Chapter 11
Health

1.0 Main Points

This chapter reports that the Ministry of Health (Health) and 14 of its agencies complied with authorities governing their activities except that Health did not follow the *Financial Administration Manual* for sole-source contracting. Those agencies had reliable 2013 financial statements. Health did not follow Canadian generally accepted accounting principles for the public sector for reporting shared ownership agreements and funding and liabilities for regional health authorities' long term debt. Also, Health and those agencies had effective rules and procedures to safeguard public resources except Health needs to improve its processes in the following areas.

Health needs to follow its processes for promptly removing unneeded user access to its information systems and data. Lack of timely removal of unneeded access to systems and data increases the risk of inappropriate access to sensitive information.

Also, Health has not implemented a process to verify medical services that patients received and were billed by doctors. Verifying medical services would help ensure that Health pays doctors only for services provided, and could help Health identify and recover any money lost as a result of incorrect billing.

In addition, Health needs to comply with the *Financial Administration Manual* when entering into contracts for services. It needs to ensure that there is adequate documentation to support sole-source contracting decisions.

Health still does not have a capital asset plan. This increases the risk that the healthcare system may not have the capital assets it needs to deliver the services citizens require.

Health also needs to communicate its business continuity equipment needs to its information technology (IT) service provider and complete testing of its business continuity plan.

2.0 Introduction

Health oversees the provincial healthcare system. It also regulates the delivery of healthcare in Saskatchewan. To ensure the provision of essential and appropriate services, Health establishes provincial strategy and policy direction, sets and monitors standards, and provides funding. It oversees a healthcare system that includes 12 regional health authorities (RHAs), Saskatchewan Cancer Agency (SCA), Athabasca Health Authority,[1] affiliated healthcare organizations, and a diverse group of professionals. Health works with the RHAs, the SCA, and other stakeholders to recruit and retain healthcare providers, including nurses and physicians.[2]

[1] The Athabasca Health Authority operates under an agreement between the province, Canada, and six northern First Nations. The Ministry of Health funds the Authority for acute care expenses.
[2] Ministry of Health, *2012-13 Annual Report*.

2.1 Financial Overview

For the year ended March 31, 2013, Health had revenues of $22.4 million including $9.3 million from transfers from the federal government.[3] As reflected in **Figure 1**, Health spent $4.6 billion to deliver its programs and services.[4] Information about Health's revenues and expenses appears in its annual report.[5]

Figure 1—Major Programs and Spending

	Estimates 2012-13	Actual 2012-13
	(in millions)	
Central Management and Services	$ 12.7	$ 11.5
Regional Health Services	3,234.1	3,209.0
Provincial Health Services	220.0	215.6
Medical Services and Medical Education Programs	819.0	780.9
Drug Plan and Extended Benefits	382.1	345.2
Early Childhood Development	10.9	10.9
Provincial Infrastructure Projects	47.7	42.6
Total Appropriation	4,726.5	4,615.7
Capital Asset Acquisition	(48.1)	(42.7)
Capital Asset Amortization	1.8	2.5
Total Expense	$ 4,860.2	$ 4,575.5

Source: Ministry of Health, *2012-13 Annual Report*

2.2 Related Special Purpose Funds and Crown Agencies

At March 31, 2013, Health was responsible for the following special purpose funds and Crown agencies (agencies):

Year-end March 31
Twelve Regional Health Authorities
North Sask. Laundry & Support Services Ltd.
Health Shared Services Saskatchewan (3sHealth)
eHealth Saskatchewan
Health Quality Council
Physician Recruitment Agency of Saskatchewan
Saskatchewan Association of Health Organizations Inc. (SAHO)
Saskatchewan Cancer Agency
Saskatchewan Health Research Foundation
Saskatchewan Impaired Driver Treatment Centre Board of Governors (Treatment Centre)

[3] Ibid., p. 34.
[4] Ibid., p. 35.
[5] See www.health.gov.sk.ca (30 October 2013).

Year-end December 31
3sHealth, Disability Income Plan – C.U.P.E.
3sHealth, Disability Income Plan – S.E.I.U
3sHealth, Disability Income Plan – SUN
3sHealth, Disability Income Plan – General
3sHealth, Core Dental Plan
3sHealth, In-Scope Extended Health/Enhanced Dental Plan
3sHealth, Out-of-Scope Extended Health/Enhanced Dental Plan
3sHealth, Group Life Insurance Plan
3sHealth, Master Trust Combined Investment Fund

We provide our audit findings for the following agencies in separate chapters:

- Regional Health Authorities (see Chapters 18, 19, and 23)
- North Sask. Laundry & Support Services Ltd. (see Chapter 16)
- 3sHealth (see Chapter 12)

Our audits of eHealth Saskatchewan, SAHO, and Treatment Centre are not yet complete. We will report the results of our audit when our work is complete.

This chapter reports the results of our audits of the remaining 14 agencies.

3.0 Audit Conclusions and Scope

In our opinion, for the year ended on or before March 31, 2013:

- **Health and its agencies had effective rules and procedures to safeguard public resources except for the matters described in this chapter**
- **Health and its agencies complied with the following authorities governing its activities relating to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing except for the matter described in this chapter:**

The Department of Health Act
The Drug Plan Medical Supplies Regulations
The Regional Health Services Act
The Regional Health Services Administration Regulations
The Saskatchewan Assistance Plan Supplementary Health Benefit Regulations
The Saskatchewan Medical Care Insurance Act
The Saskatchewan Medical Care Insurance Beneficiary and Administration Regulations
The Medical Care Insurance Peer Review Regulations
The Saskatchewan Medical Care Insurance Payment Regulations, 1994
The Prescription Drugs Act
The Prescription Drugs Regulations
The Health Facilities Licensing Act
The Health Facilities Licensing Regulations
The Mental Health Services Act
The Financial Administration Act, 1993
The Government Organization Act, 2004
The Crown Corporations Act, 1993
The Tabling of Documents Act, 1991
The Health Quality Council Act
The Cancer Agency Act
The Cancer Agency Regulations
The Public Health Act, 1994
Orders in Council issued pursuant to the above legislation

- **The financial statements of each of the agencies are reliable**

We used the control framework developed by the Canadian Institute of Chartered Accountants (CICA) to make our judgments about the effectiveness of Health's controls. The CICA defines control as comprising elements of an organization that, taken together, support people in the achievement of an organization's objectives.

We examined Health's significant programs including medical services and medical education, drug plan and extended benefits, provincial health services, capital planning, and supervision of regional health authorities.

4.0 Key Findings and Recommendations

In this section, we outline key observations from our assessments and the resulting recommendations.

4.1 Removal of User Access Needs to be Timely

Health has established processes to remove unneeded user access to its IT systems and data.

However, it does not always follow its processes for promptly removing user access from individuals who no longer work for the Ministry. During the year, three employees who had access to the MIDAS financial system left Health. These three employees did not have their access to the system removed on a timely basis. If former employees do not have access removed in a timely manner, it increases the risk of inappropriate access to the Ministry's systems and data.

1. **We recommend that the Ministry of Health follow its processes to remove unneeded user access to its IT systems and data promptly.**

4.2 Assets Constructed under Shared Ownership Agreements Incorrectly Recorded

During 2012-13, Health entered into contractual agreements for certain capital projects with seven RHAs. It calls these shared ownership agreements. The Government argues that under these agreements, Health owns a portion of the facility being built. Health based its share of ownership on the proportion of funding it provided as compared to the expected overall cost of the project. Instead of recording its funding for these capital projects as capital transfers (expenses) as done prior to entering into these agreements and as it does for other approved capital projects, Health recorded its funding of $42.2 million as tangible capital assets of the General Revenue Fund. We disagree with the accounting for these projects based on the following.

Under Canadian generally accepted accounting principles for the public sector (Canadian GAAP), to capitalize a tangible capital asset, an agency must control the risks

and benefits of the asset.[6] The risks and benefits that Health obtains from the ongoing use of the facilities being constructed under the shared ownership agreements are substantially unchanged from the risks and benefits derived from facilities currently solely owned by RHAs. These facilities are specifically designed to deliver healthcare services and their use is not easily changed. RHAs will use them in the delivery of their services. Health remains a major source of capital for such facilities and a major source of maintenance funding for them. Also, as noted below, it remains a source of funding to assist in the repayment of RHAs' borrowings related to capital projects.

The Government uses Health as its vehicle to exercise control over RHAs that are party to these agreements. Given the relationship between Health and RHAs, we do not think it is feasible to partition among them the benefits and risks associated with facilities built under these agreements. Furthermore, equating the extent of financial contribution of each party to the risks and rewards of ownership cannot be substantiated.

Health incorrectly recorded $42.2 million as tangible capital assets and did not properly record this amount as capital transfers (i.e., expenses). Use of Canadian GAAP is necessary so that Health's financial records accurately reflect the costs of its programs and decisions.

2. We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector when accounting for assets constructed under shared ownership agreements.

4.3 Funding to Regional Health Authorities for Debt Repayment Not Properly Recorded

Health provides RHAs with funding to enable them to repay the principal and interest due on their long term debt/loans. RHAs rely on this source of funding to repay these loans and Health has created an expectation or guarantee to the RHAs that it will provide them with sufficient funding to do so.

Canadian public sector accounting principles require transactions to be accounted for based on their substance. As such, loans expected to be repaid through future government funding should be accounted for as a liability and expense in the year that the expectation or promise is made.

Health inappropriately accounted for these funding arrangements on a "pay-as-you-go" basis instead of on an accrual basis. For the year ended March 31, 2013, Health did not record liabilities of $84.1 million and the related expense of $15.4 million in its financial records.

[6] Risks of owning an asset would include being responsible for the costs of ownership (e.g., insurance coverage, maintenance, and the impact of asset not being able to provide services). Benefits of owning an asset include use of assets to provide services directly (e.g., using it to provide health services) or to generate revenue (e.g., rental income).

3. **We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector to record, in its financial records, funding provided to regional health authorities for the repayment of principal and interest due on loans and the related liabilities.**

4.4 Documented Support for Sole-Source Contracting Decisions Needed

We recommended that the Ministry of Health comply with the *Financial Administration Manual* when entering into contracts for services exceeding the limits prescribed in the *Financial Administration Manual*. (2012 Report – Volume 2; the Public Accounts Committee has not yet reviewed this recommendation)

Status – Not Implemented

We recommended that the Ministry of Health document its due diligence and consideration of alternatives when awarding contracts. (2012 Report – Volume 2; the Public Accounts Committee has not yet reviewed this recommendation)

Status – Not Implemented

In 2012-13, Health did not comply with the *Financial Administration Manual* (Manual) when entering into contracts for services exceeding the limits prescribed in the Manual. The Manual requires ministries to document why the formal contracting process was not used. Health needs to ensure that it adequately documents support for sole-source contracting decisions with service providers.

We noted that, during the year, Health did not enter into any contracts with community-based organizations for new types of services.

4.5 Verify Medical Services to Patients

We recommended that the Ministry of Health implement a process to verify that patients received the medical services that doctors billed the Ministry for payment. (2011 Report – Volume 2; Public Accounts Committee agreement October 4, 2012)

Status – Not Implemented

Health pays about $481 million annually to doctors for medical services on a "fee-for-service" basis.

Prior to 2011, Health compared each doctor's billing to historical trends and sought confirmation from patients receiving medical services. In 2011, Health stopped confirming with patients that they had received the services doctors claimed for them. Comparing doctors' billings to past billing trends alone is not sufficient without seeking periodic confirmation from those who received the services.

Since we first reported this matter in 2011, management indicated that Health was revising its processes for verifying medical services. In 2013, management again indicated that Health was revising its process for verifying medical services that doctors provide to patients, and that the new process was expected to be implemented by March 2013. Verifying doctor services could help ensure that doctors bill Health correctly, that Health pays doctors only for services provided, and could help Health in its efforts to recover any money lost as a result of incorrect billing.

4.6 Updated Risk Assessments for Agencies Delivering Health Related Services

We recommended that the Ministry of Health update its risk assessments for agencies delivering healthcare services to help monitor their performance. (2011 Report – Volume 2, Public Accounts Committee agreement October 4, 2012)

Status – Implemented

Health has established a process to assess the risk that agencies delivering healthcare services may not spend money provided by Health for the intended purposes. For agencies assessed as high-risk, Health follows up to obtain timely information to monitor performance and to determine if those agencies are using money for the intended purposes. Health's processes require annual risk assessments for agencies providing health-related services on its behalf. Risk assessments for these agencies are now being updated annually.

4.7 Capital Asset Plan Not in Place

We recommended that the Ministry of Health develop a capital asset plan to help ensure that it can carry out its strategic plan. (2003 Report – Volume 3; Public Accounts Committee agreement June 30, 2004)

Status – Not Implemented

The healthcare system uses over $1.2 billion of capital assets (buildings and equipment) to deliver healthcare.

Health still does not have a capital asset plan. Health was given certain priorities in the Minister's mandate letter dated November 21, 2007. These priorities included the development of a 10-year capital plan for healthcare. Health has not yet prepared the plan. Lack of a capital asset plan increases the risk that the healthcare system may not have the capital assets it needs to deliver the services citizens require, or that it may have idle capital assets that it could use at some other location. A long-term capital asset plan for Health would also help RHAs prepare their own capital asset plans.

4.8 Business Continuity Planning Needed

We recommended that the Ministry of Health prepare a complete business continuity plan.

Status – Partially Implemented

During 2012-13, Health finalized its business continuity plan[7] but had not communicated its business continuity requirements to its IT service provider—eHealth Saskatchewan. Not communicating its needs to its IT service provider could result in Health's critical systems and data not being available in the event of a disaster. Health also needs to complete testing of the business continuity plan to help ensure its effectiveness.

[7] Business Continuity Plan (BCP) – Plan by an organization to respond to unforeseen incidents, accidents, and disasters that could affect the normal operations of the organization's critical operations or functions.