Health

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Main points

The Department of Health's mandate is to protect and improve the health of Saskatchewan people.

In this chapter, we report that information provided to the boards of regional health authorities must continue to improve to better support financial decisions. We also report that the capital equipment plans of regional health authorities continue to be incomplete.

The Department of Health advised our Office that its review of operations of the Métis Addictions Council of Saskatchewan Inc. (MACSI) identified concerns about the governance and financial management of MACSI. Cabinet requested our Office to perform a special assignment to determine whether the money MACSI received from the Department was used appropriately and for the purposes for which it was provided.

We also plan to examine whether the Department used sound oversight practices to ensure that MACSI properly protected public money and spent it prudently and for intended purposes.

We plan to report our findings and conclusions on MACSI in a future report.

Introduction

The Department of Health's mandate is to protect and improve the health of Saskatchewan people. To do this, the Department provides policy direction, direct services, and funding to health providers and health agencies.

In Chapter 2 of our 2003 Report – Volume 3, we reported the results of our audits of the Department of Health and related Crown agencies for the year ended March 31, 2003 except for the audits of the Board of Governors, Uranium City Hospital (Board) and the Saskatchewan Association of Health Organizations (SAHO). This chapter reports the results of our audits of the Board and SAHO.

We also describe our planned audit of the Métis Addictions Council of Saskatchewan Inc. (MACSI). We will report the results of this audit in a future report.

In addition, we report on the follow-up of our recommendations from two previous audits. The first reports the results of our follow-up of our 2000 Fall Report – Volume 3 recommendations on the information received by boards of district health boards (now regional health authorities) to help them make decisions. The second reports the results of our follow-up of our 2001 Fall Report – Volume 2 recommendation that health districts prepare capital equipment plans that contain the key elements for capital equipment plans in the public sector.

Our audit conclusions and findings

For the audit of SAHO, we worked with Deloitte & Touche LLP, SAHO's appointed auditor, using the framework recommended by the *Report of the Task Force on Roles, Responsibilities and Duties of Auditors* (to view a copy of this report, see our web site at http://www.auditor.sk.ca/).

In our opinion, for the year ended March 31, 2003:

- **the financial statements for the Board of Governors, Uranium City Hospital (Board) and the Saskatchewan Association of Health Organizations (SAHO) are reliable;**

- **SAHO had adequate processes to safeguard public resources; and**

- **SAHO complied with the authorities governing its activities relating to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing.**

We did not audit the Board's processes to safeguard resources or its compliance with the law because the Department told us the Board would cease operations before March 31, 2003. The hospital closed on June 2, 2003. Executive Council has not yet issued an Order in Council to dissolve the Board and to determine the disposition of the few remaining assets. The Board is negotiating the transfer of the remaining assets with the Saskatchewan Property Management Corporation.

Métis Addictions Council of Saskatchewan

Background

The Métis Addictions Council of Saskatchewan (MACSI) provides addictions services on behalf of the Department. MACSI is a non-profit corporation established under *The Non-Profit Corporations Act, 1995*. For the year ended March 31, 2004, the Department gave MACSI $2.3 million.

A recent review of MACSI's operations by the Department indicated a lack of control by MACSI's board of directors to protect public money and to ensure the money was spent only for purposes intended by the Department.

Our planned audit

Cabinet has requested our Office to perform a special assignment to determine whether the money MACSI received from the Government of Saskatchewan was used appropriately and for the purposes for which it was provided for the period April 1, 1998 to February 18, 2004. We have accepted the assignment.

We also plan to examine whether for the above period, the Department used sound oversight practices to ensure that MACSI properly protected

public money and spent it prudently and for intended purposes. In addition, we will examine if the Department took prompt and appropriate action to remedy any significant problems it knew, or should have known, about MACSI's operations during the above noted period.

We plan to report our findings and conclusions in a future report.

Health board information—a follow-up

This section describes action taken on recommendations we made in 2000 when we audited information given to health boards (now regional health authorities). To carry out their responsibilities, the boards of directors of Saskatchewan's regional health authorities (RHAs) require reliable, relevant, and understandable information.

The boards of directors (boards) of RHAs play a key role in delivering health services in Saskatchewan. The boards manage approximately $1.8 billion of public money. They must make decisions about how they will use the money to plan, organize, deliver, and evaluate health services. Adequate information helps boards make appropriate decisions.

In 2000, we examined whether boards received adequate information for making financial decisions. We used the criteria in the Exhibit 1 to assess the adequacy of the information.

Exhibit 1—Criteria for adequate board information

1. Information for board financial decisions should be relevant
- 1.1 is received by board in sufficient time to consider before making decisions
- 1.2 provides information about progress towards the district's goals and objectives
- 1.3 helps the board look ahead

2. Information for board financial decisions should be reliable
- 2.1 is accurate and complete
- 2.2 is neutral, fair and reasonably free from bias
- 2.3 is verifiable

3. Information for board financial decisions should be understandable
- 3.1 reflects an appropriate level of detail
- 3.2 explains the context of what happened and its future impact
- 3.3 provides comparative information
- 3.4 communicates in a way that makes the information useful

We reported the results of that audit in our 2000 Fall Report – Volume 3, Chapter 2D. We found that three of the six boards we examined did not receive adequate information for making financial decisions.

We recommended that boards request more relevant information that:

- is timely (received soon after the end of the reporting period, and at least one week before meetings);
- describes progress towards goals and objectives (focusing on key measures that monitor progress toward the board's most critical goals and objectives); and
- helps the board look ahead (e.g., projections or forecasts of results, service delivery volumes, staffing levels).

We also recommended that boards improve the reliability of financial and program information they receive by ensuring:

- reports include information about the financial position and program effectiveness of significant affiliates;
- reports disclose significant assumptions used in preparing projections or forecasts; and
- districts standardize the way they collect and safeguard information.

On May 30, 2001, the Standing Committee on Public Accounts agreed with these recommendations.

Action on the recommendations

Each time we make a recommendation, we monitor whether action is taken to address the recommendation. We reported our first follow-up in our 2002 Fall Report – Volume 2, Chapter 5E. In this chapter, we report our second follow-up to assess action taken up to March 2004 to address the recommendations.[1]

Both the health boards and the Department of Health have an important role in ensuring boards have adequate information. Boards are responsible to obtain useful information from their managers and the Department of Health. In addition, the Department is responsible to

[1] See also our audit of the regional health authorities in our 2003 Report – Volume 3, Chapter 2C.

establish standards for information that supports decisions within the health system.

In following up on action taken on our recommendations, we spoke with Department of Health staff who work with the RHAs. In addition, we examined examples of information that managers provided to board members of two RHAs between October 2003 and February 2004.

Department to continue oversight

The Department has taken a number of steps that should improve the relevance and reliability of the information that health board members receive.

For 2003-2004, the Department established an Accountability Document for each RHA. The Accountability Document clarifies what services each RHA must provide. It also sets out the information that the RHAs and the Department are to provide to each other.

The focus of the Accountability Document is the information flow between the Department and the RHAs, and not the information provided to the boards of the RHAs. However, the Accountability Document aims to improve the relevance and reliability of information. This should lead to improved information on which health boards can base their decisions.

For example, the Accountability Document outlines health indicators for the RHAs to use in setting direction and priorities. In 2003, the Department gave information to RHAs that compared their results on six health indicators (e.g., infant mortality, disability-free life expectancy). These key measures give boards relevant information to monitor progress toward objectives.

The Department has not yet set standards for internal financial reports to boards. It should do so. In 2003, the Department introduced a provincial chart of accounts for categorizing sources of money RHAs receive and the purposes of RHA spending. All RHAs now use common categories to record the money they receive and spend. Using a common chart of accounts makes it easier to create comparable financial reports.

The Department does not receive board information packages from all RHAs. The Department should obtain these packages to allow it to monitor the quality of information that board members receive. The Department monitors the information it receives to identify issues and concerns. In addition, the Department arranged an education session that helped board members discuss the information that they wish to receive.

Board information needs continued improvement

The 2003-04 board information we examined showed a number of positive features. In terms of relevance, the board information described the progress of RHAs toward goals and objectives. Some information helped board members look ahead and address risks (e.g., privacy, critical incidents). A few samples compared information from two time-periods to show trends. Not all information reached board members on a timely basis.

In terms of reliability, some of the board information described how the RHAs collected and analyzed data. Providing such information helps board members assess the reliability of the information. However, some projections did not describe the assumptions on which they were based. Assumptions help board members assess whether projections are realistic.

Boards are making progress, but board information must continue to improve. Health boards need relevant, reliable, and understandable information that will assist them in making decisions.

We encourage boards, as well as managers, the Department, and legislators to use the criteria set out in the Exhibit to improve the information the boards receive. We plan to continue evaluating the information that all boards use to make decisions.

Regional capital equipment plans—a follow-up

In this section, we describe actions managers took on recommendations we made during our 2001 audit of capital equipment plans in health districts now regional health authorities (RHAs).

Capital equipment is important in the health sector. If an RHA does not adequately manage its capital equipment, it risks not being able to deliver health services. Inadequate capital equipment also affects capacity to provide care that is safe, effective, and efficient. Inadequate equipment can result in increased waiting times, false test results, or faulty treatments.

Capital equipment is costly. One RHA estimates it should spend up to $20 million each year to update the $173 million of capital equipment it uses. Resources are not stable in this area—budgets vary widely from year to year. Having an adequate plan would help managers and boards respond promptly if new resources become available.

Capital equipment is also complex. RHAs plan for clinical, non-clinical, and information technology equipment. We focused on clinical equipment (e.g., beds, stretchers, monitors, respirators, diagnostic imaging, laboratory equipment, and ambulances).

In our 2001 Spring Report, we described best practices for the content of capital asset plans in the public sector (Exhibit 2): We used these best practices to audit capital equipment plans in the health sector in 2001.

Exhibit 2—best practice for capital asset plans

Public sector capital asset plans should include the following key elements:

1. the capital equipment required to support strategic objectives & programs;
2. the gap between required and existing capital equipment;
3. strategies to manage capital equipment;
4. justification of capital equipment strategies; and
5. financial implications of strategies.

In 2001, we assessed whether the capital equipment plans of two health districts adequately included the key elements of capital asset plans in the public sector. We reported the results of our audit in our 2001 Fall Report – Volume 2, Chapter 6D.

In 2001, we found that one district's capital equipment plan was largely adequate and the other district's was not. We recommended that all health districts prepare capital equipment plans that are complete.

The Standing Committee on Public Accounts considered and agreed with our recommendation on February 19, 2002.

Action on the recommendation

Each time we make a recommendation, we monitor whether managers take action. In early 2004, we talked to key staff in the Department of Health and one large RHA. We also examined what several RHAs reported about capital equipment in their annual reports.

Capital equipment plans are improving but they vary widely. Some RHAs have long-term plans for specific types of equipment (e.g., beds, lifts). Others have a more complete list of the clinical equipment they need. The Department does not require RHAs to submit long-term capital equipment plans. The Department should require complete capital equipment plans from all the RHAs so that the Department can prepare a capital asset plan for the health system.

The Department requires RHAs to submit a capital equipment summary of their budget requests each year. The RHAs prioritize urgent equipment needs. Then they decide whether to seek resources from the Department, donations, or their operating budget. The RHAs submit to the Department the summary list of potential purchases.

Based on these annual lists, the Department determines its priorities and allocates a capital equipment budget to each RHA. The Department does not yet have a capital equipment strategy for the health system. Without a long-term capital equipment plan, the Department cannot project important future needs or balance demands from year to year. The Department continues to focus on capital construction.

Long-term capital equipment plans help to provide reasonable access to safe health services. Regional health authorities do not yet have complete plans for the capital equipment they need to provide clinical services. We will continue to monitor how the Department and the RHAs work together to plan for adequate capital equipment.