

BACKGROUND

- 6.1** The Health Authorities Act was proclaimed effective December 21, 2000. It gave the Governor in Council the authority to establish health districts and District Health Authorities (DHAs) to govern them. The basis for the move to District Health Authorities was the 1999 *Report of the Task Force on Regionalized Health Care*.
- 6.2** Nine health authorities were established, effective January 1, 2001, under the District Health Authorities General Regulations, to replace the previous four Regional Health Boards and three Non-designated Organizations. Three health authorities were established from the former Western Regional Health Board (RHB):
- **DHA 1 - South Shore** - Lunenburg and Queens counties; operations include, but are not limited to, Fishermen's Memorial Hospital, South Shore Regional Hospital and Queens General Hospital. Received grants of \$39.2 million from the Department of Health in 2002-03.
 - **DHA 2 - South West Nova** - Shelburne, Yarmouth and Digby counties; operations include, but are not limited to, Digby General Hospital, Roseway Hospital and Yarmouth Regional Hospital. Received grants of \$47.6 million from the Department of Health in 2002-03.
 - **DHA 3 - Annapolis Valley** - Annapolis and Kings counties; operations include, but are not limited to, Annapolis Community Health Centre, Eastern Kings Memorial Community Health Centre, Western Kings Memorial Community Health Centre, Soldiers Memorial Hospital and Valley Regional Hospital. Received grants of \$61.3 million from the Department of Health in 2002-03.
- 6.3** Under the predecessor Regional Health Boards (RHBs), there had been only one administrative structure for the Western RHB. The Department of Health (DOH) directed that the arrangements for finance, materiel management, information technology and human resources were to be continued under the District Health Authorities (DHAs) and that no changes were to be made without DOH approval.
- 6.4** DHA 3 hosts the shared financial services in Kentville. Materiel management is hosted by DHA 1 in Lunenburg and information technology and human resources are hosted by DHA 2 in Yarmouth.
- 6.5** After the formation of the DHAs, the DHAs and Department of Health became concerned with certain aspects of the shared financial services arrangement. In 2002, two consulting firms were engaged, one by the Department of Health and one by the DHAs, to review the arrangements and make recommendations. The reports were issued in 2002. Subsequently, consultants were engaged by the three DHAs to review the other services shared.

- 6.6** This was our first audit of these DHAs. The major purpose of the audit was to determine whether the shared arrangements for financial services and materiel management were resulting in adequate management of these important areas.

RESULTS IN BRIEF

- 6.7** The following are the principal observations from this audit.
- External consultants were engaged to review all shared services. Many of the recommendations of the shared financial services reviews have been implemented and the status of implementation has recently been reported to the DHA Boards. Generally, the reviews reaffirm the advantages and economies to be achieved through a shared services approach and that a move away from this concept would not be advantageous. We saw evidence that staff and management are also committed to the concept of shared financial services.
 - We recommend that the DHAs finalize the shared services agreement and that it include clearly defined responsibilities, and service or performance standards with provisions for required reporting on achievement.
 - Our audit of the financial management area indicated that the DHAs have implemented reasonable processes for business planning, budgeting and periodic monitoring.
 - Business plans and funding levels for fiscal 2003-04 were continually updated by the Department of Health and not finalized until December 2003 - after 75% of the fiscal year had expired. Funding levels and business plans should be confirmed prior to commencement of the fiscal year to ensure that proper planning can occur.
 - During 2003-04, the DHAs entered into medical equipment leases for endoscopes. We understand that this type of arrangement is becoming more prevalent in the acute care sector as entities search for ways to replace aging capital equipment in an environment of scarce capital funds. Because the DHAs follow accounting principles for not-for-profit organizations, which are not entirely consistent with government accounting principles, there is a need to carefully analyze the accounting treatment for leases under both sets of accounting principles to ensure they are properly reflected in the financial statements of the DHAs and the government's consolidated financial statements. The Departments of Health and Finance are currently seeking information from all DHAs to determine the nature and extent of leased equipment transactions.
 - Although materiel management has formal policies, there is no reference to the processes to be followed when there are exceptions to the usual competitive process. Approval and documentation of such exceptions are necessary to ensure that there is compliance with the spirit of the government procurement policy throughout the DHAs.

AUDIT SCOPE

- 6.8** The objectives of this assignment were to:
- determine the extent to which DHAs 1, 2 and 3 share services, and assess whether the arrangements for financial services and materiel management are resulting in adequate management of these areas;
 - assess the accountability relationship between the shared financial services unit and the Boards and management of the DHAs;
 - review and assess financial management at the DHAs;
 - determine the quality assurance systems and control procedures in place over the data submitted to the Canadian Institute for Health Information (CIHI);
 - review reports from consultants and the Canadian Council on Health Services Accreditation; and
 - determine compliance with the *Government Procurement Process - ASH Sector* (for Academic Institutions, School Boards and Hospitals).
- 6.9** Audit criteria were taken from recognized sources including the Canadian Council on Health Services Accreditation, the National Quality Institute's *Canadian Quality Criteria for the Public Sector*, the Canadian Institute of Chartered Accountants *Criteria of Control Board's Guidance on Control*, the *Nova Scotia Government Procurement Process - ASH Sector*, and the *Health Authorities Act*.
- 6.10** We visited each of the three DHAs and interviewed staff and management responsible for the areas audited at both the individual DHAs and shared services host levels. We reviewed reports from external consultants, and external auditors and reviewed their files where necessary. We examined relevant documentation and tested certain transactions to ensure internal controls were adequate and compliance requirements were met.

PRINCIPAL FINDINGS

Shared Services and Accountability

- 6.11** **Formal agreement** - A shared services agreement was prepared in December 2000, but it expired in December 31, 2001 and has not yet been replaced. It included all shared services, and provided that the initial allocated cost of the services should not exceed the costs budgeted by the Western Regional Health Board and should be shared among the DHAs. Any variance between budgeted and actual costs was to be shared among the parties.
- 6.12** Responsibility for completion of a draft shared services agreement, to be ratified by the Council of Chief Executive Officers (CEOs), was assigned to the Chief Executive

Officer of DHA 3, following meetings involving CEOs and the Department of Health. The replacement agreement has not yet been completed due to many factors including the completion of special reviews by external consultants, vacancies and turnover in Chief Executive Officer and Chief Financial Officer positions, concerns relating to Directors and Officers Liability for provision of shared services, and strategic planning exercises. A replacement agreement is being developed and needs to be finalized.

- 6.13** The expired agreement did not include service or performance standards. The performance standards, targets and required reporting should be included in the agreement, the shared services policy and job descriptions. This would help to ensure that there is a common expectation regarding the standards to be achieved and appropriate accountability.
- 6.14** The CEOs have met several times to discuss issues, challenges, problems and opportunities facing tri-district services. Documentation of decisions flowing from these meetings should be improved.

Recommendation 6.1

We recommend that the shared services agreement be finalized and that it include service or performance standards with provisions for required reporting on achievement.

- 6.15** [Recommendations from external reviews](#) - External consultants were engaged to complete reviews of all shared services areas. Many of the recommendations of the shared financial services reviews have been implemented and the status of implementation has recently been reported to the DHA Boards. All three DHAs now have a Director of Financial Services position and the incumbent is on-site four days per week. This position at each DHA is assigned ownership of the annual business planning and budget preparation process. The processing of accounting data and preparation of financial reports is done on a shared basis in Kentville.
- 6.16** Generally, the reviews reaffirm the advantages and economies to be achieved through a shared services approach and that a move away from this concept would not be advantageous. We saw evidence that staff and management are also committed to the concept of shared financial services.
- 6.17** [Allocation of expenses](#) - Common shared services expenses are allocated according to a methodology established in 2000. The allocation of expenses is reviewed annually by the external auditors. The structure of certain shared services has changed since established under the Western Regional Health Board. The DHAs have noted that there are some expenses included in the allocation which are directly associated with individual DHAs rather than shared services. The original agreement provided for adjustment of costs based on mutual agreement of all parties and it would be appropriate for direct costs to be borne by the DHA which receives the benefit. Management indicated that they are in the process of reviewing cost allocations for finance, materiel management and information technology. A similar review of human resources cost allocations is planned.

Recommendation 6.2

We recommend that the DHAs and the Department of Health review the allocation methodology for expenses related to shared services to ensure that direct costs are borne by the DHA which receives the benefit of the service.

- 6.18** Overall, our review of the consultant reports and other documents indicated that there have been significant improvements in shared services arrangements and in accountability. However, as noted above, there is a need to include expectations and service standards for shared services in formal agreements and to report on achievement.

Financial Management

- 6.19** **Strategic planning** - All three DHAs have made progress in establishing strategic plans. All have mission, vision and value statements and key strategic directions have also been determined. DHA 3 released its strategic plan in January 2003 and the first status report on implementation was presented to the Board in September. DHA 2 has recently released its strategic plan publicly. The DHA 1 strategic plan is yet to be made public. The nature and timing of status reporting on implementation of the plans is to be determined. We encourage each DHA to ensure that its strategic plan is linked to its annual plan and budget.
- 6.20** **Business planning** - In late fall each year, the Department of Health advises the DHAs of the Department's financial expectations for the upcoming year. The Department of Health, in October 2002, advised the DHAs to maintain a status quo budget, identify cost drivers and not to plan expanded or additional new programs or additional staff in excess of previously approved arrangements. In addition, DOH achieved a significant milestone when it established multi-year funding targets for DHAs. The instructions to the DHAs included a 7% increase in funding for non-staff operational costs in each year of the newly established three multi-year funding targets. This information formed part of the assumptions used by the DHAs in business planning for 2003-04.
- 6.21** The DHAs submitted business plans to DOH as required. Business plans and funding levels for fiscal 2003-04 were continually updated by DOH and finalization did not occur until December 2003 - after 75% of the fiscal year had expired. The total increase in funding approved by DOH for the three DHAs was \$7.3 million which is projected to permit the DHAs to break even for the year. The DHAs do not have accumulated deficits. Funding levels and business plans should be confirmed by DOH prior to commencement of the fiscal year to ensure that approved plans can be carried out.

Recommendation 6.3

We recommend that funding levels, business plans and budgets should be approved by DOH prior to commencement of the fiscal year.

- 6.22** Although there are documented instructions to staff, broader policies surrounding the business planning and budget preparation process are not currently documented. Policies should include a timetable, assumptions, sensitivity analysis, operational plans, a review and challenge process and independent quality control sign off.
- 6.23** Responsibility for satisfactory completion of the business planning and budgeting process is assigned to management under direction of the Chief Executive Officer through the bylaws. The Finance Committee and the boards are fully informed of the business planning activities and funding requirements. Senior management and staff responsibilities in the budgeting area are clearly assigned in the job descriptions. Appropriate management and staff were provided with the instructions and budget package for the development of the 2003-04 business plan budgets. These budgets, which were part of the 2003-04 business plan submitted to DOH prior to December 31, 2002, formed the initial internal budgets.
- 6.24** **Internal budgeting** - In the spring of 2003, all three DHAs conducted budget review and challenge processes involving the director of finance, each program vice-president, director and budget manager. Formal, approved departmental budgets were communicated to managers in late July or early August. The review and challenge and communication of approved departmental budgets should occur prior to commencement of the fiscal year.
- 6.25** The budgets were also discussed at senior management meetings. However, the review and challenge process was not well documented. There have been recent management changes at the Chief Executive Officer and Director of Finance level at DHA 1 so we found it difficult to determine exactly what the senior management challenge process had been.
- 6.26** At all three DHAs, staff informed us that Finance staff ensured mathematical accuracy of the budget and supporting spreadsheets, and the accuracy of the entry of budget information into the financial systems. Documentation of these quality control procedures should include formal sign off. Our testing of the supporting documentation, management trail and mathematical accuracy found no errors although there was no formal sign off.
- 6.27** Legislation does not permit the DHAs to incur deficits. The appropriate parties (budget managers, directors and senior management) are involved in development of initiatives to balance the budget. When cost savings initiatives were required, operational plans were prepared.
- 6.28** **Capital budgeting process** - Capital requests are prioritized according to established criteria and forwarded to the Capital Review Committee for review and approval. Funds are applied first to emergency situations; unused funds are then released according to priority rating as the fiscal year progresses.
- 6.29** The Capital Review Committee's prioritized list for the three DHAs totals \$29.3 million for 2003-04. Of this, the Department has funded \$7.1 million, the Federal government has funded \$1.7 million, the foundations and auxiliaries have funded \$0.7 million and DHAs have transferred \$0.7 million from operations

funding. The amount of dollars earmarked from operations is a historical carry forward from the RHB when capital requests were funded separately. The total funding of \$10.4 million from all sources resulted in unfunded priorities of \$18.9 million. Adequacy of capital funding continues to be an area which requires more collaboration between the Department and the DHAs.

- 6.30** Although it is inevitable that historical funding patterns and available funding play a role in the annual allocation process, the DHAs should strive to ensure that the capital budgeting process is based on strategic plans and needs to the extent possible.
- 6.31** **Monitoring and forecasting** - Although the financial situation is monitored by the Boards and management, there are no policies to govern the monitoring function. Policies should include clear definition of financial information reporting formats; timing requirements; definition of thresholds for when variances require explanation; forecasting requirements; and sign off.

Recommendation 6.4

We recommend the completion of a financial policy manual including policies surrounding the business planning and budget preparation process and periodic monitoring. Policies should include a quality assurance process for the budget.

- 6.32** Monthly financial monitoring reports are provided to budget managers showing variance of actual to budget at the account level. Summaries are provided to the vice-presidents. Shared Financial Services has decreased the time required for preparation of monthly financial reports.
- 6.33** Budget managers are required to provide variance explanations within two weeks to the responsible vice-president and the Director of Finance. At DHAs 2 and 3, budget managers include a forecast to year end. The detailed forecasting procedures at DHA 1 are being developed. Financial reporting to senior management and the board at all three DHAs includes written explanations of significant variances in revenue and expense areas.
- 6.34** DOH requires and receives a summarized monthly forecast document showing actual year-to-date and forecast to year end. This document is also provided to the Finance Committee. In addition, the Department is provided with an electronic upload of all financial and statistical data contained in the general ledger on a quarterly basis. The preparation of regular, written forecasts at a more detailed level would support and enhance the forecast information provided to the Department of Health.
- 6.35** **Financial and payroll information systems** - Management of the three DHAs commented on the fragile state of the DHAs' payroll and human resource information systems. These are old systems which do not have the functionality of current technology and maintenance is a challenge. The government has decided to implement SAP R/3 in DHAs and an initial amount of \$2 million is included

in the Province's 2004-05 Estimates. The government plans to implement SAP in all DHAs and will be funding the initiative over a three-year period. Detailed plans for management and implementation of the initiative have not yet been prepared, but the Department of Health has indicated that DHAs 1, 2 and 3 will be the first to implement the new system. Although SAP does have a human resource module, the government has not made a final decision on whether that module will be implemented. The government plans to do further study on whether that particular module can meet the specialized needs of the health sector.

- 6.36** **Financial statement audit** - The DHAs' annual financial statements are audited by a public accounting firm. The external auditors prepare an annual management letter for the Board, and status of implementation of recommendations is reported through the Finance Committee to the Board. We reviewed the auditor's working papers for the year ended March 31, 2003 and found no additional matters to be brought before the House of Assembly.
- 6.37** **Leased medical equipment** - During our audit, we encountered an issue with respect to medical equipment leases. During 2003-04, the DHAs entered into leases for endoscopes. The leased equipment replaces aging equipment owned by the DHAs and provides for periodic replacement of the medical equipment over a five-year term. We understand that this type of arrangement is becoming more prevalent in the acute care sector as entities search for ways to replace aging capital equipment in an environment of scarce capital funds.
- 6.38** The rental payments are entirely based on the number of procedures performed, not on a set amount per month or year, and are appropriately described as 'contingent rentals'. This would be similar to a car lease where the payment was calculated monthly based on the number of kilometers driven rather than a fixed monthly amount. The proposed accounting for the leases was reviewed by the financial statement auditors and the DHAs decided to account for these leases as operating leases. This policy is consistent with the Canadian Institute of Chartered Accountants' accounting recommendations for not-for-profit organizations (NFPs). The process followed by the DHAs in deciding on accounting treatment of the leases was appropriate for the DHAs' financial statements.
- 6.39** However, not-for-profit accounting standards are not entirely consistent with government accounting standards issued by the Canadian Institute of Chartered Accountants Public Sector Accounting Board (PSAB). The choice of accounting standards could result in a different conclusion about whether these are operating or capital leases. For example, under PSAB, contingent rentals are included in the calculation of minimum lease payments if the number of procedures to be performed can be estimated, whereas under NFP standards, contingent rentals are always excluded from the minimum lease payment calculation and are expensed.
- 6.40** Because the DHAs are Government Service Organizations, the DHA financial statements are consolidated with those of the Province and amounts must be adjusted, during the consolidation process, to correspond with PSAB pronouncements.

- 6.41** We discussed this issue with staff of the Departments of Health and Finance, and the Province is now asking all DHAs for information about leased equipment to gain information about the nature and extent of leased equipment transactions, and the related accounting policies.
- 6.42** The DHAs' financial statement auditors, in a July 2003 letter to management, stressed the need for appropriate review and analysis of proposed lease transactions and the related accounting policies. We concur with this observation.
- 6.43** Also, under Section 59C(1) of the Provincial Finance Act, DHAs must seek Governor in Council approval for *financial obligations* including capital leases. *Financial obligations* are broadly defined and, without further clarification in legislation or Regulations, may be interpreted to include all leases extending beyond the current year - regardless of whether they are accounted for as capital or operating. Section 59C(3) gives the Governor in Council the right to make Regulations exempting organizations or programs from this requirement but no exemptions have been made. We believe that, under the current legislation, all DHA leases are required to be approved by Order in Council. We acknowledge that this may not be practical and that further clarification of the intention of the legislation is required.

Recommendation 6.5

We recommend that all proposed lease transactions be thoroughly analyzed by DHA management to determine due regard for economy and efficiency, compliance with government legislation and policies, and appropriate accounting treatment in the financial statements of the DHA and the government's financial statements.

Systems for Collection of CIHI Data

- 6.44** **Background** - The Canadian Institute for Health Information (CIHI) is a not-for-profit corporation that provides health information on a national basis. All of Nova Scotia's publicly-funded health facilities are required by way of a provincial/territorial bilateral agreement to submit health data to CIHI. This data is then used by CIHI to develop and maintain national health information standards, databases and registries. CIHI also reports summarized data to the provinces and facilities for use in managing the health system.
- 6.45** On September 30, 2002 the Department of Health released a report on the Province's health indicators in conjunction with a commitment by all provincial jurisdictions and the Federal government to issue reports on comparable health indicators. This document was titled *Reporting to Nova Scotians on Comparable Health and Health System Indicators: Technical Report*. We provided an audit opinion on the accuracy of the data and adequacy of the disclosure contained in this technical report. A second report is to be issued by all jurisdictions in November 2004.
- 6.46** For the 2002 Report, we could not provide assurance on reported indicators originating from CIHI's Discharge Abstract/Hospital Morbidity Database due to

a lack of documentation of CIHI quality assurance processes at the national level. Since the source of data in the Discharge Abstract/Hospital Morbidity database is data from hospital patient records which are extracted and submitted to CIHI by individual hospitals, we decided to examine the controls over this process at the three DHAs. Our objective was to review the controls and quality assurance processes in place at the entity level over data collected and submitted to CIHI.

- 6.47** **Observations** - The health records divisions within each DHA are responsible for abstracting data from patient charts and submitting it to CIHI monthly. Our testing of the DHAs' various edit checks and controls over the abstraction process revealed that the edit checks and controls are operational and functioning properly.
- 6.48** However, due to CIHI's difficulties in implementing a change in coding methodology from ICD-9 to ICD-10, the DHAs had not been able to submit any health information to CIHI for processing since March 31, 2003. CIHI needed to revise its systems to deal with the new coding methodology and experienced problems. CIHI requested hospitals to delay data submissions until these problems could be solved. The revision also required hospitals to upgrade abstracting software to incorporate the revised CIHI grouping methodology. The supplier of the software has only recently performed the required work at the DHAs. At the time of writing this Report, the DHAs were in the process of submitting the 2003-04 data which had been delayed.

Accreditation

- 6.49** The Canadian Council on Health Services Accreditation (CCHSA) has recently begun to accredit DHAs rather than individual hospitals and plans to conduct an accreditation review on the DHAs every three years. The first review of the three DHAs included in our audit was performed in 2002. The process was based on a self-evaluation performed by the DHA teams in 2002 which was followed by a survey visit. Each of the DHAs received accreditation with the requirement to report on the status of implementation of the recommendations; in February 2004 for DHAs 1 and 3 and August 2004 for DHA 2. This is the second highest of the five possible outcomes from an accreditation.
- 6.50** The review recommendations focussed on various topics such as community health needs assessment; ethics issues; strategic planning; quality monitoring and improvement; risk management; regular fire drills, disaster planning; and environmental issues.
- 6.51** Each DHA has submitted a response covering the status of implementation of the recommendations to CCHSA for review and consideration.

Procurement

- 6.52** Procurement for the three DHAs is performed by shared Materiel Management which is located in Lunenburg. Materiel Management recently completed an agreement with a national co-operative health buying group to achieve economies. In addition, this arrangement will also simplify many of the materials

management policies as the buying group will assume the tendering requirements. Management expects that the arrangement will result in savings of 10%, and we encourage management to monitor whether the expected savings are achieved.

6.53 The government's procurement policy for the hospital sector requires the entity to maintain appropriate records to support the rationale for sole-sourced or alternative procurement transactions or tenders awarded to other than the lowest bidder. Although the DHAs have procurement policies which are consistent with the Government Policy, there is no specific policy that deals with the required approval or reporting of exceptions to the usual procurement process. A policy relating to exceptions is necessary to ensure the spirit of the government procurement policy is complied with.

6.54 We selected a total sample of 30 procurement items from all three DHAs for testing. We found the following exceptions:

- two instances where the procurement process was not managed by materiel management and we were unable to determine that the contract was awarded to the lowest competent bidder;
- three instances where contracts were extended without a competitive process until either the effective date of the new agreement with the national buying group or the expiry date of existing agreements at the other DHAs to facilitate bulk purchasing; and
- two instances where a competitive process was not followed because of medical preferences.

6.55 Management indicated that they had approved the exceptions to the requirement for a competitive process, but the rationale for each exception was not documented and the circumstances did not fit the Specific Circumstances Where Alternative Procurement Practices are Permitted (*Government Procurement Process - ASH Sector*, page 7). Management indicated that the DHAs are working towards obtaining common agreement on medical procurement to reduce the number of exceptions because of medical preferences. Participation in the national cooperative health buying group should help to ensure that a competitive process is followed for those procurements in the future.

6.56 With numerous moves and changes in materiel management over the past several years, some documents have been destroyed or lost. Materiel management should implement a records retention policy, as required by the government procurement policy.

Recommendation 6.6

We recommend the DHAs draft additional procurement policies which comply with the *Government Procurement Process - ASH Sector*. These should include a policy on alternative procurement practices and a records retention policy.

6.57 A Canadian health care management and consulting firm was engaged to conduct an operational review of materiel management. A draft report was presented in August 2003. The review includes the following two key comments:

- “It is clear that the shared services environment for Materiel Management is more beneficial than District Materiel Management organizations. This is primarily driven by expense leverage, savings opportunities associated with volume, sharing of expertise and service capabilities. The Nova Scotia Ministry of Health as well as many other health care organizations across Canada, and also staffs within the tri-districts all recognize the benefits of a shared Materiel Management Service. A move away from this model would be considered a backward direction.” (page 81)
- “The direction and commitments from the CEOs with respect to shared services has been somewhat lacking in the past. Assuming a continuation of the shared service environment for Materiel Management, it is imperative that the tri-district senior management (Boards, CEOs and VPs) agree on a philosophy and vision of what the expectations are of each shared service and the shared services collectively. There must be clear direction, commitment and support for these services. This is a critical change that must occur.” (page 81)

CONCLUDING REMARKS

- 6.58** The benefits of shared services for DHAs 1, 2 and 3 have been reinforced by several external reviews. To achieve the maximum benefit from the services and adequate accountability, a shared services agreement needs to be finalized. The agreement should include clearly defined responsibilities and service standards and provisions for reporting on achievement.
- 6.59** Our audit of the financial management area indicated that the DHAs have implemented reasonable processes for business planning, budgeting and periodic monitoring.
- 6.60** DHAs face challenges in obtaining funding to replace aging capital equipment. This has led to the decision to lease certain medical equipment. All potential lease agreements need to be appropriately analyzed by management to ensure due regard for economy and efficiency, compliance with government legislation and policies, and appropriate accounting treatment in both the DHAs’ and the government’s financial statements.
-

DISTRICT HEALTH AUTHORITIES 1, 2 AND 3'S RESPONSE

The Districts are generally supportive of the findings and recommendations made in this Report. The DHAs were pleased that your audit was able to confirm that reasonable processes for business planning, budgeting and periodic monitoring were implemented, and you noted significant improvement in shared services arrangements and in accountability. The DHAs look forward to making improvements in the processes as identified in the recommendations contained in this Report.

Comments are limited to Recommendation 6.5.

- DHAs must comply with GAAP whereas the Province must comply with PSAB. The accounting for leases differs between the two principles. The DHAs agree that a dual evaluation of operating leases must occur. When a lease is determined to be capital for the province's purposes, the DHAs' accounting treatment cannot be affected. Resolution of this issue is best made at a provincial level.