, unwieldy process of having to link files and it really becomes a barrier to doing a lot of these studies.

So that gives you an idea, I guess. This, keep in mind, is making the best use of existing information. At the same time we're now actively working with the districts to plan then the development of common systems. And the districts are really quite enthusiastic about that because they realize they won't have the resources to build the kinds of systems we need.

And districts themselves will need to share information. For example, if you're providing services to someone from another district, that other district would have use for that information so that they can maintain a profile on their population in terms of planning and evaluation.

We're also, as I mentioned, working at the national level. I'm actually chairing a working group that's looking at the whole issue of person-oriented information to facilitate just the kind of thing we're talking about here, the effectiveness analysis and so on.

So we're trying to make the most use, as Duane mentioned, of pooling our efforts nationally. There's a lot of work to be done here in terms of understanding indicators, looking at practice protocols and so on.

So maybe I'll just leave it there. There's much more I could show you, but it gives you an idea of what we have.

I'm a little sorry about . . . Actually I'm using the inverted; the real version is in blues and reds. It's great on a screen. It's difficult to project except in a really dark room. So it's actually the reverse of what the real colours are.

The Chairperson: — I have a couple of questions on this. How secure is it, from the department's perspective, in assessing information with details of names of individuals who might be listed on the department's schedule but shouldn't be on another district schedule? Is that fairly secure, or how have you done things so that you could provide that?

Mr. Gardner: — This information is all aggregated by five-year, age and sex group, and by individual town, village, etc. So there are no personal identifiers involved.

We're also providing — I didn't mention a manual — to districts in terms of the use of the system, how you should interpret and use the reports and that type of thing.

So this information is all aggregated. The more detailed database that I referred to, we are developing a scrambling mechanism so that health services numbers, for example, will be scrambled in a way that you can't identify the individual but yet you can link together information for research purposes. And we're working to develop a . . . We have an access policy now, but we're going to adjust that policy in accordance with the changes in the technology.

The technology we're using itself, we went out over the past year and evaluated technologies. We've selected a technology that allows us a great deal of flexibility in terms of providing security, in terms of the data, in terms of who can access it, what data elements they could access, and so on.

But it's, you know, in the health area, that's a really important concern and one that certainly, together with the districts and other health providers, as we're developing the new systems, we're going to pay a lot of attention to in terms of ensuring that confidentiality concerns are met at the same time that providers have access to information to provide more integrated care.

The Chairperson: — To who or whom — I don't know what the correct way to say that would be — but to who would you provide the information and who will be allowed to have it?

Mr. Gardner: — It will depend on the type of information and . . .

The Chairperson: — Okay, the information as you provided it here today.

Mr. Gardner: — This information will be provided to the district, district boards, in terms of doing planning.

The Chairperson: — Okay. Will they be able to get profiles of other districts in order to do their planning?

Mr. Gardner: — Yes, they will.

The Chairperson: — Will they be able to get information about their own client use, let's say doctors and nurses and patients and the type of patients that they've seen in their health districts? Will that information be provided there? Minus the name or with the name or . . .

Mr. Gardner: — In terms of this particular system, because it's aggregated data it doesn't identify individuals. In terms of the new systems that we're building, certainly we want to build an information system that allows them to utilize the information for patient care purposes. So they will be collecting information in terms of health record information and they will have access to the records of their own clients with . . . they will provide access in terms of making sure that the correct providers have access to case information to allow them to provide integrated services. In terms of any access for research or other purposes other than patient care we would, as I say, scramble the identifiers so that we protect the privacy.

The Chairperson: — So a health district would be able to identify an individual who was, let's say it was a doctor who was . . . that they would want to pay special attention to if he was over-utilizing the system. Or I'm not going to say abusing, but refer to that, you could identify that to see whether in fact . . . And would the name be on there then for that health district board to say that's a problem; we should maybe take a look at that?

Mr. Gardner: — Yes. I mean that's a decision that we'll take with the districts and with the physician community in the context of designing an information system that meets everyone's needs. So I think certainly there's a need for information that allows . . . to be able to look at practice patterns. And indeed hospitals do that now internally. But we'll want to make sure that all of us have a mechanism in place where that can be done appropriately and there's appropriate access to it.

The Chairperson: — Have you got a catalogue already of how you're going to do that, a profile of the things that you're going to say these people can have access to this information, these people can have access to this information, these people can have access, and it's a progressive kind of access line and have you got a catalogue of that? Or are you planning one and . . .

Mr. Gardner: — We are planning it. We certainly know what access people have to information now.

And really I guess I'd like to emphasize the development systems has to be a collective process with the health care providers, with the districts. I mean the department, I think, can facilitate. We have certain interests in terms of ensuring that districts have proper information to deliver and manage programs and ensure effectiveness.

But it needs to be a collective process and that's the reason that we're currently involved with the three districts that were mentioned earlier, in actually working together with their staff to look at the full spectrum of information needs. From that, I anticipate then there'll be processes to develop those systems, develop the access, you know, related to data in those individual systems that's appropriate for the types of uses.

The Chairperson: — Would members of the Assembly have access to that information? And I mean all of them, not to the individuals but to the . . .

Mr. Gardner: — In terms of the aggregate information? At this point in time it will simply be the department and the districts. I anticipate once we've worked with the districts and fully developed this system then we will collectively have a set of policies around what type of information would be accessible.

There's some of this information, frankly, that would be quite useful, I think, in the public domain to help the public as, you know, in the districts, working with the public to understand health services, health needs. But I think we want to be careful to define which data elements are most appropriate in that forum or in other forums including the Legislative Assembly.

The Chairperson: — How much could you evaluate effectiveness of the delivery system of a health care program in each of the areas if you had the profiles as you've outlined them here? Can you, with the database that you have, could you do that?

Mr. Gardner: — As Duane mentioned earlier, I think there's a lot of work to develop better indicators. Certainly this begins, though, to give us information that we currently have which are at least broad indicators of the types of uses of information, some of the needs, factors, and so on. It'll get more refined though.

But part of the issue is people beginning to work with the data, frankly. Because historically, because there hasn't been this kind of information available, people haven't used it. And so as they use it, I think we're anticipating people will develop more kinds of indicators they feel are useful to them.

This is a database, so we will just continue to add information and indicators as there's a need for it. It's quite a flexible approach.

The Chairperson: — Is the auditor going to be able to have access to names and individuals on that database in relation to do audit functions?

Mr. Gardner: — I wouldn't anticipate that there would be a need for names specifically.

The Chairperson: — Okay.

Mr. Gardner: — I think most, for instance, effectiveness . . .

The Chairperson: — But the information would be . . .

Mr. Gardner: — Exactly. Most effectiveness studies would look at a cohort of population with certain characteristics. So we're designing the database to facilitate that kind of thing by, as I say, scrambling the identifiers.

The Chairperson: — Any other questions?

Mr. Strelioff: — Do you see a market for the system and programming and maybe even the information system . . . the information itself? A market within Saskatchewan or a market elsewhere?

Mr. Gardner: — Well I think within Saskatchewan we certainly see it as a common system that we would develop so everyone would be a partner — the districts and other providers in developing it.

It could have exportability beyond the province since we're further down the road in terms of integrating services. It's a possibility.

Mr. Perrins: — And I think relating it to health outcomes when the world's looking at that. How do you connect? Because it's gone beyond the financial information, the program information, but still hasn't gotten to health outcomes. So that's why we have to keep pushing it more that direction.

You see the demographics and you could extrapolate from that poverty rates in certain districts and the connection to illness rates, etc., you know, and what strategies would you take to target in the district. I mean that's . . . and then the strategies you take succeed. So it's . . . that's not there. That's when you start to see the successful outcomes.

Mr. Strelioff: — And perhaps the revenue-generating ability of expertise . . .

Mr. Perrins: — That's right. Well there's no question that's what's so exciting about the kind of material that Neil's developed.

Mr. Gardner: — Few provinces at this point have thought as comprehensively about health information because largely they're still operating separate programs. But I know from a lot of recent contacts I had, there's a lot of interest in what we're doing. And so, you know, I think there are future possibilities of that type.

Ms. Haverstock: — Well there's been a lot of interest on the part of the pharmaceutical companies to have been able to have access to or a database on it regarding the drug plan.

Mr. Gardner: — Yes.

Ms. Haverstock: — And I've always been rather surprised that they are unable to be able to make that link in, because it would be of great, great value in having something done on a database like this, with that being one of the components in . . .

Mr. Gardner: — Actually at the present time they do in the department have a unit called the pharmacoepidemiology unit that does do work for drug companies on drug studies. Because we have a rather unique data base.

Ms. Haverstock: — But not in the context of what they're trying to do in a place like Manitoba where the companies actually have their linking of research dollars with actual people who are interested in pharmacoepidemiology. And I mean the researchers are linked with research dollars from pharmaceutical companies and they don't have the opportunity to have a database like this.

Mr. Gardner: — Yes.

Ms. Haverstock: — So I mean we would be in a far, far

better position than other places.

Mr. Gardner: — Yes, we have been working with the researchers, especially from the university, that have a strong interest in health research.

Ms. Haverstock: — Yes. This is just tremendous, by the way. I'm very impressed.

Mr. Gardner: — Okay.

Mr. Perrins: — Well it's easier dealing with this than going to Mankota.

The Chairperson: — The drive is tough, I take it.

Mr. Van Mulligen: — I've got a question for the auditor. What opportunities do you see, what efforts might be made, to coordinate the activities of those who will be doing the audits of the health boards in terms of sharing information, in terms of examining standards, and in having an opportunity to discuss issues that are comparable and therefore being able to improve services that they provide for the health boards? Recognizing that once all the health boards are elected, your involvement may be somewhat less than it is now during this transition period. But I don't know what opportunities there are for that particular service to have information sharing opportunities to discuss issues and so forth.

Mr. Strelioff: — Well I think there are quite a few opportunities right now. On the transition period we have discussed with the department on the development of a standard — we call an accountability framework, a little bit — dealing with the common financial statements and the types of audit reports, and ensuring that all the auditors are examining the service agreements and management agreements, and providing that information out for the . . . I had it broken up in between 6 and 24.

For the 24, we were hoping to move that through the department and have the department move the information out. And we have also talked about bringing the public accounting firms and the CFOs (chief financial officers) together in meetings where we could talk about some of the common issues that relate to accounting or auditing or financial management. So there should be some forums there that move forward.

So that, I hope, will help get the boards moving on a fairly common footing fairly quickly, and also the auditors examining those boards, and providing forums for the groups to come and meet and discuss issues.

On a longer term basis I plan to, as the boards move into an elected phase, move into examining cross-board issues. And this is the kind of databases that are being created to facilitate cross-board issue examinations.

Initially the approach would be not that sophisticated; it would be more ensuring that best practices in terms of board . . . roles and responsibilities of boards, annual reports that are issued to the community and also issued to the department are shared, and the best practices are identified in allowing the communities to move forward as quickly as possible. And then gradually moving into more sophisticated analysis of issues, as the boards themselves begin to report on their effectiveness, and sharing practices through the department and among the boards.

As a community across Canada, the legislative auditors are also working more together to try to identify best practices across the country. In fact, probably at the next conference of legislative auditors and the conference of public accounts committees, you will see specific cross-Canada projects initiated, dealing with accountability frameworks and costs of services. That's a very big issue across the country, as it is in Saskatchewan, trying to determine what the costs are of specific services, and compared among boards, but also compared across Canada.

So I see lots of opportunity to share information, and share information among the boards, among the auditors, and across the country. I am actually pretty excited about that. For an auditor, pretty incredible.

The Chairperson: — Well I will take that as the concluding remarks of the committee's hearings today. I want to say I appreciate the opportunity of having met with the Department of Health and providing a detailed assessment and answering the questions.

There were a number of questions that were asked that didn't have answers here, and I've been asked to ask you to provide them to us in the normal fashion that you usually do. And there is no time line ever, not to my knowledge at least, for these but for the information of the members I think it would be as quickly as possible, and I know that you will do that.

I think I want to say this too, that it's the first time that there has ever been a department called before this committee in what I would call an audit review, not as a review of the Public Accounts and of the audited statement and a review of how you do the audit. So I want to thank you for allowing yourselves to be guinea pigs. And it's greatly appreciated by us in how we view and how we will ask questions in the future, and we want to thank you for that and taking the time to do it. Because it isn't easy sitting and being on the block for six hours in a day, and I want to thank you for that.

The one item of business that we have to conclude with on is an agenda for the meetings in January. I have a report from Robert about one item that has a qualifier for the meetings in January and that is the Department of Finance. The meetings are to be held from the 17th to the end of that week. The day of the 20th is cabinet budget finalization, so John Wright would not be able to be here.

I would suggest we call him on Monday to come forward with his Department of Finance in the

auditor's report and we'll do that first of all — this is only a suggestion, but I just lay this before the committee — first of all and then follow the format of the agenda as it's itemized in our index and go through the index as its identified there with qualifying that there were, I think, four that we had indicated earlier that need not be called.

And I want to say another thing regarding this, and that is that what I would like to suggest to the committee, that we deal with the auditor's report — let's use Agriculture as an example — we'll deal with the Department of Agriculture and then we'll deal with the Public Accounts component of the Department of Agriculture at the same time and then we're finished with it and we don't have to call any additional witnesses. And I'd like to have the committee's approval to work with that.

The other thing that I was prepared to suggest, and it was raised as a way to make the time of the public service a little bit more proficient, and that was to have them on call rather than on stand-by here, have them on call from the department. And I would say that I probably would solve the problem this way, and I agree with that, but I would solve the problem this way, by saying sometime when I don't have too many more people on a list, I would say, is it time for me to ask the Clerk to call the other department? And I would like to have the committee's consent to do that, and when I do that you won't know what . . . it's not a new thing; you'll understand what I'm trying to do. Is that . . .

Mr. Cline: — That's a very sensible suggestion and a much better use of resources.

The Chairperson: — Okay. On that basis, unless there is anything further to add, I will entertain a motion to adjourn, and I appreciate all of you being so attentive to our meeting here today.

The committee adjourned at 4:35 p.m.