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### HEALTH - NORTHERN REGIONAL HEALTH BOARD AND FOLLOW-UP TO 1998 COMMENTS ON RHBs AND NDOs

#### INTRODUCTORY COMMENTS

**7.1** During the past several years, the health system in the Province has undergone a tremendous amount of change including elimination of all but four hospital boards and the formation of regional health boards with responsibility for delivery of certain health care programs. Community health boards have also been formed. The change is not yet complete. The Speech from the Throne delivered on October 7, 1999 included the following:

*“This government will proceed with our commitment to legislate the roles and responsibilities of community health boards and eliminate the existing regional health board structure.”*

**7.2** On October 21, 1999 government announced that governance of the Regional Health Boards (RHBs) had been transferred to the Department of Health (DOH). The Minister of Health announced that government would legislate greater responsibilities for community health boards and ensure that community health boards would be given representation on new district health boards (Department of Health news release, October 21, 1999).

**7.3** On November 1, 1999 the Department of Health issued a document titled *Future Direction of the Health Care System...establishing District Health Authorities* which sets out a framework and timetable for establishment of nine District Health Authorities. These are to be in place by October 2000.

**7.4** Previous Reports of the Auditor General have commented on different aspects of change in the health system, and raised related issues. This chapter is another in that series of commentaries. Although this chapter focuses on an audit of the Northern Regional Health Board which is still a separate legal entity but now governed by the Department of Health, one of the objectives of the audit was to become more familiar with the issues and challenges facing an organization responsible for delivery of health care in this Province. Similar issues and challenges will likely face whatever organizations are put in place to deliver health care in the future. Many of the issues are basically the same, regardless of whether the entity responsible for governing and administering health programs is a community health board, a regional health board or a hospital board. We have attempted to focus this chapter on findings and recommendations that will be relevant as the government makes plans for how health programs will be governed and delivered in the future. We urge the Department of Health and the new organizations that will partner with Health in the future to incorporate the relevant findings from this audit in their plans.

#### FOLLOW-UP TO 1998 COMMENTS

**7.5** The health system in Nova Scotia is the responsibility of the Minister of Health. The House of Assembly passed the Regional Health Boards Act in 1994. Between 1996-97 and October 1999, four Regional Health Boards and four Non-designated Organizations were responsible for the delivery of a significant portion of the health care in the Province. As noted above, government assumed the responsibility for governance of the Regional Health Boards in October 1999.

**7.6** Chapter 12 of the 1998 Report of the Auditor General focussed on the financial situation of the four Regional Health Boards and the four Non-designated Organizations (NDOs). It included comments on several significant matters. Four of the more significant are summarized in Exhibit 7.1 along with an indication of related developments during the last year. Exhibit 7.2 shows the accumulated deficits of each of the RHBs and NDOs as at March 31, 1999, and the amount of related funding which DOH estimates it will provide.

## **BACKGROUND - NORTHERN REGIONAL HEALTH BOARD**

**7.7** The Northern Regional Health Board (NRHB) was established by the Government of Nova Scotia in 1994 through the Regional Health Boards Act as one of four regional health boards. Its purpose is to provide health services to approximately 151,000 residents of Colchester, Cumberland, Pictou counties and most of the Municipality of East Hants. Exhibit 7.9 on page 131 shows the annual number of inpatient days.

**7.8** The NRHB is responsible for nine health care facilities, including three regional hospitals. Exhibits 7.11 and 7.13 provide details of the location and relative size of the facilities. Hospitals were designated to the NRHB on October 1, 1996. There are 383 beds available in the approximately 800,000 square feet of space. In addition, the NRHB is responsible for addiction services, public health services and mental health services. The public health and addictions areas were devolved to the NRHB in April 1997. The NRHB has approximately 1,750 employees and approximately 200 physicians comprised of both general practitioners and specialists. The 1999-2000 expenditure budget of the NRHB approximates \$95.9 million.

**7.9** The Regional Health Boards Act permitted the Regional Health Boards (RHBs) to establish Community Health Boards (CHBs). There are ten Community Health Boards within the NRHB area. These boards were established over a two-year period. Exhibits 7.11 and 7.12 provide details of the location and relative population of the CHBs.

**7.10** Exhibit 7.4 provides management's summary of financial and medical accomplishments since the NRHB was formed.

**7.11** The Canadian Council on Health Services Accreditation (CCHSA) has performed accreditation reviews of the various hospitals within the region. The majority of these reviews were completed prior to October 1996 when NRHB became responsible for the facilities. Hospital accreditations have been extended beyond their normal terms during a transition to regional review. In future, CCHSA will not review individual facilities at NRHB but will perform a regional review. The first regional review was scheduled to be completed in 2000 and the NRHB had developed a process and assigned responsibilities to complete the required preparation. However, in view of the move to District Health Authorities, the regional review will be deferred.

**7.12** We completed our audit under Section 15 of the Auditor General Act. Our review of the NRHB was the first audit of a regional health board conducted by our Office. We conducted our fieldwork during a six-week period commencing in early September 1999.

## **RESULTS IN BRIEF**

**7.13** The following are the principal observations from our audit.

- The Northern Regional Health Board members performed their governance responsibilities well, although there were deficiencies in the Board's approach to

financial management. Due to recurring deficits, we believe that there is a need to ensure strong financial management practices in organizations responsible for the delivery of health care, particularly at the Board level. Specific suggestions include creating a separate finance committee of the Board, and ensuring that there is a board member(s) who has a professional accounting designation and/or extensive financial management experience in a large organization. We believe that it is important for the Board to ensure that annual budgets do not include projected deficits.

- Upon designation, the NRHB inherited an accumulated deficit of approximately \$7 million from the predecessor facilities. The Board incurred a deficit each year since then, and there is evidence that deficits were a systemic problem. Each of the Regional Health Boards and Non-designated Organizations had accumulated a deficit by March 31, 1999. The Department of Health indicated to these organizations that they should maintain services and not decrease staff, which limited the Boards' options for dealing with the financial situation. For 1999-2000, government has increased funding to the Boards and NRHB expects it will not incur a deficit.
- We believe that there is an urgent need for the Department of Health to complete a strategic direction for the health system, and to clarify how the business and strategic planning processes should occur in the health sector. This is important to ensure that all *partners in health* are directing their efforts towards achievement of the same strategic directions. We acknowledge that the recent release of *Future Direction of the Health Care System...establishing District Health Authorities* is one step in the planning process for a restructured health system. The NRHB was involved in an extensive strategic planning process from 1997 to the time of our audit in the fall of 1999. Working groups presented reports to the Board and the final report and implementation strategy was scheduled to be presented to the Board by the end of January 2000.
- The Department of Health should review and approve or disapprove key planning documents such as business plans, construction plans and budgets which are submitted by its *partners in health* on a timely basis. It is essential for these organizations to know, on a timely basis, whether these initiatives are approved.
- Roles and responsibilities for CHBs are not included in legislation and more than 40% of the CHB members responding to our survey were not clear on their roles and responsibilities. CHB members were not represented on the NRHB. We believe that representation of the CHBs on the NRHB would have led to better integration of planning efforts.
- The accountability relationship between the Board and the Minister was not well defined. Although Regulations require an annual report to be filed with the Minister, the contents are not specified. Responsibilities of Regional Health Boards and requirements for submission of planning information to the Minister are included in the document *Accountability in Nova Scotia's Health Care System* which does not have formal status as policy or legislation. The Department of Health has not requested compliance with all aspects of the accountability framework set out in *Accountability in Nova Scotia's Health Care System*. Accountability requirements should be specifically defined in legislation or regulation and all parties should be required to comply.

- Since responsibilities for public health and addiction services were devolved to the RHBs, there has been confusion over roles and responsibilities for these areas. There is no formal monitoring by either DOH or NRHB to ensure performance indicator targets are met. We recommend regular program evaluations and monitoring of performance to provide for consistent delivery of public health and addiction services throughout the Province.
- Construction contracts for preliminary phases of the design and construction of the new Cumberland County Acute Care Facility have been awarded without formal government approval of the project, including a firm funding commitment. Costs incurred to date have been paid from the local share (i.e. Foundation funds). Complete agreements, signed by all parties to the project, should be in place prior to commencement of the project to ensure that planned project costs and allocation of costs are agreed to by all involved. All parties involved in the project (DOH, the NRHB and the Highland View Regional Hospital Foundation) have assumed significant risk by proceeding with portions of the project without complete, properly approved financing agreements for the entire project.
- Our 1998 Report commented on transfers of hospital funds (donations and shareable and/or non-shareable operating surpluses) to hospital Foundations by predecessor hospital boards at the time of formation of the RHBs. In addition to the amounts identified in our 1998 Report which involved hospitals devolved to other RHBs, the NRHB predecessor hospital boards transferred a total of \$10.3 million of funds to Foundations prior to designation of the hospitals to the RHB. Approximately half the funds were donations but the source of the remainder is not determinable from the audited financial statements. We recommend that the Department of Health investigate the details of all transfers that hospital boards made to Foundations when the RHBs were formed.
- The Northern Regional Health Board does not receive financial information from Foundations because there is no legal requirement for Foundations to submit such information. We recommend that the Department of Health examine the relationship between Foundations and boards in the health sector to ensure that there is adequate accountability for funds raised in the community for health-related purposes.

## AUDIT SCOPE

7.14 The objectives of the assignment were to:

- Review and assess the performance of the governance function at Northern Regional Health Board with an emphasis on planning, policy setting, and monitoring.
- Review and assess the NRHB's accountability relationships, specifically:
  - the external accountability relationship between the NRHB and the Department of Health; and
  - the internal relationships between the NRHB and its community health boards; and the Board, its central office and individual facilities/programs.
- Review and assess performance reporting, particularly with respect to indicators of economy and efficiency.

- Determine whether systems and practices in the following areas provide for adequate controls, and due regard for economy and efficiency:
  - financial management;
  - information technology;
  - procurement;
  - addiction services and public health; and
  - construction of the Amherst hospital.
- Determine whether there is compliance with legislation and certain government policies.
- Determine the major changes that have occurred since the Regional Health Board assumed responsibility for the facilities in 1996.

**7.15** The audit criteria were taken from recognized sources including the Canadian Council on Health Services Accreditation's *Standards for Comprehensive Health Services*; the Canadian Institute of Chartered Accountants Criteria of Control Board's *Guidance on Control and Guidance for Directors - Governance Process for Control*; and CCAF-FCVI Inc.'s *Six Principles of Effective Governance*.

**7.16** The general criteria used for this audit are summarized as follows:

- There should be clearly defined responsibilities and accountabilities for the NRHB.
- The NRHB members should understand the objectives and strategies of the organization.
- The NRHB members should understand what constitutes reasonable information for good governance and obtain it.
- Once informed, NRHB members should be prepared to act to ensure that the organization's objectives are met and that performance is satisfactory.
- The NRHB should fulfill its accountability obligations to stakeholders by reporting on performance.
- The NRHB's strategic directions should be defined through a process of strategic planning.
- The NRHB should have processes to allocate human, financial and physical resources, and to monitor financial performance.
- Performance should be monitored against the targets and indicators identified in the organization's objectives and plans.

## PRINCIPAL FINDINGS

### *Governance, Accountability and Performance Information*

**7.17** *Summary* - The Board performed its governance responsibilities well. Board meetings were well attended, and the Board members devoted many unpaid hours to their responsibilities. Board members were provided with development opportunities, the Board established a process for evaluating its performance in certain governance areas, and it developed a policy for evaluation of the Chief Executive Officer (CEO). We have identified deficiencies in the Board's approach to financial management (see paragraph 7.59 below).

**7.18** Roles and responsibilities for CHBs are not included in legislation and more than 40% of the CHB members responding to our survey were not clear on their roles and responsibilities (see Appendix 7.2, page 119). CHB members were not represented on the NRHB. We believe that representation of the CHBs on the NRHB would have led to better integration of planning efforts.

**7.19** The accountability relationship between the Board and the Minister is not well defined. Although Regulations require an annual report to be filed with the Minister, the contents are not specified. Responsibilities of Regional Health Boards and requirements for submission of planning information to the Minister are included in the document *Accountability in Nova Scotia's Health Care System* which does not have formal status as policy or legislation. Presently, there are no regulated responsibilities or accountabilities for CHBs. The Department of Health has not requested compliance with all aspects of the accountability framework set out in *Accountability in Nova Scotia's Health Care System*. Accountability requirements should be specifically defined in legislation or regulation and all parties should be required to comply.

**7.20** Accountability within the Board could be improved by preparation of annual statements of objectives or expectations for senior management against which performance could be judged.

**7.21** Performance indicators, relative to achievement of strategic directions, have yet to be defined and implemented.

**7.22** *Survey of RHB and CHB members* - As part of our audit, we distributed surveys to members of the Northern Regional Health Board and its Community Health Boards. The purpose of the surveys was to solicit members' views on certain issues impacting the role and effectiveness of their boards. Two similar surveys were used; one for RHB members and one for CHB members. The survey instrument was modelled on one which has been used by legislative auditors in other provinces to study governance, and by our Office in a previous study of university governance (see Chapter 6 of our 1996 Annual Report).

**7.23** The questionnaires were mailed out during the first part of September 1999 and were to be submitted by September 30, 1999. Therefore, respondents were not yet aware of the elimination of the RHBs.

**7.24** The results of the survey of RHB members are located in Appendix 7.1 to this Report (page 116), and the CHB results are located in Appendix 7.2 (page 119). The survey results confirm many of the findings and observations noted below.

**7.25** *Governance* - Section 5(3) of the Regional Health Boards Act provides for the selection of RHB members by the Minister. All members were volunteers and received no honorarium. Board members were reimbursed for necessary expenses to attend meetings.

**7.26** The initial board membership consisted of 16 members and there were 15 members when the Board was disbanded. A number of the members agreed to a request to extend their terms, and 12 of the 15 members' terms were due to expire on December 1, 1999.

**7.27** Section 4 of the bylaws includes conflict of interest guidelines and a standard of conduct for directors.

**7.28** Attendance at the regular meetings, which were often held in different communities, was very good.

**7.29** The Board and Department of Health provided orientation and other educational opportunities to RHB members. The Board had not completed a self- assessment which is important for appropriate evaluation of the effectiveness of the governance function. Recently, through the Quality, Governance and Policy Committee, the Board had commenced an evaluation of certain governance areas for compliance with the CCHSA standards.

**7.30** *Relationship between Board and senior management* - The NRHB has had two CEOs. The Board delegated the search and selection of the first CEO to the Executive Committee which engaged a consultant to assist in the search. The initial CEO was engaged in late 1995 and remained until he resigned in June 1998. At that time, an acting CEO was appointed from within the senior management group. In November 1998, the Board approved appointment of the acting CEO to the CEO position based on a recommendation from the Board's consultant. The consultant documented the rationale for the recommendation to not hold an open competition in correspondence to the Board.

**7.31** The executive management positions are filled based on contracted service agreements. Each of these contracts contain severance provisions which average 12 months.

**7.32** The NRHB has not developed full job descriptions as it is developing an internal Performance Development Program which will include performance reporting as part of the job description. We examined a sample of senior management job descriptions which clearly defined roles and responsibilities. However, there were no statements of measurable expectations or objectives. We believe there should be statements of measurable performance objectives to monitor performance of senior management.

**7.33** A Board bylaw and policy require annual evaluation of the CEO. The evaluation of the first CEO was conducted by the Executive Committee in 1996 in accordance with the policy. Annual performance evaluation of the current CEO is not yet due. The contracts of employment for the two CEOs employed to date have not included mutually agreed upon expectations or objectives. Clearly expressed expectations or objectives should be a standard requirement to ensure objectives are achieved.

**7.34** *Accountability* - The Regional Health Boards Act and the regulations contain a few general accountability requirements. For example, RHBs are required to file an annual report with the Minister. The Department of Health document *Accountability in Nova Scotia's Health Care System*, which does not have the formal status of legislation or policy, represents the only defined accountability requirements for the health care system. However, we believe that it should have formal status to ensure that it is implemented.

**7.35** *Accountability in Nova Scotia's Health Care System* requires RHBs to submit an annual Health Services Business Plan to DOH and specifies the contents. This plan, after approval by the Department of Health, is to set out expectations for the RHB for the year. The other cornerstone to the accountability process is annual reporting on whether the expectations have been achieved.

**7.36** The Department of Health has not required RHBs to submit all components of the Health Services Business Plan, and the Department has not approved the plans on a timely basis. (See Exhibit 7.1, page 122.) We acknowledge that the 1999-2000 approvals were delayed due to the Provincial election. The NRHB has submitted business plans as required by the Department. Reporting on performance in relation to objectives has been less than adequate, but this is a common problem throughout the health system in the Province.

**7.37** The Director of Health Systems Planning at NRHB is responsible for development of performance indicators. The topic of development of performance indicators has been mentioned in Board minutes since mid-1997. The Board has had a recent refresher update on the topic and a presentation by senior management on four performance indicators. However, performance indicators relative to achievement of strategic directions have yet to be defined and implemented.

**7.38** Regulations under the Regional Health Boards Act indicate that "*the Board shall provide the Minister with an annual report containing such information as the Minister requires*". The annual report has been submitted in each of the past two years, however the Minister has not required any specific information to be included. The report has been widely circulated particularly in the past year and presented at the annual meetings. The annual report could be improved through the addition of reporting on performance indicators or results. Further improvements could also include reporting on achievement of objectives identified in the business, strategic or operational plans.

**7.39** The NRHB developed a strategy in the summer of 1996 for internal and external communications. This included bi-monthly newsletters and Board meeting highlights distributed to approximately 125 key stakeholders in the region, including the media. Board meetings were not open to the public. The Board recently passed a resolution that at least three of its meetings (including the annual general meeting) would be held in different locations throughout the region and that they would be followed by a public information and question/answer session.

**7.40** *Relationship with CHBs* - The Regional Health Boards Act and regulations do not include defined responsibilities and accountabilities for Community Health Boards. *Accountability in Nova Scotia's Health Care System* includes expectations of the RHBs and the CHBs. Included among the expectations for CHBs are "*providing the RHB with a community health plan, and providing developing, coordinating and supporting the implementation of a community health plan.*" Our survey of CHB members and RHB members (see Appendix 7.1 page 116 and Appendix 7.2 page 119) indicated that there is a need to better define the roles and responsibilities of CHBs. NRHB management indicated that CHB members were provided with orientation and development opportunities which stressed CHB roles and responsibilities. The majority of CHB members responding to our survey indicated that the development opportunities provided were useful.

**7.41** NRHB has established 10 CHBs with approximately 12 to 15 members each. NRHB support staff approached existing community groups and hosted public meetings to discuss the creation of CHBs and to seek volunteers who would be interested in coming together to form a CHB steering committee.

**7.42** Individuals were encouraged to apply for positions on the CHBs. A nominating committee reviewed applications and requested approval from the NRHB of recommended individuals. The CHB members are all volunteers and receive no honorariums. Expenses for travel and meals are reimbursed to the CHB member.

**7.43** There are no staff employed by the CHBs as the Regional Health Boards Act prohibits staffing of CHBs. The CHBs are staffed by volunteers only. The NRHB provided support staff, consisting of a total of two full-time staff and one part-time staff, all with additional responsibilities.

The NRHB also absorbed certain indirect overhead costs. The support staff meet monthly with each CHB to assist in preparing required information. In 1998-99, the budgeted total cost of CHBs at the NRHB was approximately \$50,000 plus the staff costs.

**7.44** Community health plans have been submitted by four of the CHBs to the NRHB. Plans for two CHBs are near completion and plans for four CHBs are yet to come. The four plans submitted were approved by the NRHB subject to inclusion in the NRHB's business planning process. This implies that the plans will not be fully considered and implemented until funds are available. The NRHB's Strategic Planning Steering Committee recently recognized a need to integrate community health plans into the NRHB's strategic planning process. This is discussed in more detail in paragraph 7.58 below.

**7.45** The community health boards members are not represented on the Regional Health Board. We believe that representation of CHBs on the RHB would provide for better integration of planning.

**7.46** *Relationship with Foundations and Auxiliaries* - Each of the nine health care facilities has its own charitable Foundation. The Foundations are independent from the NRHB and support hospitals and communities where they are located. Section 10 of the Regional Health Boards Act states

*“Notwithstanding any enactment, trust or agreement by which a hospital foundation is established with respect to a designated hospital, whether established before or after the designation, the foundation shall, as the foundation considers appropriate,*

*(a) continue to use its funds to benefit the hospital or for any other charitable purpose for which the foundation is established; or*

*(b) where the designated hospital is no longer operated as a hospital or no longer exists, use its funds to benefit the health-care programs of the regional health board in the area formerly served by the hospital.”*

**7.47** The NRHB does not receive financial information from Foundations as there is no legal requirement for Foundations to submit such information. Accordingly, the Board has no knowledge of the Foundations' financial situation and ability to support longer-term program plans and related capital and facilities planning.

**7.48** Hospitals annually request assistance from Foundations to acquire capital equipment. Recently, in connection with the new facility planned to replace the Highland View Regional Hospital, the NRHB requested financial information including a copy of the most recent financial statements of the Foundation (see paragraph 7.111). The request remains outstanding.

**7.49** One of NRHB's goals for the current year was to *“establish and support closer working relationships with the foundations and auxiliaries in the region.”* We support this goal. We also believe that the Department of Health should consider the role of Foundations in the health care system and ensure that there is adequate accountability for funds raised in communities for health-related purposes. *Future Direction of the Health Care System...establishing District Health Authorities* indicates that planned changes may strengthen the relationship between District Health Authorities and Foundations.

**7.50** *Physicians* - The Department of Health has a physician human resource plan which, according to NRHB management, is currently being updated. The NRHB does not provide input

to that plan or approve it. However, the NRHB approves new physician positions in the region. The Board receives impact analysis as input into the approval decision. The Medical Director provides explanations to DOH on the variances between the plan and the actual physicians in the region. The NRHB has been experiencing medical staff shortages and is actively recruiting replacements. The Board is updated on physician vacancies monthly.

### ***Strategic Planning***

**7.51** *Summary* - We believe that there is an urgent need for the Department of Health to complete a strategic direction for the health system, and to clarify how the business planning process should work in the health sector. This is important to ensure that all *partners in health* are directing their efforts towards achievement of the same strategic directions. We acknowledge that the recent release of *Future Direction of the Health Care System...establishing District Health Authorities* is one step in the planning process for a restructured health system. In addition, DOH has indicated that it will be reviewing current and previous planning initiatives, some mentioned below, to identify the strategic issues that require management in the restructured health care system.

**7.52** Our audit determined that the NRHB had been involved in an extensive strategic planning process and that the final report and implementation strategy was scheduled to be presented to the Board by the end of January 2000.

**7.53** *Department of Health's planning process* - The Department of Health has described the process for health planning in the Province in recent documents. *Health Services Business Plan Requirements - 1998-99* seem to imply that the business planning process is "bottom up". The following extract from *Health Services Business Plan Requirements - 1998-99* illustrates that point:

*"The Regional Health Boards and Non-Designated Organizations are responsible for developing collaborative planning mechanisms to ensure their health service business plans reflect an integrated approach to planning particularly on service delivery issues. In Nova Scotia, this integrated planning process occurs from the community, to the regional, to the provincial levels - through a process that sees community health plans integrated by the Regional Health Boards as part of the regional health services business planning process; and health services business plans integrated by the Department of Health as part of a provincial health planning process that is inclusive of the budget and service implications."*

**7.54** Another extract from the same document implies that the business planning process is more "top down" and based on a strategic plan for the Department of Health.

*"Health service business plans should reflect how the goals and strategies of the RHBs/NDOs will contribute to the goals for the health care system, as articulated in the strategic plan."*

**7.55** The following is an extract from the draft document *Health, Service, Sustainability: A Strategic Plan for the Nova Scotia Health System* which gives another description of the planning approach:

*"The Department of Health's role is to lead and facilitate the development of a strategic plan for the health system...but the plan for the health system can only be successful if it is implemented...and, it will only be implemented, if all those individuals and organizations responsible for parts of the health care system understand and support the mission, concur with the strategic priorities and implement action plans in each area."*

**7.56** Regardless of the approach, it is important to note that the Department of Health has not completed a strategic plan for the health system so the planning process is not functioning as described above. The need for a strategic direction for the health sector is urgent. The Department has been developing strategic directions which are included in a draft document titled *Our Health Care System - Managing Required Priorities and Actions* (August 1999) which has not yet been formally approved by government. The November 1999 release of *Future Direction of the Health Care System...establishing District Health Authorities* is a recent contribution to planning. The Department and the RHBs/NDOs also participated in other strategic planning efforts including the Plan for the Health Investment Fund which was brought forward by government and defeated in the House.

**7.57** *NRHB's strategic planning process* - The NRHB was involved in an extensive strategic planning process from 1997 to the time of our audit in the fall of 1999. Working groups presented reports to the Board and the final report and implementation strategy was scheduled to be presented to the Board by the end of January 2000.

**7.58** The Department of Health's *Accountability in Nova Scotia's Health Care System* requires the CHBs to develop a community health plan, consult with the community on the health plan and submit the plan to the RHB. The RHBs' requirements include "*assessing and approving community health plans and integrating these into regional health plans.*" In September 1999 the NRHB Strategic Planning Steering Committee discussed the need for integration of the CHB plans into the NRHB strategic plan, and agreed that this should be done.

### ***Financial Management***

**7.59** *Summary* - We reviewed the financial management practices at NRHB at both Board and management levels. Due to the recurring deficits, we believe that there is a need to ensure strong financial management practices in organizations responsible for the delivery of health care, particularly at the Board level. Specific suggestions include creating a separate finance committee of the Board, and ensuring that there is a board member(s) who has a professional accounting designation and/or extensive financial management experience in a large organization. We believe that it is important for the Board to ensure that annual budgets do not include projected deficits. We also recommend that the Department of Health should approve funding and business plans for RHBs and NDOs on a more timely basis.

**7.60** *Background* - The responsibility for governance of nine facilities was designated to NRHB on October 1, 1996. At that time, the facilities each had separate financial systems and staff. The separate financial systems were discontinued over time with the final consolidation taking place in 1998-99. The PRESTO financial system previously used by the three regional hospitals was adopted for the Board. The Finance Division has a staff of 19 and is physically located at the Colchester Regional Hospital site.

**7.61** Exhibits 7.5 and 7.6 show the NRHB inherited an accumulated deficit of approximately \$7 million at the time the responsibility for the hospitals was designated to the RHB on October 1, 1996 and that it has incurred a deficit each year since then. The deficit has been increasing each year. Exhibit 7.7 provides information on the expenses by program since 1996-97. Exhibit 7.8 shows that salary costs comprise approximately 69% of the Board's annual expenditures.

**7.62** *Board's role* - The Board was aware of its financial management responsibilities, and of the distinction between the roles of governance and management. The Board functioned at an overview level and appropriately delegated many of the detailed responsibilities to management. In some areas, particularly financial management, we believe that the Board should have assumed more detailed monitoring responsibilities. Based on our observations at NRHB, we have suggested certain

improvements in monitoring and control of financial management for future boards in the health sector.

**7.63** The NRHB did not have a separate Finance Committee. Rather, the whole Board functioned as the Finance Committee. This method of operation has the advantage of having all Board members informed of the financial situation and responsible for making related decisions. However, it also means that the agenda for Board meetings includes both financial and important non-financial issues. Accordingly, the Board cannot devote entire meetings to detailed discussion and resolution of financial issues. We believe that boards in the health sector should establish finance committees to deal with financial issues in greater depth. Such committees should then bring recommendations and observations to meetings of the full board for discussion and action.

**7.64** We believe that boards in the health sector should include at least one person who has a professional accounting designation and/or extensive financial management experience in a large organization to ensure that the board has a sound grasp of financial management and reporting issues. This is especially important in the current fiscal environment when health sector boards are experiencing financial difficulty. There were no professional accountants on the NRHB. Management has informed us that some of the members had business experience.

**7.65** The only written financial information the Board received on a regular basis was the Consolidated Statement of Operations (see Exhibit 7.15). This is a high level summary showing budget and year to date actual balances for facilities (in total), NRHB operations, addiction services and public health. The Board did not receive any information on the financial performance of individual facilities. This was intentional in an effort to focus the Board on the region rather than specific facilities. However, it also meant that the Board could not compare the performance of individual facilities and benchmark the performance of one facility against the other. Such comparisons are often useful in identifying opportunities for improvements in performance. We recommend that Board members receive information on both programs and facilities to ensure that there is sufficient information to identify opportunities for improved performance.

**7.66** The Board did not receive written explanations for variances between actual and budgeted financial results. However, the VP Corporate Services attended Board meetings and discussed reasons for variances to date and forecasts for the remainder of the year. We believe that written variance analysis should be a component of regular financial reports to boards to enable members to adequately perform their monitoring function.

**7.67** One of the major finance-related functions of boards is to review and approve an annual budget. NRHB senior management gave direction to staff for preparation of the annual budget. Direction was largely based on maintenance of programs as a priority. The Board approved requests for funding which were submitted to DOH. Once DOH indicated the approved funding (generally three to four months into the fiscal year), the Board reviewed the budget and indicated their approval. Since the Board's inception, all the budgets have been deficit budgets with the exception of 1999-2000. We understand that the 1999-2000 budget is balanced, as the Estimates have been approved, funding approval letters have gone out and the Department of Health has indicated that there will be no deficits.

**7.68** We are concerned by the approval of deficit budgets each year, although we understand that the Department of Health communicated to RHBs that programs and staff should be maintained and that initiatives identified in the business plans should not be implemented until approved by the Department. There is evidence that deficits were a systemic problem throughout the health sector in the Province. Each of the Regional Health Boards and Non-designated Organizations had accumulated a deficit by March 31, 1999. We recommend that future budgets in the health sector

should not include a deficit and we understand, based on information from the Department of Health, that the 1999-2000 budgets do not include deficits. Rather, boards should take necessary action to ensure that annual budgeted expenditures do not exceed the resources available to the organization.

**7.69** We recommend that governing boards be involved in the review and challenge of staff-prepared draft budgets. We also recommend that boards be actively involved in reviewing and challenging requests for funding which are submitted to the Department of Health.

**7.70** *Department of Health's role* - The Department of Health allocates funds to the RHBs and NDOs. In recent years, DOH funding announcements have occurred too late in the year. The NRHB did not know its approved revenues from DOH, at the earliest, until June or July of the fiscal year. As a result, cost centre managers have not received their approved budgets until mid-summer. To enable appropriate financial management for the entire year, funding approval should be received prior to the start of the fiscal year. This would allow staff to assess planned expenses and available revenues before any funds are expended. Changes needed to help bring the deficit under control could then be implemented.

**7.71** One solution to the lateness of funding announcements would be multi-year funding. If DOH informed RHBs and NDOs of probable funding for the next three to five years, then these organizations could make realistic plans for the future. This would support better planning. The RHBs and NDOs could incorporate multi-year projections of DOH funding in their own planning for achievement of goals and objectives over the next three to five years. NRHB provides budget figures for the current year in its Business Plan and estimates for each of the next two years. The 1998-99 plan indicated the budget would be balanced by 2000-01.

**7.72** In recent years, the budget direction from Health has been to maintain programs and services. NRHB management indicated that it has continually reevaluated programs and services in an effort to reduce costs. DOH requested that NRHB not cut services or staff which limited the Board's options for dealing with the financial situation. NRHB identified certain cost savings that could not be implemented due to this direction from DOH. There have been payments from DOH to NRHB as compensation for the delay of some of these initiatives. DOH should approve RHB and NDO business plans prior to the start of the fiscal year to ensure there is agreement on approved initiatives, and timely implementation. The Department of Health indicated that it is working on a new template for business and operational planning.

**7.73** *Internal financial management practices* - We noted the following with respect to required improvement in NRHB's internal financial management practices:

- *Budgeting* - We recommend review of programs, during the annual budget process, to determine if there is a more cost efficient way to deliver the services. Such a review could help identify cost savings that could be implemented without significant impact on service levels.
- *Variance analysis* - Currently, NRHB staff provide explanations of significant variances between actual and budgeted results to senior management and to DOH. There are no documented guidelines on what constitutes a significant variance. Written variance explanations are not provided to the Board. In order to improve the budget monitoring process, we recommend that management document guidelines for variance analysis and that written explanations be provided to the Board and to DOH, upon request, for such variances.
- *Program vs. facility information* - The current internal financial reporting format is facility-based and users must make adjustments to convert to a program basis.

NRHB is moving to a new, program-based reporting system. This will provide reports for program managers that show program totals across the region. We support management's efforts to generate more useful management reports.

- *Monthly financial information* - Financial reports, including forecasted results to year end, were not always prepared on a monthly basis due to the demand on human resources caused by merger of the separate facility financial systems. We believe that regular monthly financial statements, including forecasts to year end, are necessary for appropriate monitoring of financial performance.
- *Inclusion of budgeted figures on audited financial statements* - The audited financial statements of NRHB do not include the Board-approved budget for the year. Comparison of actual results to the financial plan is important for accountability purposes. We recommend that the audited financial statements show the approved budget figures.

**7.74** *Capital budgeting* - There are no written capital budgeting policies but there is an informal process that is well understood by staff. DOH provides little funding specifically for capital equipment and capital funding is obtained from other sources. (See Exhibit 7.10, page 131.). NRHB can choose to allocate some of its operating funds to capital projects, but does not have the right to make commitments which affect future years. NRHB can choose to allocate some of its operating funds to capital projects as long as this does not result in an operating deficit. Capital lists are prioritized by site and for the region. Senior staff at NRHB review funding available and determine what can be done in the current year versus what can wait.

**7.75** Most capital equipment funding comes from one of the nine Foundations or nine Auxiliaries associated with the hospitals. See Exhibit 7.10 for details of NRHB's sources of capital funding. NRHB proposed that any equipment funded by a Foundation will stay at that location. We recognize that Foundations raise funds within their communities and people are likely more willing to provide support if they know the funds will directly benefit the community. However, this could lead to inequities across the region with certain areas having more equipment than others or equipment being located in a less than optimal location. As noted in paragraph 7.49, we recommend that the Department of Health examine the relationship between Foundations and boards in the health sector. *Future Direction of the Health Care System...establishing District Health Authorities* indicates that planned changes may strengthen the relationship between District Health Authorities and Foundations.

**7.76** *Workload measurement* - NRHB does not make use of a workload measurement system. GRASP (a common nursing workload measurement system) was used in the nursing departments of NRHB's three regional hospitals but has been discontinued. NRHB management indicated that three of the four RHBs have discontinued the use of GRASP. The Department of Health does not require that RHBs use GRASP. CCHSA requires that hospitals have processes for allocating human resources and that protection and control of resources be achieved, in part, by measuring workload. Workload measurement systems provide standards for facilities to track staffing requirements, and to allocate staff to programs and functions. Allocation of nursing staff in the same manner as the prior year does not provide any information on whether current patients are receiving an appropriate level of care due to changes in volume, case mix and acuity. We recommend that workload measurement systems or other processes/methodologies be used to ensure staffing levels in hospitals are appropriate for the required standard of care.

## ***Procurement***

**7.77** *Summary* - In general, the procurement function has been well managed. The procurement division completed centralization in mid 1998 and has implemented a procurement policy which is consistent with government's requirements for the ASH sector (academic institutions, school boards and hospitals). The policy had not yet been brought to the Board for approval. Reporting on alternative procurement practices and sole source contracts to DOH as required by the ASH sector policy has not, but should, occur. Contract renewals should be publicly tendered and comply with the requirements of the ASH sector. New initiatives, which we support, have been introduced and are planned to achieve significant cost savings.

**7.78** *Findings and observations* - Purchasing for the NRHB, except for drugs and dietary services, is handled at a central location based out of the Aberdeen Hospital. Prior to the completion of the centralization process in July 1998, procurement was handled directly by the various regional sites. The purchasing section currently has five full-time equivalent personnel, including the Director, a Certified Professional Purchaser, who are directly responsible for the procurement function for the entire region. For the 1998-99 fiscal year, centralized purchasing at the Aberdeen Hospital issued 8710 purchase orders with an approximate dollar value of \$12.6 million.

**7.79** Procurement practices, since January 1, 1996, for all academic institutions, school boards and hospitals (ASH sector) must comply with the requirements detailed under the Government of Nova Scotia Procurement Policy - ASH sector. For acquisitions of goods over \$25,000, services over \$50,000, and construction over \$100,000, the ASH sector entities' procedures must comply with the obligations identified in the Atlantic Procurement Agreement (APA). The APA requires that all acquisitions above the thresholds outlined above be advertised publicly in a newspaper or posted on an electronic public bid notice system and the entity may also invite a minimum of three suppliers for quotes. Acquisitions under the public tendering thresholds are governed by the policies and procedures of the specific ASH sector entity. ASH sector contracts above the public tendering thresholds which were not tendered publicly, for reasons of expediency due to circumstances such as emergencies or sole source of supply, are required to be reported quarterly to the Department of Finance Procurement Branch. ASH sector entities are also required to establish specific policy circumstances permitting alternative procurement practices.

**7.80** Management developed a draft regionalised procurement policy. Highlights of the procurement policy include public tendering thresholds consistent with the ASH sector requirements. The policy had been presented and accepted by senior management but had not yet been approved by the Board.

**7.81** The NRHB procurement policy does not outline unusual circumstances where alternative procurement practices may be followed as required by Section 8 of the ASH Sector Government Procurement Policy.

**7.82** The policy does not, but should, include policies and procedures to be performed by staff, in respect to acquisitions below the public tendering thresholds, to ensure that due regard for economy and efficiency has been achieved. Currently no formal process has been established by management to ensure that the reporting requirements for alternative procurement practices and sole source contracts under the Government Procurement Policy are being complied with.

**7.83** NRHB management is in the process of implementing a Purchasing Card System to help reduce the cost of procurement for goods under \$1000, and to improve the availability of such goods to the user. This new system is designed to reduce the costs associated with smaller dollar acquisitions by reducing the number of purchase orders, receiving reports, invoices and cheques, and

eliminate purchase requisitions processed by staff. A process of product standardization is also underway throughout the region with a goal of decreasing costs by reducing the number of procurement transactions and increasing the economy and efficiency of product utilization. Management expects to realize significant cost savings from these new initiatives but, because the process is not complete, actual savings could not be determined at this time. A benchmarking exercise has been initiated by management to compare procurement operating costs of the NRHB with other health boards through out the Province. To date, the comparisons are incomplete as only one other regional board has responded to requests for information. Benchmarking exercises are initiatives we support and we suggest management continue in its efforts to report this information to the Board.

**7.84** Detailed testing in the procurement area noted examples of acquisitions through the central purchasing department which were not in compliance with the Government Procurement Policy - ASH sector requirements. In the case of two of the files reviewed, the NRHB used alternative procurement practices and failed to report the procurements to the Department of Finance's Procurement Branch as required under the ASH sector requirements. The total dollar value of the unreported procurements examined was approximately \$99,000. The ASH sector policy requires that all contract renewals be tendered again at the end of the contract effective date. A review of the food services contract at the Aberdeen Hospital indicated that this particular contract, which has an effective date of one year, was renewed annually without being publicly tendered as required. The contract has been ongoing since the creation of the NRHB; the 1998-99 contract value is \$808,388.

**7.85** In 12 sample items tested, documentation did not exist detailing what steps had been performed by staff to ensure that the best possible price was solicited from suppliers. Management was able to provide reasonable explanations in respect to the due diligence of the procurement practices relating to these specific items, but should ensure that sufficient documentation exists as evidence that due regard for economy and efficiency has been achieved.

**7.86** Effective April 1, 1998 the Provincial Drug Distribution Program (PDDP) agreement was signed by all the Regional Health Boards and Non-designated Organizations and the Province of Nova Scotia. The PDDP program requires that the parties to the agreement purchase all their drug requirements, where reasonable, through the program. A limited number of drug purchases were examined during the audit which provided evidence that drugs purchased directly by the regional pharmacies, where reasonable, were purchased through the PDDP. Some of the smaller sites throughout the region do not currently purchase all their drug requirements through the PDDP.

**7.87** Discussions were held with NRHB management and in particular Colchester Regional Hospital pharmacy staff regarding internal controls in respect to the procurement of drugs. Both management and staff indicated that, due to a limited number of personnel, the segregation of the key functions of procurement such as ordering, receiving, recording, and payment authorization may in some cases be performed by the same staff member. The results of testing indicated that four invoices from one particular supplier in the amount of \$733, which were purchased through the PDDP program, were paid to both the supplier and the PDDP. Management indicated that these errors were made during a time period in which new staff were being trained and the errors are isolated to that period. Management plans to follow up to ensure that no other similar instances have occurred. The external auditors' management letter dated August 31, 1999 noted instances where purchase orders from the pharmacy were not being signed for approval. Of the 15 items we sampled in respect to drug procurement, one purchase order was not signed.

### ***Information Technology***

**7.88** *Summary* - The information technology area has been well managed. While there are no formal Board-wide policies, there are procedures which ensure data security and integrity.

Operational information reports to management have been and continue to be augmented through the utilization of improved reporting modules. However, good management practices should include the establishment of performance indicators which are not presently available. There is a need to improve monitoring and planning by management of the utilization of resources and the prioritization of requests. Funding for planned initiatives requires DOH commitment and approval which is not timely and remains outstanding in some cases.

**7.89** *Findings and observations* - The information technology section of the NRHB currently consists of five full-time employees including the Director. The Director of Information Systems is responsible to the Vice President, Corporate Services for the planning, development, implementation and management of the technical aspects of the NRHB information and communication systems and resources. The day-to-day operations of the information technology section are the responsibility of the Manager of Information Systems who is supported by three technicians located at the three regional hospitals. The information technology section currently services nine individual sites and has an operating budget of \$0.9 million. The NRHB has been operating since the fall of 1998 without a full-time Director of Information Systems. The position of Acting Director has been created in the interim until a qualified replacement can be found. Many of the position accountabilities of the position of Director have been split between the Acting Director and the Vice President of Corporate Services.

**7.90** No formal organization-wide policies and procedures had been developed in respect to the management of information. Management provided current site-specific practices in respect to the backup of data, software, hardware, password security, etc. which appear to be reasonable. The external auditors' management letter dated August 31, 1999 noted weaknesses in the system of internal control in the areas of logical access security and the safeguards in place for the protection of equipment in the event of fire. Management commented that due to staffing shortages and the focus on Y2K related issues that the weaknesses identified have not yet been addressed.

**7.91** An information technology (IT) strategic plan has been developed which identifies four major planning initiatives for the region. The plan has been presented to the Board and was to be approved as part of the strategic planning initiative. In developing the plan, management recognized the limitations of the current site-based, non-integrated health information system and, therefore, in conjunction with the three other RHBs and the Cape Breton Healthcare Complex collaborated on a request for proposal (RFP) for an integrated patient information system. The implementation of the new system, once funding has been secured, is expected to provide a completely integrated health information system. In January 1999 the integration of the financial management system was completed for all sites throughout the region. The region has contracted, in conjunction with two other regional health boards, for the provision of an e-mail and Internet service. Consultants were contracted to help the Board determine priorities for system acquisition, assess current resources and assist in developing a plan to achieve its goals. A Year 2000 project plan has been developed and is on schedule to be completed as planned. Management has been providing regular Y2K status reports to the Board. Funding of \$3.7 million for Y2K remediation expenditures has only recently been officially confirmed by DOH.

**7.92** Information technology operational requests are handled directly by the IT technician at the site in which the request originates. Based on discussions with management, no policies and procedures currently exist in respect to the prioritization of operational requests or the documentation of such requests. In practice, requests are handled by the technicians based upon the IT staff person's judgement as to the urgency of the request. Due to the small number of staff and the lack of a system of prioritization and tracking of IT requests, there is no monitoring of the technicians' activities. Management has indicated it is aware of this and is currently developing policies and procedures to address these issues.

**7.93** Management has not developed any performance indicators in respect to information technology management. Performance indicators should be developed and reported to management on a regular basis.

### ***Public Health and Addiction Services***

**7.94** *Summary* - Since responsibilities for public health and addiction services were devolved to the RHBs, there is confusion over roles and responsibilities and the decision-making process for the establishment of policy. There is no monitoring by either DOH or NRHB to ensure performance indicator targets set out in *Health Standards* are met. We feel it is important for good accountability to establish clear lines of authority and clarify roles and responsibilities. We also recommend regular program evaluations and monitoring of performance indicators be undertaken. This should provide for consistent delivery of public health and addiction services throughout the Province.

**7.95** *Background* - Public health concentrates on issues of health promotion and protection and illness prevention, through vaccination and education such as prenatal classes and diabetes education. Emphasis is placed on the delivery of three core areas: Communicable Disease Prevention and Control; Non Communicable Disease and Injury Prevention; and Health Enhancement. Public health also administers grants provided by DOH to non-profit groups for proposals addressing community health needs. Public health's central office is located at the Colchester Regional Hospital site and there are five additional sites. Staff total 39.6 full-time equivalents (FTEs), including a director and 21.8 FTE public health nurses.

**7.96** Addiction services provides drug and gambling dependency prevention, treatment and rehabilitation. There are two withdrawal management inpatient programs at NRHB, one in Pictou and one in Springhill, as well as two specialist positions for problem gambling. There are three outpatient programs located in New Glasgow, Truro and Amherst. Addiction services has 51 FTEs including a director.

**7.97** Public health and addiction services were devolved to the regional health boards in 1997. Both programs are funded from a non-portable budget provided by DOH. RHBs require DOH approval to move funding from either public health or addiction services to another area of the board.

**7.98** *Roles and responsibilities* - Prior to the devolution of public health and addiction services, DOH produced *Accountability in Nova Scotia's Health System*. This document set out the roles and responsibilities of the Department of Health and the Regional Health Boards. Among other roles, it states that DOH "*develops standards, monitors and evaluates quality of the health care system*" and an RHB "*governs, manages, and delivers quality health services for the region*".

**7.99** Despite the roles set forth in *Accountability in Nova Scotia's Health System*, staff at DOH and NRHB indicate the roles and responsibilities of the Department versus those of the RHBs are not clear. There is a lot of confusion surrounding who can make decisions and how much authority DOH has with respect to the health boards. Staff in addiction services and public health at NRHB indicate there is a good working relationship with DOH staff.

**7.100** There are monthly meetings of regional directors and Provincial program directors from DOH in both public health and addiction services. Although DOH does not appear to have the authority to require attendance at these meetings, staff indicated that NRHB directors regularly attend. There are also committees with members from the regions and the Department. NRHB also schedules internal meetings between the senior management group and management of devolved programs.

**7.101** We recommend that roles and responsibilities be clearly defined and communicated to all parties involved. The lines of authority between RHBs and DOH should be made clear. These are essential steps for proper accountability in public health and addiction services.

**7.102** *Program evaluation* - DOH has not conducted any formal program evaluations of either public health or addiction services at NRHB since devolution. However, perinatal care was monitored as part of a Health Canada project. Public health and addiction services staff from DOH have visited NRHB since devolution. These visits provided an opportunity for discussions between DOH and NRHB but did not include formal program evaluation. DOH does not have any established policies for program evaluation of public health or addiction services.

**7.103** We recommend that DOH set up regular program evaluations in public health and addiction services to ensure the RHBs are delivering these programs consistently with the overall Provincial direction, and that the programs are effective.

**7.104** *Health Standards* - Prior to devolution, DOH released *Nova Scotia Health Standards*. This document detailed standards with measurable targets for public health and addiction services. There is no formal monitoring of *Health Standards* by either DOH or NRHB although some aspects are monitored informally. The Department has indicated they are working on this and hope to have monitoring implemented for January 2000 in public health.

**7.105** Addiction Services at DOH uses a system called STATIS to collect information on client utilization for performance indicators. Outcomes such as wait times, client satisfaction and others are measured separately. The information captured by the STATIS system and other sources is not currently sufficient for DOH to fully monitor the implementation of health standards.

**7.106** Public health reports certain performance indicators such as immunization, vision screening and breastfeeding rates.

**7.107** DOH has worked with both public health and addiction services at the RHBs to establish a mechanism for monitoring *Health Standards*. The Department of Health has indicated that work is in progress. There are no economy or efficiency indicators for public health or addiction services. Case costing is not done Province wide and would not be appropriate for public health. In the case of addiction services, the information systems are not capable of producing case cost statistics. NRHB does some manual case costing work. In public health, the emphasis is on health promotion and prevention so cost per day or similar statistics would not be appropriate measures. We recommend that the issues surrounding monitoring *Health Standards* be resolved and regular monitoring against standards be implemented.

### ***Construction of New Hospital***

**7.108** *Summary* - Construction contracts for preliminary phases of the design and construction of the new Cumberland County Acute Care Facility have been awarded without formal government approval of the project, including a firm funding commitment. The government has not responded to the NRHB's request for approval of the project, however, the government has approved the award of the individual contracts. Costs to date have been paid from the local share (i.e., Foundation funds). A complete agreement, signed by all parties to the project, should be in place prior to commencement of the project to ensure that planned costs and allocation of costs are agreed to by all involved. All parties involved in the project (DOH, the NRHB and the Highland View Regional Hospital Foundation) have assumed significant risk by proceeding with portions of the project without complete, properly approved financing agreements for the entire project.

**7.109** *Findings and observations* - The new Cumberland County Acute Care facility, formerly the Highland View Regional Hospital, being built in Amherst will occupy approximately 190,000 square

feet and is planned to have 78 beds. During discussions, DOH staff have told the NRHB to proceed with construction of the facility, but DOH has only formally approved two tenders relating to site work. Contracts for the site preparation, worth approximately \$750,000, have been awarded and the work has begun. Costs incurred are being paid from the local share (i.e. Foundation funds). The building construction is scheduled to commence in the spring of 2000, with occupancy planned for early 2002.

**7.110** The NRHB does not have an agreement with the DOH regarding funding for this facility. A budget, approved by the Board, of \$54.2 million was submitted to the DOH in early summer 1999. However, the Minister of Finance's June 1998 *Budget Address* indicated that "*Planning is underway for a new regional hospital in Amherst.*" The budget has not been approved by the Department, and an Order in Council has not been issued for the project. We are concerned by the delays at the Department of Health in responding to the RHB's request for approval. Included in the Estimates for 1999-2000 is approximately \$1 million for the new facility.

**7.111** DOH normally pays for 75% of these projects. The Board has signed an agreement with the Highland View Regional Hospital Foundation stipulating that the Foundation will contribute a maximum of \$6.8 million to the project. The Board has requested audited financial statements from the Foundation but these have not been provided. The Board has been advised that the Foundation received pledges of \$7.5 million, but actual collection and cash on hand are not known by the Board. If the Department pays for only 75%, there will be an unfunded amount of approximately \$6.75 million. The Board has no sources of revenue to fund the excess.

**7.112** In October 1998 the Deputy Minister and other representatives of the Department of Health met with representatives of the NRHB and Highland View Regional Hospital Foundation to discuss the issues regarding financing of the hospital construction project. The Acting CEO of the NRHB then wrote to the Deputy Minister summarizing the results of the discussion. That letter indicates that NRHB proposed that it incur debt financing for the shortfall, and that payments would be made from two sources. New revenue sources arising from the facility (e.g., paid parking and physician office space rental) would be used to make payments and the remainder would be serviced by payments from the Department of Health. A response from the Deputy Minister of Health dated November 17, 1998 indicated that the Acting CEO's letter accurately summarized the discussions that had taken place in October. From this correspondence, we believe that it is reasonable to draw the conclusion that the Department of Health has made a commitment to fund not only its 75% of the construction costs but a portion of the shortfall, although there are no formal agreements to support this commitment.

### ***Transfers to Foundations***

**7.113** *Summary* - Chapter 12 of our 1998 Report commented on transfers of hospital funds (donations and shareable and/or non-shareable operating surpluses) to hospital Foundations by predecessor hospital boards at the time of formation of the RHBs. We followed up on this issue during our audit of the NRHB. The NRHB predecessor hospital boards transferred a total of \$10.3 million of funds to Foundations prior to designation of the hospitals to the RHB. We recommend that the Department of Health examine the relationship between Foundations and boards in the health sector, and investigate the details of all of the transfers that hospital boards made to Foundations when the RHBs were formed.

**7.114** *Findings and observations* - Note 9 to NRHB's 1997 financial statements identified a total of \$10.3 million of funds transferred to Foundations by predecessor hospital boards during the two years and six months prior to October 1, 1996. (This amount is in addition to the \$10 million identified in our 1998 Report which related to two other boards.) Note 9 to the 1997 financial statements is reproduced as Exhibit 7.14 to this Report (page 134). A copy of this note was

conveyed to the Department of Health by the NRHB on April 21, 1999 in response to a request for information.

**7.115** We attempted to determine whether the transferred funds originated from donations and endowments, or shareable operating surpluses. As stated in our 1998 Report, we believe that the source of funds should be an important consideration for the RHBs and the Department of Health when deciding on appropriate future action.

**7.116** We reviewed the financial statements of each of the predecessor hospitals for the last fiscal year prior to devolution to the NRHB (1995-96) and the financial statements of the NRHB for the year of devolution (1996-97). Each of the transfers was recorded on the financial statements. In total, our review of the financial statements resulted in the following information regarding the source of funds transferred:

Source of Funds	Amount of transfer to Foundations
Restricted endowment funds	\$ 3.7 million
Unrestricted endowment funds	\$ 1.8 million
Unrestricted operating funds (Note 1)	\$ 4.2 million
Unrestricted capital fund	\$ .5 million
<b>Total</b>	<b>\$ 10.2 million</b>

Note 1 - Unrestricted operating funds include both shareable and non-shareable items. The source of transferred funds is not determinable.

**7.117** Our conclusion is that approximately half of the transferred funds came from endowments. The source of the remainder of the funds transferred is not determinable from the information available at the current time, more than three years after the transfers occurred.

**7.118** We did not investigate whether the NRHB's predecessor hospital boards had the legal authority to make these transfers. In paragraph 12.19 of our 1998 Annual Report (page 136), we noted that the external financial statement auditor of one of the other RHBs had reached the conclusion, for that specific RHB, that "*it was unclear whether the predecessor Boards had the authority to transfer the funds.*" We believe that further investigation into the question of legal authority is required for all transfers made prior to designation of hospitals in the Province to RHBs.

**7.119** As note 9 in Exhibit 7.14 describes, approximately \$5.7 million was transferred to trusts for which there are legal agreements regarding use of the funds. For the remaining funds, there are no agreements and Foundations exercise complete control over the funds. As noted in paragraph 7.47, Foundations do not provide audited financial statements to the NRHB. The NRHB receives no information regarding the existence and disposition of the funds, and therefore has no assurance that the funds are properly controlled.

**7.120** In addition to our recommendation in paragraph 7.49 relating the need for the Department of Health to examine the relationship between Foundations and boards in the health sector, we repeat our recommendations from our 1998 chapter. The Department of Health should undertake the following actions:

- investigate all of the transfers that hospital boards made to Foundations when the RHBs were formed;

- take action to ensure that the RHBs obtain legal authority or recover the funds in any cases where the hospital did not have the legal authority to make the transfer; and
- ensure that there are appropriate agreements between the Foundations and the RHBs and/or hospitals to define accountability for the control and disposition of the transferred funds which are in the custody of the Foundations.

## CONCLUDING REMARKS

**7.121** The governance and management of health care in the Province has undergone massive change and the change will continue as the alternative to the Regional Health Board structure is implemented.

**7.122** Planning and communication are essential components of implementing change. We acknowledge government's recent communication of its plan to establish District Health Authorities in *Future Direction of the Health Care System...establishing District Health Authorities*. We urge the government to complete its detailed plan for coming changes, and to communicate the plan to the public and those involved in health care governance and service delivery on a timely basis.

**7.123** Our audit of the Northern Regional Health Board led us to the conclusion that deficiencies in planning at the Department of Health, and the Department's delay in approving RHB business plans and capital requests, led to problems at the RHB level. When boards are not informed of funding decisions on a timely basis, and told that they must maintain services and cannot implement initiatives until approved, then the boards are effectively paralysed.

**7.124** The current system lacks clarity with respect to roles and responsibilities and accountability relationships. One example is the lack of legislated role for community health boards. Another is the failure of the Department of Health to legislate and completely implement *Accountability in Nova Scotia's Health Care System*, particularly the sections relating to the submission and approval of the Health Services Business Plan and performance reporting.

**7.125** Replacing RHBs with another form of governance structure will not correct the problems in the health care system unless the Department of Health and its *partners in health* make a concerted effort to resolve the planning and accountability problems which are inherent in the current system.

*Appendix 7.1***GOVERNANCE AND ACCOUNTABILITY SURVEY RESULTS  
MEMBERS OF THE NORTHERN REGIONAL HEALTH BOARD**

We sent the survey to 15 Regional Health Board members and received 12 responses, a return rate of 80%. Many of the RHB members who responded had prior experience as board members in other sectors; 11 respondents (92%) had experience as a board member for other not-for-profit organizations excluding hospitals; and 7 respondents (58%) had experience on hospital boards.

Respondents indicated that the average time they devote to the Regional Health Board, committee meetings and related activities in a typical month, excluding July and August, is 16.8 hours with a range of 8 hours to 40 hours. This is a significant time commitment, especially in view of the fact that RHB members are not paid a salary or honorarium but only reimbursed for expenses. A majority of respondents (75%) indicated that this time commitment was consistent with their expectations at the time of appointment.

Members of RHBs are appointed by the Minister of Health under the provisions of the Regional Health Boards Act. Our survey asked RHB members whose interests they thought they must primarily represent. Their responses indicated overwhelmingly that the primary interest they must represent is that of the public served by the Northern Regional Health Board. The source of the appointment does not appear to affect the interests which the RHB members feel they must represent (i.e. although appointed by government, the interests of the public are of primary importance to board members).

The survey responses give useful insight into how the RHB members view such important issues as responsibilities and accountabilities, and functioning of their respective RHBs. The following extracts from the survey responses are meant to give a brief summary of significant matters that were brought to our attention through the surveys.

Overall, RHB members were satisfied with the composition of the board and the way it functioned. All of the respondents indicated that there was a good mix of experience and knowledge, skills and abilities; demographic and geographic representation; and people from medical and non-medical backgrounds on the RHB. All of the respondents indicated that the board had established the appropriate committees, the committee members understood their responsibilities, and the committees do a good job of carrying out their responsibilities. A majority of board members (75%) indicated that the board was presented with sufficient, relevant information to make informed decisions. 92% of board members indicated that board meetings are well run, and the board works well together as a team.

The following extract from a survey response is indicative of the types of comments received from RHB members:

*“It is my view that this board stepped into territory not previously entered in Nova Scotia. That we organized well - have staffed with competent professionals and have a board that works well together.*

*However - we are only 4 years old - have only operated hospitals (9) for three years and in that time have had a change in C.E.O. and had a major problem with operational problems in one major hospital which was dealt with professionally and expeditiously.*

*We have undertaken a \$50 million capital program and have opened two clinics in rural communities and have developed 10 community health boards.”*

When given a list of 21 potential responsibilities and asked to choose which were more important to the role of the Regional Health Board, RHB members chose the following:

- selecting the CEO
- liaising with community health boards and addressing their needs
- ensuring accountability obligations are discharged
- setting strategic directions and goals
- evaluating the performance of the CEO
- approving by-laws and policies
- monitoring the achievement of goals and objectives

These responses are consistent with the roles and responsibilities of Regional Health Boards defined by the Department of Health.

The survey included a series of questions regarding accountability. Highlights of the responses follow:

Is it clear to whom the members of the Northern Regional Health Board are accountable?  
Yes - 67%                      No - 33%

Is there clarity with respect to what the Regional Health Board is accountable for?  
Yes - 83%                      No - 17%

Is there clarity with respect to the current role and responsibilities of the community health boards?  
Yes - 67%                      No - 33%

Is there clarity with respect to the future role and responsibility of community health boards?  
Yes - 33%                      No - 67%

92% of RHB respondents indicated that they were primarily accountable to the public and the government, through the Minister of Health. All of the respondents indicated that the Board has a role to play in achieving the government's goals in the area of spending reductions. Our conclusion is that, generally, the RHB members understand their roles and accountabilities. However, their understanding of the future role and responsibility of community health boards is less evident.

There were some areas where responses indicated that the Board could be more active. These included:

- *Planning* - Only 50% of respondents indicated that the Board's operational plans are linked to its strategic plan. Only 50% of respondents indicated that there was a health service plan for the Northern Regional Health Board. (The Health Service Plan is a key component of the process of setting expectations as per the Department of Health's 1996 publication *Accountability in Nova Scotia's Health System*.)

- *Performance measurement* - Only 33% of respondents indicated that specific performance targets have been established for the Northern Regional Health Board. Only 58% of respondents indicated that programs were reviewed on a regular basis.
- *Monitoring achievement of government's goals* - Only 25% of the respondents indicated an awareness of the targets for the health system included in *Government By Design* and that the Board is actively monitoring progress in achieving those targets.

Board members were generally satisfied with the information they receive. They noted two areas where they were receiving insufficient information - costs associated with specific clinical cases, and information on how the costs of Northern Regional Health Board compare with other Regional Health Boards. We believe that such information would be useful in monitoring the economy and efficiency of the RHB's operations.

As noted above, RHB members are generally satisfied with the composition and functioning of their board. We asked whether there were any impediments to the effectiveness of the Northern Regional Health Board. All respondents indicated that there were impediments to effectiveness and some of their comments follow:

- *"uncertainty as to future of RHBs makes board's position difficult"*
- *"Not always clear communication with Department of Health"*
- *"lack of funding - future uncertainty of existence of RHBs - lack of regulations for CHBs"*
- *"...financial commitments from the Department [of Health] and the time taken to provide commitments on financial matters"*
- *"underfunding for operations expected"*
- *"lack of multi year funding; funding approved too late in fiscal year; need for strategic direction established by DOH;..."*

We also asked whether the members had any suggestions for improving the effectiveness of community health boards. The following are typical of the responses received:

- *"Give them [RHBs] the autonomy they should have. Fund them adequately. Set up terms of reference for adequate representation and how this is achieved."*
- *"Clear and timely decision as to future of boards"*
- *"Now that community boards are in place get them involved."*

*Appendix 7.2*

**GOVERNANCE AND ACCOUNTABILITY SURVEY RESULTS  
MEMBERS OF THE COMMUNITY HEALTH BOARDS**

We sent the survey to 112 Community Health Board members and received 64 responses, a return rate of 57%. Many of the CHB members who responded had prior experience as board members in other sectors; 44 respondents (68%) had experience as a board member for other not-for-profit organizations excluding hospitals; and 9 respondents (14%) had experience on hospital boards.

Respondents indicated that the average time they devote to the Community Health Board, committee meetings and related activities in a typical month, excluding July and August, is 7.4 hours with a range of 2 hours to 30 hours. This is a significant time commitment, especially in view of the fact that CHB members are not paid a salary or honorarium but only reimbursed for expenses.

The survey responses give useful insight into how the CHB members view such important issues as responsibilities and accountabilities, and functioning of their respective CHBs. The following extracts from the survey responses are meant to give a brief summary of significant matters that were brought to our attention through the surveys.

When given a list of 14 potential responsibilities and asked to choose which were more important to the role of their respective Community Health Boards, CHB members chose the following:

- developing a community health plan
- performing community health needs assessments
- monitoring implementation of the community health plan
- fostering community development that encourages people to actively participate in local health planning
- identifying and supporting the broad determinants of health

These responses are consistent with the roles and responsibilities of Community Health Boards defined by the Department of Health.

78% of respondents indicated that advising the Northern Regional Health Board is a very important part of their role. However, only 18% of those same people agreed with the statement *The Regional Health Board uses input of the community health board in making decisions*. These responses raise issues with respect to the CHB members' perception that the Regional Health Board does not make use of CHB input. Members of the NRHB indicated that liaison with the CHBs and addressing their needs was an important responsibility.

The survey included a series of questions regarding accountability. Highlights of the responses follow:

Is it clear to whom the members of your community health board are accountable?  
Yes - 72%                      No - 28%

Is there clarity with respect to what the community health board is accountable for?  
Yes - 52%                      No - 48%

Is there clarity with respect to the current role and responsibilities of your community health board?

Yes - 58%                      No - 42%

Is there clarity with respect to the future role and responsibility of community health boards?

Yes - 23%                      No - 77%

Although the majority of respondents answered positively to the first three questions above, the responses indicated that a significant number of CHB members did not know to whom they were accountable, for what they were accountable, and were not clear with respect to the role and responsibilities of the community health board either now or in the future. These questions indicate a need to further educate board members regarding roles and responsibilities, and accountability.

Further evidence with respect to the lack of clarity with respect to roles and responsibilities may be found in narrative comments written by the survey respondents. The following are examples of those comments:

- *“I’d like to know what we’re supposed to be accomplishing.”*
- *“We at times are given the accountability but no authority. We are a token title only!”*
- *“The role of the CHB is not clear to the public, who display a high degree of apathy until they need medical services and don’t get what they want fast enough. We have no money to work with and no autonomy.”*
- *“...There is the appearance that our CHB is accountable for certain responsibilities. However, I do not find this to be the practice. Our accountability relationship with the NRHB is minimal. I have no sense of input into decision making at a regional level, no sense of participation or consultation with the NRHB on health issues, and no sense of local involvement being valued by the NRHB. We are usually presented with information, new initiatives impacting our catchment area, etc. after the fact. I feel we are a board who’s role is to ‘rubber stamp’ changes/plans/initiatives that have already been decided....I try to convince myself that there has been some progress in the relationship between our CHB and the NRHB. Yet repeatedly, I am left with no sense that the health care system is being built from the ground up. Am I frustrated and confused about the status of our CHB? Yes. Am I likely to continue to participate in the CHB after the end of my term? I do not think so....”*

When asked to indicate to whom they were accountable, respondents indicated the following as their top choices (the number in parentheses after each choice indicates the % of respondents who selected this entity):

- the Northern Regional Health Board (86%)
- the public (78%)
- members of the public who currently have need for services provided by NRHB (53%)
- the government, through the Minister of Health (39%)

It is interesting to note that only 39% of respondents indicated that they were accountable to the government, despite the fact that government provides a significant part of the NRHB's funding. CHB members were asked to indicate whether they agreed with the statement "The Board [CHB] has a role to play in achieving the government's goals in the area of spending reductions." 44% of CHB respondents agreed with the statement while 30% disagreed (remainder were unsure). These responses indicate the need for government to communicate its accountability expectations to health sector boards, especially in relation to fiscal goals.

Section 8(2) of the Regional Health Boards Act states that "*A community health board may not employ personnel but shall utilize such personnel as are assigned to it by the regional health board.*" Only 44% of respondents believe that the community health board has the administrative support it needs to fulfill its role.

Section 8(3) of the Regional Health Boards Act states that "*A regional health board may allocate funds to a community health board for primary health care.*" In 1998-99, the budgeted total cost of CHBs at NRHB was approximately \$50,000 plus staff costs as described in paragraph 7.43. Only 22% of CHB members believe that the community health board has been provided with adequate resources to fulfill its mandate.

*Exhibit 7.1***FOLLOW-UP TO COMMENTS IN CHAPTER 12 OF  
1998 REPORT OF THE AUDITOR GENERAL**

<b>Comments in 1998 Report of the Auditor General</b>	<b>Developments during 1999</b>
<p><i>Finances</i></p> <ul style="list-style-type: none"> <li>• RHBs and NDOs reported total accumulated operating deficits of \$121.8 million as at March 31, 1998.</li> <li>• In addition, two large NDOs had incurred a total of \$69 million more in capital expenditures than available capital funding.</li> <li>• These amounts had not been recognized on the financial statements of the government.</li> </ul>	<p><i>Finances</i></p> <ul style="list-style-type: none"> <li>• RHBs and NDOs reported total accumulated operating deficits of \$234 million as at March 31, 1999 (see Exhibit 7.2, page 124)</li> <li>• The two large NDOs have incurred a total of \$83 million more in capital expenditures than available capital funding.</li> <li>• On September 28, 1999 the government released a year end forecast update for the 1998-99 fiscal year, and announced that RHB and NDO financial results would be consolidated with those of the province.</li> <li>• Government set aside \$314 million to fund prior years' deficits. This amount is to be used to writeoff accounts receivable from the RHBs/NDOs and the balance will be paid to the RHBs/NDOs to reduce their deficits.</li> </ul>
<p><i>Department of Health's Business Planning Process</i></p> <ul style="list-style-type: none"> <li>• The Department of Health had initiated a business planning process for RHBs and NDOs.</li> <li>• Business plans for 1998-99 had not yet been approved by government.</li> <li>• The Department of Health had requested that RHBs and NDOs not implement significant changes identified in their business plans until they were discussed within government and approved.</li> </ul>	<p><i>Department of Health's Business Planning Process</i></p> <ul style="list-style-type: none"> <li>• RHBs and NDOs were not asked to submit business plans for the 1999-2000 fiscal year, but year two of the previous year's plans were being validated by DOH.</li> <li>• Business plans for 1998-99 were not yet approved by government because the government was defeated, and a new government elected.</li> <li>• DOH request was still in effect.</li> </ul>
<p><i>Task Force on Regionalized Health Care</i></p> <ul style="list-style-type: none"> <li>• The Task Force was formed by the government in October 1998 to examine the current approach to delivering health care in Nova Scotia. The Task Force was to report in the spring of 1999.</li> </ul>	<p><i>Task Force on Regionalized Health Care</i></p> <ul style="list-style-type: none"> <li>• The Task Force reported in July 99. The 11 major recommendations of the Task Force are reproduced as Exhibit 7.3 to this Report (page 125).</li> </ul>

*Exhibit 7.1 cont'd*

<p><b>Comments in 1998 Report of the Auditor General</b></p>	<p><b>Developments during 1999</b></p>
<p><i>Transfers of funds by hospital boards to Foundations</i></p> <ul style="list-style-type: none"> <li>• Auditors of two RHBs identified total transfers of \$10 million of hospital funds (donations and operating surpluses) to hospital Foundations by predecessor hospital boards at the time of formation of the RHBs. We did not determine whether similar transfers had been made by the other two RHBs.</li> <li>• The Department of Health is currently reviewing the transfers.</li> </ul>	<p><i>Transfers of funds by hospital boards to Foundations</i></p> <ul style="list-style-type: none"> <li>• Our work at the Northern Regional Health Board identified an additional \$10.2 million in transfers from the nine predecessor hospital boards to the Foundations (see paragraph 7.114 page 113).</li> <li>• In March 1999, the Department of Health requested information from all of the RHBs regarding the extent of transfers. The Department of Health has not yet indicated whether it will do anything further with respect to the transfers.</li> <li>• <i>Future Direction of the Health Care System...establishing District Health Authorities</i> includes plans to review foundation issues. DOH believes that the move to District Health Authorities will lead to better relationships with foundations and auxiliaries in the future.</li> </ul>

*Exhibit 7.2*

**SUMMARY OF ACCUMULATED DEFICITS AND DEBT OF RHBs AND NDOs  
AS AT MARCH 31, 1999  
in \$ millions  
(Unaudited - Prepared by the Department of Health)**

	March 31, 1999 Accumulated Deficit per Audited Financial Statements	Plus (Less): Adjustments (Note 1)	Accumulated Cash Operating Deficit	Plus: Capital Debt	Total Accumulated Deficits and Debt (Note 2)
QEII	\$ 95.1	\$ 6.7	\$ 101.8	\$ 54.3	\$ 156.1
Cape Breton Healthcare Complex	\$ 66.5	\$ (10.2)	\$ 56.3	\$ 29.3	\$ 85.6
IWK/Grace	\$ 13.5	\$ (1.0)	\$ 12.5	\$ -	\$ 12.5
Nova Scotia Hospital	\$ 1.9	\$ (1.0)	\$ .9	\$ -	\$ .9
Eastern RHB	\$ 14.2	\$ (4.5)	\$ 9.7	\$ .5	\$ 10.2
Northern RHB	\$ 13.7	\$ (1.3)	\$ 12.4	\$ 6.1	\$ 18.5
Western RHB	\$ 19.9	\$ (4.1)	\$ 15.8	\$ 5.4	\$ 21.2
Central RHB	\$ 9.2	\$ (.3)	\$ 8.9	\$ .1	\$ 9.0
	\$ 234.0	\$ (15.7)	\$ 218.3	\$ 95.7	\$ 314.0

*Note 1 - The net adjustments to the accumulated deficits consist mainly of reductions for retained surpluses included in the equity section of the financial statements and non-cash retirement allowances, adjustments for reconciliations of accounts payable and accounts receivable, and differences in recognized deferred revenues of the RHBs and NDOs.*

*Note 2 - The Department of Health has indicated that these are the approximate amounts allocated for funding of RHB and NDO deficits and debt. DOH will apply these amounts to its net accounts receivable from RHBs and NDOs and the remainder will be paid out to the RHBs and NDOs.*

*Exhibit 7.3*

**EXTRACT FROM THE MINISTER'S TASK FORCE ON REGIONALIZED HEALTH  
CARE IN NOVA SCOTIA (pages 5-7)  
JULY 1999**

**RECOMMENDATIONS**

The Task Force feels strongly that these recommendations must be adopted in their entirety to address the issues outlined in this report and to give structure to a fully integrated, regionalized system.

- **Continue the Process of Regionalization**  
The Task Force is convinced that regionalization must be strengthened if it is to be continued. To reverse the process at this stage would further disrupt the system, increase costs, and lead to a more fragmented system of health care.
- **Develop and Strengthen Community Health Boards**  
A major step in strengthening the regionalized system will be defining in law the status of Community Health Boards. Another will be developing stronger links between Community Health Boards and Regional Health Boards by ensuring that Community Health Boards select two-thirds of the membership of the Regional Health Board....
- **Adopt a New Funding Structure for Regional Health Boards**  
The Task Force recommends adopting a new funding structure under which all funding for health care services, whether delivered by devolved services or by the Provincial Health Care Centres, be channeled through the regional boards. To support this approach, a funding formula that would allocate health care dollars to the regions on a population adjusted basis should be introduced without delay.
- **Establish a Mental Health Commission**  
The Task Force recommends that a Mental Health Commission be established to plan and set province-wide delivery standards for integrated mental health services by March 31, 2000.
- **Change the Status of the Non-Designated Organizations**  
The Task Force recommends several important changes to integrate the four Non-Designated Organization (NDOs) more closely into the regionalized system....
- **Establish a Provincial Policy and Accountability Council to Provide Leadership**  
Planning and accountability within the regionalized health care system require strengthening. The Task Force recommends that the current Provincial Leadership Committee and the Provincial Advisory Council be replaced by a Provincial Planning and Accountability Council...

*Exhibit 7.3 cont'd*

- **Devolve Home Care and Long Term Care to the Regional Health Boards**  
The Task Force recommends devolution of responsibility for Home Care and Long Term Care to the Regional Health Boards by March 31, 2000.
- **Retain the Existing Boundaries for the Present**  
...believing that any change in boundaries at this time would be premature, disruptive, and expensive, the Task Force does not recommend any change in the boundaries of the four health care regions for the present.
- **Strengthen the Relationships between Hospital Foundations and Regional Health Boards**  
The Task Force recommends a closer cooperation between hospital foundations and regional health boards to establish priorities for fund-raising and reduce delays in implementation of foundation plans.
- **Improve Health Information Management**  
The Task Force recommends that the Department of Health make a clear resource commitment to health information management, including the development of a consensus on a province-wide unique patient identifier system to track patient information across the system.
- **Develop a Long-Term Communication Plan**  
The Task Force recommends that the proposed Provincial Planning and Accountability Council establish a long-term communication plan to ensure that all Nova Scotians are kept informed of the plans, successes, and challenges of health care in general, and regionalization in particular.

*Exhibit 7.4*

**NORTHERN REGIONAL HEALTH BOARD  
HIGHLIGHTS OF REGIONAL INITIATIVES**

**August 25, 1999**

Ten community health boards established with four community health plans submitted. Primary health care issues, community development, and primary prevention emphasized and nurtured through this process.

Development of regional geriatric program with improved access to geriatric services. (Previously, patients had to travel to Halifax for these services)

Reestablishment of regional orthopaedic surgery program based at the Aberdeen Hospital.

Diabetes education centres are now located in every health care facility in the region. (Two of our facilities did not have this service prior to regionalization.)

Stabilization of regional pediatric services.

Expansion of regional mental health services including child/adolescent psychiatric consultation services.

Establishment of echocardiography services at Colchester Regional Hospital.

Satellite renal dialysis units at All Saints Hospital in Springhill and Sutherland Harris Memorial Hospital in Pictou with plans for a third unit at Colchester Regional Hospital in Truro (in partnership with the QEII Health Sciences Centre).

Patient care enhancements with the development of regional clinical practice guidelines, clinical pathways, evidence-based approaches to patient care (eg. Regional pneumonia pathway).

Lead role in federally-funded Rural Palliative Home Care Project of Nova Scotia and Prince Edward Island.

One of eight national participants in LoPHID (Local Public Health Infrastructure Development) federally-funded research projects. The three research cycles in this region are: perinatal care and caring in northern Nova Scotia; children speaking up: eating, physician activity and dental care; and the path to school: infancy to five years.

Funding and supporting, with the Department of Health, Dalhousie University and the Amherst Association for Health Adolescent Sexuality, a teen health Centre in Amherst High School. A similar initiative is being pursued for the Cobequid Education Centre in Truro.

Unique interprovincial partnership with South East Health Care Corporation of Moncton, New Brunswick, and Highland View Regional Hospital to address recommendations put forth in an independent review of Highland View Regional Hospital.

*Exhibit 7.4 cont'd*

Development and design of new regional acute care facility in Cumberland County.

East Hants Health Outreach Clinic offering blood collection services, ECG services and mental health services (in partnership with the Colchester Regional Hospital Foundation).

Construction of Parrsboro and Area Professional Centre (in partnership with the South Cumberland Community Care Centre Foundation).

Renovation and upgrading of Aberdeen Professional Centre. The former nurses residence now houses tenants including public health services, addiction services, Home Care Nova Scotia, physicians' offices, Nova Scotia Community College, Tearmann Outreach, VON and the Canadian Mental Health Association.

Pursuing the reestablishment of the Colchester Regional Hospital Phase II project.

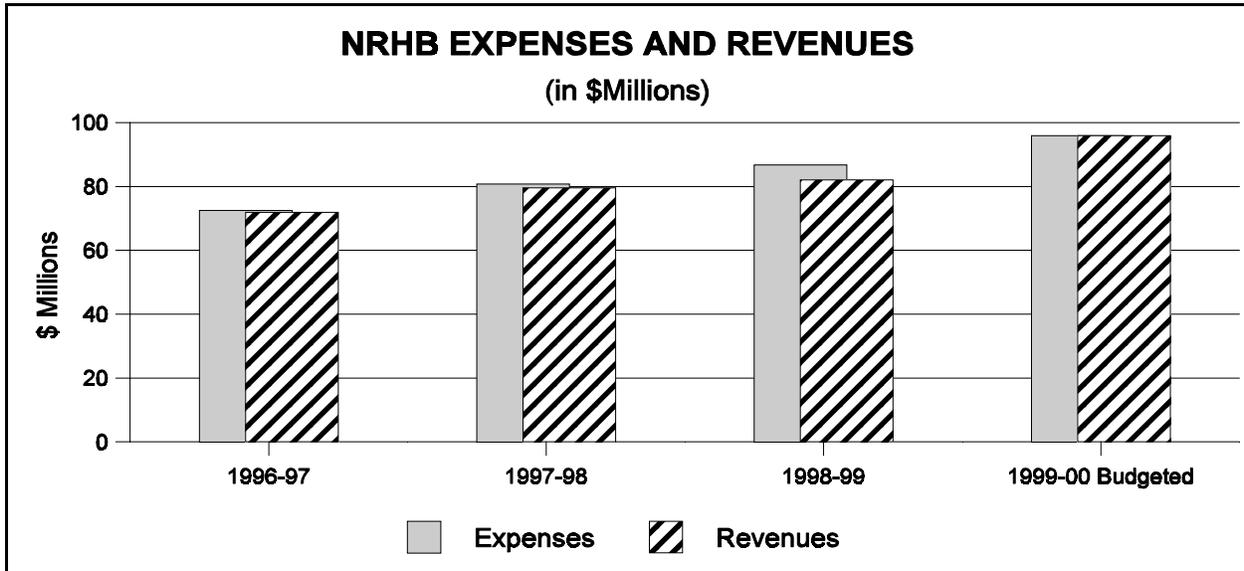
Consolidation of financial services and business office functions with savings of \$300,000 redirected to patient care.

Prime vendor agreement with Toshiba providing diagnostic imaging services, supplies and equipment which will reduce costs by almost \$1.5 million over seven years.

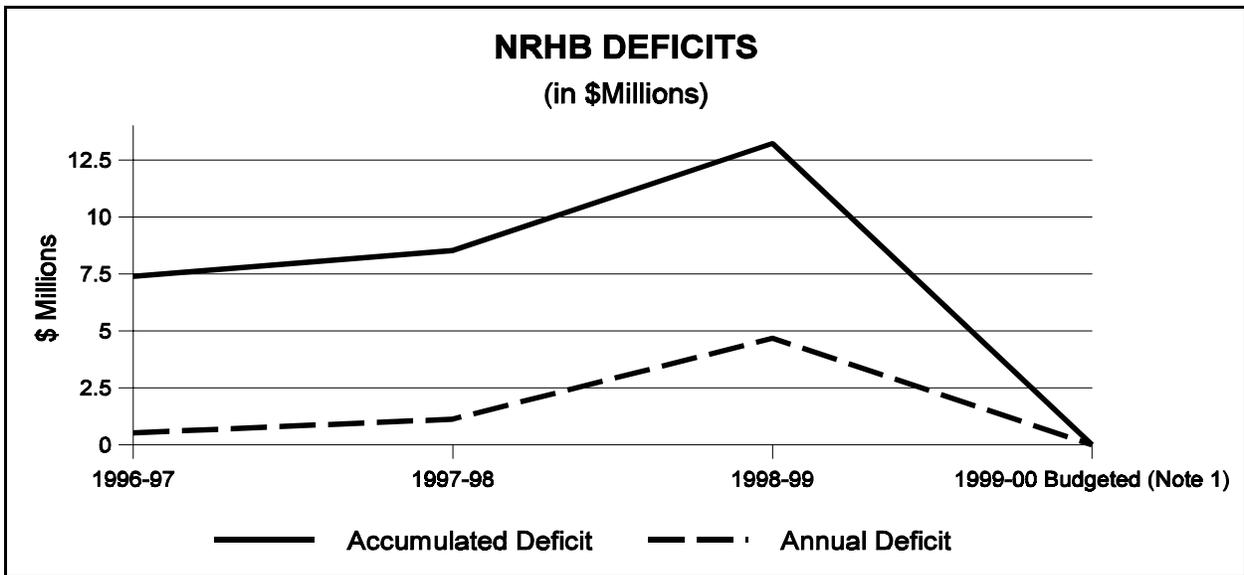
Prime vendor agreement with Can-Med for medical/surgical supplies, reducing overall costs.

Participating in the provincial TeleHealth program.

*Exhibit 7.5*



*Exhibit 7.6*



Note 1 - 1999-2000 projection of accumulated deficit is based on the assumption that the Department of Health will fund all RHB accumulated deficits during 1999-2000.

Exhibit 7.7

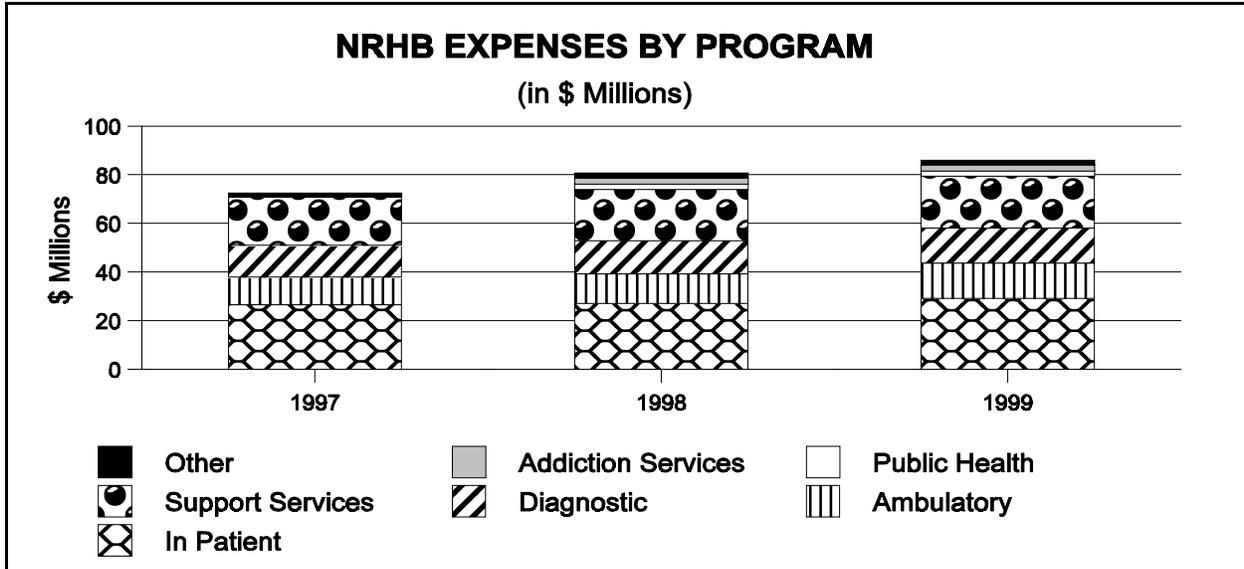
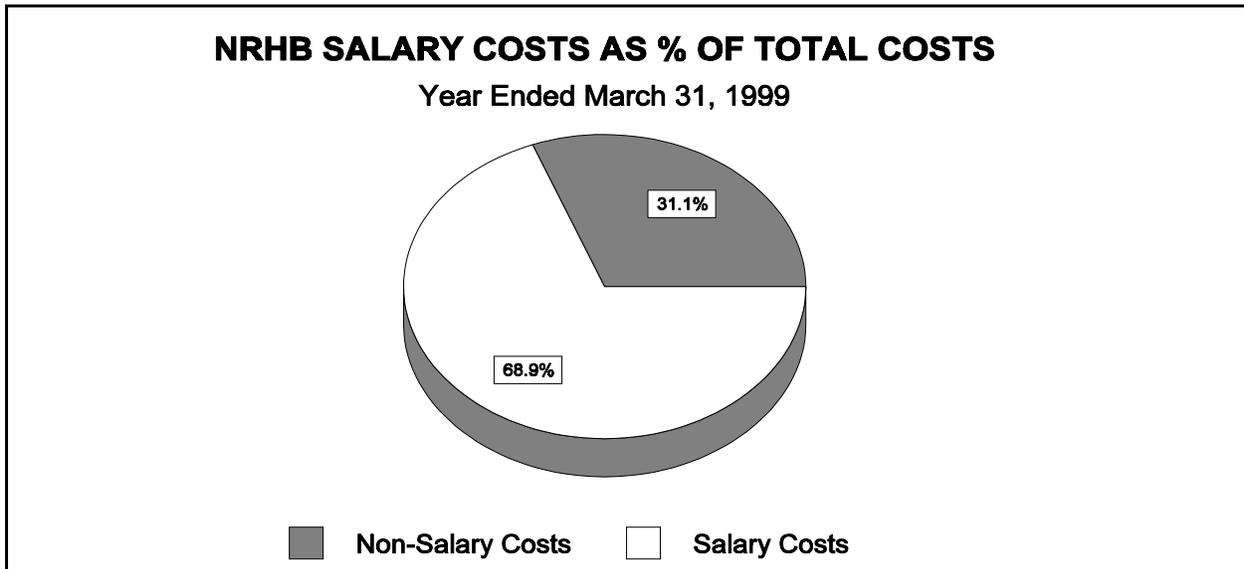
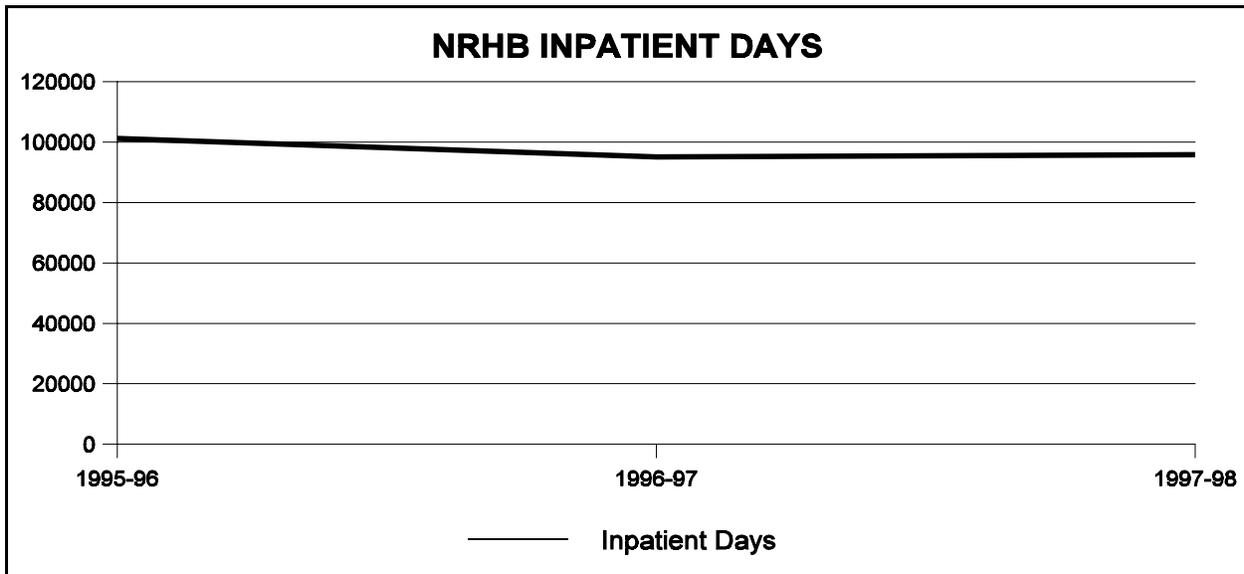


Exhibit 7.8



*Exhibit 7.9*



*Exhibit 7.10*

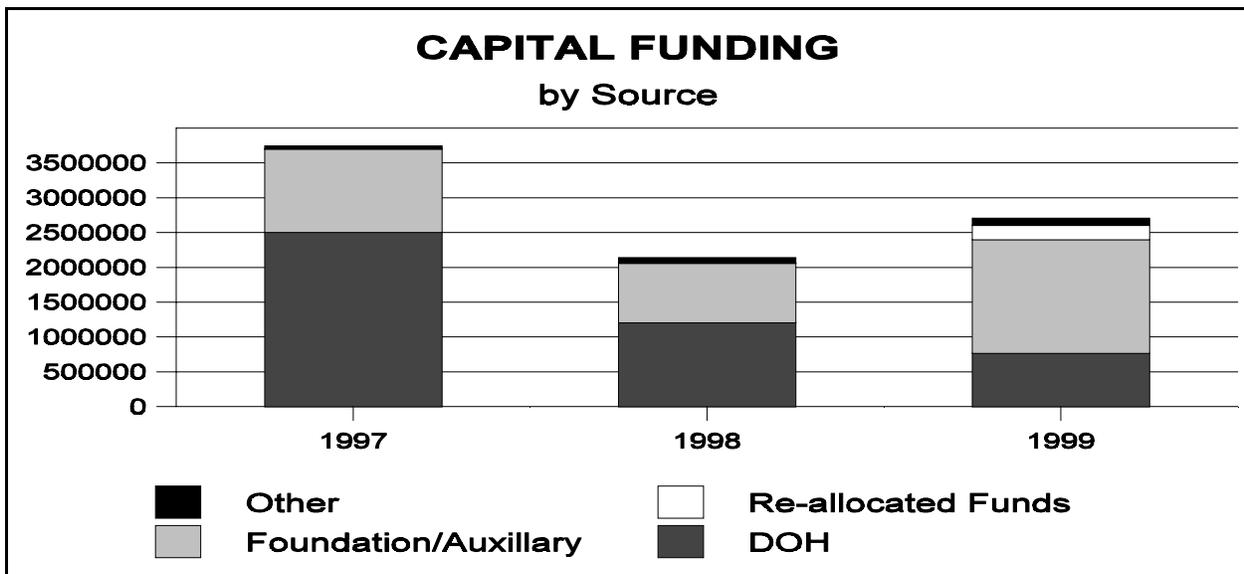
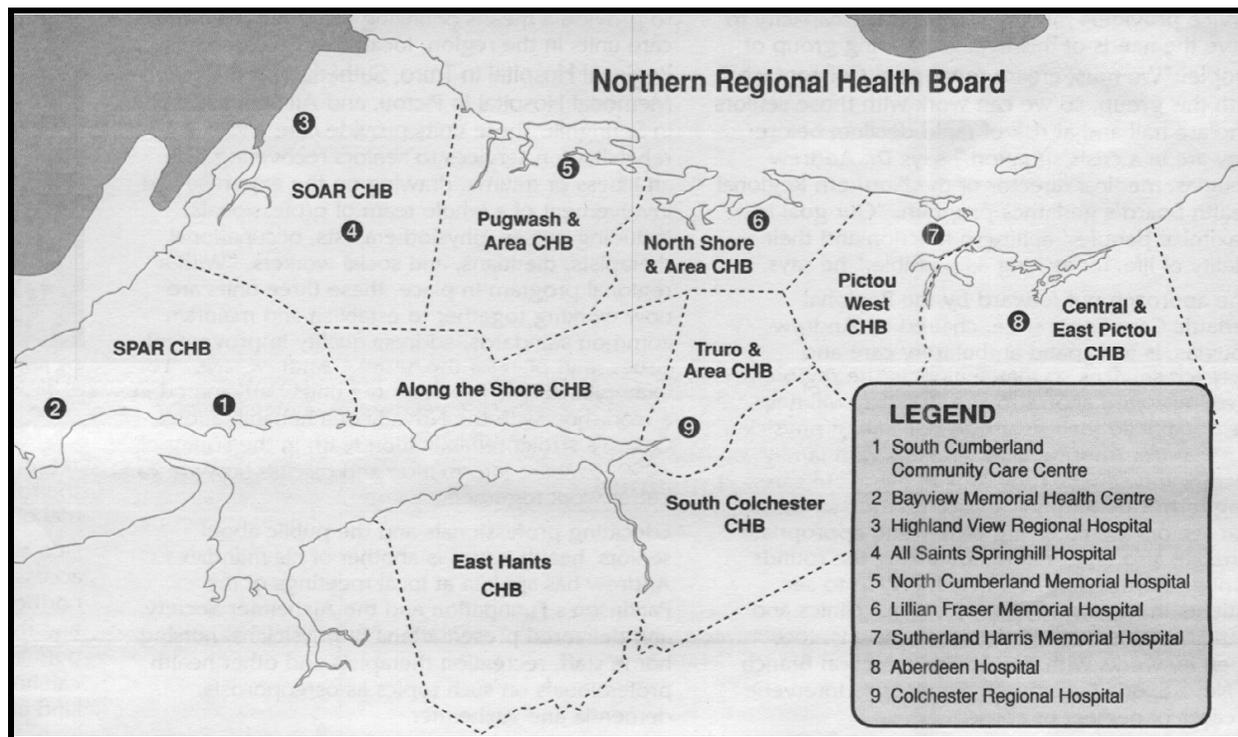
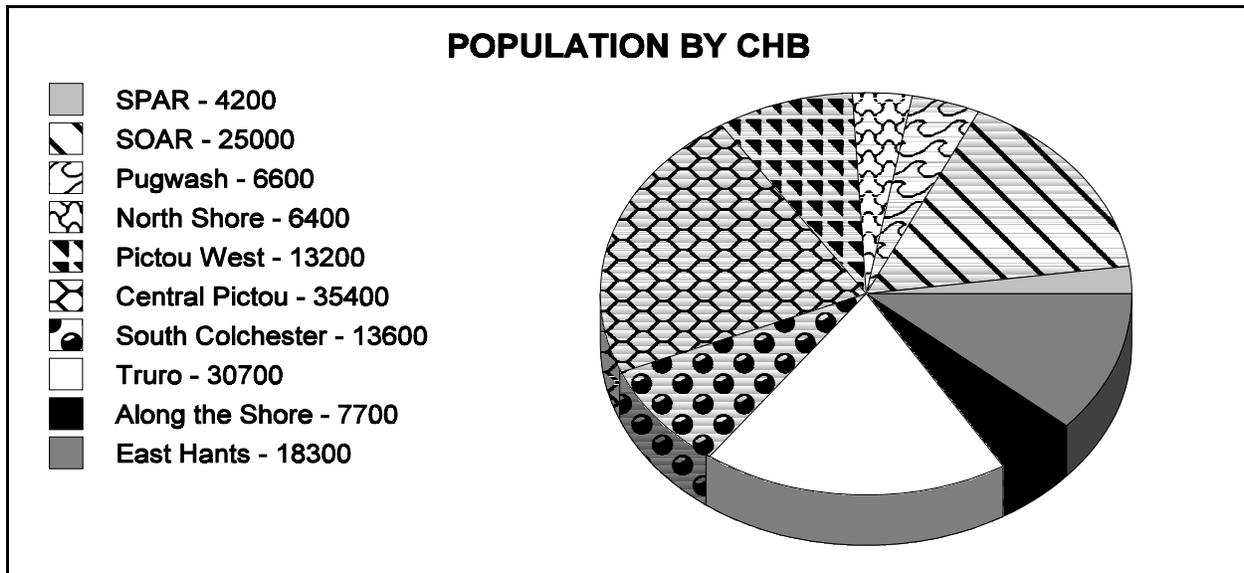


Exhibit 7.11

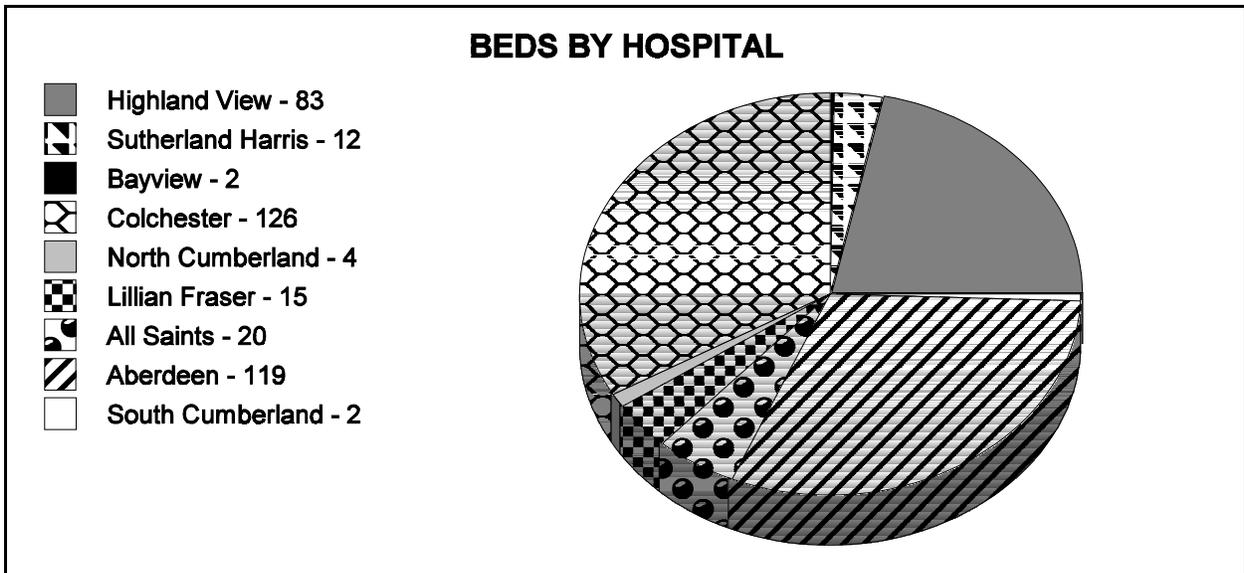
**NORTHERN REGIONAL HEALTH BOARD  
LOCATION OF FACILITIES AND COMMUNITY HEALTH BOARDS**



*Exhibit 7.12*



*Exhibit 7.13*



*Exhibit 7.14*

**NORTHERN REGIONAL HEALTH BOARD**  
**NOTE 9 TO THE MARCH 31, 1997 FINANCIAL STATEMENTS**

**9. Transfer to foundations**

For the past two years and the six month period prior to October 1, 1996, the date of designation, the directors of the predecessor facilities transferred funds and assets, which arose primarily from donations and operating surpluses, to foundations which were associated with the respective facilities, as follows:

	<b>Funds Transferred</b>	<b>Assets Transferred</b>	<b>Total</b>
Aberdeen Hospital Commission	\$ 2,109,968	\$ -	\$ 2,109,968
All Saints Springhill Hospital Corporation	751,095	-	751,095
Bayview Memorial Health Centre	91,898	71,707	163,605
Colchester Regional Hospital Commission	3,630,400	-	3,630,400
Highland View Regional Hospital	1,134,173	-	1,134,173
Lillian Fraser Memorial Hospital	92,313	-	92,313
North Cumberland Memorial	150,807	250,816	401,623
South Cumberland Community Care Centre	143,448	-	143,448
Sutherland Harris Memorial Hospital	<u>1,856,727</u>	-	<u>1,856,727</u>
	<u>\$ 9,960,829</u>	<u>\$ 322,523</u>	<u>\$ 10,283,352</u>

On September 18, 1996, the Aberdeen Hospital Commission and the Aberdeen Hospital Trust established a trust fund of \$2,109,968 to be administered by the trust. The indenture of trust has the following requirements:

- a) The payment of annual payments of \$252,000 by the trust commencing on October 1, 1996, and ending on December 31, 2005, for the leasing of diagnostic imaging equipment for the Aberdeen Hospital.
- b) After the trust has met its total ten year commitment, then the trust may transfer the balance of the remaining funds, if any, to the Aberdeen Hospital Foundation to be used according to the objects of the foundation.

On April 12, 1994, the Colchester Regional Hospital Commission and the Colchester Regional Hospital Foundation established a trust fund of \$3,630,400 to be administered by the foundation from the financial reserves previously held by the hospital. The trust agreement defined two allowable uses for these funds:

*Exhibit 7.14 cont'd*

- a) Programs and services based at Colchester Regional Hospital, and
- b) Health care programs and services primarily benefiting residents of the communities previously served by the hospital.

Except for the foregoing trust agreements, these monies are being held in the accounts of the foundations, to whom the funds were transferred, on the understanding that the funds will be expended at the discretion of the foundation for the benefit of the facilities, for which the funds were originally raised.

These assets have not been recorded in the accounts of the facilities, as the board of directors of the Northern Regional Health Board do not have custody or control over the funds.

*Exhibit 7.15*

**EXAMPLE OF FINANCIAL INFORMATION RECEIVED BY THE BOARD  
UNAUDITED - FOR ILLUSTRATIVE PURPOSES ONLY**

**CONSOLIDATED STATEMENT OF OPERATIONS**

	<b>Facilities</b>	<b>RHB Operations</b>	<b>Drug Addiction</b>	<b>Public Health</b>	<b>Regional Budget</b>	<b>Totals</b>
<b>Revenues</b>						
Actual - YTD	\$ 77,956,249	\$ 236,132	\$ 2,632,650	\$ 2,561,500	\$ (1,214,338)	\$ 82,172,193
Budget - YTD	<u>\$ 77,396,713</u>	<u>\$ 226,587</u>	<u>\$ 2,630,100</u>	<u>\$ 2,561,500</u>	<u>\$ (1,214,338)</u>	<u>\$ 81,600,562</u>
Variance	\$ 559,536	\$ 9,545	\$ 2,550	\$ 0	\$ 0	\$ 571,631
<b>Expenses</b>						
Actual - YTD	\$ 79,257,956	\$ 1,414,395	\$ 2,632,650	\$ 2,605,056	\$ 860,643	\$ 86,770,700
Budget - YTD	<u>\$ 77,380,713</u>	<u>\$ 1,319,012</u>	<u>\$ 2,633,307</u>	<u>\$ 2,572,095</u>	<u>\$ 2,442,750</u>	<u>\$ 86,347,877</u>
Variance	\$ (1,877,243)	\$ (95,383)	\$ 657	\$ (32,961)	\$ 1,582,107	\$ (422,823)
<b>Surplus/(Deficit) before vacation</b>						
Actual - YTD	\$ (1,301,707)	\$ (1,178,263)	\$ 0	\$ (43,556)	\$ (2,074,981)	\$ (4,598,507)
Budget - YTD	<u>\$ 16,000</u>	<u>\$ (1,092,425)</u>	<u>\$ (3,207)</u>	<u>\$ (10,595)</u>	<u>\$ (3,657,088)</u>	<u>\$ (4,747,315)</u>
Variance	\$ (1,317,707)	\$ (85,838)	\$ 3,207	\$ (32,961)	\$ 1,582,107	\$ 148,808
<b>Vacation expense</b>						
Actual - YTD	<u>\$ 624,140</u>	<u>\$ 9,603</u>	<u>\$ 32,934</u>	<u>\$ 9,025</u>	<u>\$ 0</u>	<u>\$ 675,702</u>
Actual - YTD	<u>\$ (1,925,847)</u>	<u>\$ (1,187,866)</u>	<u>\$ (32,934)</u>	<u>\$ (52,581)</u>	<u>\$ (2,074,981)</u>	<u>\$ (5,274,209)</u>

Note: The foregoing represents preliminary information as the year end is not finalized.