5.

FINANCIAL PLANNING AND BUDGETING - CAPITAL DISTRICT HEALTH AUTHORITY

BACKGROUND

5.1 The Health Authorities Act received Royal Assent on June 8, 2000. The Act provides for the creation of District Health Authorities (DHAs) and community health boards. Certain sections took effect January 1, 2001 and other sections became effective April 1, 2001. District Health Authorities are responsible for governing, planning, managing, delivering, monitoring, evaluating, and allocating resources to health services within their districts and for providing planning support to the community health boards. Community health boards are responsible for developing community health plans encompassing primary health care and identifying ways to improve the overall health of the community.

5.2 Section 6(3) of the Act provides for the creation of the Capital District Health Authority (CDHA). CDHA operates eight health care facilities, including the Queen Elizabeth II Health Sciences Centre, the Nova Scotia Hospital, and the Dartmouth General Hospital (see Exhibit 5.1). It also has responsibility for Drug Dependency, Home Support Central, and Public Health services. The organization employs approximately 750 physicians and 8,500 nursing, technical and other staff at 31 locations covering approximately 4.2 million square feet of space.

5.3 CDHA is governed by a single Board of Directors. The Executive Committee and the Finance and Audit Committee are two committees of the Board with particular financial responsibilities. These committees are chaired by Board members. The day-to-day operations of CDHA are administered by the Executive Management Team, consisting of the Chief Executive Officer, 10 vice-presidents and the Medical Officer of Health.

5.4 CDHA receives the majority of its funding from the Department of Health. Most of the funding is portable, that is, funds are transferable between programs and capital. However, there is some non-portable funding as well (see Exhibit 5.2). Non-portable funding is targeted for specific programs and is not transferable to other programs. Section 31 of the Act does not allow DHAs to budget for a deficit.

5.5 For the 2000-01 fiscal year, the Queen Elizabeth II Health Sciences Centre, the Nova Scotia Hospital and the (former) Central Regional Health Board were budgeted as separate entities. Actual operating expenditures for the combined organization were $484.6 million, with revenues of $468.4 million. The $16.2 million deficit was funded by the Department of Health. For the 2001-02 fiscal year, CDHA budgeted revenues and expenditures of $492.4 million, including $3.9 million for capital projects (see Exhibit 5.3 and 5.4).

5.6 Section 4(2) of the Health Authorities Act which provided for the creation of the Capital Health District includes the Izaak Walton Killam-Grace Health Centre for Children, Women and Families (IWK-Grace) as part of the Capital Health District under a separate board of directors. Due to the timing of the second proclamation of the Act, business plans of the IWK-Grace were provided separately from CDHA for 2001-02. For the 2002-03 fiscal year, a joint business plan is to be presented for both CDHA and the IWK-Grace.

RESULTS IN BRIEF

5.7 The following are the principal observations from this audit.

- The Capital District Health Authority was established in 2001. Preparation of the first budget for the new organization was a challenge for the management team and Board, especially because CDHA had been informed that its Provincial funding would not increase over the amount provided to the predecessor organizations in the prior year. Subsequently, CDHA's funding was increased by $27.2 million.

- CDHA's process for budget preparation was appropriate and the Authority submitted its budget request to the Department of Health in the required timeframe.

- Those who make decisions on budgets require information about the assumptions underlying the budget submission. The quality of the budget is largely dependent on the completeness and reasonableness of the assumptions. We recommended improvements to the documentation and communication of assumptions underlying the CDHA's budget submission.

- Senior management instructed staff to maintain expenditures at the prior year's level. However, statistical information on volumes circulated with the budget instructions indicated that service volumes were expected to increase in certain areas. There were no approved operational plans to 'close the gap' between the impact of increased activity levels and available funds. Similarly, during the budget process the Department of Health requested CDHA to make cuts of $9.6 million to its expenditures, of which $5.2 million was assigned to clinical areas. There was no approved operational plan to achieve the clinical reduction.

- CDHA has analyzed its long-term capital needs although the analysis is incomplete in some areas. The Department of Health and CDHA should work toward establishing a common perspective on those needs, and an appropriate funding strategy. CDHA's 2001-02 capital budget submission to the Department of Health, based on departmental requests, totaled $53.5 million. CDHA allocated $3.9 million of Department of Health funding to capital, and $5.3 million is anticipated from other sources such as Foundations. The balance of $44.3 million has not been funded in the current year.

AUDIT SCOPE

5.8 The objectives for this assignment were to:

- determine whether the 2001-02 budget information used by government to make decisions related to the Capital District Health Authority has quality and integrity;

- determine whether the budget preparation process was sound;

- determine whether there is an appropriate process to monitor actual versus budgeted results for 2001-02; and

- review and assess the preparation process and support for the Capital District Health Authority's 2001-02 capital request submitted to the Department of Health, and the amount of the approved capital budget.

5.9 Our objectives focused on systems and procedures to support preparation of the budget, and did not include formation of an opinion on the reasonableness of the amounts included in the budget. Consequently, we express no opinion on reasonableness of the budget, or whether assumptions are suitably supported, consistent with the plans of the government and CDHA, provide a reasonable basis for the budget, and are fairly reflected in the budget.

5.10 Our approach was based on interviews, review of documents and correspondence, and detailed testing of a sample of line items reflected in the budget.

5.11 The scope of this audit did not include the IWK-Grace Health Centre for the reasons described in paragraph 5.6.

PRINCIPAL FINDINGS

Description of the Business Planning and Budgeting Processes

5.12 *Introduction* - Business plans serve as the foundation for the budgeting process. CDHA was required to prepare a business plan for the 2001-02 fiscal year. The format and template used to prepare the business plan were provided by the Department of Health. Key information in the business plan included the mission statement, strategic directions, and projected budget.

5.13 *Establishment of objectives* - CDHA detailed the organization's values, mission, vision and strategic directions in its 2001-02 business plan. The strategic directions were outlined under the headings of Building Our Culture, Developing an Integrated Population Health System, and Supporting Integration. Senior management was responsible for developing initiatives within the three broad categories. More specific departmental objectives and individual objectives for directors were linked to these.

5.14 In some cases the linkage between the budget and business plan could be established. For example, an extra $1.0 million was budgeted for human resources development in support of the first objective. In other cases there were narrative descriptions of new initiatives and funding. In yet other cases, such as information technology and finance, integration was occurring as part of ongoing operations and was included in the budget allocation.

5.15 Since the majority of CDHA's budget is funded through the Department of Health, it is essential that CDHA's focus and direction be consistent with the Department's objectives. The Department of Health's strategic initiatives are set out in its business plan. We were informed that CDHA ensures its organizational strategies and initiatives are consistent with the Department's objectives which are included in the budget package which CDHA receives from the Department.

5.16 *Link to performance information* - Performance targets and strategies to achieve the targets should be linked to the goals and priorities set out in the business plan. Many of the initiatives from CDHA's business plan are still under development. Unless appropriate targets and outcome measures are established, it is difficult to determine progress, allocate resources and determine the adequacy of the allocation. We recommend that CDHA proceed to develop appropriate performance targets.

5.17 *Description of the budgeting process* - The budget process began in early November with the distribution of a budget package from central office to senior management, directors and managers. Senior management directed that the budget be prepared under the assumption that funding from the Department of Health would not exceed the 2000-01 level and opportunities for further savings should be identified.

5.18 The budget packages were completed by the managers, reviewed by the directors and returned to the budget office by early December for tabulation and completion of the overall budget. Over the next month, directors of all departments presented their budgets to the executive management team for review and challenge which resulted in a decrease of $5.8 million from the initial submissions.

5.19 A Department of Health communication, issued in late January 2001 to CDHA, requested preparation of a balanced budget based on funding targets provided at that time. The initial targets were essentially the forecast actuals for 2000-01. In order to achieve this target, CDHA decreased its initial expenditure budget by $37.7 million. By mid-February, the budget was approved by the executive management team and presented to the Finance and Audit Committee for approval.

5.20 In late March, the Department of Health communicated an increase in funding of $27.2 million and suggested certain clinical and administrative reductions. The budget was revised and approved by the Board on April 5, 2001. The final budget allocations were communicated to managers and directors on April 20, 2001.

5.21 *Recommendations* - Our primary recommendation for the business planning and budgeting process is that performance targets should be established.

Appropriate Governance and Management Structure - Audit Findings

5.22 *Introduction* - Budgeting is a complex process which requires input from throughout the organization on many aspects of operations such as program changes, assumptions and cost and service volume projections. This information is the basis for important decisions and needs to be accumulated, summarized and communicated to senior management, the Board and the Department of Health. A clearly defined structure of functions and processes is needed to provide overall direction in the creation of the budget and to monitor progress in its development. Responsibility, accountability and authority for the preparation of the budget should be clearly assigned.

5.23 *Roles and responsibilities* - The Chief Executive Officer reports to the Board and is part of the Executive Management Team. The terms of reference for the Executive Management Team include responsibility for planning and financial management. Day-to-day financial management of the CDHA is under the direction of the Vice-President, Administration through to the Director of Finance. Key financial management positions reporting to the Director include Manager of Budgeting, and Manager of Financial Reporting. The Finance Department has a total complement of 75 employees.

5.24 Job descriptions for all the key financial management positions include appropriate responsibilities as well as requirements for professional accounting designations. The responsibilities include planning and budgeting, monitoring and reporting, cash management, and establishment of annual goals.

5.25 *Policy framework* - The budget planning cycle, directions and policies were well documented, clear, and adequately communicated to appropriate parties. The planning cycle included the steps from start through to completion and approval. The budget package included an outline of the budget process, milestone dates, assignment of responsibilities, budget worksheets, volume statistics and activity reports.

5.26 The budget preparation plan did not address the need for separate and early development of assumptions, nor was there any direction requiring disclosure of the sensitivity of the assumptions. Decision makers and users of budget information should be aware of risks and sensitivities related to assumptions. There was no evidence of risk and sensitivity analysis being requested by or provided to senior management and the Department of Health. We recommend the plan and procedures be revised to include these items.

5.27 *Relationship with Department of Health* - The Department issued business plan and budget guidelines to the DHAs in late January 2001. The guidelines set out the timetable and format of the business plan to be submitted to the Department. The instructions also included directions to produce a balanced budget based on the initial funding targets which were provided. This level of funding required CDHA to identify $37.7 million of expenditure reduction initiatives.

5.28 CDHA followed the guidelines and submitted a draft business plan to the Department of Health on February 12, 2001. The Department reviewed the plan and initiatives internally and assessed the impact on the Department's programs. Following review with central government, additional funding of $27.2 million was provided and CDHA was requested to introduce initiatives for clinical and administrative cost reductions of $9.6 million in balancing the budget. Final funding was communicated to CDHA at the end of March 2001.

5.29 In Chapter 3, paragraph 3.66, we included the consultants' recommendation *"The Department of Health should expand its planning and forecasting processes to include multi-year projections to coincide with the timeframe for many of its strategic initiatives."* CDHA has requested multi-year funding projections from the Department to improve the planning and budgeting process.

5.30 *Recommendations* - Our primary recommendation for this area is that policies and procedures should require documentation and communication of assumptions, and a discussion of related risks and sensitivities.

Sound Financial Reporting Standards - Audit Findings

5.31 *Introduction* - Information contained in the budget should be reliable, and prepared in accordance with generally accepted accounting principles. Readers and users must be assured of the completeness, accuracy and reliability of the information being provided. In the following paragraphs, we comment on issues related to the quality of the budget document.

5.32 *Accounting principles* - The Department of Health specifically communicated the requirement for application of generally accepted accounting principles in the financial records of the District Health Authorities. CDHA's business combination plans included a review of the financial statements of the various components to ensure consistent accounting treatment for consolidation and budget purposes. During our audit of the budgeting process we did not encounter any deviations from generally accepted accounting principles.

5.33 *Assumptions* - The key assumptions underlying a budget should be known to the users of budget information. Senior management should define certain basic assumptions regarding expectations for the upcoming year. The assumptions should be reasonable and supportable - obtained from past performance or from future economic conditions. The quality of the budget is largely dependent on the completeness and reasonableness of the assumptions. These assumptions should be communicated to decision makers so that they can understand the reasonableness of the amounts presented to them.

5.34 To be reasonable, assumptions need to be consistent with the plans of the organization and reflect the expected economic effects of anticipated strategies, programs and actions, including those being planned in response to expected future economic conditions. To be supportable, assumptions need to be based on the past performance of the organization, studies or other sources that provide objective corroboration of the assumptions used. The process used to develop assumptions should be based on relevant information that is reasonably available at the time the budget is prepared.

5.35 There are two types of assumptions which are relevant to the budget process. The first are assumptions related to Province-wide factors such as population growth, income levels, Gross Domestic Product, and costs of major inputs such as fuel and wages. The second are department and program-specific assumptions related to costs of inputs and service levels. For example, a relevant assumption in the provision of health care would be hours of nursing care per patient day.

5.36 The Department of Health included specific instructions in the business plan and budget guidelines provided to the DHAs (see paragraph 5.27). However, the instructions did not include assumptions to be built into the budgets or the requirement for the DHAs to provide to the Department the assumptions utilized in producing their budgets. We suggest the communication of appropriate assumptions between the Department of Health and the DHAs.

5.37 The CDHA budget instructions described in paragraph 5.25 contained a section entitled *Population Health Assumptions*, which included a statement that the current mix of programs is to be maintained. A section entitled *Labour Assumptions* contained a statement that staffing and scheduling patterns will maximize productivity and meet operational needs. The business plan submitted to the Department of Health, described previously in paragraph 5.28, included a page outlining the assumptions incorporated in the plan. We found these assumptions were at too high a level or incomplete. For example, the only non-financial assumptions related to provision of services were:

- *"Due to our unique regional obligation to deliver tertiary and quaternary service, we cannot eliminate clinical programs. If we were to eliminate these services, there would be no cost savings because of the need to purchase these services from other provinces, without removing the costs associated with, for example, pre and post-surgical care."*

- *"The business plans for fiscal 2000/01 consisted of major reduction [sic] in Administration and Support Departments and reduction [sic] in managers. Thus further budget reductions will impact clinical services."*

5.38 Assumptions related to cost-drivers were submitted to senior management in early fall. We noted where these and other assumptions were in some cases documented and provided by program managers as part of their budget submissions. However, there was no documentation of senior management approval of the assumptions.

5.39 In most cases where assumptions were stated, we found they were adequately supported, although mainly through internal sources. We noted there was minimal documentation prepared on the risks and sensitivities of the amounts budgeted. Documentation of risks and sensitivities is especially important because clinical services are largely patient/client driven, and there is a risk of increased or decreased demand for services at any time during the year.

5.40 For the clinical and community health departments, statistics including projected clinical volumes/program activity for 2000-01 and assigned budget volumes for 2001-02 were included with the budget package. We were informed that the inpatient budget volumes were developed based on the number of beds available and projected occupancy rates. However, the ambulatory volumes were based on volume budgets developed prior to 2000-01.

5.41 We found the use of the budget volumes was not consistently applied in the budget process. Some unit managers adjusted the budget volumes to better reflect where they felt activity levels would be. Others used alternate sources of data to determine volumes for their budget calculations. In yet other cases, activity volumes were not factored in the budget calculation. We also found price increase assumptions for supplies were not consistently factored into the budget. Senior

management indicated that CDHA's budget process was based on the funding targets established by the Department of Health which resulted in a focus on available funding rather than expected activity levels. Management indicated that price increases and other factors were considered during the budget process and that, because of limited funding, program managers were expected to cover these increases within their assigned budgets. Targets were not increased if management felt the increases could be managed.

5.42 We suggest the volume, activity and price factors be considered by senior management earlier in the budget planning process. Senior management should develop assumptions based on these factors and other economic data. Senior management should present their assumptions to the Board, through the Finance and Audit Committee, for review and discussion. The risks and sensitivities associated with the assumptions should also be communicated. The Board needs only to indicate where they might disagree with the assumptions to be used, otherwise the assumptions should go forward to the managers and directors as the basis for preparation of the budget.

5.43 *Documentation and support* - The total operating budget of $488.5 million includes $343.3 million in compensation (salary and benefits) and $145.2 million in supplies. We selected a sample of compensation line items totaling $66.3 million (19%) and supplies totaling $34.7 million (24%). From the revenue budget of $61.8 million (excluding Department of Health funding) we selected a sample of line items totaling $41.0 million (66%). We examined the supporting documentation, verified calculations and assessed the adequacy of supporting analysis for the items.

5.44 Our findings resulting from examination of the test items are described as follows (see Exhibits 5.6 and 5.7 for further information). For 87% of compensation, 51% of supplies, and 15% of revenue items tested, support was sufficient. For $8.4 million (13%) of compensation, $13.2 million (38%) of supplies and $35.0 million (85%) in revenue, the 2001-02 budget amounts were based on either the budget or forecasted results for the 2000-01 fiscal year. The supporting analysis was not sufficient because it did not take into consideration possible increases in the cost of providing services or increases in volume and activity levels. For the remaining $3.8 million of supplies (11% of supplies, utilities-electricity), there was little or no evidence to support the factors used in the calculation of the budget amounts.

5.45 *Reliability* - Information presented in the budget should be supportable and free from error or bias. It should be linked to economic and program related assumptions and historical trends of actual costs. Users of the information must be able to depend upon it to faithfully represent what it purports to represent. Reliability is undermined when the amount in the budget bears little relationship to expected results.

5.46 The direction from senior management was to maintain expenditures at last year's level. The assigned budget volumes referred to above generally showed increases in activity. There were no operational plans on how to achieve reductions from the volumes indicated to activity levels which could be supported by the funding level.

5.47 More specifically, as mentioned in paragraph 5.28 above, to achieve a balanced budget CDHA was requested by DOH to reduce its expenditures by $9.6 million, of which $5.2 million was allocated to clinical areas. We were informed that senior management considered this amount as a target. No specific operational plans to accomplish this reduction were established.

5.48 At the time of our audit in early fall, the clinical portfolio was overexpended and management had been struggling to meet the budget target. The minutes of the Finance and Audit Committee indicated concerns with this situation and also efforts to implement cutbacks and strategies. In our opinion, there was no documented, approved plan to achieve the clinical reductions.

5.49 *Quality control* - Budget submissions from the managers and directors were submitted either by electronic file or on paper documents. There was no requirement for documented sign off at this initial stage. We noted that managers in the clinical units signed off on the paper copies of the standard staffing summary forms. We found the review and challenge processes to advance budget submissions at the senior management levels through to the Board were well documented.

5.50 Budget analysts are expected to complete a reasonableness review as they enter the budget information into the budgeting system. The Manager of Budgeting advised us that he also does a reasonableness review. There is no internal audit function at CDHA which could provide independent review of budget submissions within the organization. We recommend CDHA consider establishing an internal audit function which could provide independent review of the budget submissions and supporting analysis.

5.51 *Time lines* - The Department of Health, in its guidelines, established the time frame for the submission of business plans and budgets. While we recognize that significant organization and system changes were taking place at the Department during 2000-01, we found the time frame established was too compressed. We understand the Department was aware of this difficulty and has plans to address the problem for the 2002-03 budget cycle.

5.52 Within CDHA, we found that information was provided on a timely basis, although within a very tight time frame relative to the target dates set by the Department of Health.

5.53 The target date for Board approval of the budget is March, before the start of the fiscal year. To achieve that target, the House of Assembly must approve the Provincial Estimates prior to that time. An issue of concern is that the House is not approving the Estimates early enough to enable the Department of Health and CDHA to finalize budgets prior to the beginning of the fiscal year. Approval of the budget in March would enable monitoring of budgets and actual results to commence at the beginning of the new fiscal year.

5.54 *Recommendations* - Recommendations for sound financial reporting standards include:

- The Department of Health should communicate appropriate assumptions to the DHAs. The DHAs should communicate assumptions underlying budget submissions to the Department.
- Senior management should develop and communicate overall budget assumptions to the Board, prior to the commencement of the budget preparation process.
- Directors and managers should be required to document operational plans to achieve budget reductions communicated by senior management.
- Where feasible, objective, external support should be provided for assumptions.
- There should be formal sign-off on the budget recommendations at each level in the process.
- CDHA should consider the feasibility of establishing an internal audit function which could play a role in quality control during the budget process.

Sound Monitoring Process

5.55 *Introduction* - A sound monitoring process depends on appropriate policies and procedures for monitoring financial performance. Appropriate monitoring involves regular review of revenues and expenditures along with an analysis of operational resources. Timely reporting of findings is

an important component of a sound monitoring process and must start early in the schedule. Early reporting of monitoring results improves management's ability to assess financial and operational goal achievement, and make changes as required.

5.56 *Policy framework* - We expected that senior management would establish and communicate policies concerning the monitoring of financial performance. We also expected that budget to actual comparisons would be performed and criteria for the provision of written variance explanations would have been developed.

5.57 The Capital District Health Authority has formal monthly monitoring policies and procedures. Within the Finance Department, reporting to the budget manager, are a number of budget analysts responsible for completing these procedures. Staff utilize a computerized system which captures information at the cost center level.

5.58 Section 21(1) of the Health Authorities Act requires District Health Authorities to submit monthly and quarterly financial statements to the Department of Health. Two financial officers at the Department are assigned to monitor and follow up on the financial performance information and provide reports to the Director, Finance-Health Services.

5.59 CDHA policies require all variance analysis to be completed in a standard format. The budget analysts are responsible for providing explanations for all significant variances within their respective portfolios. Thresholds are established to determine the variances to be investigated and reported at the cost center and financial statement level. Explanations for variances over certain thresholds must be provided to the Finance and Audit Committee.

5.60 *Forecasting* - CDHA prepares monthly financial statements and variance analysis starting in April, at the beginning of the fiscal year. Preparation of forecasts for the fiscal year begins in September. Management advises that sufficient information is not available prior to that time to complete a meaningful projection. The policies on forecasting requirements are not documented. We suggest formal policies on forecasting be established.

5.61 *Timeliness* - CDHA policies require all variance analysis to be completed by the budget analysts and forwarded to the budget manager two days following the monthly close.

5.62 Monthly reporting to the Department of Health, as required by Section 21 of the Act, has not occurred. Compliance was delayed until *A Framework for Accountability Based on the Health Authorities Act of Nova Scotia* was presented to the CEOs and DHAs. The presentation has recently been completed by the Department. The monitoring report format is essentially the same as in prior years. CDHA's recent submission of budget leadsheet monitoring reports required collaboration and clarification with the Department, following which the reports were satisfactorily completed.

5.63 *Recommendations* - Recommendations for a sound monitoring process include the following.

- Monitoring reports in the required format should be provided to the Department of Health on a timely basis.
- Forecasting policies and procedures should be established.
- Operational plans and strategies to achieve budgetary targets should be formalized.

Capital Budgeting Process

5.64 *Introduction* - CDHA's ability to provide services is dependent upon maintenance of its capital infrastructure. Facilities, equipment and technology require upgrades and updating. Appropriate cost-benefit analysis should be required as support and justification for the analysis of resources required. Exhibit 5.4 sets out the detailed capital budget expenditures and funding levels for 2001-02, the first year of the new CDHA.

5.65 *Policies and procedures* - CDHA staff and management follow documented procedures for completion of the capital budget. Time lines and responsibilities are established and communicated. Thresholds have been established and communicated for items considered to be capital assets. Budget presentations to the executive leadership team include prioritized lists and estimated costs. The procedures also require a challenge and review process to be completed at the executive management team level. Once approved, funds are released at three different times during the year. Periodic reporting against the approved budget is provided to senior management and the Board.

5.66 *Needs determination and prioritization* - The 2001-02 capital budget was the first capital budget for the new consolidated organization. The process included participation from the appropriate representatives of the predecessor organizations involved. Current activities include consolidating policies, procedures and staff. As well, a space planning review is under way to ensure maximum utilization of space and facilities.

5.67 CDHA has listings of longer-term capital requirements for information technology and renovations. Long-term capital equipment requirements for the Queen Elizabeth II site have been documented but there is no list for the entire CDHA. We suggest that CDHA and the Department of Health collaborate and develop a common perspective on the longer-term capital requirements. Benchmarks of capital spending in similar organizations could be used in this process.

5.68 *Capital equipment* - Requests are prepared at the department level. A second level review and approval is required before the item is added to the department capital request list. The Capital Committee consists of medical staff, a vice-president, clinical directors, biomedical engineers, and materiel management staff. Members collaborate in determining the priority of the listed items.

5.69 *IT hardware and software* - The budget is based on a project implementation report compiled from IT managers' requirements completed in prior years. Projects are prioritized by the Director of IT, based on a strategic direction established by the Executive Management Team, for operational commitments, system upgrades or to prevent imminent systems failure.

5.70 *Capital renovations* - The capital renovations list is brought forward from a review of prior year capital renovation priorities and adjusted for impacts from clinical priorities. The list is prioritized at the executive level.

5.71 *Submission to Department of Health* - The Department of Health differentiates between operating and capital in determining annual funding for DHAs. Correspondence from the Department indicates capital funding may be used by the DHAs, at the discretion of the DHA, to assist operational requirements. However, it appears that operating funds could not be used for capital requirements without approval of the Department. Of CDHA's total funding from the Department, $3.9 million was allocated toward its capital budget requests.

5.72 Section 30 of the Health Authorities Act states that DHAs shall not make any expenditure for the acquisition of capital items unless it is provided for in an approved health-services business plan or has the prior written approval of the Minister of Health. The CDHA Board complied with the requirement and included a capital budget component in its business plan, which the Department

approved. The capital request aggregated $53.5 million (see Exhibit 5.4). Funding expected from all sources amounted to $9.2 million including $3.9 million funded by the Department of Health. Capital requests of $44.3 million were deferred to future years. We suggest that CDHA and the Department of Health develop an appropriate funding strategy for the longer-term capital requirements.

CONCLUDING REMARKS

5.73 The Capital District Health Authority is a very large organization with responsibility for delivery of significant health programs and services. The 2000-01 fiscal year was a year of transition and as such was not a typical year for the CDHA. The CDHA formation required analysis and reorganization of services in all areas, including planning, finance, and medical programs. Within the same time frame, budget preparation and financial year-end processes were also carried out within Department of Health time lines. CDHA management and staff have successfully completed considerable fundamental steps in business planning and budgeting during a very demanding time in CDHA's evolution.

5.74 Because CDHA receives most of its funding from the Province, the quality of its budgeting processes is important to the Department of Health and the House of Assembly. The Department and House need to have good information about the assumptions included in the budget submission to determine whether the requested amounts are reasonable and to support an appropriate allocation of funds. We have recommended improvements to the process for documenting and communicating underlying budget assumptions.

5.75 During a period of fiscal restraint, it is very important for organizations to have operational plans in place to deal with 'gaps' between projected expenditures based on service volume expectations and funding allocations. Otherwise, the likelihood of achieving fiscal targets is reduced. We noted instances at the CDHA where approved, operational plans to achieve fiscal targets are required.

Exhibit 5.1

HEALTH CARE FACILITIES OPERATED BY THE CAPITAL DISTRICT HEALTH AUTHORITY

Queen Elizabeth II Health Sciences Centre
Nova Scotia Hospital, including the East Coast Forensic Psychiatric Hospital
Dartmouth General Hospital and Community Health Centre
Hants Community Hospital
Twin Oaks Memorial Hospital
Musquodoboit Valley Memorial Hospital
Eastern Shore Memorial Hospital
Cobequid Multi-Service Centre

Exhibit 5.2

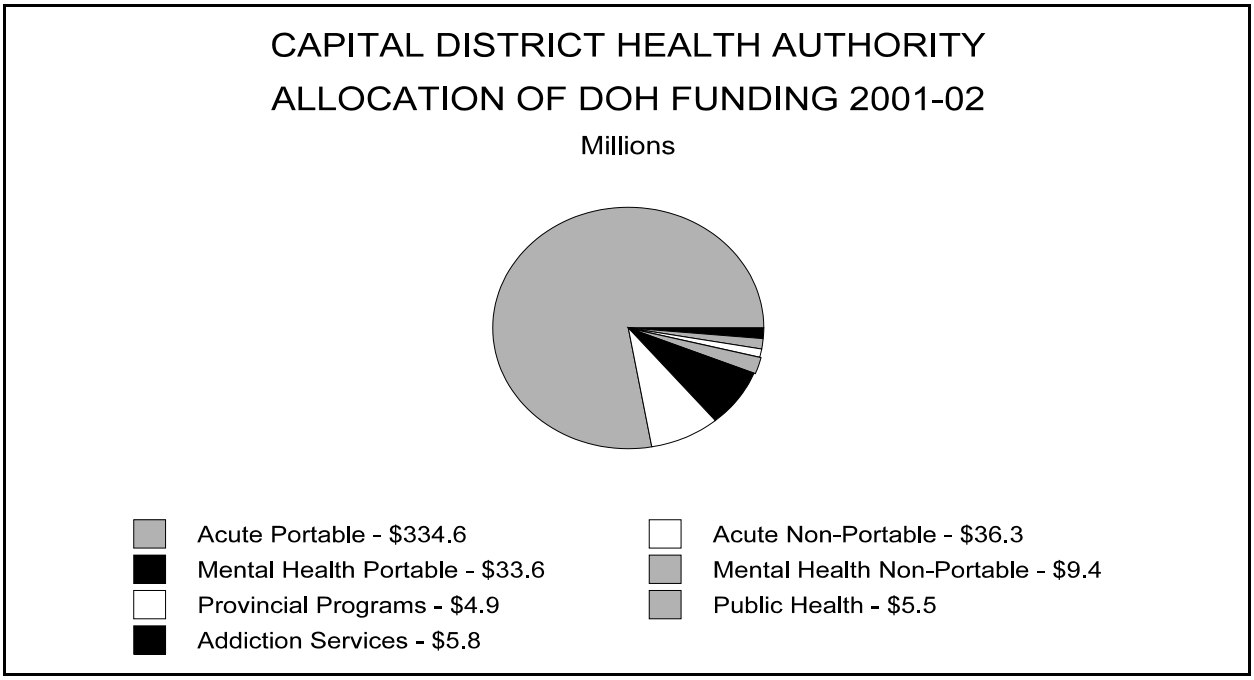


Exhibit 5.3

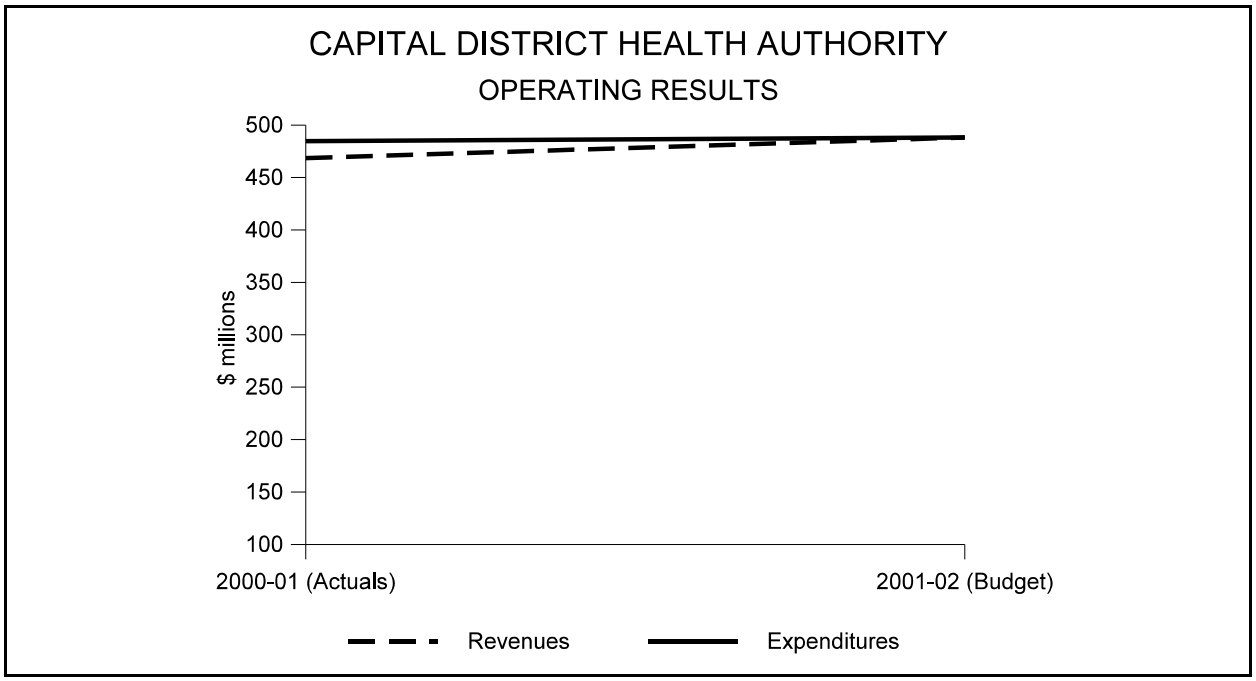
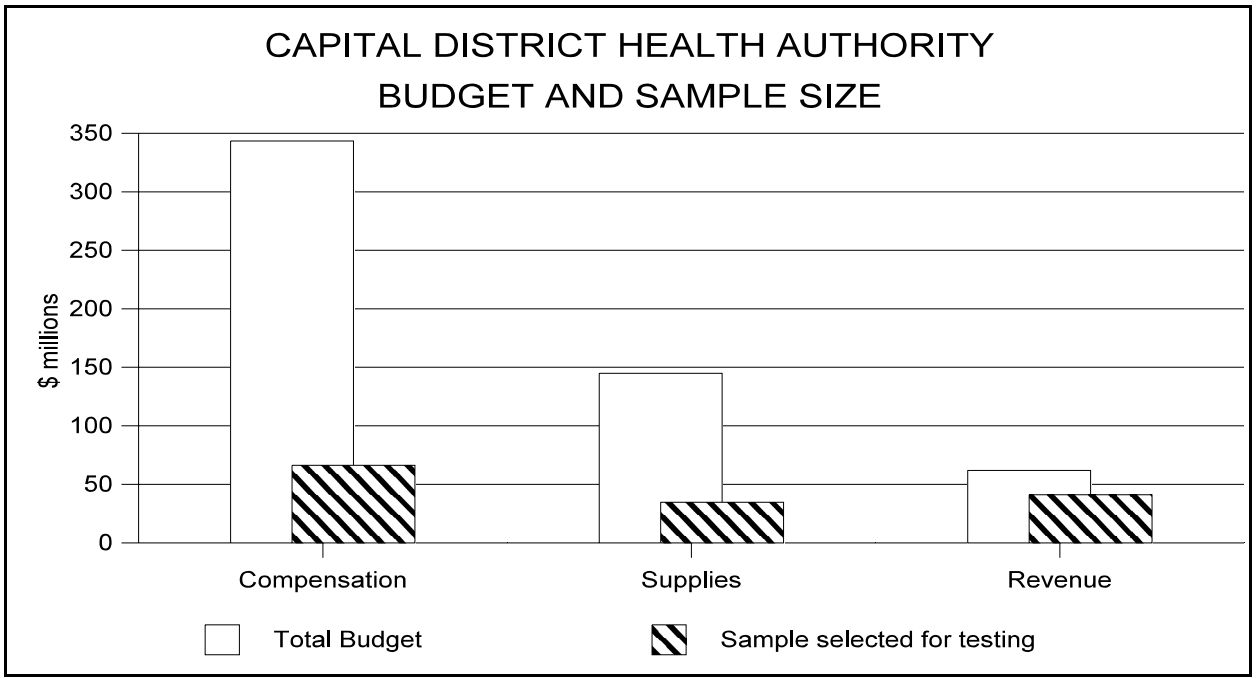

CAPITAL DISTRICT HEALTH AUTHORITY
OPERATING RESULTS
$ millions
500
450
400
350
300
250
200
150
100
2000-01 (Actuals)
2001-02 (Budget)
Revenues
Expenditures

Exhibit 5.4

CAPITAL DISTRICT HEALTH AUTHORITY
CAPITAL EQUIPMENT AND RENOVATIONS SUBMISSION
FISCAL 2001-02
($ 000's)

REQUEST	
Capital Equipment	
Capital District Health Authority	$ 4,700
Nova Scotia Hospital	1,100
QEII Health Sciences Centre	21,900
	$ 27,700
Information Technology	16,600
Capital Renovations	
Capital District Health Authority	1,750
Nova Scotia Hospital	2,100
QEII Health Sciences Centre	4,800
Dept. of Comm. & Epidemiology	600
Total Request	$ 53,550
FUNDING	
Department of Health	3,900
QEII Foundation	2,000
Dartmouth General Foundation	500
Hants Foundation	175
NS Hospital Foundation	50
Partners for Care	2,000
Dept. of Comm. & Epidemiology	600
Total Projected Funding	$ 9,225
Deferred capital requests	**$ 44,325**

Exhibit 5.5



**Excluding Department of Health funding*

Exhibit 5.6

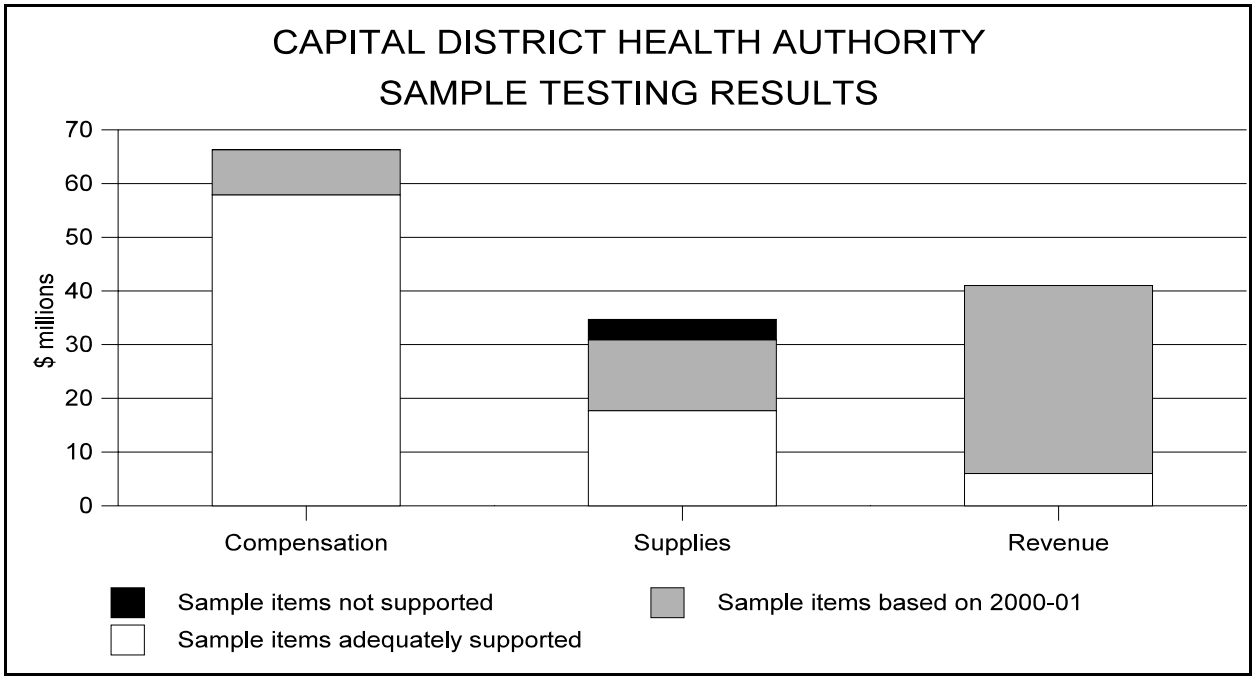


Exhibit 5.7

CAPITAL DISTRICT HEALTH AUTHORITY
SAMPLE TESTING RESULTS

Compensation	**$ Millions**	**Supplies**	**$ Millions**
	Budget based on 2000-01		
Physiotherapy	4.7	Cardiac Catheter Unit	4.5
Emergency	3.7	OR Orthopedics	3.5
		OR Cardiac	5.2
	8.4		*13.2*
	Budget not adequately supported		
		Utilities - electricity	3.8
Total	***8.4***		***17.0***

CAPITAL DISTRICT HEALTH AUTHORITY'S RESPONSE

The Capital District Health Authority was created on January 1, 2001 under the Health Authorities Act. It integrated the QEII Health Sciences Centre, former Central Regional Health Board and the Nova Scotia Hospital under one Board of Directors.

The financial planning and budgeting process as audited by your department was during the first year of our operation as a new organization. Initially, we were operating three distinct and separate finance departments, using three different information systems. Under this challenging scenario, we were successful in developing a consolidated budget for the CDHA in order to have an approved budget in time for the start of our fiscal year on April 1, 2001.

We are delighted to report that, to date, we have been successful in consolidating all administrative and support departments, including Financial Services, in the CDHA. We have also consolidated to a single Finance & Human Resource Information System for the District.

Overall, we concur with the results of your report and view the recommendations as an opportunity to improve our systems and processes as the organization grows and matures.

We make the following specific comments with respect to Section 5.7 "Principal Observations of this Audit":

- *We are delighted that the Auditor General noted that our budget preparation was appropriate and that submissions to the Department of Health were within required timeframes. This accomplishment, in our first year of operation, under three different financial systems, was due to the hard work and dedication of our staff.*

- *We agree with the recommendation concerning improvement to the documentation and some of the assumptions underlying our budget submission.*

  We do note however that we did prepare assumptions, mainly through a cost driver document that was submitted to Executive Management, Finance & Audit and Department of Health.

- *We agree there was no approved operational plan in place to save the $5.2 million allocated to clinical areas. It was our plan to place this in Clinical Services as a target and develop a plan during the first quarter. Due to the pressures in clinical workload there was no opportunity to obtain the savings targets. Executive agreed to maintain the target and look for opportunities throughout the organization. This was not successful and we are projecting a year-end deficit of approximately $5 million.*

  We have since been advised by Department of Health that there will be additional funding for fiscal 2001/02 to cover over-expenditures in oncology drugs, dialysis and overtime for nursing related to non-recruitment. We estimate receiving $3-5 million based on this commitment.

- *We agree with the recommendation that the Department of Health and CDHA work together to develop a funding strategy for capital equipment. Our capital funding is totally*

  inadequate to maintain current medical technology, information technology and renovation to our facilities.

  We have to date, developed annual and five-year projections for the Department of Health. As well, we have recently completed a document "Five Year Capital Requirements & Funding Sources/Alternatives" which we have submitted to the Department of Health.

We endorse the observations and recommendations concerning the importance of the Department of Health developing appropriate documentation, sensitivity analysis and assumptions and in communicating this to the health system in a timely manner.

DEPARTMENTAL AUDITS