“It’s Time To Act”

A Report on the Health and Social Services System

of the Northwest Territories

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1.0 AN OVERVIEW OF REPORT

Our Observations and Concerns

This Report addresses the issues and matters assigned to us in our terms of reference (see Appendix "A"). We were issued four broad objectives:

1. To optimize the effectiveness and efficiency of the NWT health and social services system today and for the future (sustainability).
2. To establish an appropriate accountability framework that clearly defines roles, responsibilities and authorities.
3. To recommend a governance structure that supports the accountability framework while respecting strategic directions of NWT governments (self government negotiations, regionalization, etc.)
4. To recommend an appropriate financing framework for the health and social services system.

We have attempted to stay within those boundaries rather than trying to address issues which are clearly beyond the scope of this inquiry. Where we believe that we have observations which pertain to issues which are somewhat beyond our terms of reference, we have provided the insight without necessarily feeling obliged to recommend how it ought to be addressed. The intent of our review, in some ways, is to remove the impediments to a sustainable health care delivery system. This we have attempted to do as well as to address ourselves to the equally challenging task of determining how best the services can be delivered.

Some of the related issues which are also pertinent to the delivery of health and social services (and they are numerous) are concurrently under review either by the Department itself or by various external consultants. This includes the review of human resources, on Acute Care, the use of information technology and other related issues. Where possible, we have attempted to indicate the connection to our work and how the common results can proceed.

Based on the comments from those who are trained and skilled in actual health and social service delivery, we not believe that the personal health of individual residents of the Northwest Territories is in any immediate danger of deterioration. However, we also do not believe that the present health and social services system, which supports the concept of "healthy bodies and healthy minds", will be sustainable in the long term. In fact, it may be placed under even more significant strain unless the discussions and negotiations relative to self-government and the further devolution of services and authorities are delicately balanced with the realities of a complex service delivery system.

1.1 Timing of this Report

We believe that the timing relative to the consideration of this Report is appropriate. There has been evidence even during the course of our work that the present system is flawed and under considerable stress. Front line staff who are striving to deliver adequate service express frustration relative to the lack of available resources in their area of work. Managers of the system are struggling to meet what often appear to be unrealistic expectations relative to service delivery, reporting, measurement of results and so on. The medical profession

has made a real commitment to make the system work but recognize that they do so in a political and governance environment which appears to thwart rather than enhance quality services.

Other healthcare professionals point to the real dangers of not being able to find replacements for those who are retiring or resigning and to the lack of cooperation in achieving truly comprehensive, integrated patient care. Board members complain of the problem of the increasing and seemingly uncontrollable costs in maintaining what is presently in the system and the difficulties of finding adequate replacements for both professional, managerial and front line staff.

The Department of Health and Social Services has commissioned many studies and reports over the last decade. Some of these reports have been high-level and strategic (*Med-Emerg Report*, May 1997), while others have been program specific (e.g. *It Takes a Community: A Report to The NWT Department of Health and Social Services on Child Welfare Services in the Northwest Territories*). Essentially, all of these reports provided snapshots of the state of affairs relative to various elements of health and/or social services and made recommendations to improve the delivery of these services.

In January 2000, the Minister of Health and Social Services released a document called *Our Communities Our Decisions: Let's get* on with it*! - Final Report of the Minister's Forum on Health and Social Services*. In this document, members of the Minister's Forum observed that some 180 recommendations have been made relative to health and social services since 1993. Forum members went on to state their concern that "too much time has elapsed and too few of these recommendations have been implemented."

What is remarkable about most, if not all of these reports, is that they identify many of the same problems and challenges and make many of the same recommendations, over and over again. There is considerable frustration across the system and within Government generally relative to the disparity between action taken and reports produced. That is, we were regularly reminded that this Report is simply one of many- all of which were aimed in some way or another to improve the system and yet the collective wisdom and best efforts showed little tangible evidence of any substantive progress. (It has been our observation throughout our Review that the reports are not the problem-the lack of action is).

The vast majority of those interviewed spoke to the need to make whatever system changes are needed to simplify and rationalize the system now rather than await another round of discussions, forums and reports. As a result, and given our findings, we are recommending that action be taken on the essence of this Report during the fall of this year (2001) while there is still a sense of momentum.

1.2 The Legislative Environment

It is our view that the legislative envelope within which the system is expected to function has become overly complex and thus difficult within which to function. While we are cognizant of the fact that much of the legislation is beyond the scope and authority of the Government of the NWT to impact substantially, this Government has had a significant impact through the creation of some of the legislation and regulations, directives, regulations, memoranda of agreement/contribution agreements. It is also evident that the Department realizes that there is much

work to be done in this area. Given the complexities, this is not something that can be changed overnight, but it can be fast-tracked, and, in this instance, should be.

In brief, and so as to reduce the potential for confusion relative to the complexities which surround the evolution and devolution of authority, the following is central to how the system functions:

> **The Government of Canada** provides the broad framework for all Provinces and Territories through the Canada Health Act (and its five key principles) primarily (and the 25 other pieces of legislation) and through particular funding programs which are directed towards specific goals and criteria. **The Constitution Act** empowers Provincial Governments to make laws respecting health services; **the Northwest Territories Act** provides the GNWT with similar powers.
>
> **The GNWT** provides the key policy and strategic directions and acts as a leader of the health and social services system through the powers granted to the **Minister of Health and Social Services** and through the approved plans and policies of the Legislature.
>
> **The Minister of Health and Social Services** is accountable to the Legislature and, through it, to the people of the NWT for the implementation of a comprehensive health and social services system which promotes, protects and provides for the health and well-being of the people of the NWT.
>
> **The Deputy Minister and Department** administration act on behalf of the Minister in accordance with policy and regulations.
>
> The Minister, through the Legislation, Directives and Contribution Agreements and Memorandums of Understanding, empowers the **Boards of Health and Social Services** to act on the Government's behalf respecting the delivery of the services as funded by the GNWT.
>
> **The Boards, primarily through the HIHSSA Act, but also guided by Department policy and Ministerial Directives** offer programs and services and manage the attendant facilities
>
> **The Boards** are also responsible for other key aspects including assessing the needs of people living in the jurisdiction of the Board
>
> **The trustees** of these Boards are held accountable for the mandate granted to them by the Act(s); the trustees establish Board **policies and bylaws** to enable them to govern their respective Boards
>
> The trustees are responsible for hiring a **chief executive officer** (who, in turn, retains the rest of the staff) for the management and direct delivery of the approved programs and services
>
> The **medical staff, nurses, other medical and social service practitioners and professionals, together with support staff** deliver the services in accordance with the legislation which governs their respective profession or occupation and/or the standards which have been designed either by the Department or by an independent professional group and adopted by the Department.

What needs to be done? We believe that the legislative envelope, within which the system operates, needs to be governed by **a clear set of principles** which should be used to guide those involved in operationalizing the Department's mandate.

These principles are recommended as follows:

That the legislative umbrella within which the Health and Social Services functions should be comprehensive, clearly-defined and uncluttered.

That the legislation guiding the functioning of the proposed NWT Authority and the proposed Regional Services Authorities be incorporated within one Act and that other current references (as appropriate) to the mandate of regional services (currently health and social services) boards contained within other Acts be rescinded.

That detailed directives to Boards be incorporated within the regulations supporting the new Act; that Ministerial Directives be only utilized in peculiar and emergent circumstances wherein the legislation and regulations are not sufficiently clear; and that the additional clarity be provided by regulation as quickly as possible.

That the Act be permissive to the extent that the new Regional Services Authorities may have their mandate enlarged to incorporate other Territorial services/programs which might legitimately be discharged on a regional and community level.

That all Boards and subsequent appointees to Boards be briefed by the Department as to the intent of the applicable legislation insofar as it impacts Regional Services Authorities, Community Services Councils and the proposed NWT Health and Social Services Authority.

1.3 Accountability in the System

The preceding overview of roles and responsibilities is a classic example wherein the practice does not follow the theory. The input we received from our extensive interviews raised the following concerns:

The type of accountability described in legislation does not appear to match practice.

There are situations in which the Department and Boards are both giving direction to the CEO (sometimes a contradictory message).

The Chief Executive Officers are often perceived by their Board members as the experts in their system (i.e. most involved and most knowledgeable) and therefore most accountable. Unfortunately, there has been an over-dependence on these senior administrators rather than shared spheres of authority and mutual respect.

The Minister and the Deputy Minister recognize significant problems in their roles relative to the issue of accountability. While the necessary clout appears to be there in legislation, policy and directives, Boards often appear reluctant to pay attention until something big goes off the rails (i.e. releasing an entire Board from its responsibilities).

The Boards have similarly felt frustrated in dealing with the Department which controls much of the larger agenda and yet which seems so distant from the actual problems which Boards encounter “on the ground”.

Some CEOs have felt trapped by the local political situation wherein a small but powerful group appears to control most elements of the community even if the Board was determined to act independently.

The credibility of the Government/Department has suffered

given that they have not acted on previous studies.

The Department frequently demands immediate answers from Boards but will then sit on the requests from Boards for months. Further, there may be no response to the information provided to the Department by the Boards.

There is a lack of consistency in Financial Statements. There is no usage of a common chart of accounts. This hinders comparisons between Boards and reduces the ability to measure performance.

- Auditors may not be providing sufficient notice of financial system issues to the Boards and the Department in order to provoke the desired response.

1.4 The Structure of the System

This Report deals primarily with how best to structure the health and social services system such that the needs of each resident are considered paramount rather than any other considerations. Thus, we consistently heard, and had reinforced, the notion that health and social services are not issues to be based on boundaries or political considerations. People want the best health care and social services possible within available and reasonable resources. This requires the positioning of resources as close to the consumer as possible without spreading the supply so thin such that one vacancy or holiday threatens the delivery system.

Further, the scarcity of key professional resources is forcing a re-thinking of what is realistic in terms of service delivery to the more remote and very small settlements. Based on what we have observed and heard from those within the professions, the day of one-person stations or delivery units is neither sustainable nor acceptable. As well, the notion that each community, regardless of size or remoteness, should have hands on control over all of its service delivery system (particularly in the areas of health and social services, which was our mandate) was not deemed either reasonable or realistic. It is believed by those whom we interviewed, and who are experienced both in their respective professions and in the north, that the actual delivery system will be incapable of providing quality service if the human resources continue to be spread over such a broad spectrum of management and governance bodies.

As noted in our brief historical timeline, this has been a system in evolution for many years. The key elements of the present delivery system have been in place since 1994 with the creation of a single department of Health and Social Services and since 1997 with the creation of single Boards of Management (now numbering nine). This structure of Boards and their administrations has struggled to deliver an adequate level of service given the problems spoken to earlier relative to accessing doctors and other medical/social service professionals.

1.5 The Number of Boards

The number of current Boards has also had a negative impact on the quality of support systems. That is, we found in a number of instances, willing people who were simply ill-equipped to do the work intended. There are certain skill requirements in a number of these functions that even the best of intentions will not negate. This is particularly important in such areas as financial management and overall coordination (as provided by the Chief Executive Officers).

Where the skill levels are inadequate to these tasks, the system itself is placed in

considerable jeopardy. We believe that this is an issue worthy of some note given the momentum towards self-government throughout the NWT. It is our view that this concept must be addressed with a clear-headed understanding of the realities facing the NWT relative to the availability of professional resources. That is, governance needs to be recognized as a separate issue distinct from that of professional and support resources and qualified service delivery.

1.6 Role of Non-Governmental Organizations

It has been apparent to us that the role of non-governmental organizations (NGOs) has been generally under-valued. These groups offer a wide array of services to the residents particularly in the broad field of social services. Given that many of the needs of people are in this field, including such issues as substance abuse, family abuse and the need for ongoing family support, the services provided by many volunteers and others who often serve with limited remuneration should be accorded high value. Unfortunately, it has been our observation that the NGOs are given scant attention and may seldom, if ever, be expected to discuss their services and issues with "their" Health and Social Services Board. Some complained of being expected to submit annual budgets reflecting no change in funding without the opportunity to present their actual needs to the Board. Others are only consulted at budget time and then in a more stressful set of circumstances which often surrounds budget deliberations. While there are examples of Boards holding discussions with their NGO counterparts, the former situation (i.e. virtually no contact) appears to predominate.

1.7 Role of the Department of Health and Social Services

The Department of Health and Social Services obviously plays a significant if not predominant role in the overall system. It has a variety of roles delegated to it by legislation and policy.

The Department, unfortunately, has been placed in the position of trying to guide the system as well as act as a manager in it. It is viewed as the backstop for problem resolution with respect to a number of the nine Boards. In some ways, the Department has tried to do too much and has found itself stretched too thin. Like other employers in the NWT, it too has experienced some turnover of key personnel and thus the ongoing need to re-visit the key departmental priorities and strategic goals.

One of its roles has been that of acting as an advisor to the Boards and assisting them in meeting their requirements. That role has not been made clear either to the Department or the Boards and has resulted in considerable stress between representatives of both parties. In some measure, the Boards have tended to view the Department more as a "truant officer" than a colleague in part at least because of the lack of role clarity and in part because the Department has not been able to staff that area with highly experienced health administrators.

It is the perception of many of those working in the system that there has not been as much collaboration as had been anticipated between the Boards and the Department. While we realize that there are now initiatives underway to counteract this perception (i.e. the Leadership Council), the prevailing and historic view has been one of a "truant officer-errant student" relationship rather than a collaborative one. The Boards have felt that they are expected to "go it alone" but that they will be reined in

whenever the Department or Minister feels that they have exceeded their range of authority.

1.8 The Impact of Regionalization on Resources

One of the key underlying issues which gives rise to this problem is the dispersal of resources which an overlay of nine boards requires. That is, each CEO and Board, in an understandable effort to provide "their" residents with the best service possible, and in response to the pressures from their respective Boards, tries to offer a full range of services. While this may sound commendable, this effort simply serves to stretch already thin resources close to or beyond the breaking point.

Professional staff complain of having no one to back them up in their community in terms of working normal work hours; of inadequate supervision on some very delicate issues; of no peer review system to ensure quality as well as professional growth; of few opportunities for staff development; and so on. Most are concerned with the potential for error brought on by fatigue.

1.9 Funding Patterns

The funding patterns also cause us some concern. While the system may be under-funded from a global viewpoint, the actual placement of financial support appears to bear little resemblance to where the areas of greatest need would most likely occur.

There is, of course, no simple answer here. The geography and dispersal of small populations in relatively isolated communities results in major impediments to accessing necessary services. While we have reviewed several funding models being utilized in other jurisdictions and have constructed several drafts of our own, the factors mentioned previously bode against any straight-forward solution. We have, however, designed the essence of a model which we believe will meet the local situation and the challenges imposed by one large populated center, with significant variations in size and accessibility and needs encountered elsewhere.

1.10 The Style of Board Governance

The style of Board governance has also been a significant source of concern, both within some of the Boards and by the Department. The understanding and use of the present governance model has limited the effectiveness of the Boards' ability to govern and direct the organization appropriately and with confidence. The inappropriate use of what is commonly known as "the Carver Model" has resulted in Boards which appear to serve little discernible purpose and Chief Executive Officers who appear to exercise tremendous control and prerogatives (due at least in part to what we perceive as a "power vacuum").

It is our observation that a new style of governance is needed in order to break the present mode in order to bring back a better balance of power into these organizations. Given that we are recommending significant changes in the number and structure of Boards, now would be an appropriate time to create a new way of doing business.

1.11 Clusters Of Service

It is our view that the most effective way of restructuring the present system is to establish key "clusters of service" which will act as the hub for the designated outlying or neighboring communities. Such clusters will be designed in such a way as to be as responsive as possible to the needs of those in the surrounding area, while recognizing that certain acute health requirements may only be met through

accessing the expertise which is resident at the Stanton Hospital, or, in more specialized circumstances, through an agreement with the Capital Health Authority in Edmonton.

These clusters are an essential component of our recommended restructuring. They ensure that scarce professional and administrative resources are strategically positioned so as to permit easy access from the outlying communities and so as to put these resources within the reach of health and social service professionals and the necessary administration which accompanies service delivery. There are two levels of these clusters: one which concentrates the corporate systems into one location; and, secondly, one which clusters the professional resources and minimal support structures into three key regional centers.

1.12 Board Management

We have noted several concerns relative to the services and systems which support the operation of the Boards and their administrations. These pertain to:

- Linkage of administration to the Board
- Business planning
- Communication practices
- Use of information technology
- Financial management practices
- Human resource management practices.

These systems need to be addressed and improved if the corporate environment is to function as intended.

1.13 System Financing

One of our requirements was to conduct an Operational Audit of each of the Boards in order to assess their present style of operating and the use of information technology and financial systems and practices. We have provided an in-depth report on these matters to the Department on a confidential basis. It is clear from our work in this regard that there are some serious inadequacies relative to sound business and financial practices. These need to be addressed by the administrations and Boards involved as well as by the Department.

We also note that there have been and are concerns relative to the degree of financing available to individual boards and communities as well as to meet the growing demands placed on the system by the increasing cost burdens faced by the major hospital facility (Stanton).

1.14 Service Delivery

One of our assigned tasks was to review and comment upon the effectiveness of the present delivery structure and system. In each of our interviews, we asked questions pertaining to what is working and what is not. Most, if not all, of those being interviewed were quick to share with us their views and concerns. While we have shared some of this material before in our briefing of the leadership of the health and social services system, it will be useful for those not intimately involved in the system but concerned nonetheless to be made aware of our findings.

A summary of the observations presented to us by health and social services administrators, support staff, medical practitioners, Board members, MLAs, and others follows:

- General improvements to how health and social services are delivered are essential if the services provided are to be maintained at a reasonably high level

The lack of clarity of roles in the system has been a significant cause of service delivery problems

Need for all stakeholders to be participants in developing the preferred direction, to understand it and to move with it

Resources are not sufficiently integrated; too much turf protection; system too small to successfully manage these boundaries

Key skills are often lacking; too much structure and not enough qualified people

Roles of non-governmental organizations has been largely ignored or at least under-valued; we need to rely on these organizations if the social service needs of people are to be met

The manner in which Boards are governed has resulted in instances of Board member interference with the staff who are delivering the services; in other instances, the role of the Board has been so marginalized that those employed in the system are scarcely aware of its existence

Records management has been inadequate to the needs; results in a waste of energies and duplication of patient assessments

General belief that the resources of the system are too widely dispersed to be effective; the lack of back-up is causing key professional people to want out

Department is keen to help but may lack the resources (or mandate) to do so

Need for increased awareness by the public as to what access to specialized health services is realistic; demands placed upon the system may not be achievable

Increased focus on recruitment has been helpful; results may not yet be consistent with the efforts or the investment of time and resources

Retention of professionals appears to be the bigger issue; most believe that removal of special allowance relative to vacation travel, housing has negatively impacted the rate of retention; others point to the overall shortage of impacted professions and the attractive salaries paid elsewhere

Many of the key issues and problems occurring at the community level relate specifically to substance abuse and the perceived shortage of attractive lifestyle options and models

Focus needs to be on promotion and prevention activities if long term outcomes are to be impacted successfully.

2.0 BACKGROUND

The issue of health care has received significant media coverage over the past few years, initially due to the rapidly rising costs of providing health care services and, subsequently, the recognition that there are serious shortages in the supply of health care professionals. While much of that focus has been on the difficulties that jurisdictions are having finding and retaining nurses and doctors, other professions have also proven to be of significant concern (e.g. physiotherapists, speech pathologists, dentists, medical officers of health, etc).

The Northwest Territories (NWT) has not been sheltered from either of these two significant impacts. Its problems have been compounded by the added challenge of recruiting people to the north where lengthier and harsh winters together with the potential of "isolation" for periods of time await those who respond to advertisements and contacts. As well, the costs of servicing a relatively small population dispersed across a very substantial geographic area have continuously risen, often beyond the expectations of those in the health and social services sectors.

While our Report points to various areas of Departmental responsibility which need to be improved and/or clarified, it would be unfair to paint the picture that the Department has not been actively trying to address those areas for enhancement which have been brought to its attention. In many instances, these steps or measures have involved the active cooperation of the Health and Social Services Boards. Based largely on information which we requested from the Department or have culled from its files, the steps taken which are of fairly recent vintage include the following. Some of these are addressed in more detail in the body of the Report.

- The encouragement of an ambitious post secondary training program in conjunction with Aurora College to train health care workers
- Worked alongside its counterparts in other Territories and Provinces, together with their federal counterparts, in examining options and alternatives designed to make improvements to the health and social services system
- Established an office of Recruitment and Retention in order to coordinate the efforts of the GNWT in these important areas
- Created a Locum Relief Pool which is intended to provide locum nurses on short notice to all boards; all nurses registered in the pool have successfully completed the Introduction to Nurse Practitioners program through Aurora College
- Introduced a Market Supplement Program including a recruitment bonus, retention supplement and Nurse Educator Consultant (NEC) program; the creation of the Nurse Educator Consultant position appears to have been quite successful, (the budget allowed for 3 positions one in Inuvik, Rae and Fort Simpson); the NEC had the mandate to orient and train new staff especially in the communities
- The Department has guaranteed employment for all nurses and social workers; this initiative (a component of Maximizing Northern Employment) allows the Department to increase the number of Nurse Educators by an additional 7 (total of 10) who will then be

responsible to mentor new nurses in acute care facilities or community health centers; the existing mentorship program for nurses will be expanded to the mentor nurses in the communities; the Department will also be able to develop a social work mentorship for new grads working in the communities

The Department has expanded its recruitment advertisement campaign reaching many potential candidates with their new marketing campaign – 'Way Of Life"

The "Physician Recognition" ceremony, hosted by the Department, to recognize long-term physicians was well received and gave the Department positive coverage in the Medical Post; it appears to be the first of it's kind in Canada.

Through the Northern Development Program, the bursary programs for northern students enrolled in a health care program have been largely successful with the number of applicants increasing every semester.

Conducted a comprehensive review of the Information Technology and Management systems to ensure that information is readily available for policy and decision-making as well as for reporting outcomes and results; this report to coincide with the results of our System Wide Review

A plan to expand the introduction of "telehealth" as a concept to the NWT; an initial pilot project indicated that the Department needed to ensure that there was adequate training and support in place before the service was fully introduced in all areas; the Department is committed to expanding this concept as resources are made available

As part of the 2002/05 Business Plan development and 2001/02 Board budget development, the Department and Boards jointly undertook an operational planning exercise; this work resulted in well-substantiated information for submissions to FMB for budget increases for uncontrollable cost increases; the work also laid the foundation for Department staff to understand the Board budgets and where financial pressures are as well service levels; this, the Department sees as helpful to developing funding allocation models

The Department is taking steps which it feels will move the NWT towards implementation of a primary health care (PHC) model; PHC has been described as an appropriate, affordable and sustainable method of meeting the healthcare needs of the residents; the model will also build upon the inclusion of nurse practitioners who graduate from the program initiated by Aurora College (and supported by the Department); this program is intended to provide nurse practitioners with the skills to function effectively as the first point of contact in communities without physicians; the model will also work towards a more operational notion of service integration wherein members of the various professions will work cooperatively in their service to patients in their care; planning is reportedly underway for a pilot program in one of the Yellowknife clinics

The purchase of health clinics by the Health and Social Services Boards has enabled the medical community to focus their energies more exclusively on patient care without the significant strain of clinic management; this has been a

part of the transition of doctors from the traditional “fee for service” arrangements to a salary/contract model; based on our discussions with the various stakeholders in this initiative, we understand that both sides believe that the transition is proceeding quite well

The Department has responded to a perceived need to re-establish capacity relative to oversight of clinical practices; it was felt that with the transfer of much of the responsibility for program delivery to the Boards, that the Department was under-resourced in this area; that is now being addressed with the establishment of two more senior positions

Dr. Anne Fanning was commissioned to do a review of the NWT’s TB control program following the reported death of a NWT resident from that cause; her investigations resulted in 26 recommendations including steps which the Department should take to improve the program; this report is being addressed by the Department following the Minister’s acceptance of an action plan; a funding request has gone forward to support the enhancement of the Communicable Disease Program

The Department has been attempting to respond to the recent review of the child welfare mandate and services, which was conducted by representatives of the Child Welfare League, by developing a three year action plan which will address the 46 recommendations

A Joint Leadership Council and a Joint Senior Management Council were established as forums for more formal exchanges of information and messages; these have just recently been initiated by the Minister and appear to be gaining the endorsement of Chairs and Chief Executive Officers.

3.0 METHODOLOGY

This has been a very complex and lengthy review. A part of the dilemma encountered was the need to review an organization which is undergoing continual challenges which need to be responded to immediately. Thus, in some ways, we have been attempting to review and assess a moving target. To the extent possible, the Department has withheld moving forward on certain issues recognizing that they would be under consideration by our Report. We have appreciated their cooperation.

Our review process was designed so as to ensure:

- a clear understanding of the complexities of the system
- an awareness of the relevant work which has been previously done
- the opportunity for each of those who are involved in the health and social services system to actively participate and convey their views on what improvements were necessary
- our understanding of the needs of the more remote and smaller centres and the differences they are faced with in relation to the larger communities
- the changes which have been made over time and how those have impacted the system
- the potential impact of the ongoing discussions relative to land claims and self government.

In that regard, we:

- met with the Department to ensure a good understanding of the objectives and to convey our expectations relative to client cooperation and the availability of relevant documentation
- conducted individual and confidential interviews with:
  - the Premier, the Minister and other Cabinet members/MLA's as appropriate
  - the Deputy Minister of Health and Social Services
  - senior staff of the Department of Health and Social Services (both individually and in small groups as appropriate)
  - the Deputy Minister of the Financial Management Board Secretariat and senior staff as appropriate
  - the members of each Health and Social Services Board (either the Board as a whole or individually as appropriate) on site in each community
  - the members of each senior administration (as available) on site in each community
  - Members of any related Territorial professional associations e.g. NWT Medical Association, NWT Registered Nurses Association, NWT Association of Social Workers
  - The President and another executive member of the Union of Northern Workers
  - Representatives of various non-governmental organizations
  - The appropriate representatives of Capital Health Authority in Edmonton
  - And other individuals who are (or were) involved in the fields of health and social services in some manner which relates to our terms of reference.
- Attended meetings of each of the nine Boards
- Conducted Operational Audits of all Boards
- Provided briefing sessions for:

The Chairs and CEOs

The Premier and Cabinet members

The Minister and staff

The Standing Committee on Accountability and Oversight

Conducted a thorough review of all applicable background data from NWT Health and Social Services, including, but not limited to:

Business plans (3-5 years)

Annual reports (3-5 years)

Budgets (3-5 years)

Audited financial statements for each Board (3 years)

Copies of any financial directives regarding deficit projections and interim control measures issued by the Territorial Government

Policies and procedures related to Government and Board practices

Copy of the applicable organization charts

Copies of position descriptions which we note as appropriate to our review

Copies of sample monthly, quarterly and annual financial reporting packages in use at the Board level

Relevant correspondence

Written responses to various inquiries appropriate to this study.

The Report will be tabled with the Minister and then the Legislature as per the process as outlined by our contract with the Department.

There have been various studies done over the past decade which have had some impact on the system or have at least contributed to an understanding of the problems encountered in delivering this complex array of services in so vast a geographical area. Where relevant, we have tried to reference these in the scope of our Report. We are indebted as always to the work which others both within and external to the system have done.

4.0 LEGISLATION AND POLICY FRAMEWORK

4.1 Background and Observations

While it is not our intention to fully describe all of the key dates or events which have marked the often colorful history of the Northwest Territories, it may be useful in setting the stage for the reader to understand some of the key background events. These have been gathered as a result of interviews and telephone calls with those who have been involved with the system for some time as well as information which we have extracted from documents largely provided by officials of the Department of Health and Social Services. A more extensive listing of dates/events is available from the Department. (It should be noted, based on our experience in trying to get the complete historical story of how the present system evolved, that we encountered significant gaps in attempting to re-construct an historical picture. It would be useful, in case similar studies are undertaken in the future, for the Department to undertake an "historical portrait".

1800s Health care provided by the missionaries, fur trading companies and the RCMP; first nursing station built in 1867 at Fort Providence by Roman Catholic Church (Order of Grey Nuns)

1900s Department of Indian Affairs provides health services to treaty holders under the "medicine chest" clause

1944-45 **Federal Government establishes Department of National Health and Welfare**

- **1954-55** Northern Health Services Program established by Federal Government to provide health care to natives and non-natives of Yukon and the NWT
- **1960** Territorial Hospital Insurance Services Program established; Territorial Hospital Insurance Services Board established
- **1966** Medical Care Insurance Act was passed; provided physician services to Canadians free of charge; program funded by federal and provincial governments
- **1967** Seat of territorial government moved from Ottawa to the NWT
- **1968** GNWT Department of Social Development created-includes Territorial Corrections Services and Territorial Alcohol Education Program
- **1969** Department takes on responsibility for administering social assistance, blindness and disability allowances, child welfare, medical social services and rehabilitation
- **1971** GNWT enters into agreement with Government of Canada for provision of the Medical Insurance Program

- **1977** GNWT assumes responsibility for Medical Travel and Supplementary Programs; Department of Social Development restructured and renamed the Department of Health and Social Services
- **1978** GNWT establishes a separate department of Health
- **1981** Alberta/NWT federal region split into two offices; NWT Medical Services Region established and based in Yellowknife; First NWT Board of Trustees selected for the Baffin Region; included representative of the Federal Medical Services Branch as well as the GNWT
- **1984** Canada Health Act proclaimed; statement of the five fundamental principles to guide health care delivery system
- **1988** Transfer of remaining responsibilities of health from the federal government to the GNWT, excluding Non-Insured Health Benefits; regional hospital boards established
- **1993** Special Committee on Health and Social Services reports with over 30 recommendations
- **1994** Cabinet approves consolidation of Departments of Health and Social Services based on recommendation of Special Committee
- **1995** "Working Together for Community Wellness: A Directions Document" published
- **1995** Social Assistance transferred to Department of Education, Culture and Employment
- **1997** All regional administrative offices brought together under single boards of management for both health and social services; four new boards created thus resulting in a total of twelve boards
- **1997** Report by Med-Emerg International completed which formed the basis of the new strategic plan (completed in 1998)
- **1998** Minister approves the "Core Services Document"
- **1998** Department's Strategic Plan "Shaping Our Future: A Strategic Plan for Health and Wellness" released
- **1999** NWT divided into two: new Territory of Nunavut created; three boards became the responsibility of the new territory
- **1999** Minister's Forum on Health and Social Services established to consult with the communities
- **1999** The NWT Health Status Report produced by the Department of Health and Social Services and edited by the Chief Medical Health Officer

- **2000** "Our Communities, Our Decisions" a Final Report of the Minister's Forum is issued; results in five "action priority areas" and twenty-six more specific recommendations
- **2000** "Towards A Better Tomorrow", a vision document by the Legislative Assembly (March 2001)
- **2000** "It Takes a Community", a Report on Child Welfare Services in the NWT published by the Child Welfare League of Canada, resulting in some 58 recommendations
- **2001** Department commissioned a review of Information Technology services by Sierra Consulting

- **2001** FMBS commissioned a review of Accountability by the McLeod Institute
- **2001** Department commissioned a comprehensive review of the health and social services system by Cuff and Associates Ltd.

The legislative and policy framework are key to whatever changes are made to the health and social services system. While this does not negate the need for greater simplicity and clarity of language and roles, the system rests on a legislative underpinning. In order for the system to function with a common understanding as to legal requirements in vitally important areas (e.g. standards of care; professional accreditation/qualifications; reporting requirements; and so on), the Department must do all it can to bring about sufficient simplicity in the system so as to make it into a solid, comprehensive and understandable basis upon which to make clear judgments.

As we have tried to find our way through the morass of requirements which have been placed upon Boards and their administrations over time (both legislative and policy driven), we are convinced of the need to de-layer and streamline the legislative envelope.

4.1 Legislation

The legislative framework, which guides the delivery of health services in the NWT, is interwoven with impacts from both the Federal and Territorial Governments, as well as being quite complex. There are:

25 Federal Acts and related pieces of legislation

27 Territorial Acts and related pieces of legislation

Associated regulations

Ministerial Directives

Contribution Agreements/Memoranda of Understanding

While we realize that many of these pieces of legislation are beyond the control of the GNWT, the objective should still be to make the system as straight-forward as possible. This scale of legislative direction has rendered those working both with and in the system subject to the potential of significant legal challenge given the complexity of the legislative environment in which each person engaged by the system is expected to function. It is also our observation that the vast majority of those working in this sector (outside of the Department) are largely unaware of these overlays of legislation, the accompanying regulations and Ministerial Directives other than those which are quite specific to their scope of work.

Given the work which has been done in this area over the past decade by most of the Provinces and individual health authorities, we believe that the simplest approach would be for the Department to seek the counsel of one or more of their intergovernmental contacts, and/or external legal counsel, and set a time-specific schedule for reviewing and producing a comprehensive yet concise legislative framework within which the health authorities are to function. The present timetable which has been proposed lacks a strategic focus and is not particularly time sensitive. We see value in imposing strict yet realistic deadlines relative to the completion of the legislative review and the necessary amendments or changes which emerge.

The key to the proposed new system will be the establishment of a separate piece of

legislation "An Act to Establish the NWT Health and Social Services Board and Regional Services Authorities" which clearly outlines the roles and responsibilities as recommended herein for the proposed new system. Such a document would outline the necessary authorities and responsibilities of the revised system of governing boards and their responsibilities to the Minister. The key to the legislative framework is the need for one document which addresses the essential responsibilities of governing bodies. This observation was also set out in the previous "Med-Emerg Report (May 1997) wherein it states " The THIS Act and the Public Health Act should be consolidated and amended…". We agree. Drafting should commence immediately.

As well, we note that there are other pieces of legislation which the Department has had on its platter for some time. The extent of administrative and drafting resources at the Department of Justice has resulted in the Department of Health and Social Services being both perceived by some as slow and reluctant to act. It is not a simple matter to change existing legislation or to create something new. Generally speaking, there are a number of vested interests at stake and a considerable degree of consultation expected. Unfortunately, the perceived enormity of the task simply makes it look almost impossible to tackle successfully. Thus, the need for a new Public Health Act, which has been reported on before (Wilson Report, 1993), as well as that of an Act to regulate the health professions (exclusive of doctors and nurses who have their own legislation) appears to be recognized but yet still delayed.

We also wish to be on record as recommending a name change for the present "Boards". It is our view that the present practice of describing the entire Health and Social Services operations as "Boards" has clouded the issues of responsibility and accountability. Thus, the Department has a Board Support Unit which, in fact, sees its role as being in support both to the governing Board and to its administration. Because of its title, however, many of those working in the regional system expected that the Unit had the "Board" as its client.

We have chosen to refer to the principal governing body which will guide the delivery of services and ensure the application of Territorial standards and measures as the "NWT Health and Social Services Authority" while those involved in more direct service delivery will be referred to as "Regional Service Authorities".

While this step, if not viewed in the overall context may seem a minor issue, we can assure the reader that reducing role confusion is an essential ingredient of what we are proposing and this is one element of clarity.

4.2 Roles and Responsibilities of the Government of Canada Relative to Health and Social Services

The delivery of health and social services is governed generally by the Constitution of Canada and the Northwest Territories Act and, more specifically, by the Canada Health Act. The Canada Health Act sets out the parameters for the assurance of a public health system in Canada. According to Health Canada (as noted in Turning the Tide - Saving Medicare for Canadians, British Columbia Medical Association, June 2000 Page 13) the purpose of the Canada Health Act was to:

> *"establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law*

that must be met before a full cash contribution may be made."

The Act is based on the following guiding principles:

- Universality of coverage
- Comprehensiveness of coverage of health services provided by hospitals and medical practitioners
- Accessibility without barriers
- Portability of coverage
- Public administration on a non-profit basis

According to Health Canada, the role of the federal government in health care "involves the setting and administering of national principles or standards for the health care system (i.e. the Canada Health Act), assisting in the financing of provincial health care services through fiscal transfers, and fulfilling functions for which it is constitutionally responsible. One of these functions is direct health service delivery to specific groups including veterans, native Canadians living on reserves, military personnel, inmates of federal penitentiaries, and the Royal Canadian Mounted Police. Other federal government health-related functions include health protection, disease prevention and health promotion." (The health services for the only reserve (Hay River) are contracted to the Deh Cho Health and Social Services Board).

Since the early 1970s when the GNWT first established a Health Insurance Program, Indian and Northern Affairs Canada (INAC) has paid for the provision of insured hospital and physician services for status Indians and Inuit. The agreement to cover this funding has been in dispute for some time due to major concerns which the GNWT has relative to the level of funding committed to by INAC. The funding cap proposed by INAC is considered by the GNWT to be considerably below what it feels will be the actual cost increases. There are significant monies (over $18 million in outstanding claims) involved in this dispute which the GNWT will need to pursue with vigour in order to arrive at an agreement.

The Non-Insured Health Benefit Program is funded by Health Canada, and administered by the GNWT. This program provides specified coverage for status Indian and Inuit residents requiring benefits not covered under the Hospital or Medical Care programs. These benefits include identified drugs, dental work, various supplies and equipment required for medical treatment, vision care and eyeglasses and co-payments for transportation for medically required services not available in the home community. This program is in some dispute between the two levels of government due to disputes relative to what the federal government feels is its responsibility towards funding additional costs incurred by the GNWT due to non-collectable accounts receivable related to NIHB.

We have been made aware of the fact that there are various other federally-initiated programs which either the NWT administers on behalf of Health Canada or vice versa. Among these are the following:

- Aboriginal Head Start
- AIDS Community Action Program
- Canada Prenatal Nutrition Program
- Population Health Fund
- Canadian Diabetes Strategy
- Hepatitis C Fund

First Nations & Inuit, Home and Community Care Consultation and Training.

The Northwest Territories Act provides the Legislature with the authority to make laws relative to the delivery of health and social services. The Legislature is also responsible for determining the total funding to be made available for both health and social service functions.

An agreement between the Government of Canada and the GNWT of March 1, 1988, effectively transferred the responsibility to deliver the health program to the GNWT. The Government of Canada also agreed to transfer the administration of "… all lands…together with the buildings, facilities and structures thereon…" and all moveable assets associated with the program and facilities. The Government also agreed to replace the Inuvik General Hospital no earlier than 1997on an agreed upon percentage cost share formula; and to continue with its share of costs for air transportation for diagnostic and treatment purposes.

The federal government, through the First Nations and Inuit Health Branch, according to a presentation on the mandate of the Northern Secretariat, also maintains an ongoing role and interest through participating "…in policy development regarding health programs and their implementation in the Territories…implementation of the Territorial Wellness Framework…NIHB funding pressures in the Territories…self government negotiations". The Territorial Wellness Framework, referred to earlier, is an initiative of the three Territories and the federal government (Health Canada) to create what has been referred to as a "one window" approach to the coordination of health promotion and wellness funding into the Territories.

4.2.1 A Framework to Improve the Social Union for Canadians

In February 1999, the Government of Canada and the Governments of the GNWTs and Territories agreed to **A Framework to Improve the Social Union for Canadians.** This agreement outlines certain principles; agrees to the right of freedom of movement of all Canadians; agrees to enhance the degree of transparency and accountability to their citizens; agrees to work collaboratively with each other on social trends, problems and priorities; offer to consult more on any new initiative which may impact other Governments; work with Aboriginal peoples to find practical solutions to their needs; and the Government of Canada agreed to serve notice of at least one year prior to making any changes in funding.

The importance of this agreement lies in the endorsement of certain principles relative to how social needs will be met in an environment of equity and fairness. Further, the Governments indicated their commitment to "…adequate, affordable, stable and sustainable funding for social programs".

4.3 Territorial Legislative Guidance

In the final analysis, and in the minds of most people whom we interviewed, it is the Government of the NWT who provides the overall legislative guidance as to how the health and social service functions are to be delivered. The Premier appoints the Minister of Health and Social Services from a list of Cabinet members and assigns that person the authority to act as the lead spokesperson and legislator on matters falling within the purview of that portfolio. The GNWT formulates the broad strategic and policy direction for these functions subject to the approval of the Legislative

Assembly. The Government approves the funding allocations including that which the Department transfers to the nine Boards. The Standing Committee on Social Programs, on behalf of the Legislative Assembly as a whole, serves as a watchdog on the Department (and other Departments which have been assigned to this Committee) and may challenge the affairs of the Health and Social Services portfolio. The Committee is expected to:

> "Review legislative and policy proposals; multi-year business plans and budgets, Bills, boards and agencies, including programs for seniors and youth
>
> Review departmental performance, including that of boards and agencies; and
>
> Consider any other matter referred by the House". (Legislative Assembly and Executive Council Act)

The Minister, on behalf of the Premier and other members of the Cabinet, is expected to provide leadership to the portfolio and, as necessary, act as the spokesperson and defender of the Department's business plans, budgets, proposed legislation and new initiatives.

4.4 Department Policy

In order to bring added clarity to the roles and mandate of the Minister, Deputy Minister and Department of Health and Social Services, the Cabinet in 1999 approved the **Health and Social Services Establishment Policy** (which is available in its entirety from the Department of Health and Social Services). This document is central to our study as it sets out:

- who is responsible and accountable for the health and social services system
- the mandate of the Minister and the Department of Health and Social Services "to promote, maintain and enhance the health and well being of individuals and families in the Northwest Territories"
- the guiding principles for the Minister to oversee the Department
- that the health programs and services should exhibit the *Canada Health Act* principles of comprehensiveness, universality, portability and accessibility, public administration on a non-profit basis
- the scope of the policy (i.e. that it applies to all employees of the Government of the Northwest Territories)
- the accountability of the Minister to the Executive Council and the Deputy Minister to the Minister
- the responsibility of the Deputy Minister for the management of the Department of Health and Social Services including the planning, administration and other functions necessary to further the Department's mandate.

4.5 Ministerial Directives

The Minister, on behalf of the Cabinet and Legislature of the NWT, has ultimate authority for the overall quality of the health and social services system. As such, the Minister may, from time to time, issue "directives" which seeks to expand upon or clarify certain issues. These are generally items of some significance which may either be in dispute or which the Minister feels may warrant further clarification. According to the definition provided by the Department, a directive is "a policy instrument whereby one level within a government or someone in authority within government directs another level of

government or an agency of government to take a specific course of action".

We were made aware of a few such Directives, one dealing with "Board Roles and Responsibilities". This Directive, which came into effect on July 1, 1998, has as its purpose, and we quote "…to clarify the relationship between the Minister of Health and Social Services and all Health and Social Services Boards except for the Stanton Regional Health Board". Specifically, this directive:

> "defines the Boards service areas;
>
> defines the roles of the Minister and the Boards;
>
> defines the responsibilities of the Minister and the Boards;
>
> specifies the health and social service facilities each Board is responsible for managing, controlling and operating and lists any exceptions or restrictions to Boards' authority to manage, control and operate health and social services facilities".

The other Directives with which we were made aware deal with such issues as:

- Roles and Responsibilities of the Stanton Regional Health Board
- Complaints and Commendations
- Program Standards: Children's Group Home; Adult Group Home
- Program Standards: Long Term Care Facilities
- Program Standards: Home Care
- Board Workplace Safety Guidelines
- Board Borrowing.

4.6 Government Vision and Goals

The Department undertook a strategic planning exercise during the period of 1996 to 1998 which was useful in identifying its vision and goals. The process of developing the plan was initiated in 1996 wherein information fact sheets were sent out to all NWT residents highlighting issues relating to health and well-being. This distribution of information resulted in various group sessions with the public to discuss the present direction and to seek feedback on new priorities and directions. This resulted in a strategic plan being tabled in the Legislature in June of 1998.

The Department had retained a consulting team, Med-Emerg International in 1997 who developed a discussion document following interviews and consultations with a cross-section of those involved in the health sector. This discussion document, also known as the NWT Health and Social Services Draft Strategic Plan was the result of that work together with the additional input gathered by the Boards and Department who held a round of consultations around the Med-Emerg document.

It is our understanding that there has been no formal follow-up process to that Plan albeit the Minister's Forum was to have determined what progress was being made. We have reviewed that report and while we find much that we agree with and that is still valid today, we did not note direct reference to this issue of strategic planning. The Plan that was tabled, however, did provide certain key directions. For one, it indicated the vision and goals which the Department was to be guided by over the foreseeable future.

The Vision and Goals were reconfirmed in subsequent Depart Business Plans. Quoting from the 2001-2004 Business Plan, these were stated as follows:

“**Our Vision:** *Our children will be born healthy and raised in a safe family and community environment which supports them in leading long, productive and happy lives.*

Our Long Term Goals

Improve the health status of people in the NWT

Improve social and environmental conditions for people in the NWT

Improve integration and coordination of health and social services, including services by the government, non-government agencies, and private and volunteer sectors

Develop more responsive, responsible and effective methods of delivering and managing services.”

4.7 Development of the Regional Board Model

The original Territorial Hospital Insurance Services Board was established in 1959 by the federal government. It was a mechanism for introducing the national Hospital Insurance Plan to the people of the NWT. Since it was established, the Government of the NWT took on responsibility for a full range of services and began to move away from the traditional hospital approach to health care towards a more community-based approach wherein a full range of types of care were introduced.

This also resulted in the GNWT moving out to the regional boards (which it established initially in the 1980s) some of the responsibility for service delivery with the remainder of the health mandate being discharged by the Department (formerly of Health and then of both Health and Social Services). The Government committed itself to encouraging citizen participation at the regional level and to retain within the Department of Health some of the more centralized processes and responsibilities.

The decision to disband the Territorial Board was made in 1991 after several internal and external reports recommended such an action. The Board had ceased to perform any useful service and had little, if any, autonomy. Its remaining powers were transferred to the Minister under revisions to the Hospital Insurance and Health and Social Services Administration Act (HIHSSA).

Regional health boards have been in existence in the NWT since 1981. The present regional board model was developed initially, we understand, in the late 1980s and then amended in 1997 to include twelve boards, including those which were established to service the Nunavut area. Of course, since the formation of Nunavut as Canada’s newest Territory in 1999, those boards became part of that new jurisdiction (and subsequently eliminated as a part of their own restructuring). At the present there are nine Boards.

4.7.1 Agreements Regarding Boards

Contribution Agreements are a mechanism utilized by the Department to ensure that the nine established Boards have a clear mandate and the attendant financial support as to what is being transferred by the Department to them to be administered. The Contribution Agreement spells out:

The key definitions

The fact that the Department reserves the right to transfer roles and responsibilities to other entities

Funding provisions and the Board’s responsibility to offer the services as outlined in the Directive of the Minister

and in accordance with the approved budget

The Department's requirement to provide the funding on an annual basis as allocated by the Legislature

An agreement respecting the handling of deficits and surpluses

Restrictions on capital expenditures

Requirement to provide the Department with statements and reports as per the Financial Administration Act

And other provisions respecting such issues as indemnification, legal liability and insurance.

Attached to the Contribution Agreement are several schedules including the Ministerial Directive pertaining to Board Roles and Responsibilities; Core Services Document; and direction relative to financial reporting.

We note that not all Boards are governed by the same Contribution Agreement. In certain instances, a **Memorandum of Understanding (MOU)**(e.g. Lutselk'e) is in place which sets out much if not the same guidance. (It is our understanding that a Contribution Agreement and a Memorandum of Understanding are to be considered interchangeably; see letter of July 1996 from the Director of Population Health and Board Development.)

The MOU makes it clear that the First Nations will be accorded the same treatment as other Boards and that the Aboriginal rights will not be abridged in any way. The MOU also sets out:

The responsibilities of the Minister

The responsibilities of the First Nation

The role of the Medical Health Officer

Access to services from other Boards

The ongoing changes in the system and the right of the First Nation to participate

A commitment to strategic planning

Need for an evaluation framework

Budget approval process and cash flow

Production and submission of financial statements and reports; need for a proper chart of accounts to be maintained

Retention of surpluses and responsibility for deficits

Funding of emergency purchases

Capital planning and financing

Responsibility of the First Nation for the care of assets and facilities

The need for an Information Management system

Amendment and dispute resolution process

Remedial action; termination; indemnification

Designated officials.

Again, this is not meant to set out the terms of such an agreement in its entirety. That can be obtained from the Department. Rather, our purpose here is to provide the overall framework of legislation and regulations, etc. which envelope the system.

4.7.2 Board Policy

In addition to the foregoing plethora of legislation, regulation, directives, agreements, standards and contribution agreements/MOUs, the Boards themselves must develop their own style of governance as well as establishing how they will operate the services and facilities given over to their responsibility. In some

instances, this has been a rather straight-forward and simple process of either adopting the recommended "Carver" governance policies or, in some instances, of simply "borrowing" those of another Board.

We will not attempt to document all of the policies (both governance and administrative) and regulations or procedures other than to provide a sample listing of the topics covered by some or all Boards. The following is a listing from a sample Board governance manual and appears to be consistent with the training which the Boards received from various sources (but essentially in concert with the afore-referenced Carver Model).

Index of Policies

Policy Type: I.	**Results**
Policy Type: II:	**Chief Executive Officer Constraint**
Policy Type: III.	**Board Operations**
Policy Type IV.	**Board-CEO Relationship**

It is the foregoing policy framework which is intended to outline the Board's control over the affairs of the organization. These policies, therefore, are designed to provide the CEO and the rest of the Board organization with the direction and policy environment within which to make administrative decisions. Thus, as an example of the direction provided by policy, a "results policy" for the area of palliative care is "death with dignity"; for that of public health, the policy states "community wellness through a proactive approach". The policies of this particular Board were all adopted on the same date (which, of course, brings into question the notion that policy development is to be an ongoing process which results in new policies as the need arises). A mechanism is in place to review Board policies on an annual basis.

5.0 THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

5.1 Present Mandate and Functions

Under the direction of the Minister, the Department of Health and Social Services is mandated to provide a broad range of health and social programs and services to the residents of the Northwest Territories. The Deputy Minister is accountable to the Minister and is responsible for the management of the Department including the planning, administration and other functions necessary to further the Department's mandate.

The Cabinet in 1999 approved the **Health and Social Services Establishment Policy**. Given that we have referenced this earlier, for our purposes here we have chosen to simply re-state the elements which pertain directly to the role of the department. This policy states that:

5.1.1 Mandate

The mandate of the Minister and the Department of Health and Social Services is to promote, maintain and enhance the health and well being of individuals and families in the Northwest Territories.

The Minister is:

(i) responsible for carrying out the mandate of the Department of Health and Social Services and shall preside over the operation of the Department; and

(ii) authorized to carry out the duties described in this Policy in a manner the Minister deems appropriate for the efficient and effective fulfillment of the Department's mandate.

The Deputy Minister is:

(i) responsible for the management of the Department of Health and Social Services including the planning, administration and other functions necessary to further the Department's mandate; and

(ii) accountable to the Minister of Health and Social Services for the proper conduct of the business of the Department.

Duties of the Minister

The Minister shall develop and carry out programs and services in the Department as may be appropriate to fulfil the mandate of the Minister and Department.

The Minister shall have charge of and be responsible for:

(a) Ensuring eligible residents have access to health and social programs and services.

(b) Promoting the importance of wellness through education and training.

(c) Supporting wellness programs at the community level to assist those affected by family violence, addictions and other health and social problems.

(d) Monitoring and evaluating the physical, emotional and mental well being of the people of the Northwest Territories to determine the effectiveness of health and social programs and services.

(e) Providing family life education resources that encourage individuals and communities to seek solutions to their health and social problems.

(f) Providing quality facilities for regional and community based health and social programs and services.

(g) Working with health and social service professions to develop standards for licensing and practice.

(h) Administering all health and social service legislation assigned to the Department.

(i) Developing, evaluating and recommending amendments to health and social services legislation and policies.

(j) Protecting children and families in a manner that is in the best interests of children, and fostering an environment which supports independent family life.

(k) Promoting and supporting the independence of aged, disabled, chronically ill and mentally handicapped persons.

(l) Developing programs and strategies, in cooperation with other departments, to reduce or eliminate the spread of infectious and communicable disease and to protect the public from environmental health hazards.

(m) Providing public health advice and consultation to all departments of the Government of the Northwest Territories and related agencies.

(n) Sharing information and cooperating with other jurisdictions regarding the delivery of health and social programs.

(o) Registering and licensing health care professions.

(p) Maintaining records of births, deaths and marriages.

5.1.2 Summary of Departmental Functions

There are two substantially different and yet interdependent ways of describing the services and functions of the Department of Health and Social Services. One is to outline the "core services" of the Department while the complementary task is to describe the key functions the Department must perform.

In 1996, the Department issued a discussion paper which represented its first attempt to describe its **core services**. This paper was circulated for comment to the central stakeholders and resulted in a more definitive work being prepared and distributed in 1998. Core services were intended to meet several key goals of the Department, and we quote (Core Services of the Department of Health and Social Services):

> "ensure that our decentralized system of service delivery provides a similar range of health and social services throughout the NWT by identifying priority categories of services (i.e. an accountability mechanism for a decentralized system);
>
> provide a framework for the coordination and integration of health and social services, and the collaboration of service providers, at the regional and community levels; and
>
> provide for a new level of flexibility in the system to enable regions and communities to shape programs and services to meet specific needs and priorities".

The same paper defines and describes **core services**. Again, we quote:

> "Core services include the full range of health and social programs and services eligible for public funding which must be available or accessible to all residents of the NWT; if a core health service is not provided by a Board, it must be made available through another Board or through a program that serves the whole of the NWT. Not Every service will be provided in every community in a Board's region, nor will every service be provided by

all Boards, but all core services must be accessible to all residents of the NWT".

The defined core services and their respective descriptions follow. These are extracted from that same discussion paper:

1. Health Promotion

Health promotion is the process of enabling individuals and communities to increase control over and improve their health. It focuses on providing opportunities and resources to enable people to achieve their optimum health potential. This includes improving life skills, increasing education and increasing the opportunities for individuals to make informed and healthy choices.

Healthy Lifestyle Promotion Services

Maternal Health Services

Reproductive Health and Childcare Services

Community Development

2. Health Protection and Preventative Services

Health protection services safeguard the health and well-being of residents of the NWT. Preventative services reduce the likelihood of an undesirable health condition. Protection and prevention services are directed at individuals, families and communities who are at risk for developing health problems and towards reducing hazardous environments.

Screening Services

Intervention Services

Disease Control Services

Environmental Health Protection

Oral Health

Prevention of Injury

Prevention of Chronic Diseases and Addictions

Hearing and Vision Services

Early Intervention Services

Child Protection

Guardianship and Trusteeship

3. Emergency, Acute and Diagnostic Services

These services are intended to provide treatment and assistance in cases requiring immediate treatment and care.

Emergency Care Services

Acute Care Services

Diagnostic Services

Crisis Response Services

4. Continuing Care

Continuing care services are delivered to improve and maintain a client's physical, social and psychological health in order to promote independence and to provide the best possible quality of life for people whose diseases do not respond to curative treatment.

Home Care

Long Term Care

Extended Care

Palliative Care

5. Developmental, Rehabilitation and Support Services

These services help to improve and maintain the functional independence of clients. Services are provided to clients with impairments from injury, chronic disorder, addictions, mental distress or disability.

Rehabilitation Services

Mental Health

Addictions Services

A sixth core service was included, namely community corrections, which was subsequently transferred to the Justice Department (these services were delivered by Health and Social Services under a memorandum of understanding).

The Department of Health and Social Services is charged with a wide variety of **functions** it is to carry out or delegate to others. While being mindful of the legislation and policy statement as outlined above, the following summary of Departmental functions perhaps depicts appropriately its myriad of present roles:

Advice and coordination of the Minister's legislative agenda

Preparing briefing notes; holding briefing sessions

Advising on current legislation and regulations

Advising on any recommended changes

Ensuring that all requirements of the legislation and policies are appropriately discharged

Delegation to and Coordination of the Boards

Ensuring that Boards are appointed in accordance with the legislation

Recommending the appointment of members to Boards

Appointing inspectors to investigate any outstanding matter

Providing counsel to the Boards; responding to requests for assistance

Providing funding allocations in accord with approved budgets

Strategic Direction to the Health and Social Services System

Developing a strategic (business) planning process which accommodates the input of the Boards

Determining the priorities for the system

Assisting the Boards in the establishment of their own plans

Providing guidance relative to the establishment of effective measurement tools and techniques

Regulation, Licensing and Administration of Services

Licensing of health professionals

Regulation of health professionals

Developing and issuing standards for the delivery of services

Monitoring performance; carrying out site visits as appropriate

Entering into agreements with hospitals and other service providers for the provision of insured services

Administration of the hospital insurance plan; determining eligibility for service and amounts to be paid

Providing and Upgrading Facilities

Reviewing facility needs

Authorizing facility construction; providing funding

Supervision and inspection of facilities

Promoting Wellness Programs; Protection of Health Status

Promoting wellness through education and training of health and social service professionals and support workers; ensuring that the public and Boards are made aware of healthy lifestyles; implementing Territorial promotional programs

Monitors and evaluates the effectiveness of communicable disease and environmental health programs; maintains disease registries

- Reports on any patterns of disease; maintains an active surveillance program
- Ensures that the necessary services offered by the acute care hospitals are properly funded
- Provides support to the recruitment and retention of medical and non-medical professional personnel
- Supports the training of northerners in appropriate medical professions and occupations

5.1.3 Summary of Departmental Structure

The Department is structured around a Directorate consisting of the Deputy Minister, an Associate Deputy Minister, two Assistant Deputy Ministers and two Directors. These areas of responsibility or Divisions are described as follows:

- Population Health and Clinical Services
- Policy, Planning and Human Resources
- Financial and Management Services
- Board Support and Health Services
- Community Programs

The Deputy Minister's Directorate also consists of two staff in the function of Federal/Provincial/Territorial Relations. The latter function appears to have been added in response to a particular staffing issue and not due to the perceived need to have that function attached so closely to the Deputy Minister's office. The Department appears to make use of two strategic committees: an Executive Committee that is responsible for providing strategic and management direction for the department; and a Management Committee whose purpose appears to be one of ensuring a broad range of communication amongst the senior echelons of Department staff relative to the issues and priorities facing the organization.

5.2 Relationship to the Boards

Since the concept of Board governance evolved in 1981, the Department has been linked in various ways to the Boards with the main purpose of assisting them in terms of their service delivery. While there have been many positives relative to this notion of community empowerment, this relationship has also had its share of difficulties. Some of these problems likely evolved due to the unclear legislative foundation while other factors appear to have played a role as well. These have included:

- The lack of certainty in role definition
- Instability in Board membership
- Inability to establish sound financial systems
- A lack of reporting fiscal issues and other changes to the Department on a regular basis or until the issue was beyond resolution
- A lack of qualified resources within the Boards and, to a lesser extent, within the Department
- A lack of awareness as to the role of the Department's "Board Support Unit"
- Inappropriate coordination at the senior levels until more recently with the establishment of the leadership councils.

5.3 Current Challenges

The Department has a broad mandate and a significant array of key audiences and partners. These include:

- The Minister and Legislature
- The general public
- The Boards

- The professions
- Non-governmental organizations
- Capital Health Authority
- The intergovernmental environment
- Community and aboriginal groups/organizations
- The private sector.

As with most broadly-based and multi-faceted organizations, the Department's "agenda" is continually adjusting as it not only attempts to be a leader in its areas of jurisdiction, but as it also faces the daily challenges brought on by a plethora of allied groups and organizations and a complex delivery system. As well, this is a field wherein the public has a strong and very personal interest and a multitude of suggestions as to how they would "fix it".

On the one hand, the Department is expected to be an innovator and policy leader and, on the other, the public conscience and inspector (or" truant officer"). As a result, the Department finds itself trying to lead at the same time as it may have to remove authority from those it empowers to carry out a part of its mandate. These challenges are very difficult to balance in a political environment wherein each action may unleash considerable public criticism and calls to members of the Legislature, the Minister responsible or to the Premier (or all of the foregoing). This highly politicized milieu is seemingly unique to the north wherein the scope of population renders the delivery system a very open and highly scrutinized environment.

It is also useful to note that the Department has been impacted, like its Provincial and Territorial counterparts, by national if not global forces. Thus, the national concern relative to the continual search for qualified doctors and nurses is acutely felt in the north as well. In some ways, the shortages are even more profound in the NWT given the isolation of some communities; the lack of professional support in many communities; the cost of travel and housing; and the high salaries now being paid in the more advantaged Provinces such as Alberta and Ontario.

Further, the escalating cost of new technologies and the increasing reliance on more expensive pharmaceuticals has also resulted in a health and social services budgets which have grown more quickly than other sectors. This growth has been such that even the most careful analysis by the Department has proven to be faulty and often overly optimistic.

It is our understanding that some of the key issues which the Department is currently facing include:

- Response to the recommendations of this Report; the Department recognizes that there may be significant implications which will require their response and leadership
- Reform of the acute care delivery system; the need for optimal usage of acute care facilities and beds
- Reform of the primary care system; determining the most appropriate model of primary care
- Amendments to the present legislative framework
- Response to the self-government processes presently underway
- Dealing with the issues pertaining to Board governance and management; deficit management; operational audits
- Recruitment and retention of professional staff
- Developing a response to issues which have more recently surfaced or have

gained in significance e.g. child welfare; addictions strategy; disabilities strategy; residential schools; family violence; continuing care; seniors care; etc.

Maintaining an awareness of the broader issues which are being discussed at the Federal/Provincial/Territorial meetings which occur sporadically throughout the year.

The Department is also dealing with the recent changes in departmental leadership (i.e. new Deputy Minister; Associate Deputy; Assistant Deputy). These changes have all occurred fairly recently. While of themselves they may not indicate any profound change in the direction of the Department, they have contributed to the general sense of instability that has plagued the delivery of health and social services. These staffing changes, together with the implications for the Department as a result of our Report, will need to be monitored in terms of staff morale and productivity. It is our expectation that, once these changes are made, a greater sense of stability will result.

6.0 GOVERNANCE STRUCTURE

6.1 Background and Observations

The foregoing section dealt largely with the legislative environment within which these "Boards of Management" are expected to operate. Presuming that the legislation has been clearly established (and we would argue that it has not), the Boards are then left with some degree of flexibility in determining how each will function within that framework.

This degree of independence is generally presumed to be experienced through the policies of the governing body i.e. the Board. Thus, each Board is expected to establish their own statements of vision and mission together with governance policies which deal with issues which are either repetitive or major. Other issues which tend to be more of a "one off" nature may be dealt with through simple resolutions of a Board.

6.1.1 The Mandate of the Boards

Based on our understanding of how the Board system was established, we believe that the present Boards were primarily legislated into being through the Hospital Insurance and Health and Social Services Administration Act. The Act was originally approved in 1988 and has since been amended several times (1995-97-98). Section 10 of the Act provides for "Boards of Management". Section 13 of the Act outlines the powers of the Boards which it defines as, and we excerpt, "…

(1) a. shall manage, control and operate each health facility or social services facility for which it is responsible; and

b. may, subject to Part IX of the Financial Administration Act, exercise any powers that are necessary and incidental to its duties under paragraph a".

(2) For greater certainty, a Board of Management may be assigned or delegated power, duties and functions for managing, controlling or operating social services facilities under any enactment.

(3) The health facilities or social services facilities for which a Board of Management is responsible, and any restrictions on the Board of Management's powers, duties and functions with respect to the facilities, may be set out

a. By an order made under subsection 10(1);

b. By a regulation made under paragraph 28(1)(g); or

c. By a directive or other written instrument issued by the Minister."

While we recognize that the officials of the day felt that there were compelling reasons otherwise, it is unfortunate that there has not been a consistent beginning to the creation of the nine Boards. Six are appointed directly by the Minister, one through the Indian Act, one through the Societies Act, and one is established through the Town and Villages Act. Representation ranges from 95 to 3947 people per board member.

The roles of the Boards are conveyed with greatest clarity by the Ministerial Directive of April 1999 (subsequently updated in February of 2001) and as supplemented by the individual Boards Contribution Agreements. The former is quite detailed in its description of duties but, given their

importance in understanding how this system operates, we have chosen to re-state these responsibilities here.

Each Board:

- is delegated its authority under Section 13 of the Hospital Insurance and Health and Social Services Administration Act
- is accountable to the Minister and to the residents of its service area
- has the authority and responsibility to provide health and social services in its service area
- shall ensure Core Services are available to residents in its service area; if services are not available in the service area, the Board must ensure that residents have access to services either within or outside the Northwest Territories
- shall plan, manage, deliver and integrate health and social services
- shall assess the health and social services needs of the residents it serves
- shall ensure that programs and services are delivered in a manner consistent with all other relevant federal and territorial legislation and regulations, GNWT policies, directives and agreements, and Departmental policies, directives, standards, guidelines and procedures
- shall submit a business plan to the Minister on an annual basis
- shall submit a budget to the Minister on an annual basis
- shall submit a report on operations to the Minister on an annual basis
- shall account to the Department for the funds expended in the Contribution Agreement
- shall deliver community corrections services as laid out in the Memorandum of Understanding between the Department and the Department of Justice
- shall manage, operate and control health and social services facilities in its service area.
- In the case of the Stanton Regional Health Board, in addition to the above, it shall assist other Boards to provide Core Services to their residents.

Each Board will:

- provide services that are consistent with the strategic direction of the Department, Core Services, the appropriate standards and the needs of its residents as reflected in the Board's Business Plan.
- develop, set and evaluate compliance with standards for service delivery in order to achieve improved health and well being.
- ensure that money is spent in the pursuit or improved health and well being, administering the health and social services system in a manner that does not threaten its ability to meet basic human needs over the long term.
- establish and maintain a proper system of records and account of assets and liabilities in accordance with the Financial Administration Act.
- consult with the Department regarding any changes made to Board policies which would impact on the Department and the terms and conditions of the Contribution Agreement.
- provide information requested by the Department related to the delivery of programs and services under the Contribution Agreement.

monitor regional and community health and service delivery outcomes.

The Minister and the Boards will:

- develop a health and social service information system which can be directed toward the improvement of health and well being for residents.
- respect the privacy of individuals when using health and social services data.
- ensure that the provision of programs and services is coordinated at the Board and territorial level.
- cooperate to develop methods that will measure the effectiveness of health and social service delivery in order to improve the health and well being of Northwest Territories residents.

6.2 Board Governance Models

We are mindful of the fact that there are both proponents and opponents of the present governance model, commonly referred to as the "Carver Model". We also respect the fine work which one of the leading experts on corporate Board governance has done and has contributed to the thinking and practices in this field. We note that this model was also endorsed by the 1997 Med-Emerg International Inc. Draft Strategic Plan which included in its recommendations that " The …Boards should adopt the Carver model of governance".

Unfortunately, the model has either not been well-understood or has been wrongly applied. As a result, it is our view that:

- Boards as a whole, with some exceptions, lack a good grasp of their roles
- Board members do not understand how the Board is expected to add value to the system
- Board training and Board discussions are focused almost exclusively on broad policy issues which are already in place and which are expected to be monitored by the Board; unfortunately, both the Board training process and materials which we were able to review appear to limit any real understanding of Board operations
- Key issues and concerns confronting the organization may either go unheard or are discussed without much depth of understanding resulting in little or no direction to the CEO
- As a result, key Board matters such as the Business Planning and budget development processes are simply ratified by the Boards without a clear understanding as to what they imply; we did not hear, nor did we perceive from the written record, of any assessment of actual results
- The CEO's power and authority has generally increased in response to the vacuum created by a non-involved Board
- Concerns of Board members relative to the performance of the CEO either lack a suitable forum for discussion or are not permitted to be a part of the CEO assessment routine given that CEO performance is only to be assessed against policy criteria
- The Board policies which we reviewed were so abstract and at such a high level that assessment thereof would not produce any useful or measurable results.

The responsibility for Board involvement and understanding is a two-way street: the lack thereof is a function of a poor or inadequate advisory role played by the

CEO as much as it is a result of Board members who are not involved or who appear to be disinterested. It is our view that the Boards, as a whole, lack an adequate understanding of what they ought to be about and how they can add value to the system. In many instances, members advise us that they have yet to ascertain whether or not their presence actually makes any difference in terms of how the organization functions. This is unfortunate given the advantages that a Board can bring to any corporate undertaking.

Why is this so? It is our view that neither the CEOs nor the Boards have had a clear understanding of where a Board should (and should not) be involved. There appears to be some quaint yet misguided notion that the Boards are simply there to verify and endorse what the CEO is doing, or in many instances, has already done. When certain members have inquired relative to what lies behind the issue, they are advised that their area of inquiry is "operational" and thus more appropriately left to the CEO.

In our examination of Board minutes, we are left, at the end of the minutes with the question "so what?" In other words, what difference did holding that meeting make? If members are asked to take time out of their lives to attend meetings, then certainly there should be enough of substance on the agenda to have made the presence of Board members valuable. Unfortunately, in many instances, both in terms of meetings observed and minutes reviewed, we would be unable to ascertain what value the Board had added. That, in our view, represents a significant system failure.

6.3 Number of Boards

This is one of the key issues facing the health and social services system. It is our observation that:

> The present delivery system is not sustainable given the current structure of nine boards; this has placed an undue burden upon the entire health and social services resource base.
>
> The nine Boards require individual servicing from a governance and administrative perspective which taxes the resources of the NWT.
>
> Given the relatively small size of some of the present jurisdictions, the resources which are available, are severely restricted. In fact, having a Board, lends the view that there ought to be sufficient resources available in each Board jurisdiction.
>
> There does not appear to be any substantive rationale as to why all of these Boards exist. The problems which at least some of them have encountered are often due to a lack of expertise or local "politics".
>
> The fact that there is no mechanism for sharing resources between the Boards results in staff growing disenchanted with their present employer and then leaving the NWT rather than simply moving to a separate jurisdiction within the NWT system.

6.4 Board Trustee Appointment

As noted earlier, there are nine health and social service boards in the Northwest Territories. With the exception of three of these boards, the membership is appointed by the Minister of Health and Social Service as outlined in the Hospital Insurance and Social Services Administration Act (HISSA). The three remaining boards' membership is decided by either an election process or as outlined in the Indian Act, the Societies Act

or the Towns and Municipalities Act. Some of the significant matters are excerpted as follows:

<u>The Hospital Insurance and Health and Social Services Administration Act:</u>

enables the Minister to establish appointment criteria as detailed under the following sections:

Board of Management

10. (1) The Minister may, by order, establish a Board of Management for one or more health facilities or social services facilities.

Composition

(2) A Board of Management shall be composed of a chairperson and the number of members, being not less than five, that may be fixed by the Minister.

Recommendation from single council

(3) Before appointing a Board of Management for the carrying out of operations in one community, the Minister shall solicit from the council of that community, names of persons suitable for appointment as members of the Board of Management.

Recommendation from councils

(4) Before appointing a Board of Management for the carrying out of operations in different communities, the Minister shall solicit from the councils of those communities, names of persons suitable for appointment as members of the Board of Management.

Representation of community

(5) The Minister shall satisfy himself or herself, when appointing members of a Board of Management, that the membership adequately represents the community or communities served by the Board of Management.

Term

11. (1) The chairperson of a Board of Management holds office during pleasure and, subject to subsection (2), the members shall hold office for a term of three years.

Reappointment

(3) The Minister may, at the expiration of the term of office of a member of a Board of Management, reappoint that member, but no person shall hold office for more than three consecutive terms.

Vacancy

(4) Where, for any reason, a vacancy occurs in the membership of a Board of Management, the Minister may appoint another person to fill the vacancy for the unexpired term of office of the member being replaced.

Appointment during pleasure

(5) Notwithstanding subsection (3), the Minister may, where the Minister considers it in the public interest to do so, designate any member of a Board of Management, in addition to the chairperson of a Board of Management, to hold office during pleasure.

<u>The Indian Act:</u>

There is no specific section that deals with Board appointments. The Act simply allows the Band Council to enter into an agreement with the GNWT to contract services associated with Health and Social Services.

<u>The Societies Act:</u>

We were advised that at least some of the Boards may have registered under the Societies Act. This has added an unnecessary layer of complexity and confusion to the governance of the Boards as a number of requirements of the Societies Act may be in actual conflict with the requirements of the health and social services legislation and the agreement

between the Government of the NWT and the Board.

The Boards have not complied with the requirements of the Societies Act regarding completion of bylaws, annual general meetings, the preparation and custody of minutes and other requirements.

The Societies Act also permits the acquisition of real and personal property and provides for the ability to sell and mortgage against assets, all of which conflict with the agreement between the GNWT and the Boards.

The Towns and Municipalities Act:

There is no specific section that deals with Board Appointments. The Act simply allows the Municipal Council to enter into an agreement with the GNWT to contract services associated with Health and Social Services.

The representation population served and the legislative authority for the nine boards is as follows:

Board Name **Population served** **Population to Board Member**	**Communities**	**Legislative Authority and Nominating Agencies**
Inuvik Regional Health and Social Services Board 9,845 1,640	13 communities: Aklavik, Deline, Fort Good Hope, Colville Lake, Fort McPherson, Inuvik, Tsiigehtchic, Tulita, Norman Wells, Paulatuk, Sachs Harbour, Tuktoyaktuk, Holman	**Hospital Insurance and Health and Social Services Administration Act (HIHSSA Act)** 6 member Board appointed by Minister representing: Gwich'in Tribal Council Sahtu Secretarial Incorporated Inuvialuit Regional Corporation Norman Wells Inuvik
Stanton Regional Health Board 41, 606 3,467	All communities of the NWT and also provides services to Nunavut	**HIHSSA Act** 12 member board appointed by Minister. Chairs of 8 regional Boards and 3 from Yellowknife and 1 from Yellowknife Dene Band
Yellowknife Health and Social Services Board 17,897 1,988	3 communities: Detah, Ndilo, Yellowknife	**HIHSSA Act** 9 members appointed by Minister, representing Ndilo, Dettah, and Yellowknife
Dogrib Community Services Board 2,709 225	4 communities: Rae-Edzo, Rae Lakes, Wha Ti, Wekweti	**HIHSSA Act** 12 member Board appointed by Minister representing each of the 4 communities, each having 3 reps

Lutselk'e Health and Social Services Board 386	<u>1 community:</u> Lutselk'e	**Indian Act** Health and Social Services are administered and delivered by the Lutselk'e Dene Band

Deh Cho Health and Social Services Board 3,373 259	<u>9 communities:</u> Fort Simpson, Fort Liard, Fort Providence, Hay River Reserve, Jean Marie River, Kakisa, Nahanni Butte, Trout Lake, Wrigley	**HIHSSA Act** 13 member Board appointed by Minister. Ft. Simpson has 3 members, Ft. Providence and Ft. Liard each have 2 members and the remaining communities each have 1 representative
Deninu Community Health and Social Services Board 572 95	<u>1 community:</u> Fort Resolution	**Societies Act** 6 member Board with 2 members each appointed from the Metis Assoc., Deninu K'ue First Nation, and Deninoo Community Office
Hay River Community Health and Social Services Board 3,947 563	<u>2 communities:</u> Hay River and Enterprise. Provides health and services to Hay River Reserve	**Cities, Towns, and Villages Act** 7 member Board appointed by Council with 2 members each representing the town of Ft. Smith, Salt River First Nation, and Metis Nation Local 50 plus chair
Fort Smith Health and Social Services Board 2,728 389	<u>1 community:</u> Fort Smith	**HIHSSA Act** 7 member Board appointed by Minister with 2 members each from town of Ft. Smith, Salt River First Nations, and Metis Nation Local 50

6.5 Role of Board Support and Health Services

During the course of our Review, it was reported to us by many of the Board members and staff alike of the Health and Social Services Boards that they do not feel they are obtaining adequate support from the Department of Health and Social Services. While this sweeping statement should not be interpreted as a condemnation of the total relationship, it is clear that there was considerable confusion and mixed signals as to the expected roles and what resources were going to be made available. While the relationship has shown signs of improvement, including recently, it is clear that the Department and Boards treat each other with a mixture of collegiality and suspicion.

There has been, and continues to be, confusion about the role of the Department regarding Board support and education. It became apparent to us that some of the concerns stemmed from the misuse of the term “Board” and some from a lack of adequately experienced staff in the area of Board management and relationship-building. It is our view and has been our

experience that the use of the word "board" generally refers to the governing body of a particular organization. Thus, when we hear the term "Board support" we expect that those involved would primarily be involved in helping the Board(s) with their governance responsibilities. This has not always been thus understood by the Department staff who also have viewed the composite Board-administration as being their "client". Thus, a good portion of their time has been spent in meeting with members of staff within the "boards" and very little attention paid to helping a Board understand its own functions.

Again, we would argue that the lack of personnel who are experienced in this regard has been a major contributing feature to the inattention given to Board governance. For the most part, the staff of the Board Support Unit have backgrounds in other endeavours and thus, at least initially, lack the degree of confidence necessary to advise Boards and their senior administration. We note that some of the Boards have engaged others who are seemingly more experienced in this area to assist in their orientations. Unfortunately, this orientation process, regardless of how well conducted, is never enough. A Board requires ongoing advice relative to how it conducts its own business even to the point of understanding what that business is.

It appears certain that the Department does want to help when requests come from the Boards. We were quite impressed by the diligence of the staff and willingness to find the right sources of information in response to requests from the Boards.

More and more regional people are contacting "Board Support and Health Services" within the Department for assistance. This division or unit of the Department appears to be gaining more credibility with the regions as time goes on. However, this too depends upon the particular Board in question, the person in the region making the request, the consultant assigned to the region, and so on.

Some of the positive feedback received during the interview process included the following:

> "Usually someone gets back to me."
>
> "The business planning facilitation process is getting better."
>
> "They seem interested in helping."

However, there was also some negative feedback received. Some of the comments were:

> "There is not much experience there."
>
> "Why does the Department send someone to sit at our meetings? "What is it they are supposed to do? Are they inspectors or supporters?"

There is also a question whether the Board Support and Health Services Unit or Division should act as the 'gatekeeper' for all requests that may come to the Department from the regions. Under this scenario, if a request comes in to obtain information or expertise normally housed within another branch of the Department, 'Board Support Unit and Health Services' would nevertheless facilitate the request and follow up to see that it was handled properly.

It is our view that much of the criticism, which we heard relative to the role of this Unit, has more to do with a lack of clarity of expectations and less to do with actual performance. For example, some felt that this Unit was to serve as "clearing house";

others that it was the “gatekeeper”; and still others felt that this Unit would serve as a coordinating centre for requests from the regions. We were unable to find any supporting documentation indicating that this “clearing house” or “gatekeeper” role should be included in the mandate of the Board Support and Health Services Unit.

Unfortunately, the Department has made little effort to clarify just what services these willing and eager staff are to be performing and thus their status is left somewhat in limbo. In many ways, the Department is fortunate that it has been blessed with quality young people who are prepared to give this their best effort. We believe that this could be so much more rewarding if the Department employed a “train the trainer” philosophy with their staff and brought in people who possessed more governance and Board-management experience to act as mentors, even on a short term contract basis.

6.5.1 Board Education

It is clear that the whole approach to board orientation and education has not been well thought out and executed. It is our understanding that, when the Health and Social Service Boards were formed, the education and orientation programs for boards were offered in a somewhat laid back and haphazard fashion. This is apparently echoed by the comments which we received relative to Board training:

> Board orientation and training is not a priority of the GNWT.
>
> The Department did not want the NWT Health Care Association to do board education.
>
> Staff from one of the other boards did training for other boards in the governance and policy area.
>
> There was initial board education but it died out.
>
> There are new members on boards who have not had any orientation or education regarding board governance.
>
> Board education is critical but it isn’t happening.
>
> Most boards do not understand the Carver method of governance.

For a time, the former Northwest Territories Healthcare Association organized the Board training programs. At other times, one or more of the Boards directly organized these education sessions for their own Board and arranged for resource people to assist them. This included drawing from the resources from both private business and Stanton Regional Hospital Board to help them through the process.

While there appears to have been more of a concentrated effort initially to offer board education programs, particularly in regard to the Carver model of board governance, these efforts decreased as time went on. And as new people were appointed to the Boards, the situation soon arose where some Board members and their CEO’s had some board governance education, while others had no exposure to this education at all.

With the dissolution of the NWT Healthcare Association, the responsibility for board education seems to have shifted to both the Department as well as to the individual Boards. It does not appear, however, that there is any one organization designated with the mandate to organize, coordinate, deliver, and evaluate a high quality board education program. Partly as a result of this absence of responsibility, the frequency and quality of the training has been diminishing. To their credit, some of the Boards are following up with their own training, including quite recently.

6.6 Our Observations

While we have been impressed, in the main, with the commitment and enthusiasm of Board members, we have been less than impressed by the actual quality of Board governance. This is the result of a number of inter-related factors, with no one party the target of any inordinate degree of blame. These factors include:

- An inadequate appraisal of the objectives of Board governance
- The description of the Boards as "Boards of Management"
- The type of governance model chosen which appears to be either ill-suited to this particular milieu or to strong Board leadership at the local level
- The degree of training and the lack of any rigorous follow-up for all Board members
- The absence of any real understanding as to what value a governing Board is expected to bring to the organization
- An approach to policy development which places virtually all ownership and responsibility in the hands of the CEO.

6.6.1 A Summary Comment

We have spent some time on this topic of Board governance due to our conviction that a sound understanding of governance principles and practices is essential to quality Board leadership. For whatever reasons, this critical underpinning of an effective organization has never really caught hold as the local proponents of the governance model must have hoped. As a result, it is our view that the Boards, taken as a whole, have not received the kind of proactive, systematic, focused leadership which is necessary to achieving results in any system. Instead, the Health and Social Services organizations have been relying largely upon the administrative direction provided by the chief executive officers (and their senior staff) and only marginally upon the Boards who were charged with that task.

In order for organizations to function fairly and effectively, they must be guided according to:

- Clear legislation which outlines the jurisdiction for the actions taken
- Regulations which give clarity and added meaning to the legislation
- Policies and bylaws which describe the organization's basic mode of operation and governance
- A Business Plan which describes the goals, objectives, targets and outcomes to be achieved
- A clear set of governing framework principles and policies within a policy development mindset which provides for ongoing review and revision
- Comprehensive Board governance training (from someone other than the CEO) within 1 month of the appointment of any new member
- Detailed administrative operating procedures (or regulations)
- Clearly written position descriptions and expected actions and results for each function.

We describe these in more detail in other sections of this Report.

7.0 ACCOUNTABILITY WITHIN THE SYSTEM

7.1 Background and Observations

Of considerable importance to the functioning of the Health and Social Services system is a solid grasp of the principles of accountability. These principles, which have been defined in a variety of ways by various organizations and governments, reflect a particular emphasis or bias based on the nature of the organization in question. In this instance, the Auditor General has provided some of the key parameters in the Auditor General of Canada's "Five Principles of Effective Accountability" (see Section 7.7). As well, the GNWT may be able to place this issue within a broader Territorial-wide context shortly given its current review of "Third Party Accountability" through contract with an external firm. Their report may, or may not, have a degree of impact on what we report here.

In the main, the significance of this issue is due to the fundamental nature of democracy. At its heart lies the principle underpinning of accountability. That is, for any organization to function effectively and as intended, it must understand to whom it is accountable. It must also appreciate how that accountability is to be conveyed and what information and/or results are expected by those to whom the accountability is owed.

7.2 Accountability Defined

Accountability has been defined as "the obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities" (Alberta Health, November 1998). This conveys three distinct messages:

1. the need to report or answer;
2. the reporting must be in reference to the assigned responsibilities; and
3. the reporting must be to those conveying the authority.

The Report referenced earlier (i.e. Accountability: An Action on Health Initiative) underscores five "…important elements which underlie effective accountability relationships:

- roles and responsibilities are mutually understood and accepted
- performance expectations are explicit and accepted
- sufficient resources, including authority to act, are provided
- review and feedback are carried out, and
- follow up actions, including rewards and sanctions, may be taken to improve performance.

It should be noted that the Premiers and Territorial leaders of Canada, in their *Communiqué on Health* issued subsequent to the 2000 meeting of First Ministers, agreed to provide clear accountability reporting to Canadians. This underlines the significance which governments are giving to this issue as well underscoring the difficulty in achieving a common degree of understanding of key indicators and ability to report. In this instance, the First Ministers

concentrated on the need to establish a common definition of comparable health system indicators.

7.3 Roles, Responsibilities and Authorities

As we indicated at the outset, it was clear that the authors of the current legislation and the subsequent policy framework wanted to be clear as to who was accountable to whom and for what. It is our view that this was intended to be quite clear as noted in the following excerpts from the Health and Social Services Establishment Policy**,** as revised on May 10,1999:

The Minister:

- is the devolved authority for health service provision in the Northwest Territories Act and the Transfer Agreements (1982, 1986, 1988) with the federal government
- is responsible for maintaining a relationship with the federal government and ensuring health and social services in the NWT continue to meet national principles and requirements
- must ensure that the NWT adheres to the five principles of accessibility, universality, portability, comprehensiveness, and public administration as they are set out in the Canada Health Act
- is accountable to the GNWT and the public for the provision of health and social services
- develops and implements policy and legislation, and co-ordinates the planning, management, and delivery of health and social services through the Boards
- allocates health and social services resources to the Boards; the Boards shall retain any surplus or deficit incurred by their resource allocation
- develops, approves and issues standards and guidelines for the provision of services--in the absence of NWT standards, recognized Canadian standards are to be used…

Each Board:

- is delegated its authority under Section 13 of the Hospital Insurance and Health and Social Services Administration Act
- is accountable to the Minister and to the residents of its service area
- has the authority and responsibility to provide health and social services in its service area…
- shall ensure that programs and services are delivered in a manner consistent with all other relevant federal and territorial legislation and regulations, GNWT policies, directives and agreements, and Departmental policies, directives, standards, guidelines and procedures
- shall submit a business plan to the Minister on an annual basis
- shall submit a budget to the Minister on an annual basis
- shall submit a report on operations to the Minister on an annual basis
- shall account to the Department for the funds expended in the Contribution Agreement

Under the responsibilities of the Minister and the Boards

The Minister will:

- implement and administer legislation and regulations, GNWT policies, directives and agreements, and Departmental policies, directives, standards, guidelines and procedures for health and social services provision.

describe Core Services to be provided.

set strategic direction and priorities for the NWT health and social services system.

develop a human resource plan consistent with the Department's and Board's strategic goals.

set and evaluate compliance with territorial requirements for service delivery in order to achieve improved health and well being.

carry out site visits, reviews, inspections, evaluations and audits to assess and evaluate Board operations as deemed necessary by the Minister.

gather data related to health and social service delivery in a timely and effective way.

consult with the Boards regarding legislation, policy and directives pertaining to Boards' authority, responsibility and accountability prior to making changes which impact on the boards and the terms and conditions of the Contribution Agreement.

monitor population health and service delivery outcomes.

Each Board will:

provide services that are consistent with the strategic direction of the Department, Core Services, the appropriate standards and the needs of its residents as reflected in the Board's Business Plan.

develop, set and evaluate compliance with standards for service delivery in order to achieve improved health and well being.

ensure that money is spent in the pursuit or improved health and well being, administering the health and social services system in a manner that does not threaten its ability to meet basic human needs over the long term.

establish and maintain a proper system of records and account of assets and liabilities in accordance with the Financial Administration Act.

consult with the Department regarding any changes made to Board policies which would impact on the Department and the terms and conditions of the Contribution Agreement.

provide information requested by the Department related to the delivery of programs and services under the Contribution Agreement.

monitor regional and community health and service delivery outcomes.

7.4 Need for Clarity

It is essential that the accountability of one part of the delivery system to the other is clearly set forth in the legislative and governing documents. This is what should be conveyed in the guidelines which envelope the legislation. Rather than clarify this matter, the information, which we have reviewed, tends to "muddy the waters".

While the foregoing statements of Ministerial and Board responsibility would appear to be both prescriptive as well as descriptive, they contain within them the seed of confusion which may be a contributing factor as to why the health and social services system has not functioned as intended to date. Accountability needs to be viewed as a simple but profound construct and one which is distinguishable from other related concepts like "responsibility" and "answerability". Its clarity lies in the fact that Boards are to be accountable in a vertical sense up to the Minister (and thus to the Government). This simplicity cannot be maintained if there is

dual accountability which, in fact, is what the current statements require. Embedded in this comprehensive policy statement, which was crafted by the Government, is the clause "that the Board is accountable to the Minister and to the residents of its service area".

We would argue that the legislation, which takes pre-eminence to any other instrument, is clear in assigning the accountability of the Boards to the Minister. The Hospital Insurance and Health and Social Services Administration Act points to the Minister as having the power to establish the Boards and similarly to dismiss them and appoint a public administrator. Thus, while the Boards may feel a particular sense of answerability to the public in that jurisdiction, the Board is still ultimately accountable to the Minister.

Unfortunately, we have noted that a number of Board members feel a primary sense of obligation to the body which either elects or nominates them to the Board. This is not simply a matter of respect for the "community" from which they were appointed. We were made aware that nominating agencies, who felt that "their" Health and Social Services Board member did not adequately represent or reflect their particular views on the issues or would not accede to their demands, had demanded that they step down or had even notified the Board that the member no longer represented them and that the Board was to dismiss that individual and accept their new nominee. These examples draw into doubt the Minister's control over the appointment process and/or the respect by all parties for the legislated powers of the Minister.

7.5 Non-Governmental Organizations

Non-Governmental Organizations are defined as any organization that provides health and/or social services programs and is not considered part of a Territorial, Provincial or Federal Government. Up until now, all Boards are expected to use FMB Guidelines for Contracts and Contribution Agreements that, for the most part, are very general regarding roles, responsibilities, and accountabilities.

It is our understanding that new Guidelines are under development between the Department and a Health and Social Services Board that could ultimately serve as a model for the administration of contributions, contracts, and grants throughout health and social services in the Territories.

Non-Governmental Organizations (NGOs) play a major role in the provision of health and social services in the Northwest Territories. As a result, it is very important that the Department establish a model agreement that clearly defines the roles, responsibilities, financial and program accountabilities, and performance measurements for each NGO service provider. At the moment the role and value of the NGOs appears to us to have been poorly understood and under-valued. Thus, we were advised that seldom are such organizations called into meetings of the Boards (other than the Yellowknife H & SS Board) and may only be in contact with the Boards or their CEOs whenever they are required to bring in an updated version of their budget proposals (which are essentially a repeat of prior years) or when there is a significant crisis to attend to and which involves the NGO.

Any new arrangement or model agreement with non-governmental organizations should clearly indicate that such external bodies, which are not established by the Government, are not accountable to the

Board other than for those areas of service which it contracts with the Board and for the funding which it receives from the Board. That is, such NGOs are accountable in a general sense to their own members or to whomever their articles of incorporation would so determine. Their accountability to the Board in the areas of services delivered and funding received should be made clear in any funding or service agreement. Similarly, such an agreement should specify the obligations of the Authority to meet with, and communicate with, the respective NGOs on matters related to their services and issues pertaining to budget and reporting.

7.6 Assessment of Current Levels of Accountability

The preceding overview of roles and responsibilities is a classic example wherein the practice does not always follow the theory. The input we received from our extensive interviews raised the following concerns:

- The type of accountability described in legislation does not appear to match practice.
- There are situations in which the Department and Boards are both giving direction to the CEO (sometimes a contradictory message).
- The CEOs are often perceived by their Board members as the experts in their system i.e. most involved and most knowledgeable and therefore most accountable.
- The Minister and the Deputy Minister each see problems in their accountabilities from not being able to direct Boards; Boards only seem to pay attention when something big goes off the rails i.e. releasing an entire Board from its responsibilities.
- Some CEOs have felt trapped by the local political situation wherein a small but powerful group appears to control most elements of the community even if the Board was determined to act independently.
- The credibility of the Government/Department has suffered given that they have not acted on previous studies.
- The Department frequently demands immediate answers from Boards but will then sit on the requests from Boards for months. Further, there may be no response to the information provided to the Department by the Boards.
- There is a lack of consistency in Financial Statements. There is no usage of a common chart of accounts. This hinders comparisons between Boards and reduces the ability to measure performance.
- Auditors may not be providing sufficient notice of financial system issues to the Boards and the Department in order to provoke the desired response.

7.7 The Accountability of the Chief Executive Officer

One of the keys to the system of accountability is the role and sense of accountability of the chief executive officers. This individual is obviously central to how well the overall system works. If the CEO is alert to their responsibilities and anxious to develop a solid relationship with their respective Board, then the CEOs role will be the “glue” that helps to bind the system pieces together. Where that is not the case, and either personality, or lack of role clarity, or both, get in the way, then the CEO may be a significant cause for overall system failure.

As we view this important role, the key tasks of a Chief Executive Officer should include:

- providing policy advice to the Board
- directing the organization according to the direction of the Board, the legislation, bylaws and policies
- managing the day to day operations
- establishing administrative goals and objectives
- providing guidance to the senior staff in the performance of their duties
- guiding the development of the Business Plan and budget through ensuring appropriate involvement by the Board in the various stages of their development; reporting on the financial health of the organization
- reporting to the Board on all matters deemed to be substantive or key to the organization's operations and continued functioning
- developing effective mechanisms for communicating with the key stakeholders and public
- performing all the requirements directed to the CEO by legislation and regulation.

These key duties require the CEO to have developed a reasonable degree of proficiency in:

- Board-CEO relations
- senior management leadership
- policy development
- human resources/labour relations
- strategic planning
- budgeting/business planning
- managerial skill development
- motivation of employees; and
- written and verbal communication.

The CEOs are retained by their respective Boards and are under contract to the Boards. At the same time, it is our understanding that the CEOs are placed on the GNWT senior management (Hay) plan and may also be a part of the GNWT benefit program. The contracts, as signed by the CEOs, also include clear provisions respecting termination by either party which also includes termination of employment as an employee of the GNWT pursuant to the Public Service Act.

Some of the contracts, which we have reviewed, do not include any statement of CEO duties except that they "…agree to manage the Board as outlined in GNWT policy and as instructed by the Board and Deputy Minister…" This provides for both a lack of clarity in functions as well as a dual reporting relationship. It is our view that the position description for each CEO should be appended to their contracts; that a copy should be placed in the hands of each Chair and Board member; that a copy should be filed with the office of Deputy Minister; and that in each instance, the Minister retains the authority and option of dismissing not only the Board but also the CEO of each Authority.

7.8 Principles for Accountability (Impact on Board Governance)

As a part of our terms of reference, we were asked to comment on the degree of fit between what the Boards were presently doing with Auditor General of Canada's Five Principles of Effective Accountability. Our comments and comparisons follow:

Clear Roles and Responsibilities

The roles and responsibilities are defined in legislation, policies and directives but are not well understood at either the Departmental and Board level. Without a clear understanding of each other's roles and responsibilities, there can be no agreement between the parties-an aspect

which is fundamentally lacking at this time. What is somewhat uncertain is the question of whether or not the lack of clarity is due to an inappropriate framework or inexperience with the system or confusion brought on by a multiplicity of legislation, regulation, directives and agreements.

Clear Performance Expectations

It would appear at present that the performance expectations of the Boards concentrate almost entirely on budget performance. What is needed is a clear understanding of what performance expectations are; why they are important; and how they can be effectively measured. The Department and the Boards need to become partners in this exercise in order for the objectives of both to be accomplished without any unnecessary duplication. Each party ought to agree on what to contribute to the end result, including inputs and outputs to achieve the desired outcomes. (In this vein, we note that work is required on a re-definition of the term "core services" which currently appears to be so inclusive that it almost becomes meaningless to most Boards.)

Balanced Expectations and Capacities

The performance expectations of both the Department and the Boards need to be clearly linked to, and in balance with, their capabilities (authorities, skills, and resources). Again, the definition of Core Services places an expectation, but the expectation has no relevance to the capacity of the region. There needs to be a step-by-step approach to this process of performance measures or else it will simply fade away with the other seemingly important requests being placed upon the system.

Credible Reporting

Both parties need to report credible and timely information to demonstrate performance achieved and what has been learned. Again, the key it would seem is a gradual and well-thought process in this regard. Obstacles need to be defined and removed. Training needs to occur. As noted earlier, there is a lack of consistency in financial reporting from Boards and there is no common Chart of Accounts used throughout the system, which hinders any meaningful comparisons and reduces abilities to measure performance.

Reasonable Review and Adjustment

Enlightened, informed review and feedback on performance achievements should be carried out by the Boards and Department, where achievements and difficulties are recognized and necessary corrections are made. For example, Boards are expected to submit timely financial and business plans to the Department but do not receive timely responses back from the Department. Boards are required to develop Business Plans, but are expected to provide new programs/services within existing funding levels that by its nature discourages meaningful, progressive business planning.

7.8.1 Adequacy and Effectiveness of Accountability Relationships

Within Boards

Boards are generally not provided with information that allows them to measure their performance as a provider of health and social services (e.g., goals, objectives, challenges, outcome measures, targets, strategies, and resource requirements). They do not generally receive annual written reports (other than financial) that tell them how well they met the health and social service needs of their people.

Between Boards

Again, the lack of consistency in financial and patient data reporting hinders comparison between Boards and reduces Boards and the Department's ability to measure performance.

Between Boards and NGOs

As noted earlier, there is no standard agreement for Non-Government Organizations that clearly defines the expected roles, responsibilities, financial and program accountabilities, and performance measures for each services provider.

Between Boards and the Department

Until such time as the roles and responsibilities of both the Department and the Boards are clearly enunciated and understood by both parties, accountability relationships and expectations will continue to be disjointed. Again, the legislation is at least reasonably clear, but the practice is not.

Between the Boards and the Public

There are no clear accountability expectations between the Board and the public. Boards were presumably established with the intent to promote program integration and to encourage local and regional input. The current system does not reflect community empowerment and does not encourage or foster any meaningful dialogue between the Board and the community—hence no meaningful accountability expectations are evident.

Between the Boards and the Minister

The legislative accountabilities are reasonably clear; however, the roles and responsibilities of each party as they relate to the Department are certainly not clear from the perspective of the Boards. Until the relationship of the Department and the Boards is clearly enunciated and practiced, the accountability relationship between the Boards and the Minister will remain clouded.

Gaps in the Existing Accountability Framework

The major gaps in the accountability framework are primarily gaps in practice rather than gaps in legislation. There are too many examples of inconsistent behaviour. For example, policies are either ignored or are applied in an inconsistent manner (medical travel usage, operating deficits, program funding, etc.). This tends to dilute any meaningful accountability framework.

7.8.2 Summary of Observations

This is a significant and important element in the overall system in terms of how well it functions. It should not be discounted as another requirement which lacks meaning and realism. If the principles of accountability are clearly understood, then the actual day-to-day practice will become more meaningful. Thus, the Department needs to understand where its accountability lies and how it is expected to deliver on its commitments. The Boards also require clarity in terms of their viability as organizations and how much of that depends upon developing open and confidence-based relationships with the Minister and her administration.

8.0 BOARD MANAGEMENT SYSTEMS

8.1 Background and Observations

In order for the practices of Board governance and management to function as intended, the following systems must be in place and adequately addressed:

- Governance Roles and Responsibilities
- Business Planning
- Accountability
- Financial Planning, Forecasting, Administration and Reporting
- Human Resource Planning, Management and Monitoring
- Systems Support

While we have addressed some of these issues in other sections of our Report, there needs to be a good understanding of the inter-relationship of these functions. That is, the ability of the system to function as intended relies upon the balance achieved in managing each of these interrelated components.

Thus, the governing body must have a clear appreciation of its roles and responsibilities and an acute awareness of its accountability to the Minister for the effective delivery of each service component. That will not happen without a solid system of reporting to the Board and involving the Board in those elements which are key to its comprehension of how the whole system works.

Business planning is an exercise which is central to the identification of goals, objectives and strategies. It speaks to the attainment of measurable targets and the monitoring of those against pre-established outcomes. The process need not be all that complex or onerous particularly where the familiarity with it is relatively new. However, it is essential that the Board be involved at the outset and not simply looked to for some form of global and unquestioning approval, which unfortunately, has too frequently been the case.

The lack of awareness as to accountability has been one of the contributing factors to the current problems which plague the health and social service system. We believe that the issue of accountability was presumed to have been understood at the outset. This has apparently not been the case. The system design was predicated on the notion of Ministerial accountability to the Legislature and, through the Legislature to the public for the effective running of the system. In this hierarchy of levels of accountability, the Boards were to be accountable to the Minister and the CEO (and their administrations) accountable to the Boards.

The system relies upon a strong and healthy economic base. While the continued demands for increased funding are of ongoing concern, the actual management of existing resources is at least more manageable. Unfortunately, the skill level needed to conduct relatively complex financial issues has been difficult to attract and retain. As a result, Boards have not always had access to quality financial forecasts or reports nor are they consistently involved in the planning of expenditures and their monitoring. An effective system relies on both components: a well-trained administration who understands the nuances and complexities of financial management; and a governing Board which grasps their role and who asks the types of questions needed to maintain effective control of the resources.

All of this is dependent upon the ability of the system to attract and retain quality people in the right positions. These are complex matters which may not readily lend themselves to always hiring locally. That is, the skill set required may need to be brought in from “the outside” until such time as the Government’s pledge to train and equip local northerners can match the actual demand. As noted later in this same section, the Government’s task has become increasingly difficult given the opportunities afforded by a healthier private sector economy. The key to this quandary will likely lie in a healthy dose of realistic expectations and a longer timeframe than may be politically palatable. Nonetheless, the present need for resources cannot be maintained within the present structure.

8.2 Adequacy of Current Planning Systems

While considerable attention has been paid to the need for improved planning by the Department and by the Boards, this critical function still lacks the coordination and understanding which are so critical. Thus, the Department has, over time, developed its planning processes to a considerable extent, with increasingly more involvement at the supervisory and senior levels of the Department. The Department has developed an approach to Business Planning for its own purposes and has tried to convey the importance of a similar process “out in the field”.

For a number of reasons, this has not been as well-received as the Department intended and expected. The onus appears to have been placed on the CEO of each Board to appropriately involve their Board and administration in the process. Some have done this particularly well. Others have paid lip service to this given their assessment that other issues deserve more of their attention or that their Board is not likely to be interested.

As a result, the Boards, which are expected to be complementary parts of the overall system, may or may not share in the Department’s view of the future. This, unfortunately, creates a disconnect within the overall planning model and draws into question the degree to which all parts of the system are operating on the same wavelength.

The Department’s 2001-2004 Business Plan also listed the Principles which were to “guide the planning and actions of the Department, health and social services boards and other agencies who are partners of the health and social services system. These principles were developed in response to public consultations to develop the Department’s strategic plan. They follow:

> Universality: All residents of the NWT have access to the services they need, and are treated fairly and with respect in the health
>
> Personal Responsibility: Individuals and families have personal responsibilities to address their health and social needs.
>
> Basic Needs: Publicly funded programs and services will address basic health and social needs when these needs cannot be met by an individual or family.
>
> Sustainability: The health and social services system will operate in a way the does not threaten its ability to meet basic health and social needs over the long term.
>
> Continuation of Care: Programs and services will fit together as seamlessly as possible and will be integrated with other GNWT services wherever possible.

Prevention-oriented System: All activities of the health and social services system will support the maintenance of physical, social and mental health, in addition to the treatment of illness and injury.

People-oriented System: All activities of the health and social service system will support an approach which places the needs of people first."

While we believe that the vision and goals need to be looked at afresh subsequent to the adoption of this Report, we believe that these point in the right direction and are generally supportable. It is our view, however, that a revised Business Planning Process will be required which will ensure adequate involvement by the Board members as well as by the administration across the organization. We have provided an outline of such a system in our recommendations together with an Exhibit (see section 11.7) which sets out the steps in sequence and in a diagram for encouraging a more comprehensive understanding as to how this revised Business Planning cycle is to function.

8.3 Adequacy of Current Information Technology

The results of our Operational Audits point to the need for considerable improvement by at least some of the Boards in terms of their information technology systems. The key findings of our audits revealed that:

- orientation and training of new staff to existing IT systems was often not undertaken, particularly for locum staff
- training of staff on new territorial systems was included on the initial roll-out of software systems, but resources for training of new staff was not provided to the Boards
- while IT systems have significant problems, we found IT staff with the Department and the Boards to be individually motivated and committed to serving their organizations
- investment in IT systems and training for the Department and the Boards is inadequate to control or manage the Department and Boards information resources at a level that supports quality decision-making
- resources to maintain current IT systems and hardware are inadequate, and the available resources are spread too thinly. There was almost no ability to deal with legacy IT systems and data due to the high turnover in staff that had been experienced by the Department
- development of Telehealth services at additional sites seen as positive by IT staff, Boards and clients
- the approach by the Department and the Boards is very focused on information technology vs. information management
- insufficient cooperation is occurring between Department and Board IT staff
- some staff in remote locations reported being without operable computer hardware and/or email access for up to 3 months
- Department staff reported that there was no emphasis in the past on quality assurance on data stored by the Department, and that reporting from data currently held was problematic
- Board management made little use of the Departments ability to provide reports, as they had found in the past, that by the time the report had been produced the issue had been resolved

- staff reported that information being entered into CFIS was not always accurate, and some staff had not entered CFIS data as they had not received any training
- current IT systems are mix of Board and territorial systems, a situation that inhibits the systems ability to integrate financial and operational information
- due to the different financial and payroll software systems being utilized by the Boards, there is not a large enough pool of trained and experienced staff within the territory to support the needs of the organizations. This has caused some problems to the Boards, particularly in the area of payroll services
- management and staff at the Boards see little value in applying scarce time and resources to entering data into territorial systems, as they see minimal useful reporting in return. Information being forwarded to the Department was commonly termed as being sent into the "black hole".

8.3.1 Review of the Current System

At the same time as the operational audits were being undertaken, an *Information Management / Information Technology Strategic Plan for the Department of Health and Social Services of the Northwest Territories* was being developed by Sierra Systems Consultants. Additionally, Sierra Systems Consultants also took on the interim role as Manager of Information Services for the Department. Recognizing the overlap of the development of this Action Plan with the work being undertaken by Sierra Systems Consultants, both of our groups shared observations and strategies regarding the current IT system so that recommendations from both reports would be coordinated.

Based on this previous coordination it is not proposed to duplicate the findings contained in the *Information Management / Information Technology Strategic Plan for the Department of Health and Social Services of the Northwest Territories* report.

We support the following directions included in the Sierra Systems Consultants report *as applied within the governance structure and priorities recommended by this Action Plan:*

- to develop territorial systems in concert with national and regional health-related initiatives
- to implement strategies around the development of Information Management services
- to install new systems and upgrade existing systems towards the development of an integrated Information Management / Information Technology system
- to continue the development and extension of Telehealth services
- to complete the development of a Data Warehouse
- to standardize financial, material management and payroll systems used by the Boards.

8.4 Adequacy of Current Financial Systems

In reviewing the current financial systems and the corresponding financial management systems, it is important to measure them against an applicable and cohesive standard. The Boards currently operate as a part of a territorial department budget, which requires the standard to be one that applies to the federal/provincial/territorial model of department management.

The Financial Management Capability Model published by the Office of the Auditor General of Canada in 1999 provides a system that supports the following objectives of financial management:

- ensure that managers have support for decision making;
- ensure the availability of timely, relevant and reliable information, both financial and non-financial;
- contribute to managing the risks to the organization;
- help the organization make efficient, effective and economical use of resources;
- enable managers to account for their use of resources;
- establish a supportive control environment; and
- enable the organization to comply with authorities and safeguard its assets.

(This model is available at http://www.oag-vg.gc.ca/domino/other.nsf/html/99cm1_e.html)

This system represents a model that is valid for the delegated authority system utilized by the Health and Social Services Department and Boards, and will be used as a basis of both our financial review and the financial recommendations in this report.

8.4.1 Review of the Current System

The present financial management system is characterized by the following problems:

- Financial and payroll systems are inconsistent between the Department and Boards, with the both utilizing a number of different financial software packages.
- The capability to operate financial management systems varies by Board and time as trained financial officers are not readily available, and the specific knowledge of financial software packages needed is also not readily available in the Northwest Territories.
- A basic financial control framework does not exist, with many Boards and management staff in the system lacking sufficient financial and operational information to manage their responsibility areas.
- The role of the auditors to the Boards has not been sufficiently clear so as to provide the level of information required by the Department to undertake its mandate of fiscal control.
- Financial practices have not been standardized across the system.
- Operational information is inaccurate and incomplete; and delays in its circulation prevent the effective use of what information is available.
- The system has not met the basic requirements on financial reporting required by the agreements between the Department and the Boards.

8.4.2 Finance and Payroll Systems

Both financial and payroll systems differ across the system with the Department and Boards utilizing a number of different systems. This has lead to various problems and has increased the difficulty in applying fiscal controls across the system.

One of the most significant problems has been the lack of trained financial officers within the Northwest Territories. This has been made worse by the number of different software packages utilized. The use of a single software package for all Boards would create a pool of trained and skilled staff within the Northwest

Territories that can be shared between Boards during staff shortages.

The Department and Boards have not utilized a standard Chart of Accounts for the services provided making it difficult to make any comparisons between Boards, or to collate financial information across the system. Information requests by the Department require extensive manual work by both the Boards and the Department, reducing accuracy and timeliness, and increasing the level of frustration within the system.

At the suggestion of our consultants the implementation of a standard Chart of Accounts for the use of all Boards is being accelerated, thereby allowing for the future regular electronic exchange of information. This should provide significant improvements in the system's ability to share information, and reduce the workload on financial officers.

8.4.3 Need for Financial Controls

Health and social services programs have shown significant deficits over the past two financial years. Financial information and forecasts of the yearend deficit have been received by the system too late, if at all in some cases, for the Boards to exercise any measure of control on the situation.

Financial and operational information is simply too inadequate to provide the appropriate level of control for a system spending over $200 million a year. Elsewhere in this Report, the role of the Boards has been reviewed with regards to the policy mandate/governance style under which they have chosen to operate. This current governance model has been a part of the reason why the Boards have not taken a stronger role in the development of a financial and operational control framework. That is, the CEO constraint policy format has not resulted in Boards requiring that the CEO demonstrate that there are adequate financial and operational controls in place. As long as budgets were met and services were apparently provided, everything was assumed to be working well. Now that deficits have resulted and services in some areas have not been provided, the Boards and the organizations lack the tools and the information to manage the situation appropriately. Examples of services not being provided within the system include delays in immunization programs, lack of professional staff training, diversion of funds to or from one program to other programs, etc. being observed by our consultants.

Financial systems and procedures were inconsistent across the Boards, and the lack of guidelines for auditors results in financial statements that cannot be compared directly from Board to Board. There were many instances of managers and supervisors in the system not receiving sufficient financial or operational information to manage their units.

Attempts by the Department to control spending and services through controls on individual programs have resulted in a distortion of programs and loss of ability by Boards to prioritize services. An example is the new home care funding proposal which is based on the existing levels of service, and not on the needs of the communities.

8.4.4 Need for Accurate, Timely and Complete Data

For financial and operational information to be useful, it needs to be accurate, timely and complete. Data is being collected only on a number of the services provided, and not all services. Much of the current data is collected manually and staff involved could not vouch for its accuracy as there were few checks for errors, and staff had not been provided

with written procedures on collecting the data.

8.4.5 Meeting Agreement Requirement on Reporting

Agreements between the GNWT and the Boards required the monthly reporting of variances with projections of yearend variances. No Board has submitted on a monthly basis and some Boards have not received a variance report in over a year. The financial management system has not met the basic requirements on financial reporting required by the agreements between the Department and the Boards.

8.4.6 Need for Improvement of the Financial Management Framework

In the Financial Management Capability Model the lowest level of financial management is called "The Start-Up Level". The model describes this level as:

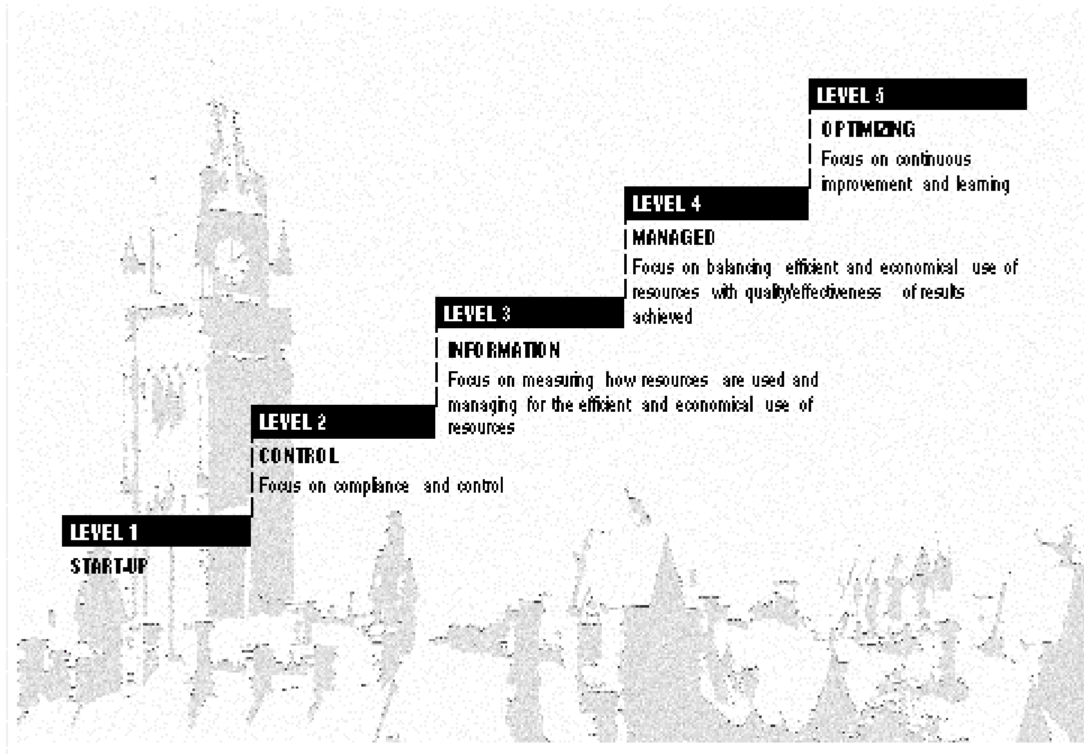
"The Start-up Level describes the financial management characteristics of an organization that has not yet established its key policies and practices or its control framework. At this level, in the absence of established practices, the organization's ability to achieve its business or program objectives depends on the often-isolated efforts and accomplishments of individuals. In these circumstances there is no certainty that such accomplishments would be repeatable or sustainable.

This situation might exist if an organization has experienced dramatic changes in its operations - for example, if it has implemented a new program or policy, amalgamated with another department or relocated its operations. If it has not effectively managed the increased risks associated with the change, the organization could be at the Start-Up Level of financial management capability.

The lack of repeatable, sustainable practices of financial management and control means that any data produced may not be complete, accurate or reliable. Similarly, without an adequate control framework in place, assets may not be adequately protected or resources adequately controlled."

This statement very closely reflects the state of the financial management framework of the Department and the Boards. While there are exceptions to this, with certain units operating at more advanced levels, the large majority of the health and social services system currently have not attained an adequate level of financial control. The current financial system is not stable with regular failures in financial and operational controls across the system. The financial system must improve if it is to regain the confidence of both the citizens of the Northwest Territories and the Legislature.

Concurrently with the changes recommended in Department and Board organization structures recommended by this Report, the health and social services system also needs to progress to a higher level of financial management capability. To provide a focused effort, the use of a system such as the Financial Management Capability Model is essential. The Financial Management Capability Model provides for a number of levels of capability which are outlined in the following diagram:



The health and social services system needs to develop its financial and operational information systems on a step-by-step basis. This should be done by ensuring that prior to having the system proceed to the next level, all aspects of the financial management system and the supporting operational information systems have reached the current level targeted**.**

8.4.7 Review of Audited Financial Statements

A review of audited financial statements for all Boards for the years 1998 to 2000 (that is for the year ends of the 1997/1998, 1998/1999, and 1999/2000 financial years) was undertaken as a part of our analysis of the current financial systems. A number of slides (See Appendix) were prepared to present this analysis.

Slide 25 Audited Financial Statements: 1998 to 2000 Revenues: provides an analysis of revenues for all 9 Boards and the following information is highlighted:

- Revenues for the 9 boards of Health & Social Services increased by $15.7 million (13%), from $121.1 million in 1998 to $136.9 million in 2000.
- The largest dollar increase was $9.5 million (9%) in Territorial Operating Advances.
- The largest percentage increase was 50.7% ($2.8 million) in “Other program & service revenues”.
- Total revenues in 2000 were $136.9 million.
- Territorial Operating Advances comprised the largest share of revenues, $115.1 million or 84.1% of all revenues.
- Revenues from Recoveries & Non-insured services accounted for 8.2% of all revenues in 2000, or $11.3 million.

Slide 26 Audited Financial Statements: 1998 to 2000 Expenditures: provides an

analysis of expenditures for all 9 Boards and the following information is highlighted:

Expenditures for the 9 boards of Health & Social Services increased by $20.2 million (17%), from $118.9 million in 1998 to $139.1 million in 2000.

The largest increase was $13.5 million (19.9%) in Hospital & Health Program & Services.

Expenditures on Social & Wellness Services increased by $3.8 million (16.9%).

Total expenditures in 2000 were $139.1 million.

Hospital & Health Programs & Services comprised the largest share of expenditures, $81.1 million or 58.3% of all expenses.

Expenditures on Social & Wellness Programs & Services accounted for 18.9% of all expenses in 2000, or $26.3 million.

Slide 27 Audited Financial Statements: 1998 to 2000 Revenues & Expenditures: provides an analysis of revenues and expenditures based on percentage change for all 9 Boards and the following information is highlighted:

Total revenues increased by 13% ($15.7 million) from 1998 to 2000.

Revenues for operations, programs & services increased by 11.1% ($12.3 million).

$9.5 million (9.0%) Territorial Operating Advances, the lowest increase of any revenue sector.

$2.8 million (50.7%) Other program & services revenues.

$12.3 million (11.1%) Total operating, program & service revenues.

Total expenditures increased by 17% ($20.2 million) from 1998 to 2000.

Expenditures on Hospital & Health Programs & Services increased the most by 19.9% ($13.5 million)

Slide 28 Audited Financial Statements: 1998 to 2000 Expenditures by Board in 2000: provides an analysis of the current expenditures by all 9 Boards and the percentage change in expenditures by Board since 1998. The following information is highlighted:

Total expenditures in 2000 were $139.1 million.

One-third (or $46.6 million) of all expenditures were incurred by the Stanton Regional Health Board. Of these expenditures, 31.7 million (66%) are for Hospital Services.

The three boards of Stanton, Inuvik & Yellowknife accounted for 71.2% ($99 million) of all expenditures in 2000.

The largest percentage increases in expenditures occurred in

- Deh Cho, 22.7% or $1.9 million, of which

  $1.0 million was in Social & Wellness Programs & Services,

- Inuvik, 20.9% or $6.7 million, of which

  $5.5 million was in Hospital & Health Programs & Services

- Fort Smith, 18.6% or $1.6 million, of which

  $1.37 million was in Hospital Services.

Slides 29-31 are included as the basis for determining the equitability of funding to the Boards (see Chart “Per Capita Expenditures”).

Slide 29 Audited Financial Statements: Per Capita Expenditures (1 of 3): provides the method used to calculate adjusted values for population and expenditures. The following information is presented in the slide.

> The objective of this section is to assess the per capita expenditures of each board. In order to do this it was necessary to make the following adjustments to the financial information and population data.
>
> The population numbers for 1998 and 2000 were estimated by interpolating between the 1996 Census and the forecasts for 1999 & 2004 produced by the NWT Bureau of Statistics.
>
> The population for the Stanton Regional Health Board was assumed to be the total population for the NWT.
>
> Each Board's "Adjusted Expenditures" is equal to their Total Expenditures (prior to adjustments), as reported in the Audited Financial Statements, minus revenues they received from Recoveries & Non-insured Services. This is expected to be an appropriate estimation of the costs of providing health & social services to the residents of the board.
>
> "Adjusted Hospital & Health Programs & Services" is equal to the Board's expenditures on hospitals & health plus a portion of the expenditures on Administration, support services & other expenditures.
>
> "Adjusted Social & Wellness Programs & Services" is equal to the Board's expenditures on social & wellness plus a portion of the expenditures on Administration, support services & other expenditures.
>
> The result is that
>
> Adjusted Expenditures "equals" Adjusted Hospital & Health Programs & Services "plus" Adjusted Social & Wellness Programs & Services

Slide 30 Audited Financial Statements: Per Capita Expenditures (2 of 3): provides the definition of expenditure categories for the calculation of per capita expenditures. No previous definition of grouping for dividing services into two categories was available. The following two groups were developed after review with the Department:

Hospitals & Health Programs and Service: Primary & Acute Care, Nursing Inpatient, Ambulatory Care, Medical Travel, Diagnostic & Therapeutic, Dental Therapy, Nutrition & Prenatal, Public Health, Community Health, and Environmental Health.

Social & Wellness Programs and Services: Alcohol & Drug, Brighter Futures, Children (In Care, Welfare, other), Community Corrections, Community Development, Community Wellness, Elderly & Handicapped, Family Counselling & Violence Prevention, Foster Care, Home Care & Independent Living, Intervention Studies, Justice Programs, Psychiatric Drop In, Special Needs, and Treatment Centre.

These groups were then used to provide the following analysis:

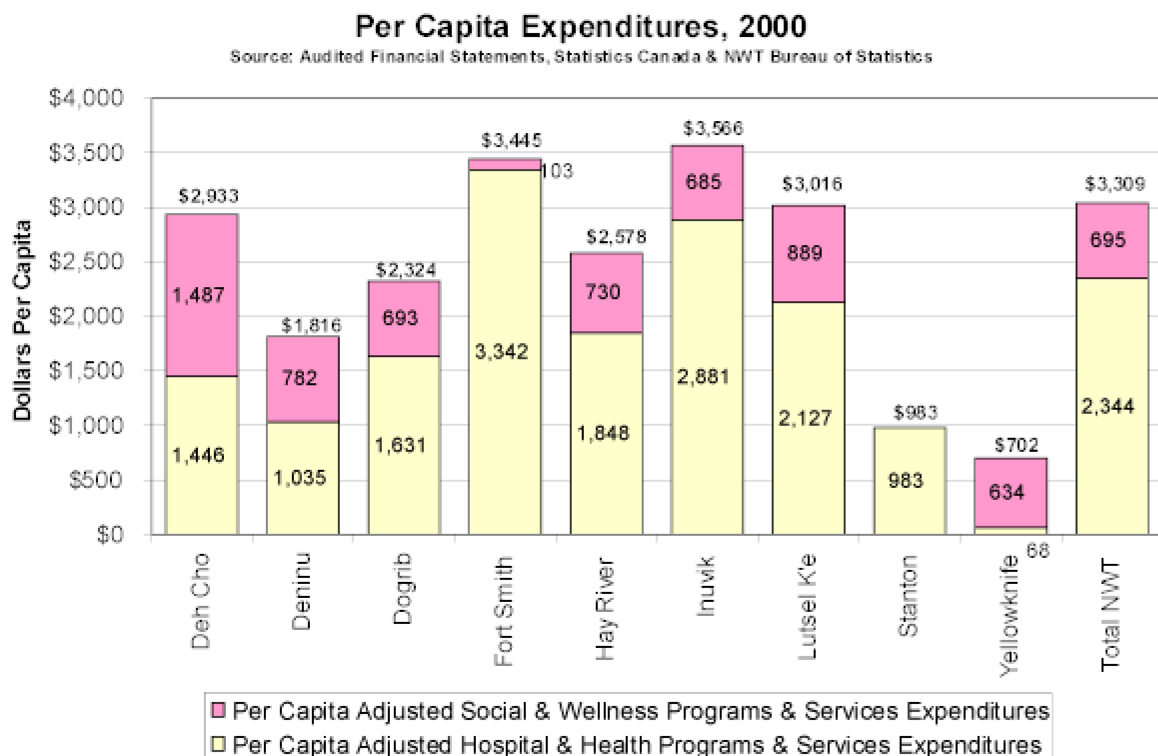
> The Audited Financial Statements for the nine boards varied significantly in the descriptions they each used to identify their expenditures on health & social services.
>
> The per capita expenditures for each of the boards was calculated by dividing the "adjusted expenditures" (as defined in the previous slide) for each board by the population of the Board.

The table on Slide 30 shows the per capita adjusted expenditures for each of the nine boards for the years 1998 to 2000.

Slide 31 Audited Financial Statements: Per Capita Expenditures (3 of 3): provides the analysis of per capita expenditures during the period 1998 to 2000 The analysis was based on the per capita costs as calculated by dividing the "Adjusted Expenditures," as per the Audited Financial Statements, by the population within the area serviced by the board. This calculation is inaccurate to the extent that a board provides programs & services to individuals outside the board's geographic area. The analysis highlights the following information:

- The average per capita board costs of health & social services in the Northwest Territories was $3,039 in 2000, which is a $341 (12.6%) increase over 1998.
- The cost of Hospital & Health programs & services increased the most, by $283 per capita (13.7%), from $2,061 in 1998 to $2,344 in 2000.
- The cost of Social & Wellness programs & services increased by $58 per capita (9.1%), from $637 in 1998 to $695 in 2000.
- Fort Smith has the highest per capita cost for Hospital & Health programs & services, $3,342.
- Deh Cho has the highest per capita cost for Social & Wellness programs & services, $1,487.

The following graph is included on this slide and shows that there is no apparent equability in the distribution of funding to either group of services on a per capita basis. The distribution has also been analyzed on the basis of community and demographic needs, and there is little correlation to needs.



The following slides provide an analysis of revenues and expenditures for each Board for the years 1998 to 2000 (that is for the year ends of the 1997/1998, 1998/1999, and 1999/2000 financial years). Each slide

also includes a detailed table on the breakdown of revenues and expenditures, and the changes in revenues and expenditures from 1998 to 2000.

Slide 32 Audited Financial Statements: 1998 to 2000 Deh Cho Health & Social Services Board: the analysis shows that:

Total Revenues in 2000 were $10.3 million, which represents a $1.9 million (22.6%) increase over 1998.

Territorial Operating Advances accounted for the largest dollar increase of $1.34 million (17.8%)

Total Expenditures in 2000 were $10.1 million, which represents a $1.9 million (22.7%) increase over 1998.

The largest increase in dollar expenditures occurred in Social & Wellness Programs & Services, $1.0 million (32%) over 1998.

Slide 33 Audited Financial Statements: 1998 to 2000 Deninu Community Health & Social Services Board: the analysis shows that:

Total Revenues in 2000 were $1.23 million, which represents a $0.28 million (29.5%) increase over 1998.

Other program & service revenues accounted for the largest increase of $0.48 million (135.6%). Expenditures identified as “Development” increased by $0.40 million.

Total Expenditures in 2000 were $1.04 million, which represents a $0.08 million (8.3%) increase over 1998.

The largest increase in expenditures occurred in Social & Wellness Programs & Services, $0.16 million (82.0%) over 1998.

Slide 34 Audited Financial Statements: 1998 to 2000 Dogrib Community Services Board: the analysis shows that:

Total Revenues in 2000 were $6.22 million, which represents a $0.10 million (1.6%) decrease over 1998.

Other programs & service revenues accounted for the largest decrease of $0.12 million (22.7%).

Total Expenditures in 2000 were $6.57 million, which represents a $0.89 million (15.7%) increase over 1998.

The largest dollar increase in expenditures occurred in Hospital & Health Programs & Services, $0.83 million (22.1%) over 1998.

Slide 35 Audited Financial Statements: 1998 to 2000 Fort Smith Health & Social Services Board: the analysis shows that:

Total Revenues in 2000 were $9.95 million, which represents a $1.09 million (12.2%) increase over 1998.

Recoveries & Non-insured services accounted for the largest dollar increase of $0.50 million (127.7%)

Total Expenditures in 2000 were $10.36 million, which represents a $1.63 million (18.6%) increase over 1998.

The largest dollar increase in expenditures occurred in Hospital & Health Programs & Services, $1.37 million (21.2%) over 1998.

Slide 36 Audited Financial Statements: 1998 to 2000 Hay River Community Health Board: the analysis shows that:

Total Revenues in 2000 were $10.81 million, which represents a $1.68 million (18.4%) increase over 1998.

Other program & service revenues accounted for the largest dollar increase of $0.92 million (235.9%)

Total Expenditures in 2000 were $10.77 million, which represents a $1.54 million (16.8%) increase over 1998.

The largest increase in expenditures occurred in Hospital & Health Programs & Services, $1.38 million (38.5%) over 1998.

Slide 37 Audited Financial Statements: 1998 to 2000 Inuvik Regional Health & Social Services Board: the analysis shows that:

Total Revenues in 2000 were $38.0 million, which represents a $5.1 million (15.5%) increase over 1998.

Territorial Operating Advances accounted for the largest dollar increase of $4.1 million (14.2%)

Total Expenditures in 2000 were $38.7 million, which represents a $6.7 million (20.9%) increase over 1998.

The largest increase in expenditures occurred in Hospital & Health Programs & Services, $5.5 million (27.4%) over 1998.

Slide 38 Audited Financial Statements: 1998 to 2000 Lutselk'e Health & Social Services Board: the analysis shows that:

- Total Revenues in 2000 were $1.18 million, which represents a $0.08 million (6.3%) decrease over 1998.

  Territorial Operating Advances increased by $0.06 million (7.2%)

- Total Expenditures in 2000 were $1.17 million, which represents a $0.12 million (9.6%) decrease over 1998.

It was noted that Lutselk'e Health and Social Services Board financial statements include revenues & expenses related to municipal & band operations. Where it could be determined, from the descriptions appearing in the statements, these revenues & expenses were omitted.

Slide 39 Audited Financial Statements: 1998 to 2000 Stanton Regional Health Board: the analysis shows that:

- Total Revenues in 2000 were $44.9 million, which represents a $3.9 million (9.5%) increase over 1998.

  Territorial Operating Advances accounted for the largest dollar increase of $2.5 million (7.3%)

- Total Expenditures in 2000 were $46.6 million, which represents a $5.9 million (14.6%) increase over 1998.
- The largest increase in expenditures occurred in Hospital & Health Programs & Services, $4.4 million (15.9%) over 1998.

Slide 40 Audited Financial Statements: 1998 to 2000 Yellowknife Health & Social Services Board: the analysis shows that:

- Total Revenues in 2000 were $14.3 million, which represents a $1.96 million (15.8%) increase over 1998.

  Recoveries & Non-insured services accounted for the largest dollar increase of $0.96 million (727.9%)

- Total Expenditures in 2000 were $13.8 million, which represents a $1.72 million (14.2%) increase over 1998.
- The largest increase in expenditures occurred in Social & Wellness Programs & Services, $1.72 million (18.3%) over 1998.

Slide 41 Fort Smith: Revenues & Expenses 1997 to 2000: this analysis shows that:

- Revenues for the Fort Smith Health & Social Services Board increased by $4.7 million (88%), from $5.2 million in 1997 to $10.0 million in 2000.

Territorial Operating Advances account for $4.3 million, or 92%, of the increase. This is due primarily to the amalgamation of social services with health in 1998.

Other Revenues; Patient Services decreased by $0.5 million (71%) from $.7 in '97 to $.2 in 2000.

Expenditures have increased by $5.1 million (96%), from $5.3 million in 1997 to $10.4 million in 2000.

Hospital Services account for $4.5 million, or 88%, of the increase in expenditures.

Slide 42 Fort Smith: Revenues April 1997 to March 2000: this analysis shows that:

Territorial Operating Advances totaled $8.2 million, or 83% of total revenues for Fort Smith Health & Social Services Board in 2000.

Territorial Operating Advances more than doubled between 1997 & 2000, from $3.9 million in 1997 to $8.2 million in 2000.

This is due primarily to the amalgamation of social services with health in 1998.

Eight programs identified in the table on the slide account for over 70% of this increase.

Expenditure recoveries totaled $0.9 million in 2000;

$0.5 million from housing, cafeteria & other revenues,

$0.4 million from medical travel recoveries.

Slide 43 Fort Smith: Expenses April 1997 to March 2000: this analysis shows that:

Total Expenditures in 2000 were $10.4 million

Hospital Services account for $8.9 million, or 86% of total expenditures

Medical Travel totalled $1.1 million (11%) in 2000

$0.5 million for GNWT staff & Boards, and

$0.6 million for THIS program travel.

Other expenditures totalled $0.3 million in 2000, and was comprised of other program costs.

- Hospital Services Expenditures increased by $1.1 million (14.3%) from $7.8 million in 1998 to $8.9 million in 2000.

  Nursing inpatient costs increased the most, $0.3 million (34%) from $0.9 to $1.2 million.

- Compensation costs totaled $4.8 million in 2000, which is 53% of total Hospital Services Expenditures.

  Ambulatory care accounts for the largest share, $1.6 million, or 34% of total compensation costs.

- Non-compensation costs increased by 23% as compared to a 7.5% increase in compensation costs.

Slide 44 Fort Smith: Hospital Services Expenditures April 1997 to March 2000: Operational data on the use of hospital and health services at the Fort Smith facility does not support the level of health services expenditures recorded. This problem was found to be only partially caused by financial system and accounting errors, with the majority of additional expenditures (in comparison to other regions) caused by an operational emphasis on the provision of hospital services. The analysis shows that:

Total Expenditures increased $5.1 million (95.7%) from 1997 to 2000, which is due primarily to the

amalgamation of social services with health in1998.

Hospital Services Expenditures account for

86% of total expenditures, or $8.9 million, and

88% of the total increase in expenditures, or $4.5 million.

Regional Service Programs were $3.0 million in 2000. In 1997 expenditures were zero, the increase is due to the amalgamation of social services with health in 1998.

Nursing Inpatient expenditures increased the most, by $476 thousand (62%) from $767 thousand in 1997 to $1.2 million in 2000.

The Department and the Fort Smith Health and Social Services Board were notified of these findings during the course of our study, and the Department and the Board have been working cooperatively to resolve the financial system problems reported.

8.5 Operational Audit of Board Management Systems

8.5.1 Process for Undertaking Operational Audits

An operational audit was undertaken for each Board based on a review of management and administrative processes, using previously developed financial information from financial statements, auditor management letters, and information gathered by the Government of the Northwest Territories was undertaken for each Board. The operational audit of each Board included:

a review of issues observed or noted in the financial statement or the auditors management letter;

assessing the integrity of financial and operational information maintained by the Board staff;

determining if the critical information needed by Board management staff for operational requirements is available with regard to accuracy, timeliness and completeness;

determining compliance of the Board and staff with Territorial legislative and Board policy requirements;

assessing procedures to ensure the security of assets, and the appropriate use of those assets; and

assessing the economy, efficiency and effectiveness of the management and administrative processes utilized by the Board and its staff.

The following information in this section provides an overview those issues that affected a number of the Boards.

8.5.2 Auditors Financial Statements

Financial statements are not consistent across all Boards, making the analysis of financial status of the whole system both difficult and time-consuming. Information included in financial statements was not consistent by program area or function, and different statements included different breakdowns of financial data.

Guidelines are needed for auditors so that information provided meets the needs of both the Boards and the Department, with electronic data provided in a common format that allows for a quick and accurate financial analysis of the system.

8.5.3 Auditors Management Letters

Management letters were not at the level of reporting needed by the Department to monitor and control the fiscal status of the system. It is our view that significant issues regarding the ability of financial

management systems were not reported, such as:

- the inability to provide accurate projections of year-end variances
- that a Board had not received any financial reporting during the financial year
- that a major period of financial transactions had to be re-entered into the financial system.

The following issues were common to a number of auditor's management letters:

- increased monitoring of accounts receivable was required;
- audits of NGOs not proceeding or being followed up;
- recommendation that an explanation of significant variations from budget at the yearend is needed;
- payroll systems have not been appropriately maintained, with some Boards having numerous errors in the calculation of pay and benefits;
- lack of expertise in dealing with application of collective bargaining agreements; and
- approval of the Board not obtained for expenditures above the approved budget.

8.5.4 Integrity of Financial Information

In the case of a majority of Boards, the Board and senior management have not received financial information on a sufficiently timely or accurate basis to ensure that it is able to appropriately guide the organization. While some Boards have received monthly financial reports at their next available meeting, the financial reporting system has not provided sufficient information to allow an appropriate degree of control of the organizations and the support of decision-making processes. A small number of Boards have not received any monthly financial reporting during the 1999/2000 financial year. A majority of Boards only became aware of possible deficits in the last three months of the financial year, and a number of Boards were not aware of operating deficits until after the financial year had ended.

Delays have been experienced at a number of Boards including receiving payroll information (up to 2 months late), and medical travel costs (up to 3 months late). This severely impacts on the accuracy of financial reporting and the ability of the Boards to project yearend variances. While payroll systems can be improved to provide current data, there may be a need to look at expenditure commitments on systems such as medical travel.

A number of Boards advised us that they were having significant difficulty in recruiting appropriately qualified staff, having inadequate space and facilities, and a limited ability to provide appropriate training for staff.

8.5.5 Integrity of Operational Information

Many Boards did not collect or report data from locally provided services and only had access to data circulated by the Department and by Stanton Regional Health Board.

Where data was collected, it was found to be for limited numbers of services, with a significant amount of data being collected manually with no audit procedures. The measurement and analysis of programs and progress towards goals was typically not available, making results-based goals ineffective as a means of business planning.

In almost all locations, and for most programs, there is no verification process incorporated into management systems to

ensure that programs have been carried out in accordance with business plans and budgets. Similarly, Boards were not aware of the reality of program delivery and had no viable basis for decision-making, either on a short-term or long-term basis.

Due to lack of data available, little reporting on trends was available to Boards or senior management. This lack of information makes the development of meaningful long term planning almost impossible.

8.5.6 Critical Information Needed by Board Management Staff

The actual reporting of what we would assess as useful information to the Boards is very limited. Most CEOs presented what is called a "CEO Report" to each regular Board meeting outlining the status of programs, and reports on CEO Constraint policies (which normally provide little operational information). It is difficult to understand whether or not the CEOs were aware of how ineffectual this "information-sharing" has been or whether or not they feel the need for any Board guidance. Admittedly, some CEOs try to engage their Boards through reporting on both broad and specific issues but that appears to us to be the exception rather than the rule.

We also noted that the minutes of Board meetings recorded very few decisions being made at Board meetings, with most motions being procedural. Board members expressed that this was due to the application of the 'Carver' model, but the review of all minutes recorded by Boards during the 1999/2000 financial year showed that decision-making by Boards was typically limited to approving business plans and approval of policies presented by administration. In the one instance that we witnessed, the CEO advised the Board that the Business Plan presented that evening to them was "simply a housekeeping matter" and thus would not require much discussion. It simply had to be passed by the Board so that the CEO could forward it to the Department. This, in the space of about 30 seconds, the Board did.

8.5.7 Compliance with Legislation

Legislation that governs the delivery of health and social services programs includes 27 Territorial Acts and related pieces of legislation, associated regulations, Ministerial Directives. This material amounts to approximately 4000 pages and that count does not include Contribution Agreements or Memoranda of Understanding applying to each Board, or the 25 Federal Acts and related pieces of legislation that also relate to the delivery of health and social services programs in the Northwest Territories.

While it is unreasonable to expect members of Boards to be aware of all of this legislation (there will be only one or two people in the Northwest Territories who will specialize in this knowledge), we found that the Board members had, in a majority of instances, not received sufficient orientation to the legislation applying directly to their duties and responsibilities. This was also true for many management and supervisory staff within the system. With this lack of orientation, there was little ability by the Board to be aware if programs were, or were not, complying with legislation.

We also found that reporting to Boards on programs rarely included reference to legislative requirements that applied to those programs, thereby missing out on an opportunity to increase the Board's knowledge and background in this area. While it cannot be expected that Board members would be experts on legislation, it is essential that each member have a general understanding of the legislative environment which envelopes the overall

system and thus has a direct impact on their programs.

8.5.8 Compliance with the Agreements Between the GNWT and the Boards

Agreements between the Government of the Northwest Territories and Boards include a number of standards provisions that:

- delivery of services is a common mandate between the Department and the Board
- financial contributions, on a monthly basis, are in support of the Board role under the Ministerial Directive – Board Roles and Responsibilities
- under the Ministerial Directive – Board Roles and Responsibilities, Boards are to provide the Core Services defined by the Department
- Boards are to submit annual budgets
- operating and capital budgets are approved by the Minister
- surpluses and deficits will be carried over from one year to the next based on the Surplus and Retention Policies
- the Board will provide the Department with financial statements and reports including:
- quarterly and yearly variance reports
- audited financial statements
- annual returns as per Federal legislation
- monthly expenditure management reports
- on significant budget variances, submit amendments to the budget for the approval of the Minister
- on significant budget variances where the expenditure is required by legislation, give notice to the Minister
- keep separate (for services under the agreement) and proper financial records and accounts
- allow inspections of facilities by the Department
- indemnify and hold harmless the GNWT, and carry the specified insurance
- the Department retains copyright on work prepared under the Agreement
- mechanisms for dispute resolution
- that the Board will only contract where those expenditures are covered by an uncommitted expenditure balance within the financial year
- notice on claims or lawsuits.

Within these agreements, the most common compliance problem observed was in the financial reporting area, including: the provision of quarterly and yearly variance reports, providing monthly expenditure management reports on significant budget variances, the submission of amendments to the budget for the approval of the Minister, and the submission of notice to the Minister on significant budget variances where the expenditure is required by legislation.

In a number of cases, the Boards did not have the information because financial reporting systems were inadequate. In other cases, the information was available but not submitted to the Department. The Department, it should be noted, took a lax role with all Boards in not taking enforcement measures to ensure that financial reports were submitted.

Although yearend projections were obtained from all Boards after a number of requests from the Department, these projections were not sufficiently accurate or timely to enable the Boards and the Department to manage the system and avoid yearend deficits.

8.5.9 Compliance with Board Bylaws

Each Board was required to register under the Societies Act. This has added a layer of complexity and confusion to the governance of the organizations as a number of requirements of the Societies Act may conflict with the requirement of health and social services legislation. There are also conflicts between the Societies Act and the standardized Agreement between the Government of the Northwest Territories and the Boards. The Boards have not complied with the requirements of the Societies Act regarding completion of bylaws, annual general meetings, the preparation and custody of minutes, and other requirements.

The Societies Act permits the acquisition of real and personal property, and provides for the ability to sell and mortgage against assets, all of which conflict with the standardized Agreement between the Government of the Northwest Territories and the Boards.

We were unable to obtain the rationale as to why each Board was required to register under the Societies Act, but as there is no apparent benefit from this requirement and the requirements of the Societies Act differ from the requirements under which the Boards are required to operate, we suggest that the Boards not be required to operate under the Societies Act.

8.5.10 Compliance with Board Policy

Board policies reflect the standard 'Carver' model policies provided to all Boards, and were typically approved with little significant change. The operational audits showed that the Boards generally have not exercised their monitoring role under the policies and that Board members did not show a strong understanding of this role of the Board within its own policy mandate. There were some exceptions to this where the monitoring role was more defined, but this was often hindered by frequent changes in members on the Boards.

Financial management policies requiring CEOs not to allow actual expenditures to deviate significantly from budget was the most consistent source of infringement of Board policy. Many instances of expenditures that were significant variances from approved Board budgets were noted, with only a few instances being brought to the attention of the Boards prior to the expenditures occurring.

Many Board policy manuals include the requirement that the CEO shall not let the Board be unaware of relevant trends or significant external or internal changes. In reviewing agenda packages for all Boards for the 1999/2000 financial year, it was noted that the Boards had received little material on trends or changes at their meetings and were therefore unable to base their decisions on a broad current knowledge of trends or changes in the health and social services sector.

8.5.11 Compliance with Administrative Policy

Administration policies and procedures are in differing stages of development at each of the Boards. The most significant development is in the area of hospital facility procedures as these are based on a standard readily available in the industry and driven by the cycle of accreditation reviews. In other areas, particularly social services, there is much less policy or procedure available to guide staff.

At one Board, administrative policies and procedures were in draft form only and had not been issued to staff, while at other Boards some administrative policies and procedures had been approved and circulated. At no location did we find a

comprehensive set of approved administrative policies and procedures.

It was noted that there was significant duplication of effort between the Boards in the development of policies and procedures. The CEOs have not developed a shared process but, rather, appear to request and replicate policies and procedures from other Boards and organizations as a starting point for their own policy development. (It is our view that this type of "research" does little in terms of developing any real sense of shared commitment to the results).

With many services being delivered remotely from the corporate offices of the Boards, it is a concern that the necessary guidance provided by organization policies and procedures is not available to staff who do not have direct on-site supervision. The fact that work processes are inconsistent is, therefore, of no real surprise.

8.5.12 Procedures to Ensure the Security of Assets

As most Boards have adopted the 'Carver' CEO Constraint Policy format, most CEOs have requirements that typically require that the CEO not allow the abuse or misuse of assets; require that property be inventoried, with a security system in place to ensure safeguards to prevent loss, damage, or theft of property; and require that assets be maintained.

Across the system, limited effort has been applied to the security of assets and most Boards do not have written procedures in place relating to the inventory and use of assets. Those which do utilize a central ordering and receiving system typically ensure that new inventory receives an identification tag when received at the their facility but typically no other inventory control procedures are utilized.

One situation was found where present procedures for electronic and telephone ordering allowed for the same individual to place orders, sign for delivered goods and authorize payment. This process presents a higher level of risk than is acceptable. Purchasing procedures need to be revised to ensure that authorization of payment is performed by someone other than the person signing for deliveries.

8.5.13 Procedures on the Inventory of Assets

Typically, the inventory of assets under the stewardship of the Boards was not up-to-date and reflected a lack of specific procedures on the inventorying of assets.

It was noted that those that had undertaken an inventory of assets in the past had difficulty in the property assessment stage of this process in complying with the requirements of the Regional Offices of Public Works and Services.

For those Boards outside of Yellowknife the disposal of assets requires a significant amount of effort, with the disposal of equipment requiring direct communication with Department of Public Works and Services staff in Yellowknife. This process is significantly more involved than for Boards dealing directly with each department's Yellowknife offices and the Yellowknife disposal auction process.

The recent addition of the operation of doctors clinics to the health and social services system has added a significant amount of inventory to the system, some of which is both valuable and mobile. At the time of the operational audit, this inventory had not been appropriately tagged and inventoried.

8.5.14 The Misuse of Assets

No significant example of the misuse of assets was found or reported to the consultants during this review process. A

number of specific issues were noted as applying to one or more Boards:

- there are no procedures relating to the checking of transactions and invoices for Board vehicles that are fuelled at a cardlock facility. At a minimum, spot checks of these records should be undertaken.
- the personal use of Board vehicles by locum doctors – this was looked on as justifiable by Board management in each case based on the need to improve locum doctor's quality of life, and the need to have these same doctors return to the communities on future occasions. If this practice is to be accepted, then an exemption to current Territorial policies will have to be considered.
- policies on the use of All-Terrain Vehicles allow for the personal use of these vehicles provided that the individual accepts the liability for repairs of any damage and replacement of gasoline used. This type of policy does not provide for adequate protection for the Boards in the case of an injury accident and a stronger policy provision and the signing of a liability waiver should be considered.

8.5.15 Management of Board Financial Status

Financial management systems were found to be inadequate across the system. The system has not developed a culture that recognizes that management decisions should be based on using accurate, complete and timely information from inside and outside the system. Operational systems are not capable of providing the necessary elements of financial management, such as:

- ensuring adequate resources are available
- monitoring operations and service delivery
- measuring and managing each organization's risks
- providing sound, timely and accurate financial and operational data and projections
- monitoring and reporting on trends impacting programs on a timely basis
- meeting statutory reporting requirements.

Inadequate financial management systems have resulted in financial reporting to the Boards that provided them with little financial or planning information, and did not enable them to accurately predict impending yearend deficits. The financial management systems have also not met the requirement of providing monthly variance reports and yearend projections to the Department.

A financial reporting report received by the Department in January 2000 will be given as an example: a 3rd Quarter 1999/2000 financial report (i.e. recording the first 9 months of expenditures) forwarded by a Board to the Department showed recorded expenditures at only 50% of the approved annual budget when the financial year was 75% complete. This report was reviewed by the consultants and it was found that the financial data was incomplete with contract payments, payroll and medical travel transactions missing. That same Board finished the year, three months later, with a significant deficit. Unfortunately reporting from most Boards reflected a similar inability to accurately project yearend variances.

Senior management and Boards have responded to projected deficits only to a limited degree, with little ability to control

the situation due to the incomplete information available to them. We found that financial statements and auditor management letters were rarely shared with managers and supervisors to any significant degree, limiting their awareness of the need for improvements.

8.5.16 Efficiency and Effectiveness of Administrative Processes

Administrative policies and procedures for health and social services programs are incomplete at all Boards and staff have had little policy guidance other than to follow past program practices. As noted above, with the Boards operating facilities in many locations that are remote from their Regional Offices, this lack of administrative policy/procedure direction reduces the overall effectiveness and efficiency of the organization.

In a number of instances, Board Policy Handbooks have been developed and approved by the Board. However, it was found in some cases that policies included in the handbook were either not numbered or dated, or not provided with an index. It was, therefore, difficult to determine if the handbooks were complete or up-to-date.

There was considerable difficulty noted in the staffing of both financial and payroll positions under the Boards with appropriate qualifications needed to effectively maintain the financial and payroll systems. Where we found in the course of our operational audits, significant problems with the maintenance of financial and payroll systems, this was at least partially due to the lack of experience and knowledge of management and staff involved. In one instance we found that the Board's accounts were out of balance by $1.7 million; the staff did not know how to solve this problem, and were managing day to day based on the cash balance available at the bank.

8.5.17 Summary of Findings

The results of our Operational Audits points to the need for considerable improvement by a majority of Boards in terms of their financial and operational management systems. The key findings of our operational audits reveal (in no order of priority) that the key and common issues which have caused problems for at least some of the Boards are:

- Budget changes after budget finalized; no approvals sought; no Board motion of approval
- Lack of qualified staff to handle financial management duties
- Lack of timely financial information to the Board
- Financial reporting systems lack the capability of projecting year end financial position accurately
- Board members not oriented to the legislation which impacts their operations
- Board not complying with the provisions of the Contribution Agreement signed by the GNWT and the Board
- Little evidence of monitoring by the Board even though that is specified by Board governance policies
- Expenditures above that which the CEO is allowed to sign off on are regularly made without prior Board approval
- Financial management data not being made available to the appropriate staff
- Board Policy Handbook not kept current; appears to be regarded as a one time event rather than a continuous process
- Given that the CEO may be the only person with applicable training in the

- use of the accounting package, any change in that position results in a breakdown of the system
- Considerable confusion in the terms of employment of staff with no written policies or signed contracts
- Bank deposits are difficult to achieve without any access to local banking
- HR policies changed by CEO without notice or Board approval
- Funds have been allocated to purposes not covered by the Contribution Agreement; the Department aware of this fact
- Policies limited in their usefulness due to their very general nature
- Lack of CEO resulted in little long term planning or advice to the Board
- Front line workers finding the lack of management staff with any understanding of their service delivery policies and procedures hinders the effectiveness of their service delivery
- Operational information seldom presented to the Board; such information not gathered by staff
- Reports required by the Department are routinely months late or not sent at all
- Significant changes in the cash position of the organization seldom explained; in some instances, they were not understood by staff
- Vacancies in management positions result in improvements to practices not being maintained
- No formal process in place to ensure that programs by funded social services agencies are provided as intended
- Need for cost control measures related to medical travel
- Boards and management unable to manage deficits/surpluses when variance reports are routinely late and do not include year-end projections.

8.6 Adequacy of Current Human Resource Systems

The two obvious underpinnings of any organization are its financial and human resources. The former we deal with separately in the preceding Section. In some organizations, which are not labour intensive or which are based in low skill, mechanistic endeavours can seemingly function while experiencing a relatively high degree of turnover of employees. The vast majority of organizations, however, rely extensively upon the ongoing availability of qualified and experienced personnel. Certainly, any public health and social service system, dealing with two people-intensive enterprises, will be very reliant on the caliber of resources it is able to attract and retain. Thus, the issue of human resources must be recognized as central to the viability of the health and social service system.

8.6.1 Issues Impacting the Provision of Human Resources

There are various issues which impact the provision of quality human resources to the Department and Boards of the NWT Health and Social Services. These include, but are not limited to, the following:

- The availability of appropriate resources
- A competitive marketplace
- Compensation levels including benefit programs
- Training and development opportunities
- The opportunity to learn from others
- A reasonable level of morale internally

- Opportunity for a balanced lifestyle
- Degree of collaboration between the various Boards and the Department
- Appropriate identification of needs
- A proactive approach to identifying labour needs and finding the appropriate personnel
- A mechanism promoting an ongoing dialogue between the administrators of the system and those who actually deliver the service.

These are the type of issues which need to be considered by the senior officials of the GNWT, the Department and the Boards. Without a concerted and collaborative approach, the task of finding and keeping good people will be almost insurmountable.

The Department has a dual role to play. Not only must it manage its own human resources appropriately and effectively within the constraints of the relevant legislation and collective agreement, so too must it act in a back-up role to the nine boards which also offer various HR services to their own employees. The Department also has an emergency support role wherein the staff may be called on to fill in for boards who, for a variety of reasons, may be unable to fulfill their HR responsibilities. This has happened several times over the past few years and will continue to happen as boards struggle to find sufficient resources who must be multi-skilled in order to meet the complexities of the health and social services environment.

Human resource responsibility falls departmentally within the Policy, Planning and Human Resources Division. Its responsibilities include:

- Human resource planning
- Labour relations/collective agreement advice
- Job evaluation (department/boards)
- Departmental human resource program:
- Pay and benefit administration
- Education leave and bursaries
- Professional development
- Compensation and benefits
- Medical travel assistance
- Board human resource support
- Board human resource education and assistance
- Recruitment and retention of health and social services professionals
- Development of a northern workforce.

These are important responsibilities which are made even that much more sensitive by the difficulty in attracting qualified resources and in retaining within the service those who have been trained in how this division carries out its mandate.

8.6.2 General Human Resource Issues Impacting the GNWT

It is not that this issue of human resources has not been studied or received its fair share of attention. The GNWT, as recently as this past year (2000), conducted a comprehensive review (Human Resource Management Study) utilizing the firm of Grant Thornton. That Report provides a very comprehensive overview of the previous approach to the management of human resources in the NWT. In summary, and as a background to some of the issues which we have been asked to examine, the following observations contained within the Grant Thornton Report relative to the history of human resources are pertinent:

- In 1967 the Federal Government began to move some of the human resources serving the NWT to the north
- Between 1967 and 1975 an Executive Committee of the NWT Council (now the

Legislative Assembly) led by the federally appointed Commissioner and other bureaucrats directed the Government; resources recruited largely from southern Canada by the Personnel Department

The Drury Report of the late 1970s recommended decentralization of the Government; local governments emerged along with local education authorities, health boards and other regional governments

The 1980s saw considerable growth in the civil service (person years increased from 2845 to 6140 between 1979 and 1989; new policies encouraged the hiring of aboriginals with a new Affirmative Action Policy adopted in 1989

The 1990s witnessed considerable change; land claim groups evolved following a pattern set by the Inuvialuit claim of the 1980s; the GNWT encouraged decentralization of its services through such policies as the Community Transfer Initiative (1994-95) and Community Empowerment (1996); delivery of services was further decentralized to the communities and regions; as with the rest of Canada, the 1990s were a time of cutback and retrenchment

In May 1993, the Cabinet transferred responsibility for job evaluation, labour relations, human resource planning and employee services from the Department of Personnel to the Financial Management Board Secretariat

In 1995, the Department of Personnel was disbanded and many of its functions transferred to other Government programs

With the various transfers of personnel out to the programs and to the regions, health and social service boards and education boards account for 47% of the labour force

With considerable prescience, the Report states that 'there are likely to be greater challenges for attracting employees in years to come'.

That report makes a number of useful and relevant observations and recommendations. The following are cited here given their direct relevance to our findings:

"Inadequate levels of human resource support offered in the regions"

"no comprehensive human resource strategy…the absence of any corporate wide human resource planning…not clear at any one time what human resource needs exist"

"a need for strong political commitment to effective human resources…a number of issues raised …but they have not been dealt with effectively…"

"the employment climate in the NWT …is changing considerably …the GNWT is no longer the employer of choice…it has to work especially hard to attract and retain good personnel"

"there is a dearth of human resource expertise…especially in the regions…no regular monitoring function…"

"some of the greatest human resource challenges are beginning, and will continue, to arise in Health and Education Boards where difficulties in recruitment and retention are growing"

"critical human resource personnel should be grouped together, in 'clusters', in the regions as an attempt to develop critical mass"

"an increased emphasis should be placed on training and development across the public service…"

8.6.3 Recruitment and Retention of Resources

It is our understanding that, historically, the NWT has had a good reputation relative to the recruitment and retention of health and social services staff. The comment that "I came to the NWT for a six month adventure and have now been here for six, eight, ten years," was frequently heard during our many management and staff interviews. Unfortunately, this positive endorsement of the NWT is being colored by the relatively recent high turnover rate of professional staff in many of the rural, more isolated communities. This recent phenomenon has been described by many as the "revolving door syndrome"—"staff come and go before we even get to know their name and they get to know our community". This degree of instability often leads to mistrust, and thus a lack of continuity or consistency of care. It is our understanding that this, in turn, leads to increased expenditures such as that due to a greater number of medevac transfers.

Recruitment and retention of professional staff (doctors, nurses, social workers, etc.) is a nation-wide problem. There is a general shortage of most health care professionals and competition for these scarce resources will most likely become more intense. Alberta has recently signed contracts with both doctors and nurses that provide wage increases exceeding 20% plus improved benefits and call pay. These new contracts will make Alberta's doctors and nurses the highest paid in Canada. This inflationary trend is likely to continue across Canada. The NWT will not be exempt from these external pressures.

There are however, also local issues that impact the retention of staff. The following are a sample of the predominant concerns that were brought to our attention by NWT staff and management personnel:

High cost of travel

We were advised that it costs an NWT couple approximately $2000 more than an Edmonton couple for the same vacation. Even a weekend in Yellowknife can cost a rural NWT family several thousand dollars. While it was noted that the previous GNWT "VTA" is now built into the salary grid, many expressed the sentiment that it only represents a small increase after taxes and that it has lost its effect when one has to put out several thousand dollars at the time of travel.

We are aware that trips south do not always happen as planned and, as a result, staff have an increased likelihood of leaving the NWT because of their isolation from families, etc.

Assistance with travel costs is a significant factor in the retention of staff and the reinstatement of this benefit should be reconsidered by the GNWT. If that is considered impossible or highly unlikely by the GNWT, then other alternatives should be examined.

High housing costs

Housing costs are generally very high, and in many rural areas housing options are very limited. We were made aware of a charge of $2000 per month for essentially a bedroom attached to a nursing station.

Adequate, affordable housing is essential for those who are hoping to make the NWT their home for at least the foreseeable future. This issue should be re-visited by both the GNWT and the Boards.

Temporary relief staff

The current practice of using temporary relief staff in many rural communities is

creating a reverse incentive for regular staff. We were advised that relief staff are often provided with free accommodation and travel at least in a number of the circumstances with which we made aware. At the same time, regular staff are expected to pay for their own accommodation and travel. This begs the question—why should I work as permanent staff when I would get better benefits as a relief worker?

This issue is, in part, contributing to the "revolving door syndrome" and stresses the importance of developing a "made in NWT recruitment and retention strategy" that is developed with extensive user input.

Community expectations

We were made aware of the fact that the expectations and demands of the communities being served also has an impact on retention patterns. That is, the community may be reluctant to immediately embrace someone who may be only there for a very short stay or who gives the appearance of desiring privacy beyond work hours. The living conditions in the smaller communities may be considerably different from those which the nurse or social worker (or other health care professional) experienced in their most recent posting.

The unusual and often difficult conditions being experienced by a number of those being hired by the Boards has also lead to a higher than expected degree of turnover. This may be in part the result of the "revolving door syndrome" wherein staff were once regarded as the primary health care provider and were respected members of the community. Today, many complain of being outsiders and servants who are expected to dispense Tylenol at all hours of the night.

This perception expressed by staff highlights the need for Boards and their administration to become much more involved with their communities. This is needed to build better relationships and to develop common expectations as to the roles and responsibilities of staff in the provision of health and social services in each community.

Coupled with this, is the need to develop a comprehensive orientation program for both new and existing staff that includes an orientation to the community as well as an orientation to all aspects of the job.

As well, this is also a community issue in that community leaders need to be made aware of what they could do to help ease the acceptance of local health and social services professionals into their communities. Those who advised us of the extra efforts being taken to ensure that they were well-received and properly introduced expressed the view that this has inclined them to extend their stay and/or to return.

NWT training

The training of NWT people to work in the NWT is a very positive strategy and the Premier's initiative to expand the training capabilities of the advanced education facilities is to be commended. This should be supported with additional educational funding. Initiatives, locally and territorial wide, to financially support students (at the entry and graduate level) to obtain their competency certification in return for a guarantee of service payback should be encouraged and financially supported at the government level.

We were advised, however, that these programs must also have a territorial wide focus in that it is sometimes difficult for an individual to return to their own small community as a caregiver when they know everyone and are perhaps related to a significant number of the community. The

return of service may, therefore, have to be in another community in the NWT.

GNWT master employment agreement

Most health and social service employees are covered under a common GNWT employment contract. Inasmuch as this agreement covers all classifications of employment (i.e. professional, technical, clerical and general service staff) for a variety of work environments, it appears to have inadvertently limited the ability to deal creatively with the unique recruitment and retention needs of the health and social services sector and in particular, special needs within that sector.

The current master employment agreement restricts flexibility and affordable creativity, and consideration should be given to the establishment of separate sub-agreements for health and social service, technical, and professional workers. It is our view that the Union of Northern Workers would be amenable to this change.

Coordination of recruitment

While attempts are being made to coordinate recruitment activities for health and social services staff, there are current examples wherein regions are competing with other regions for similar staff. As but one example, we were made aware of the fact that one region was turning away applicants while a neighboring region was having to curtail services due to a shortage of professional staff.

Boards cannot afford to compete with each other for scarce professional resources. What is needed is a mechanism to ensure effective and fair coordination of recruitment activities wherein all regions participate as equal and effective partners. This is dealt with at greater length later in this Report.

There is a common perception that the various Boards are in competition with each other when recruitment strategies are considered. There also seems to be an underlying suspicion among some regions that certain Boards may be offering "quiet" or unpublicized unique benefits to some health care professionals to entice them to move to their area.

The Inuvik Health and Social Services Board is one which has had ongoing struggles to locate qualified staff. Their 2001-2004 Business Plan speaks to this when it says "Perhaps our biggest challenge is maintaining a qualified and competent staff in a period of international staffing shortages…The negative impact caused by the loss of the Board's ability to offer staff Vacation Travel Allowances (VTAs) and subsidized housing cannot be overstated." We note that their region experienced nine changes in upper management staff in the period of January 1997 to February 2001.

Part of the reason given for the lack of housing, vacation, travel, and education benefits for nurses is the fact the nurses of the NWT belong to the same union as all other NWT employees. Apparently, this makes it more difficult to provide some groups with more incentives and benefits and not to others who are in the same Union. It should be noted that nurses received these extra benefits and allowances for many years until cutbacks were made in the mid 1990's.

Initiatives to recruit professional health care personnel occur both at the Department and the regional board levels. There are signing incentives available for nurses, as well as "top-up" amounts for physician salaries. The amount of the "top-ups" depends upon the particular location involved. These signing bonuses for nurses and physicians are not viewed as particularly effective. The disparate annual

‘top up’ for physicians working in the NWT is viewed with mixed results. This ‘top up’ amount varies somewhat depending if the doctor is located in Yellowknife or in other centres. The top up for doctors in Inuvik, for example, is not seen to be appropriate given the travel distances involved.

The incentive sign-up bonus program for nurses has not had the intended impact if the feedback which we received is any indication. The program is viewed as a poor substitute for the previous arrangements made by the GNWT. Several years ago, the housing subsidies and vacation/travel allowances were discontinued for nurses. According to the considerable majority of nurses whom we were able to interview, this has created significant instability throughout the regions, and, as reported to us, is directly related to the turnover and low retention rates being observed.

Of particular concern is the way that a Board can hire a casual or indeterminate status nurse for a limited agreed to period of time. The Boards can pay for this person’s household move to and from the community as well as provide housing subsidies. This inconsistency in the way temporary and permanent nurses are treated has created a situation whereby more and more nurses consciously choose the casual route because of the increased benefits. Many people interviewed know of situations where the person involved would be interested in permanent nursing work, but simply could not afford to live in the community without the same benefits being offered to nurses on casual contracts.

The Department of Health and Social Services tabled a document “Recruitment and Retention of Health and Social Services Professionals-A Plan to Address Critical Needs” in the Legislative Assembly in February of 1998. The strategy focused on three “priority areas:

- creating a stable workforce
- increasing the competencies in the workforce
- developing a northern workforce.

The Plan was developed through the collaborative efforts of what were perceived as the key stakeholders: the Department of Health and Social Services, the Health Care Association (now disbanded), the NWT Medical Association, the NWT Registered Nurses Association and the Boards of Health and Social Services. A Recruitment and Retention Steering Committee was established at the same time and has reportedly been meeting approximately every six weeks since then. According to the original terms of reference, the purpose of the Committee was to: “To collaborate on the development and implementation of a work plan that will address the recruitment and retention of health professionals to the NWT”. The Committee has proven to be a useful sounding board for the Department’s Recruitment and Retention Unit. It has vetted the Unit’s work on the various initiatives and has provided useful insights relative to proposed initiatives.

8.6.4 The Recruitment and Retention Unit

One of the outcomes of the 1998 strategy was the formation of a Departmental unit of four positions which were established to oversee the implementation of the approved strategy. These four positions are:

- Acting Manager
- Northern Development Coordinator
- Recruitment and Retention Consultant

Support Staff

The first two positions are described as indeterminate while the latter two are casual. Perhaps symptomatic of the problems facing the NWT in its efforts to find and retain good people is the turnover experienced by this Unit of the Department. It is our understanding that there have been two different people leading the program as Managers; four different Recruitment and Retention Consultants; and two different Northern Development Coordinators. The structure itself has changed four times since its inception. For one five month period, the Acting Manager was the only person on staff.

The Unit, in spite of the problems noted above, has had a number of "successes". These have been reported to us as:

the development of Recruitment Information Packages; these have been upgraded by an external marketing consultant; an information package has been distributed quite widely

the development and management of the Nurse Market Supplement; the Legislative Assembly approved a $3 million increase in funding which comprised a recruitment bonus, a retention bonus, and funding for three nurse educator positions

the development of the Recruitment and Retention Website; initiated in March 2000; posts employment opportunities; allows professionals to submit applications on-line

the development and implementation of a Northern Development Program which assists northern students who are pursuing careers in health and social services with bursaries and work placements; initiated in the spring of 1999, the program includes assistance with practicum placements, preceptorships, mentorships, professional upgrading, summer employment, health and social services orientation

management of the Professional Development Fund; established in 1998, this initiative helps front-line workers to participate in ongoing training and development

coordination of the Nurse Educator Consultants; these positions were established to aid in the transition for many new hires to the much different northern environment; three positions were approved to work with the Boards and to offer assistance in acclimatizing the nurses to northern conditions including cross-cultural skills as appropriate and to aid in their assimilation into their respective communities

recruitment of physicians, nurses, social workers and other health care workers; a former northern based practitioner has been retained to help recruit general practitioners for the NWT; contacts have been established and pursued; medical bursaries have been established; opportunities for similar encouragement to the other professions is being explored

an agreement between the NWT and the Alberta Medical Association has been signed (February 2000) which allows the Boards to access physician locum support from the AMA pool

The Unit's responsibility has been to refer the professionals contacted to the various Boards without having the authority to actually making offers of employment. Based on the information given to us, we note that there appears to be a disconnect between the efforts of the Unit (on behalf of the Department) and the results achieved

and/or reported by the various Boards. Thus, the Unit may be successful in attracting candidates who are then referred to the Board(s) but may, in many instances, never become aware of the actual results. Certainly, some of the candidates may not be suitable; others may not be as interested after they get a closer look at the actual “on the ground” situation; and others may simply decide to accept another offer which they presently have “in the back pocket”. But still, one would think that the success rate would be quite high if the proper screening has been dutifully done prior to candidates being referred.

The Unit has employed external consultants to assist in reviewing their efforts to date. Surveys have been sent out to various professionals and the feedback will be used to provide guidance on what improvements can be made to the methods utilized to date.

Notwithstanding nor wishing to pre-judge this evaluative work, the Recruitment and Retention program appears to have significant flaws. These include:

- The lack of a suitable mechanism to ensure ongoing new initiatives and the pursuit of innovative ideas to attract the right kind of attention to the situation in the NWT
- The absence of specific measurements which would indicate the program (and Unit’s) relative degree of success; this needs to be done as precisely as possible (the actual results of placement of health care practitioners has been reported as: 16 nurses, 6 social workers; 4 physicians)
- The lack of a central reporting and coordination instrument in order to achieve enhanced follow-up to the initial contacts
- Centralized control of the process which could be a mechanism to ensure that candidates who are not appropriate to the needs of one region are not lost to the NWT as a whole
- The general lack of attention to the retention of current personnel which will be far less expensive than having to find new people
- The need to focus at least some of the Unit’s resources on how local northern talent might best be attracted and trained for appropriate careers; a part of this focus should be on those who may have left similar careers in their “previous lives” and who might be enticed back into the workforce now that the responsibilities of child care and raising a family have subsided
- The limited attention and resources granted to this key function.

8.6.5 Joint Action Activities

The Department of Health and Social Services, the Boards, the NWT Health Care Association (now defunct), the NWT Medical Association, and the NWT Regional Nurses Association have jointly developed many position papers and have authored a plan to address the critical needs for the Recruitment and Retention of Health and Social Service Professionals. Most of the preceding human resource issues have been addressed by this joint planning group. However, there is little evidence in the field that any progress is being made and it is imperative that the project move from planning to action and follow up. This issue should be immediately addressed by the Professional Resource Team which we recommend later in this Report.

8.7 Adequacy of Current Asset Management Systems

The results of our Operational Audits point to the need for considerable improvement by at least some of the Boards in terms of their asset management systems.

8.7.1 Review of the Current System

Across all Boards it was found that there was a lack of policies and procedures on the security and protection of assets. Even where some policies and procedures exist, it was found that they had not been followed consistently. Some Boards have purchasing systems that record and tag new inventory as it is received, but a majority do not. Most Boards did not have an up-to-date count of inventory, with the last count taking place two or more years ago.

Management of the Boards have not placed sufficient priority to the inventory requirements of their operations, and staff resources were often lacking or not allocated. It is essential that Boards have and apply the resources necessary to adequately monitor and control resources, and to provide the necessary security and protection of assets.

8.7.2 Improvements Required

It is necessary for the Boards to institute standard asset controls through consistent policies and procedures. The continued development of central purchasing systems should include automated asset management systems.

Security of assets also needs to be exercised through audit processes undertaken by the Department, to ensure that the security and protection of assets of the GNWT is being undertaken by the Boards.

8.8 Adequacy of Current Medical Travel Administration Systems

The issue of medical travel was singled out for specific consideration given a) its centrality to the overall delivery system, b) its cost to the Government, and c) the unpredictability in the cost increases.

Residents requiring services above and beyond what can be provided by the nurses at the health centres in the outlying communities can be transported to the appropriate hospital for secondary or tertiary care. The vast majority of patients are transported to one of three hospitals: Inuvik, Yellowknife, and Edmonton. The decision as to where the patient is transported is generally based on the referring doctor's diagnosis of the severity of the problem and his/her understanding of what services are available at which location. Further, there are certain policies/protocols in place which provide guidance as to what center is expected to be the appropriate point of destination for referrals from outlying communities.

The key policy which is expected to guide the handling of this issue is that established by the Government of the NWT (Policy 49.06), revised as of February 1998. The policy states:

> "The Government of the Northwest Territories will provide medical travel benefits to eligible persons in the Northwest Territories who must travel in order to access necessary and appropriate insured health services".

The principles which accompany this policy are as follows:

> The Canadian health care system is based on universal access to insured health services.
>
> The cost of medical travel should not be a barrier to insured health services.

> The Government of the Northwest Territories is committed to reducing the economic barriers to insured health services".

The Minister of Health and Social Services is deemed accountable to the Executive Council for the implementation of the policy with the Deputy Minister, in turn, delegated this responsibility. The policy also describes the Deputy's responsibilities in this area and we quote these given our recommendations in this matter which follow later in this Report:

> The Deputy Minister (or designate) may:
>
> accept applications for medical travel assistance in accordance with this Policy;
>
> approve treatment and care facilities for the purpose of this Policy;
>
> determine the nearest centre for necessary and appropriate insured health services;
>
> designate boarding facilities and approve private medical boarding homes for the purposes of this Policy;
>
> approve a physician's request for a non-medical escort to participate in a treatment program in order to learn how to care for the patient following discharge;
>
> approve a second non-medical escort; and
>
> establish a rate of subsidization for meals and commercial accommodations in accordance with this Policy.

The procedure of authorizing medevacs is not consistent across the regions. However, it is our understanding that a medevac approval usually goes through the following steps:

- Community nurse sees patient and makes an assessment.
- Community nurse may seek advice from another nurse in the centre if one is available, especially from a more senior nurse or nurse in charge.
- Phone call to a doctor in the region (if a doctor does in fact live or practice there) or phone call to the nearest emergency department (Inuvik or Yellowknife) to talk with a physician on duty.
- Sometimes the nurse will call Stanton Regional Hospital directly, even if he/she is outside of the region and closer to Inuvik hospital, if the situation appears to merit it.
- A decision is made if a medevac needs to be arranged, and what hospital would receive the patient.
- If the decision is to medevac the patient, a variety of procedures can then come into play. The nurse may call a staff member of the region who is responsible for arranging medevac travel details, or the nurse may call the medevac company directly. This depends upon the region's protocols, time of day, the situation at hand, etc.
- The receiving hospital usually approves the medevac before a final decision is made.
- The region involved may do a "medivac audit" after the fact, to see in fact that all medevacs were necessary. If certain trends begin to emerge from these audits, preventative education will be initiated.

The foregoing is only a "rough" outline of some of the steps that are usually taken when medevacs are being arranged. It should be noted that most of this information came from interviews with people in the system, rather than making the assumption that written policies are

being followed (in those regions with such policies in place). All this being said, as one doctor said, "the system is pretty loose".

This important issue has been reviewed several times and has been the subject of detailed review at both the Department as well as at the Board level. While we believe that the degree of study has alerted everyone involved in medical travel to its significance, it is apparent that there are still too many players involved which limits the application of lessons learned and tends to promote considerable inconsistencies.

The consulting firm of HMRG, now a part of the international firm of KPMG, undertook a major review of this single issue in July of 1998 on behalf of the then Boards of Inuvik, Kitikmeot and Stanton. Twelve recommendations ensued from this study and were based on four perspectives or principles. Again, we quote firstly the perspectives and, secondly, certain of the recommendations:

> "Patient/community focus: Ensuring the program has mechanisms in place to respond to patient and community needs
>
> Internal business strategies: Ensuring the structures, mechanisms and processes are in place to support the effective and efficient operation of the program
>
> Financial management: Ensuring resources are allocated/organized in such a way as to support the effective and efficient operation of the program
>
> Systems approach: Ensuring the program is integrated with the broader health systems, both within and across regions"

Some of the key (and in this instance more applicable) recommendations included:

> "Recommendation 2: Boards work with GNWT Department of Health and Social Services to review the envelope of travel services and travel funding regionalized to date, with the goal of standardizing travel program services and funding across Regions…
>
> Recommendation 4: Regions advocate for high priority attention by GNWT Department of Health & Social Services to the implementation of the H&SS travel management and information system…
>
> Recommendation 6: Within each Region, create a single Regional travel program management committee accountable fir the clinical and financial management of the program—policy, monitoring, planning…
>
> Recommendation 9: Establish a single air transport coordination centre, functioning on behalf of multiple Health & Social Service Regions".

This issue has been studied extensively. It is unnecessary in our view to re-visit all of these issues again as the recent work which has been done represents a comprehensive assessment of a reasonably complex issue. The problems which may have led to the prior studies being done appear to be the same or similar to the concerns which were raised with our team. These were:

> Medical travel is often uncoordinated resulting in more expenditures being incurred than necessary
>
> Staff responsible for making the arrangements are often doing so on their own understanding of the situation and with little back-up available with whom to consult

- A central coordinated system of approvals is lacking
- The mechanisms in place vary from region to region
- The high degree of staff turnover has been having a negative impact on the control of the medical travel system due to a lack of familiarity with the system and the potential for duplication, unnecessary costs and abuse of the system
- The system has become very "political" in that patients who wish to be medevaced for possibly non-medical reasons or who feel that their case has not been fully understood, see no constraint on phoning their MLA or Band Council or Mayor and applying pressure for a changed decision
- Travel permission for escorts also often becomes a "political" decision with patients and their families pressuring those whom they feel has the potential to obtain a more favourable response into seeking permission for such travel.

There have been a number of changes over the past few years as to how medical travel is coordinated and controlled. Many of these changes have been beneficial in terms of improving the control of this key component of medical care. Thus, for example, the following changes were reported:

- the nearest centre policy which restricts travel to the nearest facility offering the required services
- negotiated contracts with air carriers
- scrutinizing and restricting the need for escort travel
- booking travel on scheduled flights as much as possible
- increased coordination with the Capital Health Authority (Northern Health Services Network)
- an increase in the use of telehealth.

We were not asked to conduct a new, comprehensive review of this issue. That is a significant task of its own and our own mandate and timing requirements simply would not permit us to provide the comprehensive analysis needed. But we have reviewed the related documents provided to us on this topic and we have asked several pertinent questions of those most directly involved, and who were made available to us for interviews.

At the end of the day, and at the risk of sounding overly simplistic and optimistic, we believe that we have addressed this issue by recommending the one key component which has been missing to date. That is, **we will be recommending the centralization of the coordination of medical travel policy and coordination in one location and within one area of responsibility.** It is our view that the NWT Health and Social Service Authority should be assigned this task and should be expected to coordinate the implementation of the policy and procedure changes with the resulting three Regional Services Authorities. We also believe that anyone seeking an exemption to existing policy relative to medical travel services, including escort arrangements, should be required to fill out and submit an "Exemption Form" which will indicate the purpose of travel and the exemption being requested. Subject, of course, to prevailing laws, the costs of these requests which are approved should be publicized together with the name of any supporting position/organization. This might encourage more restraint relative to this cost driver.

We fully anticipate this to be an ongoing issue of consideration but one wherein we expect to see continuous improvements

over the foreseeable future. In this regard, targets of both a quantifiable and non-quantifiable nature should be established and the results both measured as well as widely communicated.

8.9 Adequacy of Department Support to Boards

We are of mixed views relative to the Department's relationship to the Boards. On the one hand, the legislation, regulations, Establishment Policy, Memorandum of Understanding, Contribution Agreements and Ministerial Directives appear to make it abundantly clear that the Department is to be involved in various capacities and that the Minister and Department are accountable for specific responsibilities. On the other hand, there is a considerable gray area as to the Government's ongoing degree of support to individual Boards (including their administration). It is our understanding that the Department of Health and Social Services sees its roles, relative to the Boards, as:

- Developing and implementing health policy and legislation
- Coordinating the planning, management and delivery of health and social services through the Boards; providing ongoing advice and support relative to program and service delivery
- Setting system strategic direction and priorities
- Developing a HR Plan
- Setting and evaluating compliance with requirements for service delivery
- Carrying out site visits, reviews, inspections, evaluations and audits of Board operations
- Monitoring population health and service delivery outcomes
- Licensing and regulating of health professionals
- Developing, approving and issuing standards and guidelines for the provision of services
- Allocating funding to the Boards; monitoring financial operations
- Authorizing the establishment of new facilities; approving any changes; coordinating the planning; ensuring that adequate standards are met
- Implementing territorial public education plans

Each of the foregoing is important to a comprehensive and well-run delivery system. Certainly the key to the foregoing is the degree of understanding by both components of the system (i.e. the Department and the Boards) as to who has the primary lead role and how the coordination and support will occur. It has been our observation that there has been a lack of regular coordination in this regard and a perceived reluctance by the Department to tackle outstanding matters of dispute. As a result, the rest of the Boards who may not be affected in a certain matter, question whether or not the Department is serious about its reservations on where it believes that the understood or implied obligations have been abridged. Further, given the Department's mandate in assessing and inspecting the Boards' delivery and support systems, more attention needs to be paid as to how these can occur on a more frequent basis.

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9.0 SYSTEM RESOURCING

The funding of health and social services systems in Canada has undertaken significant shifts over the past two decades. Rapid capital expansion of health facilities and social programs in the 1980's was replaced in the 1990's by severe restraints and cut-backs, which is now in the new millennium replaced by a gradual expansion of funding with concerns that the available funding be applied equitably across the populations and geographic areas served.

With provinces and territories spending one third or more of their government expenditures on health care and up to an additional one third on social services, there has been considerable effort across Canada in providing an equality in the division of funding to communities and regions, while at the same time retaining local decision-making. This has resulted in the ongoing development of funding models and the implementation and regional decision-making board systems.

9.1 History of Funding Allocations

Funding of health and social service programs in the Northwest Territories is largely reliant on funding provided by the Government of Canada. The most consistent data available on health care expenditures for the past 25 years is that from the National Health Expenditure Trends 1975-2000 published by the Canadian Institute of Health Information. Department staff did express concern on the use of this data source as not all assumptions on how expenditures have been allocated are published, but no alternative data source could be identified by the Department.

More recent data from the Department is available on the geographic tracking of expenditures and from Board financial statements, and these sources provide data on the expenditures in the areas of both health and social services.

The following slides provide an analysis of the history of funding allocations in the health care area.

Slide 15 Financial Analysis - Executive Summary: provides an overview of the three main data sources used in our analysis of expenditures in the Northwest Territories. The following highlights are included on the slide:

National Health Expenditure Trends, 1975-2000

Total health care expenditures in the NWT (including Nunavut) increased by 958% over the past 25 years.

This is an average annual compounded growth rate of 10% per year.

41.6% of NWT health expenses are spent on hospitals, this is 10 percentage points more than the Yukon, Nunavut & Canada.

Private Sector expenses dropped by 16.7 percentage points in the NWT. This compares to a 4.1 percent increase in Canada.

The average per capita expenditure on health care in the NWT (including Nunavut) was $4,063 in 1998 which is

$1,714 (73%) greater than the Yukon Territories, &

$2,274 (127%) greater than the national average.

Geographic Tracking of Expenditures, 1996/97 & 1997/98

The Geographic Tracking of Expenditures allocates expenditures on health & social services based on the geographic area that the

expenditure most closely relates to or benefits. Based on this allocation;

The Yellowknife and Inuvik service areas account for 62% of all expenditures in Health & Social Services in the Northwest Territories.

The average annual per capita expenditure on Health & Social Services in the NWT was $3,335 in 1997/98.

- Yellowknife service area had the lowest per capita cost, $2,236.
- Lutselk'e service area had the highest per capita cost of $5,463.

Audited Financial Statements, 1997/98 to 1999/00

Revenues for the 9 boards increased by $15.7 million (13%), from $121.1 million in 1998 to $136.9 million in 2000

Expenditures for the 9 boards increased by $20.2 million (17%), from $118.9 million in 1998 to $139.1 million in 2000.

The largest increase was $13.5 million (19.9%) in Hospital & Health Program & Services.

Expenditures on Social & Wellness Programs & Services increased by $3.8 million (16.9%).

One-third (or $46.6 million) of all expenditures were incurred by the Stanton Regional Health Board.

The largest percentage increases in expenditures occurred in:

- Deh Cho, 22.7% or $1.9 million, of which $1.0 million was in Social & Wellness Programs & Services,
- Inuvik, 20.9% or $6.7 million, of which $5.5 million was in Hospital & Health Programs & Services
- Fort Smith, 18.6% or $1.6 million, of which $1.37 million was in Hospital Services.

Slide 16 Total Health Care Expenditures 1975 to 2000: this slide shows total health care expenditures over the past 25 years. The year 2000 forecast is the only year showing a full separation of costs between the new Northwest Territories and Nunavut, while 1999 shows only nine months of the year when splitting of expenditures was accounted for. The balance of the data, from 1975 to 1998, reflects combined expenditures for the Nunavut and the new Northwest Territories under the Northwest Territories name. This slide also shows a comparison of expenditures by the use of funds between the Yukon, Nunavut, Northwest Territories and Canada. The following items are highlighted on the slide:

Over the 25 years, from 1975 to 2000, total health care expenditures in the Northwest Territories (including Nunavut) are forecast to have increased by $336.3 million (958%).

The "National Health Expenditure Trends" forecasts the 2000 total health care expenditures (including both public & private costs) to be

$206.5 million (56%) in the NWT, and

$164.9 million (44%) in Nunavut, for a total of

$371.4 million (100%).

The average annual rate of growth in expenses over the past 25 years is 10%.

In the NWT 41.6% of all health care expenditures were spent on hospitals,

this is 10 percentage points more than the Yukon, Nunavut & Canada.

All territories spend more than twice the percentage amount on "Other Health Spending" than the Canadian average.

Slide 17 Trends in Expenditures, Price Indices & Population 1975 to 2000: This slide provides a comparison for the Northwest Territories (including Nunavut), the Yukon and Canada in this area. The slide highlights the following data:

Total health care expenditures in the Northwest Territories (including Nunavut) are forecast to have increased by $336.3 million (958%), from $35.1 million in 1975 to $371.4 million in 2000. This compares to

680% in all of Canada, and

670% in the Yukon Territories.

The NWT's average annual rate of growth in expenses, between 1975 & 2000, is 9.9%; this corresponds to an average annual rate of growth of

5.2% in the NWT price index for health care, and

2.0% in the population of the NWT.

Canada's average annual rate of growth in expenses, between 1975 & 2000, is 8.6%; this corresponds to an average annual rate of growth of

5.0% in the Canadian price index for health care, and

1.1% in the population of Canada.

Slide 18 Private Health Care Expenditures 1975 to 2000: this slide provides an analysis for the private sector health care expenses for the Northwest Territories (including Nunavut), the Yukon and Canada, and highlights the following data:

Private Sector expenses are

out-of-pocket expenditures made by individuals

health insurance claims paid by commercial and not-for-profit firms

cost of administering claims, and other costs.

most private sector expenditures are estimated using survey data.

Private Sector expenses, as a percentage of total expenditures, has dropped by 16.7 percentage points in the NWT, from 24.8% in 1975 to 8.1% in 2000. This compares to a 4.1 increase in Canada, from 23.8% in 1975 to 28.9% in 2000.

Private health care expenditures in the NWT (including Nunavut) increased by $21.5 million (147%), from $8.7 million in 1975 to a forecasted $30.2 million in 2000. This compares to a

500% increase in the Yukon Territories, and a

750% increase in Canada.

These figures are important as they define the impact of the current health policy framework of the Northwest Territories. Based on total health care expenditures of $371.4 million in 2000, if the Northwest Territories (including Nunavut) were at the same percentage of private sector health costs as the Yukon then an additional $44.2 million would be paid by the private sector, reducing public sector health care costs by the same amount. Similarly, if at the same level of private costs as Canada, then the figure would be $77.2 million.

This is not to say that the current policy choices regarding private sector costs are right or wrong, but rather to highlight the fact that policy choices to move private sector health costs into public sector expenditures should only be undertaken on the clear understanding that this

diverts these funds from other programs in the health care system.

The Department, at the consultants request, is currently reviewing differences between the Northwest Territories and the Yukon in health legislation and policy regarding private sector costs, so that further analysis can be undertaken in this area by the Department. This process could not be completed before this Action Plan was due to be presented.

Slide 19 Per Capita Expenditures by Age & Gender: the charts on this slide highlight the typical pattern of health care costs seen in Canada. A 'U' shaped pattern with higher per capita costs for age groups for under one year, and for groups 65 years and above. The slide also highlights the following data:

> The average per capita expenditure in the NWT was $4,063 in 1998. This average is
>
> $1,714 (73%) greater than the Yukon Territories, &
>
> $2,274 (127%) greater than the national average.
>
> The lowest per capita expenditure occurs between the ages of 5 & 14. Expenditures more that double for each age group after age 64.
>
> The average per capita expenditure for females in 1998 in the NWT is $1,105 (31%) greater than males.
>
> The average per capita expenditure in the NWT exceeded the national average by
>
> $2,646 (133%) for females, and
>
> $1,956 (124%) for males.

In using the above sources of data it is important to verify the accuracy of the data being used. This is only possible in a broad sense and the following slide provides a comparison between the 1998 Board Audited Financial Statements to the Canadian Institute for Health Information database.

Slide 24 Comparison of 2000 Audited Financial Statements to Canadian Institute for Health Information Database: this slide compares the sum of the expenditures recorded in the ***Audited Financial Statements*** for each of the nine boards, to the expenditures reported in the ***National Health Expenditure Database****,* as reported in the *"National Health Expenditure Trends, 1975 to 2000"* by the Canadian Institute for Health Information (CIHI). This comparison is summarized in a graph shown on the slide. The slide also highlights the following information:

> Assuming total health expenditures were as reported by the CIHI, i.e. $147.2 million, and after adjusting for Social Services expenditures of $26.3 million, it is estimated that a total of $34.4 million is spent on other programs and services administered by the GNWT and Health & Social Services.

This figure differs from the amounts of $22.5 million (from audited financial statements) and $26.3 million (from geographic tracking) shown in the tables on Slides 23 and 24. This difference has been reported to the Department but no complete explanation of the difference is available at this time.

The following slides provide data based on the report titled *Geographic Tracking of Expenditures, Western Expenditure Data* which provide tracking of both health and social services costs within the new Northwest Territories boundaries.

Slide 20 Geographic Tracking of Expenditures: in 1996/97 and 1997/98 the Office of the Comptroller General, Financial Management Board Secretariat, of the Northwest Territories, produced a

report titled “Geographic Tracking of Expenditures, Western Expenditure Data”. The allocations are based on the geographic area that the expenditure most closely relates to or benefits. For the purposes of analysis in this report, these expenditures are aggregated to the board service areas. The slide highlights the following information:

Total Health & Social Service expenditures increased by $2.2 million (1.7%), from $132.2 million in 1996/97 to $134.4 million in 1997/98.

The Inuvik & Dogrib service areas increased the most: $3 million (8%) and $2 million (24%), respectively.

The Yellowknife and Inuvik service areas account for 62% of all expenditures in Health & Social Services in the Northwest Territories.

Slide 21 Geographic Tracking of Expenditures, Expenditures vs. Population: this slide provides the confirmation pattern where populations where lower needs are present (i.e. Yellowknife) would have lower expenditures. However, the slide also shows that populations with higher needs did not always show a corresponding higher level of expenditures. The slide also highlights the following information:

Two-thirds (66.7%) of the population of the NWT lives within the Inuvik and Yellowknife service areas.

The Yellowknife service area accounts for 29.3% of all expenditures in the NWT, whereas it accounts for 43% of the population.

The share of Health & Social Service Expenditures in all other service areas exceeds their share of the population.

Slide 22 Average per Capita Health & Social Services Expenditures: the sources of this data were the NWT Bureau of Statistics, and the Geographic Tracking of Expenditures, by the Financial Management Board Secretariat. The slide provides two graphs comparing the expenditures per capital between regions. A significant question is why the current per capita expenditures in Deninu, Dogrib and Deh Cho are lower than those for Fort Smith and Inuvik when demographic data provided in other analysis would show that health and social needs are higher in Deninu, Dogrib and Deh Cho. The slide also highlights the following data:

Based on the Geographic Tracking of Expenditures, the average annual per capita expenditure on Health & Social Services in the NWT was $3,335 in 1997/98.

The Yellowknife service area had the lowest per capita cost at $2,236 per year.

The Lutselk’e service area has the highest annual per capita cost of $5,463.

A comparison of the 1996/97 and 1997/98 expenditures to demographic data revealed a high correlation (68% to 86%) between Health & Social Services expenditures and

% Over 65 Years Old

Aboriginals as % of Population

Lone Parent Families % of Total Families

In using these sources of data it is important to verify the accuracy of the data. This is only possible in a broad sense and the following slide provides a comparison between the 1998 Board Audited Financial Statements to the Geographic Tracking of Expenditures report.

Slide 23 Comparison of 1998 Audited Financial Statements to the Geographic Tracking of Expenditures. The slide

shows that there is difference of $15.6 million between the totals of the Board financial statements and the data in the Geographic Tracking of Expenditures report. This difference has been reported to the Department but no complete explanation of the difference is available at this time. The slide also highlights that:

The largest variance ($34.3 million) is in the Hospital & Health Programs & Services (see table on Slide 23). The discrepancies between these two reports are attributed to the net effect of

Hospital & Health costs recorded as "Administration, support service & other expenditures" in the board audited statements,

Some Non-insured services incurred by the boards, and

Expenditures that are administered by the GNWT, which are not reflected in the audited statements of the boards; for example,

- $1.9 million, Adult Southern Placements
- $2.9 million, Supplementary Health Benefits
- $7.2 million, Out of Territorial Hospital Services
- $8.0 million, Physician Billings (approximate)
- the Department of H&SS operating cost

While data from the three sources analyzed (audited financial statements, Geographic Tracking of Expenditures report, and the Canadian Institute of Health Information database) differs to a small degree the differences are not sufficient to prevent conclusions on the current allocation of funding to be drawn.

Our analysis shows that the current funding allocation to Boards is not equitable and does not allocate funding to Boards based on need. This has been recognized by both the Department and the Boards, as they have worked on the development of funding models that would give a more equitable division of funding available.

We have also noted a number of situations where funding for expenditures on social services and community health issues has been diverted to health care programs. We recognize that a funding model needs to deal with the pressure on any system to move funding from preventative programs to the apparently more immediate treatment issues.

9.2 Development of Funding Models

In 1997 a draft funding model was prepared following consultation between the Department and the Boards. This model was based on dividing health and social services funding into the five streams of:

Primary & Acute Care

Long Term Care

Child Protection

Community Wellness

Extended Health Benefits

Each of these five streams was adjusted by factors such as age, gender, benefits eligibility, potential years life lost, socio-economic index, standard fertility ratio, child protection index, unemployment and education, to produce a final board cost index that was then adjusted to reflect services provided from a board to another board. The model however did not cover all health and social service funding with 20% or $47 million of the $250 million (1988 budget) being retained by the Department. This included Non-Insured

Health Benefits which represented 7% or $16 million of the total budget.

This draft funding model was reviewed by HMRG - Health & Public Sector Consulting Group who submitted their Final Report on July 31, 1998. In that report, as a part of the executive summary, HMRG states that:

> *"The areas of most concern with the 1997 NWT draft formula methodology are:*
>
> *The year to year variation in budget allocations that will result from the instability of the indicators used in the formula*
>
> *The lack of minimum funding requirements for core services / fixed costs*
>
> *These problems arise specifically in the context of the NWT as a result of:*
>
> *The small population base and its division into 11 regions, with populations ranging from 300 to 17,600 persons*
>
> *facility distribution and stand-by capacity requirements*
>
> *The main suggestions of the Review Team for revisions to the funding formula are as follows:*
>
> 1. *Agree on basic services (core / fixed costs) and fund these directly*
> 2. *Hold specialist / secondary level services funding centrally (health and social services as applicable)*
> 3. *Apply a population / needs-based model to the remaining relevant funds, ensuring that the methodology has indicators which are tied to services needs and are reasonably stable from year to year."*

Prior to receiving a copy of this report our consultants had reached very similar conclusions and we endorse the comments by the HMRG - Health & Public Sector Consulting Group. Our conclusions were based on analysis of current expenditures and a review of some of the funding models used in Canada. For illustrative purposes we provide the following outline of two such funding models in use in Alberta, chosen as Alberta health and social service authorities provide a significant level of service support to the Northwest Territories.

Alberta Regional Health Funding Model

Altogether, there are 124 population groups (and costs, based on activity files) identified for Population Based Funding. These are the result of:

> twenty age groups: (<1,1-4,5-9,10-14,15-19,20-24,25-29,30-34,35-39,40-44,45-49,50-54,55-59,60-64,65-69,70-74,75-79,80-84,85-89,90+)
>
> two gender groups: (male, female)
>
> four socio-economic groups:
>
> aboriginal (those with Treaty Status) under age 65
>
> welfare (those who received social assistance during the year) under age 65
>
> subsidy (those with subsidized health care premiums) under age 65
>
> other (non-premium subsidy under age 65 – this group represents the majority of Albertans and all persons aged 65 and older)

The composition of these 124 population groups, summarized by socio-economic groups are:

> 28 aboriginal (under age 65) groups [14 age groups x 2 gender groups]

28 welfare (under age 65) groups [14 age groups x 2 gender groups]

28 subsidy (under age 65) groups [14 age groups x 2 gender groups]

40 other groups [20 age groups x 2 gender groups]

Data Sources used by this model include:

Canadian Institute of Health Information (CIHI) for acute hospital care activity data

Ambulatory Care Classification System (ACCS) for hospital based ambulatory care

Resident Classification System (RCS) for nursing homes & auxiliary hospitals, re: Case Mix Index (CMI)

Home Care Information System (HCIS) for client specific home care data

Private Clinics data with information obtained via the Alberta Personal Health Card identifier

Methodology:

Calculate average per capita cost for each of the 124 population groups. Apply grid to each Health Authority to determine their share of provincial funding.

<u>Alberta Children's Services Funding Allocation Model</u>

The method of allocating funding to the Child & Family Services Authorities involves the following three steps:

1. Calculating the "adjusted population" for each Authority, based on

the number of children (0-17),

plus the number of children in single parent families times three,

plus the number of low income children times three,

plus the number of very low income children times four,

plus the number of Aboriginal children times five.

2. Allocating new dollars under the implementation strategy

3. Applying two adjustments to the allocation model

Resource Equalization Fund; which are meant to reimburse authorities for spending on on-reserve children, to support complex cases, and sudden or significant population growth.

Cost-of-Doing-Business; which includes allowances for costs associated distances and low population density.

Methodology:

The "adjusted population" model determines share of provincial funding for each authority.

As can be seen from these two models the use of a funding model is based on specific demographic data. Any funding model for the Northwest Territories will have to take into account the specific demographic factors that occur in their population.

9.3 Impact of Board Deficits and Surpluses

On Slide 17 we showed that the Northwest Territories (including Nunavut) average growth in health expenditures between 1975 and 2000 was 9.9%. The rate of growth of expenditures has been steady throughout this period except during the late 1980's and early 1990's, when health expenditures were restrained throughout Canada.

This growth of 9.9% is based on two major factors:

an average increase of 5.2% in the NWT price index for health care (vs.

- 5.0% for Canada over the same period)
- an average increase of 2.0% in NWT population growth (vs. 1.1% for Canada over the same period)

When the increase in health budgets to the Boards is lower than this trend the expectation will be that the delivery of services will have to be restrained and, in some cases, that levels of service will have to be reduced. This is not the case and the result has been that Boards have generated deficits in recent financial years. There are a number of basic reasons for this:

- business plans were based on continuing or increasing the current levels of service
- agreements with the Boards specify the core services to be delivered in such a way that there is little, if any, ability by a Board to reduce service levels
- financial planning resources have been divided between the Department and 9 Boards, resulting in uncoordinated and inadequate resources to analyze expenditure and service trends and submit adequate briefs to FMBS on "forced growth" issues
- budgets provided to Boards for recent financial years have not increased sufficiently for most Boards to account for increases in population, increases in health care costs, increased medical travel costs, and significant ongoing increases in personnel costs
- financial management systems are inadequate to control expenditures, or to provide accurate and timely projections on expenditure trends, with some Boards not being aware of the full scope of deficits until after the end of the financial year

In the financial year 1999/2000, yearend results varied from a surplus of $525,940 for the Yellowknife Health and Social Services Board to a deficit of $1,637,560 for the Stanton Regional Health Board. The net deficit for all Boards was $2.2 million with the most significant deficits typically being generated by those Boards have a higher portion of their budget dedicated to providing health services.

The Department has provided a policy on surpluses and deficits generated by the Boards. This policy has the aim of holding Boards accountable for expenditures, of allowing Boards to utilize surpluses and thereby curtail excessive spending at financial yearends, and of requiring Boards to recover deficits in future years through deficit recovery plans and cost minimization plans. The aim of this policy is valid but due to the lack of appropriate financial management systems in place, the results of the policy are not that which was intended. With inadequate financial and operational information available from current systems, decisions on deficit recovery and cost minimization may or may not result in the cost and service changes expected.

9.4 An Appropriate Financing Framework

As noted above, the development of a funding model to provide an appropriate financing framework has to take into account the specific demographic factors that occur in the Northwest Territories population. The following slides provide an analysis of current demographic data available:

Slide 3 1999 Population: this slide provides the most current population by community. These populations and community names are be used by other slides when calculating per capita and community statistics.

Slide 4 Demographic Analysis: this executive summary of population data provides a breakdown by the areas covered by the Health and Social Services Boards. It is important to note the significant differences shown in the table on Slide 4 between the Board areas on demographic statistics in areas such as percentage of over 65, of aboriginals, of lone parent families, and unemployment. Significant differences also occur in average household income and average individual income. The slide highlights the following data:

- The population of the NWT was 41,606 in 1999, which is 0.14% of Canada's population.
- Two-thirds of the population lives within the Yellowknife (43.0%) & Inuvik (23.7%) Service Areas.
- The population within the Yellowknife Service Area has the;
- lowest percent of people under 25 years of age
- lowest percent of seniors 65 years and older
- lowest percent of Aboriginals
- lowest percent of lone parents
- highest average household & individual incomes
- lowest unemployment rate
- The population within the Dogrib Service Area has the;
- highest percent of people under 25 years of age
- highest percent of Aboriginals
- highest unemployment rate
- lowest average individual income
- The population within the Deninu Service Area has the;
- highest percent of seniors 65 years and older
- highest percent of lone parents
- lowest average household income

Slide 5 Population 1981 to 2019 shows the actual and projected populations broken down by the areas covered by the Health and Social Services Boards. The projection is based on NWT Bureau of Statistics figures. The slide highlights the following data:

- The population of the Northwest Territories was 39,672 people in 1996, this is an increase of 9,543 (31.7%) over 1981, as compared to a 18.5% increase for all of Canada.
- The Yellowknife Service Area increased the most: 7,839 people, or 81.4%.
- The population of the Hay River Service Area decreased by 1,121 people, or 23.3%.
- The population of the NWT is forecasted to increase to 52,082 in 2019, an additional people 12,410 (31.3%).
- Two-thirds of the population (26,912 people) reside in two service areas;
- Yellowknife Service Area, and
- Inuvik Service Area.

Slide 6 Population by Age Groups (1 of 2): this slide, on the whole Northwest Territories, includes a chart showing the breakdown of population by age groups for the Northwest Territories, Nunavut and Canada, plus a chart showing the change in the breakdown of population in the Northwest Territories projected from 1986 to 2019. This slide also highlights:

- The Northwest Territories has a young population compared to the rest of Canada.

In 1996, 44.1% of the people in the NWT were under the age of 25, whereas, 33.8% of Canadians were less then 25 years old.

There are fewer seniors in the Northwest Territories.

In 1996 only 3.4% of the population in the NWT were 65 years and over, whereas, 12.2% of Canadians were seniors.

The number of seniors, aged 65 and over, in the NWT is forecast (see table on Slide 6) to increase by 3,121 (231%) from 1,350 in 1996 to 4,471 in 2019.

The Yellowknife Service Area is expected to increase the most: 1,603 people, or 525% over 1996.

Slide 7 Population by Age Groups (2 of 2): this slide provides data on the breakdown of population for the areas covered by the Health and Social Services Boards. Charts of this breakdown are provided on the slides for 1999 and the forecast for 2019. The slide highlights the following data:

The number of individuals 45 years & older is expected to more than double; from 7,455 in 1996 to 16,144 in 2019. This is an increase of 8,689, or 117%.

The percent of individuals 45 years & over is expected to increase from 19% of the population in 1996 to 31% in 2019. The largest increases are forecast to be in the following Service Areas.

4,301 (145%) in Yellowknife Service Area

1,803 (102%) in Inuvik Service Area

433 (106%) in Dogrib Service Area

2,152 (94%) in the other service areas

Slide 8 Aboriginal Population: 1996 to 2019 (1 of 2): this slide provides data on the projections of the aboriginal population in the Northwest Territories broken down by the areas covered by the Health and Social Services Boards. Data is drawn from the 1996 Statistics Canada Census and NWT Estimates and Forecasts for 1999 to 2014. This slide highlights the following data:

The number of aboriginals is forecast to increase from 18,940 in 1996 to 27,541 in 2019, an increase of 8,601 (45%). The following service areas will experience the greatest increase.

An increase of 3,532 (98%) in Yellowknife, from 3,605 in 1996 to 7,137 in 2019

An increase of 1,820 (26%) in Inuvik, from 6,965 in 1996 to 8,785 in 2019

An increase of 1,118 (82%) in Hay River, from 1,370 in 1996 to 2,488 in 2019

An increase of 2,131 (30%) in all other service areas.

Over half (55%) of all aboriginals are in two service areas;

Yellowknife Service Area,

and Inuvik Service Area.

The percentage share of the territories Aboriginals is expected to increase in two of the service areas;

Yellowknife, from 20% in 1999 to 26% in 2019

Hay River, from 8% in 1999 to 9% in 2019

a net decrease is expected to occur in all of the other service areas, from 72% in 1999 to 65% in 2019.

Slide 9 Percent Aboriginal: 1996 to 2019 (2 of 2): this slide provides data on the projections of the aboriginal population in the Northwest Territories as a percentage of the total population. Data is drawn from

the 1996 Statistics Canada Census and NWT Estimates and Forecasts for 1999 to 2014. This slide highlights the following data:

Approximately one-half, 47.7%, of the population in the NWT was aboriginal in 1996. This compares to only 2.8% in all of Canada, and 83.6% in Nunavut.

The NWT has 2.3% of Canada's aboriginal population.

The number of aboriginals, as a percentage of the total population, is forecasted to increase by 5.1% from 47.7% in 1996 to 52.9% in 2019.

As a share of their own population

The Yellowknife Service Area has the lowest percentage of Aboriginals, at 24.1% in 1999.

The Dogrib Service Area has the highest percentage of Aboriginals, at 92.8%

As a share of their own population the percentage of aboriginals is forecasted to

increase by 11% in the Hay River Service Area, from 37% in 1996 to 48% in 2019

increase by 10% in the Yellowknife Service Area, from 21% to 31%

increase by 9% in the Fort Smith Service Area, from 58% to 67%

Slide 10 Lone Parents 1986 to 1996: this slide provides data on the number of the lone parent families in the Northwest Territories broken down by the areas covered by the Health and Social Services Boards. Data is drawn from the 1996 Statistics Canada Census. This slide highlights the following data:

In 1996 there were 9,675 families in the NWT. This is an increase of 2,025 (26%) over 1986

8,105 of these families were "husband-wife" families. This is an increase of 1,615 (25%) over 1986.

1,585 were lone parent families. This is an increase of 410 (35%) over 1986.

Slide 11 Percent Lone Parents 1986 to 1996: this slide provides data on the percentage of the lone parent families and compares the Northwest Territories, Nunavut and Canada. Data is drawn from the 1996 Statistics Canada Census. This slide highlights the following data:

The number of lone parent families as a percentage of total families was 16.4% in the NWT in 1996. This represents:

an increase of 1.1% over 1986, and

is 1.9% above the national average of 14.5%, and

is 2.1% below the Nunavut total of 17.1%.

Two-thirds of the territories lone parents live in Yellowknife and Inuvik Service Areas.

The Deninu Service Area has the highest percentage of lone parents, 26.9%, which is 10.5% higher than the territory's average of 16.4%.

The Yellowknife Service Area has the lowest percentage of lone parents, 13.7%, which is below the national average of 14.5%.

Slide 12 Unemployment Rate 1986 to 1996: the slide provides an analysis of unemployment rates for the Northwest Territories compared to Nunavut and Canada, plus a breakdown by the areas covered by the Health and Social Services Boards. Data is drawn from the 1986 and 1996 Statistics Canada Census. This slide highlights the following data:

In 1996, in the NWT:

there were 27,920 people 15 years & over. Of these individuals, 21,570 (77.3%) were "In the Labour Force".

- This is 12.2% greater than the national average of 65.5%, and
- 11.2% greater than Nunavut's participation rate.

of the 21,570 people in the labour force 2,525 (11.7%) were unemployed.

- This is 1.6% greater than the national average of 10.1%, and
- 3.6% less than Nunavut's unemployment rate.

The Yellowknife Service Area has the lowest unemployment rate, 6.5%, which is less than half of the next highest rate.

The highest unemployment rates are in the following service areas;

32.0% Dogrib Service Area

28.3% Deninu Service Area

22.8% Deh Cho Service Area

The unemployment rate decreased the most in the Lutselk'e Service Area, from 25% in 1986 to 13% in 1996

Slide 13 Household Income 1986 to 1996: the slide provides an analysis of household income for the Northwest Territories compared to Nunavut and Canada, plus a breakdown by the areas covered by the Health and Social Services Boards. Data is drawn from Statistics Canada data. There is a close correlation between reducing unemployment rates and the rate of increase in household income, and of course the reverse. This slide highlights the following data:

In 1996 there were 12,195 households in the NWT. This is an increase of 2,765 (29%) over 1986

The average household income in the NWT was $66,349 in 1996. This average is

a $22,189 (50%) increase over 1986,

is $17,797 (37%) greater than the national average of $48,552,

is $16,025 (32%) greater than the Nunavut average household income.

The highest average household incomes, in 1996, were in the following service areas;

$81,726 Yellowknife Service Area,

$61,523 Hay River Service Area.

The lowest average household incomes, in 1996 were in the following service areas;

$37,163 Deninu Service Area

$41,772 Dogrib Service Area

$42,625 Lutselk'e Service Area

The largest increase in household income occurred in the Lutselk'e Service Area, which increased by $17,608 (70%) from 1986 to 1996.

Slide 14 Individual Income 1986 to 1996: the slide provides an analysis of individual income for the Northwest Territories compared to Nunavut and Canada, plus a breakdown by the areas covered by the Health and Social Services Boards. Data is drawn from Statistics Canada data. There is a close correlation between reducing unemployment rates and the rate of increase in individual income, and of course the reverse. This slide highlights the following data:

In the NWT, In 1996, there were 27,025 individuals 15 years & over with income. This is an increase of 7,415 (38%) over 1986

The average individual income in the NWT was $31,833 in 1996. This average is:

a $9,861 (45%) increase over 1986,

is $6,637 (26%) greater than the national average of $25,196,

is $7,876 (33%) greater than the Nunavut average household income.

The highest average individual incomes, in 1996, were in the following service areas:

$39,086 Yellowknife Service Area

$31,430 Hay River Service Area.

The lowest average individual incomes, in 1996 were in the following service areas:

$16,288 Dogrib Service Area

$19,329 Deninu Service Area

$18,361 Lutselk'e Service Area

The largest increase in individual income occurred in the Yellowknife Service Area, which increased by $12,904 (49%) from 1986 to 1996.

Once demographic data has been developed, then the design of a funding model can be undertaken. As an overview of this process, the following slides have been prepared but the reader should be aware that the slides are based on a funding model applying to all health and social service expenditures, and that this is not the conclusion or recommendation of this Action Plan.

Slide 45 Funding Model - Executive Summary: this slide provides the projection of expenditures increases based on the current Board service areas. Expenditure increases here have been adjusted to reflect population changes, adjustments for social needs, and inflation of the Health Care Implicit Index (see Slide 17). The adjustment for social need will be developed from data in the table on this slide and on data from a later slides. The slide highlights the following information:

Health & Social Services Expenditures for the Northwest Territories in 2019 are forecast to be

$388.6 million under the Status Quo scenario with 3% inflation, and

$414.9 million assuming per capita funding rates are equalized for all communities demonstrating greater social need.

Expenditures are forecast to increase by $255.5 million, from $159.4 million in 1999/00 to $414.9 million in 2019. The source of these increases are attributed to

$38.4 million (15.0%) due the projected increase in the NWT's population,

$23.8 million (9.3%) due to the ageing of the population,

$15.0 million (5.9%) due to the equalization of funding (i.e. Adjustment for Social Need), and

$178.3 million (69.8%) is due to inflation.

The communities identified to have the greatest social need (i.e. Group IV), had an average per capita expenditure of $4,261 in 1997/98, which was $317 (7%) less than the communities in Group II, which are deemed to have less of a social need relative to Group IV.

Adjusting for this discrepancy results in the larger "Adjustments for Social Need" for the Deh Cho (11.5%), Deninu (17.5%), and Dogrib (15.9%) boards. (refer to the table below)

The model allocates 0% to the Hay River Service Area, which consists of the town of Hay River & Enterprise, since both communities are identified as having low social need. The model allocates fewer expenditures in the forecast years as a consequence.

Slide 46 Funding Model - Methodology (1 of 2): this slide and the following slide provide a summary of the methodology utilized in the development of this funding model, as follows:

In the past the funding of health & social services in the Northwest Territories has been based on

incremental adjustments to historical budgets, and

specific facility, project and policy concerns identified during the budget process.

The objective in this study was to develop a population-based funding model where allocations are based on a community's estimated health and social service need relative to other communities.

The relative need of a community was determined by considering the

total Population

the age group profile of the community

their gender composition

other social-economic indicators such as

the number of Aboriginals

the number of lone-parent families

the number of unemployed individuals

the median income of the community

The Geographic Tracking of Expenditures for 1996/97 & 1997/98 was used to calculate the initial parameters of the model. These reports allocate the Territory's health & social service expenditures "based on the geographic area that the expenditure most closely relates to or benefits," therefore it was not necessary to take into account the services provided by one board to residents of another board. As such, services provided by one community to non-community members has been netted out. [refer to Section A of the Geographic Tracking of Expenditures, Western Expenditure Data, for the year ended March 31, 1998, prepared by the Office of the Comptroller General, Financial Management Board Secretariat]

The methodologies of the following funding models were reviewed in this study.

Alberta Health & Wellness, http://www.health.gov.ab.ca/funding/funpop.htm

Saskatchewan Health, Population Needs-Based Funding in Saskatchewan, 2001

Ontario Hospitals, Integrated Population Based Allocation (IPBA), February 2001

Alberta Children's Services,

Northwest Territories, Funding Allocation Formula, July 1997

Northwest Territories, GNWT Cost Pressures Study, February 2000

Slide 47 Funding Model - Methodology (2 of 2): this slide and the previous slide provide a summary of the methodology utilized in the development of this funding model, as follows:

The development of the funding model considered the demographic information appearing in the above table for each of the 33 communities of the Northwest Territories.

Two models were constructed; one for Health and one for Social Services.

Standard statistical tools were used to estimate the current relationship between health & social service costs and the socio-economic information contained in the above table.

The development of the model consisted of the following three steps

Calculate an adjusted population number for the health model, based on the average per capita costs, by age group, for the NWT, as reported by the National Health Expenditure Trends, 1975-2000 report.

Assign each of the 33 communities to one of four categories of "Social Need" based on the community's profile with respect to the percentage of lone-parent families, unemployment rate, percentage of Aboriginals and the median household income. Communities with similar profiles were assigned to the same category. Classification Analysis was used to assign each community to a category, refer to http://www.clustan.com/what_is_cluster_analysis.html/. The use of this procedure acknowledges the inter-relatedness of the social phenomena described by the statistics and, hence, avoids the error of "double counting."

Regression analysis was then applied to the two models (i.e. health and social services) to determine the "current average" per capita costs for each age group and the incremental costs due to the community's "Social Need". Subsequent scenarios of the model adjust the incremental costs so that groups with greater social need receive greater per capita allocations.

Slide 48 Funding Model - Adjusted Population: this slide shows the calculations of the age group weighting factor, and the adjusted population. This calculation is based on the NWT average annual per capita expenditure by age group as provided in the National Health Expenditures Trends, 1975 –2000 report. This data does include Nunavut within the Northwest Territories data. This slide highlighted the following information:

The variance in per capita costs, between the age groups, is similar in all other regions of Canada.

In developing the funding model for this study, the proportional variance in per capita costs, between the age groups, was imposed on the model by calculating an "Adjusted Population" for each of the 33 communities as described in the tables below.

Slide 49 Funding Model - Social Need (1 of 2): this slide outlines a process of grouping communities by similar levels of social needs. The statistical tool used for this is Cluster Analysis which has the advantage of allowing the classification of communities by similarity into groups, even though the demographic data type are mixed.

Each of the 33 communities were classified as having varying levels of social need based on the community's

Median Household Income,

Percentage of Lone-parent Families,

Unemployment Rate, and

Percentage of Aboriginals.

The statistical tool of Cluster Analysis was used to assign each of the communities to one of four Social Need groups; I, II, III and IV. (refer to http://www.clustan.com/what_is_cluster_analysis.html/) The results of this analysis are presented in the diagram and the table on the slide. The use of this procedure acknowledges the inter-relatedness of the social phenomena described by the statistics and, hence, avoids the error of "double counting." Furthermore, inappropriate year-to-year variations are eliminated due to group assignment being dependent on more than a one social factor.

Group I consists of four communities that are most like each other, as

compared to the other 29 communities. Based on their demographic profile, one may conclude that their social need is less then the other communities. These communities are:

Enterprise, Hay River, Norman Wells and Yellowknife.

Group IV, on the other hand, consists of 15 communities that would seem to have a higher social need relative to the other 18 communities. These communities are:

Aklavik, Déline, Fort Providence, Fort Resolution, Hay River Dene Reserve, Jean Marie River, Kakisa, Nahanni Butte, Rae Lakes, Rae-Edzo, Trout Lake, Tuktoyaktuk, Wetweti, Wha Ti and Wrigley.

Groups II & III consist of 14 communities that have demographic profiles that lay between the communities in Groups I & IV.

Group II communities are: Colville Lake, Fort Good Hope, Fort Laird, Fort Simpson, Fort Smith, Salt Plains, Holman, Inuvik, Lutselk'e, Sachs Harbour and Tsiigehtchchic.

Group III communities are Dettah, Fort McPherson, Paulatuk and Tulita.

The table on this slide, and shown below, shows the totals and averages of the values calculated for each community. The average per capita expenditure for each group is the current expenditures, and demonstrates that current expenditure patterns do not match this measure of social needs.

	Groups by Social Need				
Average of Community Profiles	I	II	III	IV	**Total**
Number of Communities in Group	4	10	4	15	33
1997/98 Expenditures on Health & Social Services (million $)	53.5	43.9	7.8	29.2	134.4
Total Population of Group (1997 estimated)	21,978	9,595	1,843	6,851	40,267
Average Per Capita Expenditure of Group	$2,435	$4,578	$4,236	$4,261	$3,339

Slide 50 Funding Model Social Need (2 of 2): this slide provides an analysis of the social needs groups against factors such as median household income, percent of lone parent families, unemployment rates, and percent of aboriginals, plus an analysis of per capital expenditures against unemployment rates. This slide highlights the following:

Social Need Group I consists of the following four communities; Enterprise, Hay River, Norman Wells & Yellowknife.

This group has the highest income level ($69,943), the lowest percent of lone-parent families (13.7%), the lowest unemployment rate (8.6%), and the lowest percent of Aboriginals (24.8%).

Corresponding to this profile, this group has the lowest per capita expenditure ($2,435) on health & social services.

Social Need Group II consists of ten communities and has the highest annual per capita expenditure ($4,578) on health & social services in 1997/98.

Social Need Group IV, which has the greatest social need, has a per capita expenditure of $4,261, which is 7% less than Group II.

Slide 51 Funding Model - Status Quo Forecast: provides a forecast based on forward projections of current expenditures based on population

changes and inflation, without adjustments for social needs. This slide includes data on the percentage change in expenditures from 1997/1998 to 2019, and demonstrates that different service areas should not receive equal proportionate increases in budget, which is the current basis for annual budget changes. The slide highlights the following information:

A population-based funding model was calculated using standard statistical regression analysis. The confidence levels of the social & health model's were 94% & 98%, respectively.

The Status Quo Forecast assumes that a board's expenditures are **only** adjusted for

the age group profile of each community within the board (e.g. per capita budgets are increased as the population ages), and

3% inflationary costs. (NB. this is 2.2% less that the 25 year average increase of 5.2% in the NWT health care index)

Total expenditures are forecast to increase by $229.2 million (143.8%) to $388.6 million in 2019.

$38.4 million is due to the increase in population

$23.8 million is due to the ageing population

$167.0 million is due to inflation (health care index)

The Yellowknife, Fort Smith, and Lutselk'e Service Areas are forecast to more than double or triple between 1999/00 and 2019.

The Hay River Service Area, consisting of the Town of Hay River & Enterprise, increases the least (84.4%).

Both communities are identified as having low social need (i.e. Group I). As a consequence, the model allocates a lower per capita rate in the forecast years.

Slide 52 Funding Model - Equalization Forecast: this slide provides a forecast based on forward projections of current expenditures based on population changes and inflation, and provide for adjustments for social needs funding for Groups II, II and IV. This slide includes data on the percentage change in expenditures from 1999/2000 to 2019 including adjustments for social needs funding, and again demonstrates that different service areas should not receive equal proportionate increases in budget. Within this model communities within Groups II, III and IV should receive an additional $15.0 million in funding to adequately serve their social needs. The slide highlights the following information:

This forecast equalizes the funding level for all groups with greater social need.

That is, the per capita funding for communities in Groups II, III & IV are all adjusted to the same level, using the maximum need rate calculated by the regression model.

Group I maintains its funding level.

In addition to the equalization of the funding rates, expenses are also adjusted for

the age group profile of each community within the board (e.g. per capita budgets are increased as the population ages), and

3% inflationary costs. (NB: This is 2.2% less than the 25 year average increase of 5.2% in the NWT health care index)

Total expenditures are forecast to increase by $255.5 million (160.3%) to $414.9 million in 2019.

$38.4 million is due to the increase in population

$23.8 million is due to the ageing population

$15.0 million is due to equalizing the funding levels of those communities with greater social need

$178.3 million is due to inflation (health care index)

Dogrib, Deninu and Deh Cho gain the most from the Social Need adjustment, as compared to the Status Quo forecast; the percentage change over 1999/00 increases by

53.8% for Dogrib, from 139.7% to 193.5% increase over 1999/00

48.5% for Deninu, from 109.9% to 158.4% increase over 1999/00

34.2% for Deh Cho, from 136.0% to 170.2%increase over 1999/00

Slide 53 Funding Model - Equalization Allocations: This slide provides a table that presents the results of the statistical estimation of the funding model using linear regression. The table shows the per capita rates of the average funding levels received by the communities in 1996/97 and 1997/98 as reported in the Geographic Tracking of Expenditures report. The table also shows the per capita rates that would be applied if the 29 communities in Groups II, III & IV were provided with the same per capita social-need rates. The slide highlights the following information:

A gender variable was considered in the estimation of the funding rates, however, this variable did not perform well in the statistical analysis. It is known that the average cost of females in 1998 in the NWT was 31% greater than males. The model could be recalculated imposing this additional cost on the different age groups and recalculating the "adjusted" populations. However it is not likely to significantly improve the accuracy of the forecast .

The model does not account for transient population.

Medical travel costs are only incorporated in the model to the extent that these expenses were appropriately accounted for in 1996/97 and 1997/98 Geographic Tracking of Expenditures report.

Slide 54 Funding Model - Equitable Forecast: this slide provide an analysis of equitable funding based on increasing per capita rates for Groups I, II, III, and IV. The slide includes a graph giving a projection of expenditures for 2004, 2009, 2014 and 2019, and a graph showing percentage increases in expenditures for each health and social services area for the period from 1999/2000 to 2019. The slide also includes the following information:

This forecast allows for equitable funding levels, increasing the per capita rate for each group with greater social need.

That is, the model allocates the largest per capita rate to communities in Group IV , a lesser rate to communities in Group III, and II.

Group I maintains its funding level.

In addition to the equalization of the funding rates, expenses are also adjusted for

the age group profile of each community within the board (e.g. per capita budgets are increased as the population ages), and

3% inflationary costs. (NB: This is 2.2% less than the 25 year average increase of 5.2% in the NWT health care index)

Total expenditures are forecast to increase by $255.5 million (160.3%) to $414.9 million in 2019.

$38.4 million is due to the increase in population

$23.8 million is due to the ageing population

$15.0 million is due to providing more funding to those communities with greater social need

$178.9 million is due to inflation (health care index)

Dogrib, Deninu and Deh Cho gain the most from the Social Need adjustment, as compared to the Status Quo forecast; the percentage change over 1999/00 increases by

62.5% for Dogrib, from 139.7% to 202.2% increase over 1999/00

56.3% for Deninu, from 109.9% to 166.2% increase over 1999/00

36.2% for Deh Cho, from 136.0% to 172.0%increase over 1999/00

Slide 55 Funding Model - Equitable Allocations: the table on this slide describes the Equitable Allocation funding scenario, which allocates a greater amount of funds to communities with greater social need. For example, communities in Social Need Group I (which includes Enterprise, Hay River, Norman Wells and Yellowknife) receive $432 per capita for social and wellness programs. However, communities in Social Need Group III (which includes Dettah, Fort McPherson, Paulatuk and Tulita) receive $966 per capita for social and wellness programs. The slide also notes that::

The 14 communities in Social Need Group IV receive the largest per capita funding rates.

For Hospital and Health Programs & Services, they receive $4,255 for every child under 5 years old. For every person 65 years and older, they receive $18,061.

For Social and Wellness Programs and Services, they receive $1,002 per person.

Slide 56 Funding Model - Capital Allocations: this slide shows the health expenditures made on capital assets for the period 1975 to 2000 and compares the Northwest Territories (including Nunavut) to the Yukon and Canada. The chart on the slide shows that this level of expenditures fluctuates severely from year to year. The chart also shows that the average annual per capita expenditures on capital for the period from 1975 to 2000 was 70% higher for the Northwest Territories (including Nunavut) than any other jurisdiction. The slide also notes that:

The National Health Expenditure Trends report, published by the Canadian Institute for Health Information, identified the annual per capita expenditure on capital for the provinces and territories, for the period 1975 to 2000.

“Capital” includes expenditures on construction, machinery and equipment of hospitals, clinics, first-aid stations, and residential care facilities. Expenditures are based on full cost or cash basis.

The above bar chart graphs the per capita expenditures on capital for NWT & Nunavut, the Yukon and Canada.

The expenditures are adjusted to reflect the value of the dollar in 1999 using the Health Care Implicit Price Index.

The per capita cost in Canada ranged from a low of $36.44 in 1977 to a high of $92.12 in 2000.

The per capita cost in the NWT & Nunavut ranged from a low of $38.36 in 1975 to a high of $547.07 in 1998.

The 26 year average annual per capita expenditure on capital is the highest in the NWT & Nunavut, at $172.89. This compares to an average of $56.56 for all of Canada.

Capital costs represent the fixed cost of doing business.

The cost of constructing new facilities and of purchasing new machinery and equipment for the facilities will vary significantly from year-to-year.

The capital cost will vary significantly between the boards & regions of the NWT from year-to-year.

The funding model should take this cost into account by allowing for an average of $172.89 per capita over the long-run (e.g. 10 to 15 years) for each health & social services board.

9.5 Principles for a Funding Model

The funding model above is based on including all funding within a formula based on demographics and other criteria, to produce per capita funding. While this type of model is prevalent in the provinces, our analysis shows that this will not work for the provision all health and social services in the Northwest Territories, for the following reasons:

per capita funding will not provide sufficient funding to maintain existing health centres, nursing stations and core programs to communities with small populations.

medical travel costs are significantly influenced by geographic location issues,

the small population base of the Northwest Territories and its division into a number of service areas results in:

significant expenditure fluctuations from year to year

further expenditure variations due to high cost health services occurring in some financial years but not others, i.e. organ transplants, placement in mental health facilities, long term cancer treatments, etc.

expenditure changes due to high cost of some southern placement services, i.e. either starting or ending the service

the need to maintain territory wide programs such as recruitment and retention

the impact of transitory populations

spending on capital assets shows severe fluctuations from year to year

In order to provide a funding model that respects the special situations that apply to the Northwest Territories, we suggest that the funding model be based on the material provided on Slides 45 through 56, adapted to meet the following principles:

A. That the following general funding principles be applied:

First – directly allocate funding to **fixed costs,** such as facility operation, staffing and maintenance

Second – directly allocate funding to **capital costs**, determined on a territory wide basis

Third – allocate funding to **variable costs**, through the use of the funding model for those health and social services programs not associated directly with facilities

B. That the allocation of funding provide for separate funding streams for the following service areas:

Fixed Costs

1. health and social service facility maintenance and operation, based on directly allocating the cost to operate approved health and social service facilities, including professional staffing
2. corporate support service, based on approved programs and business plans
3. high cost health and social services, specifically for services anticipated to exceed a set amount (e.g. $100,000) during a 12 month period, and based on allocating funding to a revolving fund carrying forward unexpended funds to future years
4. special initiatives, based on approved programs and business plans targeting specific issues or populations on a single year or multi-year basis
5. conditional program funding, based on criteria specified by the funding agency

Capital Costs

6. capital expenditures based on approved programs and business plans, and on funding of expenditures on a single year or multi-year basis

Variable Costs

7. patient care & clinical health services, based on the health funding model and allowing for multi-year commitments to organizations providing services
8. medical travel expenditures, based on the health funding model factored by an index of travel costs from each community
9. public, population and community health services programs, based on the health funding model
10. social services programs, based on the social services funding model and allowing for multi-year commitments to organizations providing services
11. transitory populations, by adding estimated population counts and demographics to the base population data.

The funding model should also provide for restriction of the transfer of funding with budgets from preventative services to treatment services.

10.0 SERVICE DELIVERY STRUCTURE

10.1 Background and Observations

The current health and social services system is founded upon a rich history of programs and services that have continually evolved and changed since their origins. While the purpose of this Report does not require us to document in detail the history leading up to the present system, it is nevertheless important to make some basic references to the more significant or obvious changes that have occurred over the years.

As the health system gradually developed, nursing stations (now called community health centres) became the main vehicle for offering health care in the Northwest Territories. For most of the last century, the Federal Government employed nurses directly. In the 1980's, the Government of the Northwest Territories took over responsibility for the nursing stations as well as most of the remaining health care system. Nursing stations were managed through a regional administrative (superintendent) system with headquarters in Yellowknife.

The system of management and governance changed with the advent of regional Boards. Most of the Boards are of fairly recent origin with most having been established as recently as the late 1980's. The system of Boards gradually evolved until 1997-98 when the responsibility for social services was integrated into the regional board structure. Concurrent with this integration, the GNWT created several new health and social service boards. By 1998, there were eleven regional health and social service boards in existence, and one hospital board for Stanton Regional Hospital in Yellowknife for a total of twelve Boards. Also in that year, the GNWT proposed that new contribution agreements be signed with the regional boards and the Stanton Hospital Board. The division of the then NWT into two Territories with the establishment of Nunavut resulted in three of the Boards being allocated to Nunavut.

10.2 Effectiveness and Efficiency of Current Service Delivery Structure

In the current health and social services system, physicians, nurses, social workers, and other professional and service personnel are working hard to address people's needs. However, the system needs to be better organized and structured to effectively meet these needs. We believe that the steps taken to integrate the professions of health and social services under one Board structure were appropriate and cost-effective. While there has not been as much integration in the combined systems as might have been expected, neither has there been sufficient attention paid to this initiative.

We note that the NWT Medical Association has supported this move as well as others. In their response to the Med-Emerg study the NWTMA states, and we quote:

> *"The NWTMA cautiously supports the concept of integrated Health and Social Services Authorities as proposed…The NWTMA supports initiatives which encourage team building among Health and Social Services care providers and coordination among programs."*

What we have failed to find is any system-wide effort or even enthusiasm for fully integrating the two delivery systems. Although there has been support for this

initiative expressed at various levels, the evidence of concrete action steps is not readily apparent. The small steps, which have been taken, are those which occur in the field between individual practitioners, who realize the need to discuss the client as a complete person, and whose lifestyle may be driving his/her over-reliance on the healthcare system.

While we recognize the downside of over-simplification of addressing this issue, it appears to us that the value of combining these resources and disciplines so as to actually benefit the patient (or client) will only become real once the leadership of the Department, the Boards and particularly the professions address this issue with a spirit of "how do we make substantial progress" rather than "what impediments exist which thwart any action on this initiative?" The latter approach will, and has, encouraged further studies albeit little tangible action. Thus, if there are legislative obstacles, what can be done to remove them? What other jurisdictions have approached this issue successfully? If none have, then maybe the NWT can take a useful lead role.

Based on our review of records, background studies and numerous interviews, we believe that we have a reasonable understanding of how service providers believe the delivery system to be working at present. These needs might be summarized as follows:

- An integrated and coordinated approach-where services are organized around the needs of the individual
- Continuity of care including physicians services, home and community care, social services case workers, acute care and care in long term care facilities
- A clear link between health care, social services and other community services
- Consistent relationships between individual and health and social services provider
- A multidisciplinary team approach to meet the health and social service needs of the individual
- Increased involvement of the individual and the community in planning and developing programs
- Services based on evidence that they provide health and social service outcomes people want and expect.

10.3 Current Health Service Delivery Model

There are several key components which, taken together, make up the present health delivery model. We describe these components as follows:

- The Community Health Nurse
- Community Health Centres
- The Major Facilities
- Physicians and Specialists
- Medical Clinics and Emergency Services
- Medical Transportation
- Telehealth
- Nurse Practitioner Program
- Alternate Health Care Programs
- The Regional Boards
- The Department of Health and Social Services

These we describe in greater detail as follows:

10.3.1 The Community Health Nurse

From the comments we received throughout our study, it became apparent

that the community health nurse is assessed, by most respondents, as the foundation of the health system. Nurses have indeed been an integral part of the evolution of the health system over the years and they continue to play a very significant part in the delivery of health care in the NWT.

The nurses often work in difficult conditions with little or no supervision (at least on site) and with a varied and often stressful patient load. Those who work in quite isolated settlements spoke of having to make decisions for which they may have lacked the training or the confidence or in the face of considerable local pressure. While many expressed their desire to work in such an environment due to its variety of cases being dealt with, the stress of being in isolated circumstances has increased the frequency of turnover and thus increased the lack of patient familiarity.

10.3.2 Community Health Centres

The eight regional health boards operate approximately 30 health centres in the NWT (approximate because the definition to date has been variously described) (see outline published by the Department of HSS -Nov. 23, 2000 - regarding the eight regions, the communities they serve, and the health centres involved; some list some communities as health stations, and others as health centres). In addition, there are several communities that are served through health centres in neighbouring communities.

The health centres offer a wide range of primary health care services, community education programs, referral services, medevac assistance, environmental programs, etc. As well, there are often particular programs offered in some health centres, and not in others due to staffing, size of the communities, and so on. The centres tend to be a place where other community workers may be located and thus there is generally information about all other related services that can be obtained through the centres. In short, these centres offer critical health services to the communities of the NWT.

10.3.3 The Major Health Facilities (The Main Hospitals in the NWT)

In our Appendices to the Report, we provide a listing of all of the services which the various "hospitals" believe that they offer. This list has not been vetted for accuracy in terms of exactly what services are provided and how much of a particular service is offered at that location. It is evident, however, that there are distinctions between the various facilities. In short, there is one main Territory-wide hospital which is publicly recognized as such (Stanton Hospital) and two facilities which offer a reduced level of service in part due to less access to health specialties (Inuvik Hospital and the Hay River H.H. Williams Memorial Hospital).

We note that the NWT Medical Association's report of February of 2001 makes the observation that there are four distinct levels of staffing and thus hospital services. The smallest they described as the nursing station which did not have a full-time resident physician. The next three are described as follows:

> "Fort Simpson, Fort Smith, Sah'tu
>
> Provide emergency room, family practice and hospital care
>
> May provide some small volume obstetrics
>
> Hay River, Inuvik
>
> Provide emergency room, family practice and hospital care
>
> Provide obstetrics and nursing home care
>
> May provide some surgical services

Yellowknife (Stanton)

Provide emergency room, family practice and hospital care

Provide obstetrics and nursing home care

Provide surgical services

Provide all speciality services deemed essential."

The report goes on to say that "the specialty services provided out of Stanton Regional hospital should be considered as a territorial-wide service". This observation was stated many times during our interviews with most people expressing the view that the NWT was fortunate to have a facility which was so well-equipped and staffed with so many knowledgeable and committed people.

Stanton Hospital

As of 1988 when the new Stanton Hospital was opened, it offered 103 beds and 14 daycare beds with a wide variety of inpatient, outpatient and community-based services. As of April 2000, there apparently still were the 103 beds open along with 16 more beds (spaces) for day surgery (10), operating room (2) and medical day care (4). (These figures are based on information obtained from Stanton Hospital).

In other reports these figures change somewhat. The Med-Emerg report in 1997 indicates that there were 84 acute care beds open at 54% occupancy, and 14 long-term care beds at 89% occupancy. Again, in keeping with the tone of this current report, we were not expected to provide a detailed description of the various services and programs (although, as stated earlier, we have had the various senior administrators put together a listing of the services which they believe they are presently providing).

As well it should be noted that it is difficult to capture all of the specific initiatives and programs that may be underway at a particular time. In many ways, it is a moving target…adjustments to programs occur regularly and reports can be out of date very quickly if they rely on details of current programs that change as time goes on. Examples of this include the closure of the surgical unit of the Stanton Hospital; the number of specialty services that are offered in the NWT at any given time; the number and type of clinics offered in different communities; etc.

It is accurate to say that Stanton Regional Hospital offers a wide variety of health services not only for the Yellowknife area, but also for the NWT as a whole. As well, the Hospital provides considerable service to residents of the Eastern Arctic (estimated by the administration as 15-20% of the total caseload). The Hospital also provides services outside the hospital as such, either in one of its community clinics, or through clinics offered on a periodic basis in outlying communities.

The core services presently offered at Stanton were listed as follows:

GP/Anaesthesia

GP/Emergency

GP/Obstetrics

Among the specialties offered through Stanton Regional Hospital at the present time are the following:

General surgery

Internal medicine

Otorhinolaryngology

Obstetrics and Gynecology

Ophthalmology

Ear, nose, and throat

Orthopedics

Pediatrics

Diagnostic Imaging

Psychiatry

(These services were listed as available June 2001).

Other specialist services are available through “southern visiting physician specialists”.

As referred to earlier, the specialists at Stanton Hospital offer a variety of community clinics throughout the north. These clinics are arranged between the local health and social services regions and Stanton Regional Hospital. A master schedule is put together by Stanton based on expressed needs and availability of specialties and distributed in March and October of each year. These services are quite substantial and include such services as: ear/nose/throat; eye; general surgery; mental health; obstetrics; gynecology; orthopedics; occupational therapy; pediatrics; radiology; speech, etc.

As well, Stanton houses an active emergency department for the residents of the Yellowknife area and referrals that come from the other health boards and, as mentioned, the Eastern Arctic. A review of documents along with interviews with key people in the system indicates that the number of emergency visits by patients has more or less remained constant over the past number of years.

Inuvik Regional Hospital

A review of the documentation states that the original hospital was constructed in 1963 with a major addition in 1971. At that time, there were 26 acute care beds and 16 long-term care beds. Occupancy rates vary from time to time; one report in 1998 indicated that the hospital runs at around 40% occupancy (not including the continuing care program which operated at around 95% at the time the analysis was made).

This facility offers primary care services, as well as a range of secondary or treatment services. It receives patients from the broader Inuvik region and offers a consultative service to health centres in the region. In addition, the facility operates both emergency and outpatient departments.

The core services presently offered at Inuvik were listed as follows:

GP/Anaesthesia

GP/Emergency

GP/Obstetrics

Among the specialties offered through travel clinics to Inuvik Regional Hospital at the present time are the following:

General surgery

Internal medicine

Otorhinolaryngology

Obstetrics and Gynecology

Ophthalmology

Ear, nose, and throat

Orthopedics

Pediatrics

Diagnostic Imaging

Psychiatry

(These services were listed as available June 2001).

At the time of writing this Report, the number of permanent doctors in the region operating out of Inuvik had decreased to four.

Hay River (H.H. Williams Memorial) Hospital

Medical service in Hay River began in the early 1950s as a church-sponsored nursing station, reportedly the first such medical service offered by the Sub-Artic Mission. The Hospital was originally founded in the mid-1950s and opened in

1957 with 6 active treatment beds. The hospital was founded by the Pentecostal Assemblies of Canada and managed by the PAOC until it was taken over by the Town of Hay River in September 1, 1996. The management of the H.H. Williams Memorial Hospital together with the Medical Clinic, Woodlands Manor and Public Health Unit (and allied social services) were transferred to the Board of Health and Social Services in September 1996.

The Hospital has 20 acute care; 80 pediatric beds; 1 birthing bed; 1 palliative care bed; 3 newborn beds; 1 intensive care bed; 1 operating room; and 16 extended care beds. In addition, there are 16 long-term care beds in the adjacent Woodlands Manor (opened in 1989).

The core services presently offered at H.H. Williams Memorial Hospital were listed as follows:

- GP/Anaesthesia
- GP/Emergency
- GP/Obstetrics

The visiting specialists clinics include the following:

- Dermatology
- Internal Medicine
- Pediatrics
- Gerontology
- Radiology
- General Surgery
- Orthopedics
- Gyn/Obstetrics
- Psychology
- Optholmology

(These services were listed as available June 2001).

For a more complete listing of services provided by H. H. Williams Hospital, please refer to the survey attached (see Appendix C).

10.3.4 Physicians and Specialists

If the health care system has as its core the many dedicated nurses who work in clinics, hospitals, health centres, nursing stations and in the broad jurisdiction of public health, a second key pillar is the role played by the broader medical community, particularly the doctors and specialists . While we were made aware of the NWT's experience with various shortages, there is no doubt that the NWT has (and likely will) been served by an array of talented and dedicated professionals.

These highly educated and trained professionals obviously have many locational options and choose to work in the Northwest Territories. We were advised that this is due in part to the career variety experienced through practicing in the NWT; in part because of the quality of life offered for families; in part because of the range of other specialists and physicians with whom to share the workload; and in part due to the sheer challenge of providing services to such a unique area of this hemisphere. It was our observation as laypersons that the residents in the NWT were quite blessed to have the range of skilled practitioners available, a thought that was echoed during our discussions with the doctors we spoke to in the Capital Health Authority and elsewhere.

It is somewhat difficult to precisely state the number of physicians and specialists who work in the NWT. This number fluctuates, at times somewhat dramatically. As well, there is a significant dependence upon 'locums' or doctors coming in from the south for variable (generally short) periods of time. As a

result, this Report will concentrate on the overall picture for the NWT as a whole, understanding that mobility occurs between regions with regard to the specialists in particular.

According to a recent report issued by the Northwest Territories Medical Association (February 9, 2001), it was stated that there were 32-34 physicians in the whole of the NWT. However, upon further analysis, this data is already somewhat out of date because of recent changes in Inuvik and Hay River. The report listed the physicians as follows:

Yellowknife area:	20
Fort Smith area:	3
Inuvik area:	7
Fort Simpson:	1
Hay River:	3

It was our observation that during the course of our work on this Report, the number of physicians in the NWT would likely be closer to the 28-30 level. Several recent changes had occurred in at least two of the smaller centres although steps were being taken to restore their base of doctors.

As the above noted report indicates "the number of specialist physicians in the NWT is sometimes debated because of locum coverage and visiting specialists. In calculating the current number of NWT specialists, visiting specialists and locum visits are taken into account." Given this dynamic, the Medical Association has presented the following figures:

Obstetrics/Gynecology:	2.4
Ear, Nose and Throat	2
Internal Medicine	1
General Surgery	2
Ophalmology	1
Pediatrics	2
Radiology	1
Orthopedics	2
Total Resident Specialists:	13.5

The report goes on to describe the number of days per year that are offered by visiting specialists. A total of 16 other specialties are involved in visiting various centres in the NWT, primarily Yellowknife and Inuvik. The number of visiting days was calculated at 579.5 days (which translates into the equivalent of approximately 2.2 positions). Locum specialists were also calculated in "weeks per year". A total of 68 weeks of specialty services were provided involving some six medical specialties. This translates into 1.3 positions. As a result, if the total number of specialist services were added together from these three categories, a total number of approximately 17.0 specialists appear to be available to the NWT (again, we note that this figure tends to vary from time to time).

10.3.5 Medical Clinics and Emergency Services

Virtually all the doctors in the NWT are now reimbursed through a salary system as opposed to the traditional "fee for service" method that was in place in prior years. As well, their respective regional Health and Social Service Boards own the medical clinics in Yellowknife and Inuvik.

Emergency services in the hospitals are provided by a rotational system of doctors working in the community. This also includes the rotation of doctors who are on locums. An unofficial estimate of the ratio of locum doctors to resident doctors working in the emergency departments of the two major hospitals has been reported to us as approximately 50%-50% each (this estimate was stated by several interviewees who are knowledgeable of the health system). What is important here is not so much whether the 50-50 statistic is precisely the accurate figure; rather the important point is that there is a

large number of new doctors working in the communities and in the emergency departments at any one time.

10.3.6 Medical Transportation

The evolving history of health care in the NWT is that residents requiring services above and beyond what can be provided by the nurses at the health centres in the outlying communities can be transported to the appropriate hospital for secondary or tertiary care. The vast majority of patients are transported to one of three hospitals: Inuvik, Yellowknife, and Edmonton.

The procedure of authorizing medevacs is not consistent across the regions. However, the majority of times a medevac approval usually goes through the following steps:

- Community nurse sees patient and makes an assessment.
- Community nurse may seek advice from another nurse in the centre if one is available, especially from a more senior nurse or nurse in charge.
- Phone call to a doctor in the region (if a doctor does in fact live or practice there) or phone call to the nearest emergency department (Inuvik or Yellowknife) to talk with a physician on duty.
- Sometimes the nurse will call Stanton Regional Hospital directly, even if she is outside of the region and closer to Inuvik hospital, if the situation appears to merit it.
- A decision is made if a medevac needs to be arranged, and what hospital would receive the patient.
- If the decision is to medevac the patient, a variety of procedures can then come into play. The nurse may call a staff member of the region who is responsible for arranging medevac travel details, or the nurse may call the medevac company directly. This depends upon the region's protocols, time of day, the situation at hand etc.
- The receiving hospital usually approves the medevac before a final decision is made.
- The region involved may do a "medevac audit" after the fact, to see in fact that all medevacs were necessary. If certain trends begin to emerge from these audits, preventative education will be initiated.

The foregoing is only a "rough" outline of some of the steps that are usually taken when medevacs are being arranged. It should be noted that most of this information came from interviews with people in the system, rather than making the assumption that written policies are followed (in those regions with such policies in place). All this being said, as one doctor said, "the system is pretty loose".

Unfortunately the whole system of medical transportation appears to lack solid coordination. This is not that surprising given the number of players involved or potentially involved in making medical travel decisions. We were advised that how medical transport is handled was dependent in some quarters upon perceived medical need (which may be determined by someone with little or no history of the particular patient; the time of the day that the perceived need arises; patient location; whether or not they worked for the GNWT or whether or not they were employees of the Health and Social Service Board. This lack of coordination and standardization is observed by those we spoke with as significant causes of increasing costs, inconsistency in decision-making; and a duplication of resources.

10.3.7 Relationship to the Services provided by the Capital Health Authority in Edmonton

The authors of the Med-Emerg Report of 1997 commented on the ongoing need for the NWT to maintain relationships with the larger southern centres in order to provide to their residents appropriate access to tertiary care. Whatever the enhancements made to secondary care…there will still be need for tertiary care that can only be supplied outside the NWT. …Certainly, net new revenue and the social and educational values of serving the North should make the servicing of tertiary care needs attractive to most university centres."

The GNWT has had a long-term relationship with other jurisdictions for care not provided in the NWT. According to the Department, this approximates $6.7 million per year on hospital services; $1 million per year on outpatient clinics; and $1.9 million per year on physician services (yearly averages for the period of 1994/95 to 1998/99). The vast majority of these expenditures (approximating $4.7 million per year) are with regard to care received in the Capital Health Authority jurisdiction (centred in Edmonton). This arrangement is governed by an agreement between the two jurisdictions for the provision of the Northern Health Services Network which was originated through a prior agreement with the Board of the Royal Alexandra Hospital (prior to the change to regionalization in Alberta in 1994). The agreement involves several CHA facilities and provides for the NHSN to:

- Plan, organize and coordinate patient referral and transfer services
- Act as the key contact between CHA health care facilities/providers and NWT health care facilities/providers
- Facilitate continuing program development and strategic planning in response to any changes in health service delivery
- Development and management of the patient referral and transfer services
- Provision of nurse liaison services
- Submission of patient health care information and statistical data
- Offer ongoing education to CHA and GNWT health care providers and NWT residents regarding applicable policies, services, and benefits available.

The CHA by agreement is obligated to house the NHSM program separately and to provide certain medical and administrative services and personnel, including a Program Coordinator, a Medical Services Coordinator, Nurse Coordinators and an Administrative Assistant.

A part of the service provided is actually offered through "Larga House" which is a program/facility available for assisting a large number of residents in arranging for transportation and accommodation needs while accessing medical services in Edmonton. This program is available to residents designated as "Status" as well as people approved by the Extended Health Benefit Program.

The CHA is also interested in providing additional services to the GNWT as programs become established and as funding is made available. Thus, for example, the Government of Alberta recently announced funding for an additional 15 innovative projects. Some of these may be of interest to the NWT such as:

- The Gait and Balance Centre for those experiencing motor impairment
- Home Nocturnal Hemodialysis Program for cost effective home

- dialysis service for those in isolated areas
- Stroke Outreach Education which is a telehealth service to improve patient management in more isolated or northern settlements

There are a number of other avenues of interest open to the GNWT subject to the degree of interest (and obviously funding availability). These issues are discussed on a fairly regular basis between members of an advisory committee (consisting of representatives of the GNWT and the CHA) which has been established. From the perspective of the CHA, the key to system improvements in this regard is the degree of communication between the key players representing the NWT. Further, it has proven to be useful to have representatives of both parties visit the facilities of their partner to understand both what is (and is not) needed or available. A group of NHSN representatives met recently with their NWT counterparts in this regard. (One example, which was cited for us, was that of needing to understand the challenges of providing a wheelchair for someone in a community with no sidewalks).

The challenges and opportunities relative to this extremely valuable service (with the benefits flowing to both parties) appear to include:

- Need to improve overall service coordination
- Mental health programs not well coordinated
- Lack of continuity in the designated NWT contacts
- Provision of opportunities for rotational services for physicians
- Coordination of air travel arrangements.

10.3.8 Telehealth

More and more of the regions are using or attempting to use this rather recent innovation to transfer important medical imaging and information to specialists to help diagnosis and the prescribing of appropriate treatment methods. There are complications emerging, however, with regard to “band width” and other major system capabilities. Apparently, the technical aspects of this and other programs are being addressed through another study process currently underway within the GNWT. A detailed review of the present IT system, and what it will take to assure the necessary capability was often expressed to us as a critical inadequacy.

10.3.9 Nurse practitioner program

Aurora College is developing a 15-month nurse practitioner program scheduled to begin in September 2001. This program is expected to be one of the initiatives which the GNWT is creating in response to the increasing difficulties of finding and retaining qualified personnel to support the work of the nurses and doctors.

However, there are some concerns related to this program. These include:

- What will be the designation at the end of the program?
- Will the program designation be recognized throughout the country?
- Will there be compensatory recognition for staff members who graduate from this program?
- If recognition factors are not built into the system, do people realize that there will likely be a “relationship problem” between the graduates of the program and those who chose not to participate?

Fear and concern were expressed that, unless these questions were positively answered, the program could backfire and

cause unintended consequences. In other words, if graduates of the program do not receive compensatory recognition, they will be tempted to leave for positions in the rest of Canada that do offer such compensation and recognition.

10.3.10 Alternate health care programs

An example of such a program is the increasing acceptance of midwifery, and the promising use of Community Health Representatives in most of the health stations. The roles played by Community Health Representatives are as follows:

- Works with the health team to promote health and healthy lifestyles
- Promotes health in the schools
- Provides health screening activities at schools and other community events
- Uses local language and media as well as traditional ways of learning to advise on disease prevention and health promotion
- Promotes safe home environments (e.g. safe drinking water)
- Promotes safety and injury prevention
- Helps to maintain records
- Aids in water testing
- Helps in the cultural orientation of new staff.

Lay dispenser programs are also in place in a small number of programs so that medication and pharmaceuticals can be dispensed under strict guidelines.

10.3.11 The Regional Boards

While we run the risk of repeating much of what was described in detail earlier in our Report, it is obvious that the Boards play a significant role in the overall health care deliver system. The current model is a hybrid of roles, responsibilities, and services offered by the eight regional boards, Stanton Regional Hospital Board, the Department of Health and Social Services, and the federal government (this review has simply referenced some of the programs funded by the federal government, as they were outside the terms of reference of the study). The eight regional health and social services boards and Stanton Hospital Board have been given significant authority and powers, including the hiring and employing of staff. While the Minister of Health of the GNWT has retained final authority in most cases, the actual delivery of health services was, in large part, delegated to the regional boards and Stanton Hospital Board.

At the risk of over simplifying the picture, the regional boards were given responsibility for the following:

- Primary health care (where the resident first makes contact with the health system)
- Secondary health care primarily through care provided at the NWT hospitals (i.e. Stanton, Hay River and Inuvik). Secondary health care is more treatment orientated often involving specialty services. Stanton Hospital in Yellowknife offers a range of primary and secondary health care for all residents of the NWT.
- Tertiary care refers to complex health treatment, advanced or chronic conditions that often require specialty services. Patients requiring this advanced level of care are referred to hospitals outside of the region, primarily the University of Alberta Hospital in Edmonton. Occasionally other southern facilities become involved
- It is important to note the different sizes of the regional boards in terms of the people they serve. As noted earlier in the demographic section of this report, the population served by

the regional boards range from a high of 17,897 to a low of 386.

10.3.12 The Department of Health and Social Services

As we have stated previously, the Department of Health and Social Services obviously plays a significant role in the present health delivery system. Its key responsibilities are outlined in its "Ministerial Directives" dated July 1999, which outlines the responsibilities it will maintain, and those delegated to the eight regional boards and Stanton Regional Hospital Board. As well, these responsibilities are referred to in several other documents, including the March 1, 2000 Strategic Plan for the Department and the 2002-2004 Business Plan.

Among the many services which the Department currently provides to the system, the following are obviously central:

- Development of overall directions, definition of core services and health standards for the NWT
- Funding to the nine boards
- Assuring health standards are met throughout the NWT
- Primary responsibility for the public health of the NWT including population health and other responsibilities associated with the Medical Officer of Health
- Board support and business plan coordination
- Legislative review
- Financial analysis
- Coordinating specific NWT-wide public health initiatives such as tuberculosis and hepatitis B
- Chief coroner responsibilities
- Public guardian.

10.3.13 Current Issues and Observations

The fact that there is considerable stress on the NWT health and social services system appears to be readily accepted by the people who participated in our System Review. (As usual, the answers to the problems cited are less readily observable than the issues).

There are significant and serious issues emerging out of the data reviewed, including both the information gleaned from past/current reports as well as data gained first hand through interviews with hundreds of residents, board members, government representatives, and health care delivery personnel. These issues must be taken seriously. They include:

Wellness and Health Promotion

The national trend towards health promotion and wellness is also reflected in varying degrees throughout the Health and Social Services Boards of the NWT. It is a key direction outlined in the Business Plan of the Department. It is also a specified goal in the Boards' business plans. There are a multitude of local programs and workshops throughout the NWT orientated to health and wellness.

From interview information, it was clear that most people agree with this direction. While this overall program thrust appears to be quite solid, there is concern at times that the resources needed for these programs are sometimes diverted to other components of the health system that are traditionally expected in the communities. This is a matter for continued vigilance.

Newness of Staff

In one region, one of the local staff said "Three years ago I knew every one of our forty nurses on staff by name. Today I know the names of three." A major review of the health system four years ago

stated: "The level and quality of care provided in the Health Centres is directly dependent upon the level of preparation and experience of the health and social service professionals who are responsible for providing service" (Med-Emerg). This "newness" manifests itself in all sorts of ways that insidiously undermines the health care system.

A comprehensive review of the turnover of nurses four years ago stated that the average length of time a nurse stays in her position is 1.8 years. During our visits and tours of the health centres, many of the employees talked about how "turnover" and "newness" of staff is having considerable impact on all sides of the health delivery system. The issues of a lack of recognition of the patients, having to gain trust in difficult circumstances, lack of consistency in care, inappropriate medevacs, and so on were frequently cited. This is not to say that all centres felt an urgent sense of crisis as many of those involved were functioning quite well despite the considerable turnover of professional resources.

For example, one member of the study team spent time in a dynamic and well-run larger health centre. The fact that it was able to function so well defied some odds, as all four nurses were new, with the nurse in charge being appointed to that position six months after she joined the staff. In this case, and likely due in large measure to the caliber and attitude of the nurses involved, this health centre was somehow managing and did get through the crises of the past year.

Some of the problems this "newness" creates, however, are noted as follows:

Increased medevacs and the resulting increase in costs.

As one interviewee said " a new nurse plus a new doctor equals medevac". In other words, an inexperienced nurse in a small northern community talking to a new inexperienced doctor in a hospital emergency department often leads to a decision to authorize a medevac. A more experienced nurse or doctor may have determined that other measures were more appropriate.

Burnout

This was very apparent as more and more interviews were completed. This is a serious problem that is increasing, and is directly related to the number of people leaving their positions and new people being hired. There tends to be vacancies created in the system that cannot be filled right away. As a result, community nurses who are left have to work harder without as much time off.

This burnout factor is also related to the significant amount of time required to train new staff members. One nurse in charge says she must spend one week training a new nurse, who often is on an "indeterminate" or temporary three-week contract. Another respondent says she keeps a telephone diary current as she has a difficult time remembering what she said to whom as she is continually in the training mode. One region updates their telephone registry of staff every month due to turnover rates.

Quality of Health Care

It is difficult to prove beyond doubt that the quality of health care is directly related to turnover and newness of health professionals. However, a gradual eroding of the quality of health care is a deeply felt opinion, held by many of the experienced professionals in the NWT.

Many examples were cited in the interview process. However, most of these examples had other multi-faceted

dimensions which pointed to a probability of other factors also being involved. An example was the TB tragedy that occurred last year. Many factors were involved in this particular situation; however, some professionals interviewed felt that inexperience resulting in some measure from the degree of turnover may have played a role.

Health Centres with One Nurse

There still are a few health centres in the NWT that have only one nurse in the community. The trend across the country is to eliminate one-person services whether they be RCMP detachments with one member, or one nurse operating out of a nursing station. The majority of people interviewed were of the opinion that the time has come and gone for such health centres. One such nurse interviewed indicated she is on call 24 hours a day, is expected to come to work at the regular time regardless of any emergencies that happened during the preceding night, and cannot claim overtime unless a patient is in the clinic in person. This is a prescription for burnout, personal safety issues or sublevel patient care.

Health Centres and Community Education

Most health centres have one "CHR" (Community Health Representative) on staff. These people tend to be local and work in the community promoting wellness, health education, and in general, being a link between the nursing station and the community. These positions are vital to carrying out the mandate of the regional Boards and the Department in promoting wellness, encouraging appropriate life style changes, and in providing further opportunities for community education.

In some cases, the community nurses on staff were not very familiar with the functions of the CHR's. However, this gap appears to be closing in many instances. One of the interesting observations was some minor envy being expressed by community health nurses regarding the educational opportunities offered to the CHR's. Nurses are having serious difficulty in taking advantage of educational programs because of the turnover and vacancy problems identified earlier.

Continuing Care

The Health and Social Services Boards are all involved in some aspect of continuing care. These services include: home care, supported living and long term care and are provided to people in their own homes; in group accommodations; seniors housing units; and other related facilities.

The overall goal of this key program is to assist people to live in their own place of living and their own communities for as long as is reasonably possible. This concept, often referred to now as "aging in place" has shown great potential in increasing the sense of independence while, at the same time, affording the system with more time to prepare for an orderly transition for people who may need increasingly higher levels of care.

The experience in the NWT has shown that:

- An increasing seniors population is placing more demands on the continuing care structure and resources
- Increased levels of intervention are resulting in people living longer and enjoying healthier lifestyles
- More and more people with disabilities are becoming aware of the services and are now entering the system
- Supported living arrangements are full; additional capacity is required

- Smaller communities are beginning to express an interest in becoming involved in offering a broader spectrum of continuing care services
- There have been and will continue to be considerable difficulties in recruiting home care workers.

The Department, with the advice and help of the Boards, is in the process of putting together a report on the "continuing care framework" which will hopefully address some of these critical issues and put them on a more strategic and planned footing.

Public Health Programs

The Department has an obligation through the Public Health Act to ensure that its public is protected relative to matters of public health. This, it attempts to do through limited departmental manpower and a reliance upon the public health staff in the regions. The Department plays a lead role in reviewing and updating the protocols and in disseminating information out to the regions. The MOH also travels out to the regions and provides direct counsel and suggestions to the regional staff through in-services and through the issuance of directives.

However, there is not any direct way it can closely monitor the progress of a health initiative that in turn is carried out by regional Boards. Due to limitations in terms of roles/responsibilities as well as to the shortage of staff resources in this important area, the Department (and the MOH) rely heavily upon the cooperation received from the Board staff. This necessitates sound linkages between both components of the broader organization which may not always occur due to the high degree of turnover in professional resources.

As a result, by the time the Department realizes there is a problem relative to a public health concern or threat, it may be a considerable period of time after the fact. In one region, there are approximately 1000 charts of individuals that need to be monitored. It is unlikely this can happen in an ideal way given the fact that community health staff are continually "running to get caught up" with the day to day demands on their time and resources.

Access to Health Services

With all the human resource problems being experienced in the smaller communities particularly and in the health centres, medical clinics, and other components of the system, the system is still working.

While the problems associated with the delivery of health care are definitely increasing, it is still impressive to see how accessible the system is in the NWT. This is particularly the case in the health centres. Residents of most of the smaller communities in the NWT have good access to the primary care system. Despite the particular problems with nurse turnover, "newness", and burnout, the staff is still somehow able to function in a professional way. There are, however, problems associated with expected accessibility to care.

Residents can usually access a health centre and see a nurse within 24 hours, often within several hours. In fact, because of the expectations built up over years and years of being very available to residents, the demands for instant treatment can be significantly and, quite frankly, unreasonably high. Many people specifically mentioned in their interviews that medical access is much better than what people have "in the south" or "in the cities". Waiting times are much higher in Yellowknife and Inuvik, but people still can access health care when it is needed.

Specialty Medical Services

This is more problematic. It is commendable that there are regular community clinics where medial specialists see patients on a pre-arranged appointment basis. However, the wait can be long, depending upon the specialty involved. While many patients can be treated appropriately and in a satisfactory manner, others experience significant frustration if they have to travel long distances to Yellowknife or Edmonton.

Alcohol and Drug Issues

Unfortunately, the abuse of alcohol and drugs continues to be a major problem in our society, and in the Northwest Territories. The relationship between substance abuse and family violence, emergency services, and utilization of the health system is clear. Respondents in some of the health centres said 80% of their emergency work is related to alcohol and drug abuse; others said substance abuse is definitely a factor in a significant number of visits to their health centres.

As a result, it is probable that alcohol and drug abuse is a major determinant of costs for the health care system in the NWT. Some of the regions feel the problems are getting worse, especially with regard to drug abuse. Some people interviewed, including staff and board members, feel virtually powerless over this situation and express real concerns because of its tragic and far-reaching impact throughout the communities.

This is a particularly difficult situation in the smaller communities. Not only are there few career positions or employment opportunities, many in the communities sense real frustration in addressing problems due to substance abuse and teenage pregnancies. The fact that some people are trying to provide models of a healthy lifestyle and safe places for their youth to visit after school is encouraging. Unfortunately, the cycle of abuse has many families in its grip. While this Report has as its focus the issues of health and social services, the problems which are faced are even more multi-disciplinary. Although this is not a short term issue, the leaders of the communities and of the NWT must be assisted in examining real opportunities for improved, quality lifestyles and healthier living.

It is our view that the absence of a strong program of leisure services is handicapping the acquisition of healthier lifestyles for the young people of the communities. There needs to be more and healthier outlets for the energies of the youth. Given the enormous societal costs of dealing with the impacts of drugs and alcohol, there would appear to be a solid argument in favour of the construction of recreational facilities and the development of related sports and recreation services. Simply trying to address the visible scars of substance abuse will likely be a never-ending and largely futile cycle.

Fragmentation of Service

People generally feel that the present health system is quite fragmented and growing more so. This is most likely caused by many different factors. Some of these are listed as follows:

Number of Regional Health and Social Services Boards

There is a widespread perception throughout the NWT that there are too many Boards. In general, people feel that the health system cannot be sustained using the current nine-board model. Outside of some clear-cut hospital services which stem mainly from three Boards, each region is trying to offer many of the same programs and services to their population. With staff vacancies and a

perpetual need to train new staff, programs can suffer.

Some projects may be delayed for an unacceptable amount of time as a result of these factors. An example of this is related to the hepatitis B program being promoted by the Department of Health and Social Services last year. It was reported by some regional health representatives that the timing for the completion of the program had to be deferred because of other urgent work in the region. This happened despite the Department's public health concerns (e.g. potential outbreak). Furthermore, it was commonly reported that smaller regions had more difficulty recruiting for positions requiring special expertise such as information technology, finances, and human resources.

Staff Turnover

High staff turnover and the resulting increase in vacant positions in the system can only add to this problem of fragmentation. This is an issue which unfortunately has not become as public nor as seemingly significant in the eyes of some of those in the system given the almost constant effort being placed on recruitment of new staff. Unfortunately, this turnover of staff is a significant factor in the problems related to us by those working in the field. A higher than normal degree of turnover can potentially result in a lesser degree of health care simply due to the lack of familiarity with the system and the patients. For example, it may result in a new and overworked inexperienced health professional to overlook some reasonable options when considering health care alternatives for patients.

Medevac Procedures and Protocol

How decisions for authorizing medevacs are made, and whether or not a receiving hospital is involved in the decision, appears to be partly related to the number of Boards in place. It is our understanding that there is a considerable degree of inconsistency in the circumstances which drive the request for medevac transportation among the nine Boards.

Pharmaceuticals and Formularies

Since the delivery of health services was given to the regional health and social services Boards, there has been some concern expressed regarding pharmaceutical protocols and education. Apparently each regional Board is supposed to have a "Formulary" which is an up-to-date manual of available drugs and a resource book on pharmaceutical drugs which can be administered in a specific facility/health centre. The concern expressed by several interviewees was that these resource books are not consistent across the regions, that they may be out of date, and that they may even be lost.

This points to another related issue. There is some discussion about the need for a centralized pharmaceutical consultancy service, whereby one person would be able to assist the regional Boards with on-going monitoring and education. This is clearly a gap in the present system given the increasing complex nature of the drugs that are coming out on the market.

Shortage of doctors

The NWT is experiencing a shortage of both nurses and doctors. It is having a negative effect on health care in all of the regions. The nursing shortage has been referred to in other sections of this Report, and will not be addressed in further detail here. However, the increasing shortage

of doctors needs to be examined in greater detail. The NWT Medical Association has done a considerable amount of work identifying the numbers of doctors needed to create a "critical mass" for sustainable medicine. In their opinion, there is an increased need for more general physicians and medical specialists. The numbers of physicians required depends upon which model of analysis is chosen. The two options are outlined below:

Population Model

This method utilizes the ratio of doctors to population based on recommendations of the "Federal/Provincial/Territorial Advisory Committee on Health Human Resources" of .94 family physicians per 1000 people.

Using this population formula alone indicates a need for a total of 39 physicians immediately, increasing gradually to 49 physicians by the year 2019. It was previously estimated that the present number of physicians working in the NWT is approximately 28-30. This formula depicts a current shortage of at least 10 physicians.

The "Service Delivery" Model

This model incorporates other factors such as distance, conditions, geography, and the "critical mass" concept. Using this method of determining the number of physicians needed at the present time, the NWT Medical Association arrived at a figure of 58 family physicians. That is approximately double the number of physicians currently practicing in the NWT.

Number of Medical Specialists

Using the population model of calculation, the number of specialists needed ranges from 38 currently to over 47 in the year 2019. As indicated earlier in this chapter, there are 16.4 medical specialist positions currently filled. The shortage of specialists for the current year would be in excess of 20 and rising as the population increases to a shortage of 30 by the year 2019.

There is a clear shortage of doctors even if one uses the conservative population based method in formula estimations. In the past year, a significant number of doctors have apparently sought employment opportunities outside of the NWT. In Inuvik, it was reported that six doctors have left. One doctor who has practiced in the north for many years feels that the number of doctors fluctuates rather dramatically every so many years; he feels it is not a trend. However, he is also very strong in stating that there is nevertheless a basic doctor shortage.

This shortage is manifesting itself in different ways. In Inuvik and Yellowknife, the waiting time to see a family physician has increased reportedly quite significantly. In some cases, people were reporting a ten to fourteen day waiting period. It should be noted, however, that these appointments were not of an emergency nature. People can access the system through outpatient or emergency services if such was the case.

As a result the waiting times being complained about may be more of an inconvenience than a serious problem. The more serious problem relates to the increasing demands that are made on the doctors themselves. Several doctors reported that this is a difficult time, not only because of the excessive demand, but also because of all the new doctors continuing to come in through locums. Several doctors are very concerned and fearful that the "critical mass" of physicians and specialists needed to

sustain good health care is not happening.

Alternate Forms of Health Care

The GNWT have shown creativity and boldness in the past in the way they have supported the expanded role of the community nurse and the lay dispenser program. In those communities that do not have a community health centre, there tends to be a local person who has been chosen and orientated to serve as a lay dispenser of certain medical supplies and pharmaceutical products. The gradual support of midwifery and the proposed nurse practitioner program are other examples. Further to this trend, several health centres provide office space and support for alcohol and drug workers that are usually funded through other programs. These programs are being accepted more and more as time goes on, and are gradually being viewed as an integral part of health education. There may be other opportunities to explore additional alternate forms of health care delivery in the future.

Outpatient and Day Surgery

There is a national trend towards outpatient and day surgery services, and this trend is also being experienced in the Northwest Territories. The Department reports that over half of the population of the NWT received an outpatient service each year between 1994/95-1998/99. The two populations most likely to access such services were seniors and infants. Those living in regional centres had the highest use of outpatient services which the Department views as not surprising given the fact that most of the visits with physicians take place within a hospital. Even where there are clinics outside of the hospital, residents still use outpatient facilities particularly outside of normal clinic hours or when they perceive that the wait will be too long.

Despite the high percentage of usage of outpatient services, it was pointed out that this was at significantly less cost than in hospital stays. The use of the outpatient service is reflected in occupancy rates of hospitals and the number of emergency visits made to the hospitals. Both of these utilization rates do not pose an overcrowding threat to the ability of the facilities to accommodate people in need. The problems being encountered are more related to shortages in the professional health field and to the annual rising costs of hospital services which are projected to double over the next two decades.

Mental Health

An area of growing importance and concern is that of mental health. Based on our interviews, we sensed a very serious level of concern that mental health services are falling behind the needs which have been growing throughout the NWT. Unfortunately, neither the actual number of service providers nor the number of professionals has kept pace with the demands.

According to the information which we received, the Department provides direct funding for a few mental health services, with the majority of funding going to the Boards. The Department funds:

- **consultant positions** in Mental Health as well as in the other wellness areas (Family Violence Prevention, Addictions, Community Wellness, Health Promotion);
- **contribution agreements** with Canadian Mental Health Association (funds provided for mental health promotion and for HELP LINE), and with the NWT Residential School Interagency Committee for victim supports;

southern psychiatric treatment and support services contract with Alberta Hospital; and

the Northwest Territories **Suicide Prevention Training**, with the intention of transitioning this program to boards and communities.

There are various agencies where support is available for residents of the NWT:

Western Arctic Helpline and HIV/AIDS Information Line: 920-2121 or 1-800-661-0844 (crisis telephone counselling & referral, 7 - 11 p.m. daily)

Stanton Hospital Psychiatry Unit: 669-4140 (24 hour response and respond to requests for critical incident stress debriefing (CISD)

Employee & Family Assistance Program: for GNWT employees. Call toll free 1-888-476-0421. Counselling provided by Northstar Counselling

Independent Clubhouse: psychiatric drop-in centre in Yellowknife. For telephone support outside of Yellowknife, call toll free 1-888-268-7708

Health and Social Services Boards

The boards are expected to provide a continuum of mental health services with their core health and social services funding. Mental health and supported living programs also meet the criteria of the Strategic Initiatives Fund.

At a minimum, all boards have some Community Social Service Workers (CSSW), nurses, home care workers, RCMP, teachers, A&D workers, and visiting or resident physicians, who provide mental health services as best they can. All boards also have access to psychiatric services for adults at Stanton Hospital or outside of the NWT. Psychiatric services for children are limited to infrequent visits of a child psychiatrist to Stanton, residential treatment services for children in care, and southern treatment.

Some Boards (most notably Inuvik) have been able to hire community mental health workers and/or regional mental health specialists, or develop a regional counselling centre (Inuvik, Yellowknife and Hay River). Some boards have access to a visiting mental health specialist from the Stanton Mental Health Clinic, and others contract with psychiatrists and/or mental health specialists directly. Some boards have a safe shelter and some have long-term care facilities. Some boards have chosen to fund regional training and/or healing workshops.

Stanton Regional Hospital has a 10-bed psych unit for adults, a visiting psychiatrist and child psychiatrist, and a Mental Health Clinic that provides counselling in Yellowknife by referral from physicians, and that also provides visiting mental health specialist services to a number of communities.

Other psychiatric supports in Yellowknife include: a psychiatric group home and supported independent living (open to all territorial residents); and a mental health drop-in center. These contracts are administered by the Yellowknife H&SS board; we note that other centres (e.g. Inuvik, Hay River) also have good support programs for the mentally ill.

Community

Aboriginal organizations and communities have access to a considerable amount of federal

community wellness program funding (including Brighter Futures, Prenatal Nutrition, Addictions, and Aboriginal Head Start programs). In 1997-98, nearly $3 million was allocated to Western NWT communities under the Brighter Futures Program. Mental health programs make up the majority of Brighter Futures spending, and include on-the-land programs for youth and friendship centres. In 1999-2000, more NWT communities applied for and received funding through the Aboriginal Healing Foundation to support healing activities in response to residential school abuses.

Communities have been successful in developing specific committees to respond to the needs of their residents. Actions such as Suicide Prevention/Response Team, Residential School Healing Circles, and Wellness committees use the expertise (often volunteer) of community members and promote teamwork.

Non-Government Organizations (NGOs)

There are many NGOs which provide mental health services, such as the Yellowknife Women's Centre and the Salvation Army. The Grollier Hall Residential School Healing Circle has territorial links with community caregivers who are currently forming the Western Arctic Caregivers Association. Somba K'e Trauma Treatment program (funded through Aboriginal Healing Foundation) provides residential trauma recovery for survivors of residential school abuses or the intergenerational effects of residential schools.

Private practitioners (social workers, therapists, psychologists) provide therapy, group work, and workshops for a fee. Most have an area of expertise, and many are willing to travel and contract directly with boards and communities.

Environmental Health

One of the most important yet largely overlooked elements of the public health system is that of environmental health. Those who work in this field are charged with ensuring that the appropriate measures are taken to protect the population from disease and dangers caused by a lack of attention to the most basic of services (e.g. potable water; sewage treatment; food preparation and storage; etc).

The key issues which were brought to our attention as being of most concern to those working as Environmental Health Officers are:

- The often isolated conditions where some of the staff must conduct their work
- The lack of supervision available because of the small numbers of those actually working in this field
- The reporting structure is somewhat convoluted in that the EHOs are expected to report directly to their designated supervisor within the Boards and yet also on a professional and statutory obligation sense to the Medical Officer of Health
- The fact that those in the communities outside of Yellowknife are generally reporting to people who are not trained in this field
- The fact that finding replacements for those who leave is very difficult resulting in the Department trying to fill in where possible; the absence of EHOs can render a community particularly vulnerable due to a lack of adequate inspections.

Integration of Health and Social Services

One of the issues which came to our attention during the course of our work was the impact and effectiveness of merging the health and social services into one portfolio. As might be expected, this has received mixed reviews. Some have argued that the current "marriage" of these two program areas has been very helpful; others that it is not worthwhile and, in fact, has been detrimental; others convey that it is only partially working. As expected, it appears to be working better in some areas than others. While there has been some overall progress in this area, there remains much to do.

In terms of what we found, the vast majority of those with whom we spoke conveyed to us the message that, despite any reservations, the combined model has great potential. On the positive side, we heard that:

- Patient case management has gradually been improving at least in some jurisdictions
- Professional collaboration in smaller communities is essential if the patient is to receive quality care
- It is important to understand what is happening in the life of the patient and his/her family in order to understand the milieu and its impact
- The cost of delivering service is lessened by the availability of both professions in relatively close proximity; information can be readily shared (if those involved are willing to do so).

From those who felt that the shared platform was not as effective as anticipated, we heard:

- The needs of the medical system overwhelm those involved in social services
- So much of what those involved in social services do is largely hidden from the general population; only when the system or people fail, does the work of social services professionals and support workers receive much attention
- The need for new dollars in health results in a disproportionate share flowing in that direction
- Some of those in the health professions are still very reluctant to share patient information and tend to hold onto the confidentiality constraints.

While we tend to see greater merit in the arguments in favour of shared services and information, we recognize the legitimate concerns of those who feel that case management is difficult due to confidentiality requirements. It is important to state that this concern can also be a defensive way of expressing a desire to stay with the "status quo". The search must be for finding ways of eliminating the barriers to implementing a case management and consultative system of cooperation, especially when both "health" and "social services" are part of the same department.

10.4 Current Social Services Delivery Model

10.4.1 Background and Observations

One of the key findings of our review was the surprisingly high degree of commonality of concern relative to the impact of social problems vis-à-vis the "health" of the community. While the sheer costs of providing health care tends to dominate any discussion or analysis of health **and** social services, the actual focus of much of what the organizations are involved with lie more in the realm of social services. Indeed, a good portion of the time of the administration of the

Stanton Hospital is spent on resolving "social" types of concerns or social causes of illness. This observation lends added weight to the argument in favour of social services being intimately linked to healthcare.

The visionary document produced by the Members of the 14th Legislative Assembly, Towards a Better Tomorrow", includes as one of its "vision statements" the following

> *"Self-reliant, healthy, well-educated individuals, families and communities doing their part in improving the quality of their own lives".*

It is interesting to note that the number one priority and number one strategy are both directly tied to social well-being. The Government's first priority was expressed as "self reliant individuals, families and communities, working with governments, toward improving social well-being". Similarly, the first strategy is "Promoting healthy lifestyle choices". We also note that the Department of Health and Social Services own Business Plan 2001-2004 has as its second goal "Improve social and environmental conditions". These are key indicators that the Government is serious about addressing the issues at hand and finding significant and sustainable ways of moving forward.

The Final Report of the Minister's Forum on Health and Social Services "Our Communities Our Decisions" was submitted in January of 2000. It spoke to many of these issues and highlighted five action priorities. Of these five, three of them deal with social well-being: giving people the training to do the job; dealing more effectively with substance abuse; and recognize and involve the NGOs more fully in the system.

As usual, the dilemma is not whether or not the leaders of the Government or the Department believe in the importance of personal and community well-being. As responsible people, each understands that there are major societal problems which will be on the legislative and departmental agenda for the foreseeable future. Rather, the difficulty lies in understanding which measures can be taken which get at the heart of issues and which make substantive difference. As a sweeping and over-simplified view of the issues, it appears to us that the greatest challenge is in helping both communities and individuals assume responsibility for their own stake in these matters.

The very recent Social Agenda Conference (June 2001) heard an address from the Minister of Health and Social Services who spoke of the very significant and troubling issues facing individuals and communities today. The Minister said "As leaders and front-line workers, we are only too aware of the social challenges facing our communities. It is unacceptable for us to turn a blind eye to the disparities that exist within our own communities. While many Northerners are achieving higher levels of education, are sober and are healthy, too many of our people are still struggling with grief, trauma and addictions".

Government programs, no matter how well intended, will regularly fail to live up to their expected targets if they do not directly involve personal efforts and ownership by those the Government is intent on helping.

10.4.2 Effectiveness and Efficiency of the Present Model

There is little doubt in our minds that, whatever the ongoing stresses and perhaps failures, the concept of placing health services together with social services makes a great deal of sense. The issues being addressed are all focused on the health and well-being of the citizens. These are not areas which

can be separated nor, in our opinion, should they be.

The Department recognizes the need for more of an integrated approach to service delivery. Their plan "Shaping Our Future: A Strategic Plan for Health and Wellness (1999) states that "People wish to see better coordination and integration of programs. A common concern is that services do not consider the needs of the person or the family as a whole".

As a generalized statement, we believe that the key agencies involved in service delivery are largely focused in the appropriate direction. There seems to be a genuine recognition of the problems and trends and a desire to take measurable and realistic steps to address these. This philosophical underpinning is perhaps best summed up by the following statement in the 2001-2004 Business Plan of the Yellowknife Health and Social Services Board herein the Board states "Health promotion, prevention and early intervention are at the core of all programs and services provided by the Board."

What appears to be lacking is an over-arching strategy and commitment by all the key players to achieving that type of philosophy and goal. Thus, while we commend the work to date by both the Department and by the Boards, there remains the need for all of the key players to be at the table discussing and arriving at an agreement as to what role each should play. While it might seem to some to be of little apparent value as an action measure, we will be recommending that a Forum on Personal and Community Well-being be held within 90 days of the adoption of this Report to begin the drafting of an NWT Health and Social Services Plan which sets out the respective roles and commitments of each of the stakeholder groups. Such a Forum should be devoted not to rhetoric but to a commitment to action. We envision a small select and representational group who will be empowered with the task of drafting principles and action steps for not just individual groups, non-governmental organizations and the private sector, and communities, but for the NWT as a whole. Such a task force should be placed under the guidance of the proposed new NWT Authority.

Ideally, each of the three Regional Services Authorities and as many Community Services Councils (as recommended herein) (or individual communities) and representatives of NWT-wide NGOs as are willing to be participants should sign off on the statements of vision, priorities and immediate action steps. Annual Forums should be scheduled thereafter which are focused on identifying areas of progress, best practices and challenges. One of the values of such a Forum will be the recognition that, in spite of the many challenges and even setbacks, that real progress is being made on many fronts. Too much of the collective energies appear to be spent on what is not happening. As a result, the real successes, which are occurring, may not be achieving sufficient recognition.

While we will comment generally on various programs and initiatives such as Child Welfare or services for persons with disabilities, it was not within our mandate to conduct detailed assessments of these programs. Other recent studies have looked at issues related to these and other programs and have made specific recommendations. Our assessment will be focused largely on what structural or delivery impediments get in the way of an effective and efficient delivery of social services.

10.4.3 The Current Social Service Model

As was stated earlier in this document, the Department of Health and Social Services is mandated to provide a broad range of health and social services to citizens of the Northwest Territories. For the purposes of this discussion, social services are considered to be:

- Mandatory services as required by the Child and Family Services Act (e.g. child protection and adoptions); and
- Services provided at the discretion of the Department of Health and Social Services (e.g. addiction and family violence services).

The Department and eight regional Health and Social Service Boards jointly govern the delivery of core social services throughout the territories. The roles and responsibilities of these governance partners are articulated in a variety of documents, including, but not limited to, legislation (e.g. Child and Family Services Act), policies, contribution agreements and ministerial directives. For the most part these roles and responsibilities have been articulated either elsewhere in this document or in other more specific documents such as *It Takes a Community*. They will not be repeated here.

For the most part, core social services are delivered either by regional board staff (e.g. social workers and other professionals such as psychologists) or through contribution agreements between Health and Social Service Boards and various professionals and community organizations (e.g. town councils, not-for-profit societies or not-for-profit corporations of aboriginal bodies).

Although some differences exist, the social service delivery model that is being used in the Northwest Territories is similar to models used successfully in several other Canadian jurisdictions. In order to provide a high-level assessment of the health of the social service system, six lines of inquiry were pursued:

- Are the purposes of the social service system, sufficiently clear, adequate and effective?
- Are roles, responsibilities, authorities and accountabilities clear?
- Do relationships among stakeholders within the system support the delivery of top-quality social services?
- Does the social service system have the capacity/capability to fulfill its responsibilities?
- Is the social service system able to measure its performance in relation to effectiveness and efficiency; and
- Is the social service system sufficiently adaptable?

Other elements of the systems that support the delivery of social services were also studied and reported on elsewhere in this document (e.g. financial management, structure).

The information used to make the following assessment was gleaned from personal interviews, historical documents and from our own observations.

Purpose of the Social Service System

The purpose of the social service system is articulated in the mission, vision, principles and goals of the Department of Health and Social Services. These have been outlined earlier in the document and will not be repeated here. More strategic direction is provided in the principles of the Child and Family Services Act.

Observations and Comments

- We consider the Department's mission vision, principles and goals, together with the principles of the Child and

Family Services Act to be clear and appropriate guidance for the delivery of social services.

The strategic underpinnings noted above are comparable to those of other jurisdictions in Canada's social service sector.

Generally, Department corporate staff and regional board CEOs were familiar with most of the organization's strategic underpinnings.

While regional child welfare staff were generally familiar with the principles of the Child and Family Services Act, they appeared to be less familiar with the Department's mission, vision, principles and goals;

Overall, regional board trustees and line staff unrelated to child welfare were least likely to be familiar with the strategic underpinnings.

It was our overall sense, that in spite of well-articulated mission, vision, principles and goals, regional Boards see themselves as quite separate from the Department as a whole. There is considerable evidence that the Department and some regional boards act quite independently from each other, relative to the purpose and priorities of the Department. As a result, regional Board alignment with the overall intent and direction of the Department is loose, at best.

It is our assessment that the composite delivery system is not sufficiently focused relative to strategic intent and will continue in this vein unless all stakeholders within the system develop a deep commitment to a cohesive and coordinated mission, vision, principles and goals. Unless unity of purpose is quickly established and sustained within the Department, regional boards and other entities will continue to work at cross-purposes and will under-perform.

Strong senior leadership will be required to bring the social services delivery system to the place of pulling together, rather than apart.

Clear Roles, Responsibilities, Authorities and Accountabilities

The Department of Health and Social Services is an organization in transition. Health and Social Services have been amalgamated. Regional Health and Social Service Boards have been established to share governance responsibilities with the Department. Power and authority has been radically decentralized. Child welfare has undergone a major overhaul. More changes are on the way. As one might expect, many of those within the Department of Health and Social Services have had to assume new roles, responsibilities, authorities and accountabilities.

Two main questions arise:

Are Department roles, responsibilities, authorities and accountabilities clear; and

Are these roles aligned between the Department and the regional Boards?

Observations and Comments

Most regional Boards report being confused about their governance roles, responsibilities, authorities and accountabilities, relative to the Minister and Department executive managers.

There is also considerable evidence that the Department, as a whole, is quite often in a crisis intervention mode. This apparently results from the fact that there are so many pressures being brought to bear on the Department from so many different quarters. Every issue takes on the appearance of a singular priority whenever the public is able to get the ear of their legislators, who then

question the Department as to what is happening. This leads to more tension due to the perceived need to not only provide an answer but also to "do something" about the problem.

Several Department corporate managers reported that they understood their roles and responsibilities, but expressed apprehension about carrying them out because they feared political censure.

Several CEOs reported role and accountability confusion relative to the Boards they report to and executive staff of the Department.

Many Health and Social Service Boards focus most of their attention on health services. In most cases, social services are all but forgotten by community governance bodies. This leaves social service staff and managers seriously under-supported by critical governance, leadership and accountability functions;

There is evidence that accountability gaps exist in the delivery of social services. The Child Welfare League of Canada Report identifies several of these.

Front line social workers and other professionals appear to be least confused about their roles and responsibilities. However, as a whole they feel abandoned by governance bodies, regional CEOs and in some cases by their immediate supervisors who carry heavy workloads and who are, in some locations, unable to provide necessary clinical support and supervision to staff.

It is our general assessment that unclear roles and responsibilities constitute a significant threat to the organization and to the responsible delivery of services. This lack of clarity is pervasive within all levels of the organization. The organization will continue to limp along from crisis to crisis unless immediate action is taken to clarify roles, responsibilities, authorities and accountabilities.

Relationships among Stakeholders

Achievement of the Department's social service mandate is wholly reliant upon effective partnerships, collaboration and cooperation. This is particularly true in organizations where governance is shared between Departments and regional boards.

Our Observations and Comments

Overall, it appears that relations between the Department and the Boards have been tenuous and suspicious at best. In part, this is due to the natural tension that typically exists between corporate offices and regional entities. There are other reasons for strained relations. Examples include:

conflicts about priorities for particular regions;

frustration related to role, authority and accountability confusion;

political tensions related to land claims and self-government;

residual application of command and control methodologies; and

conflicts have arisen and lingered in relation to business plan approvals.

Regional Boards tend to compete with each other for scarce resources. At times, the intensity of these competitions appear to compromise the unity of the system; and

We also found numerous examples of strong, healthy relationships. Staff were happy to work cooperatively with each other and with the

representatives of the Department. It was our sense that where this desire for a complementary relationship was present, children and adults clearly benefited.

The birth of a fundamentally new way of doing business (devolution) will generally create friction within an organization. To a significant extent, this has been the case with the devolution of the Department of Health and Social Services. We are of the view, however, that fundamental conflicts and tension among stakeholders, particularly those between the Department and regional boards, have gone unresolved for far too long. In many situations, prolonged conflicts have tended to hamstring and undermine the development and delivery of effective social services.

Leaders at all levels of the organization must act now to resolve conflicts and to systematically support the development of strong ongoing relationships among all stakeholders.

Capacity

The question here is: does the Department, including its Boards and NGOs, have the capacity to meet the social service needs of its citizens? This issue, in many ways, gets at the heart of the concerns relative to the delivery of social services. On the one hand, the system is plagued by a shortage of seasoned professional personnel. On the other, the nature of the organization of resources has resulted in too many of the resources being placed in administrative capacities. The focus obviously needs to be placed upon getting the right resources to those most in need of assistance. That is what happens on the front lines.

Observations and Comments

It is a major challenge to meet social service needs in the territories, given the economic and social conditions that currently exist.

We do recognize that the Department and Boards have poured considerable resources into these areas. Much of the work is done at the Board level where the focus is on the three core areas of: child protection, child and family services, elderly and handicapped services. We were particularly impressed with the dedication and commitment of social workers and other human service professionals who continue to deliver services amid increasing work pressures and in challenging environments.

Overall, caseloads are increasing and budgets are being driven upward. The workers frequently relative to their frustration in simply meeting the most urgent of the challenges rather than having any time for longer range planning or for more preventive concepts.

According to those we interviewed in the field, at least some of the people are not receiving the services they need (e.g. persons with disabilities, people with FAS/FAE, victims of violence). Often, these people tend to be some of the most vulnerable citizens.

Some people are required to move to other regions or outside the territories to receive needed services. The Department spends more than $2.6 million per year on southern treatment for NWT children.

Capacity to deliver social services is uneven. That is to say, there is more capacity (or less sense of crisis) in some regions than in others.

It is difficult to recruit qualified social workers and other human service

professionals. This is dealt with elsewhere in this Report.

Although it is difficult to retain staff, there is a fairly solid base of seasoned social workers.

The availability of related professional services (e.g., psychologists) is limited in most regions outside of Yellowknife.

Overall, it appears that leaders and managers within the system lack some of the basic competencies needed to carry out key responsibilities required by a shared governance model. While this is the case in most jurisdictions where shared governance models have been adopted, it does not have to remain that way. Other jurisdictions have initiated competency-based, job related training initiatives to retool managers and other employees for their new responsibilities.

The Department has identified the need to provide more and better competency-based training for human service professionals, including social workers. While some good work has been done in this area, particularly in child welfare, much more needs to be done in order to ensure the availability of qualified staff.

In most regions, social service staff tended to have poor morale. Many reported feeling over-worked, under-appreciated, neglected and underpaid. Staff in rural areas reported being scared, isolated and unsupported to do their jobs.

We found no evidence of attempts to systematically increase capacity by improving the efficiency of social service operations. Unfortunately, too much of the focus remains with how the system is managed and able to respond to public criticism rather than actually placing resources at the disposal of communities and those in need.

Value-for-money received some lip service. However, we found no evidence of a system designed to measure value-for-money in the delivery of social services. It appears that the typical response to increased demand for services is to request budget increases.

We found no evidence of local or system-side incentives to reward responsible service cost reductions.

While there is a wide range of people involved in various aspects of the delivery of social services, there are also serious shortcomings that must be addressed on an ongoing basis to ensure that those in need are able to access those with the training to help them in the coping with the stresses of daily living. Left unattended, these gaps in capacity increase health, safety and well-being risks for vulnerable children and adults. This is not just about increasing the numbers of professional workers in this field. A far more comprehensive strategy is needed if the overall system is to respond as anticipated.

Measuring Performance

Measuring performance is not a luxury in today's public service environment. More and more, leaders as well as community residents are questioning what results are being achieved from the resources being applied. The question which must be asked: "Is the Department able to measure the ability of the health and social services system to deliver quality social service performance and results?"

Observations and Comments

It was reported to us that standards and policies exist relative to Child Welfare and other social services. We were also told, however, that there

have been ongoing problems relative to data not being systematically collected that would enable an accurate determination of whether or not program standards are met or policies are consistently applied.

The Department does not appear to have the capacity to fulfill its monitoring responsibilities for the system. This will have the inevitable impact of increasing the potential for risk for clients and for the Department.

We found no evidence of system-wide use of performance indicators or measures in the delivery of social services. The culture of the Department is not oriented to measuring results or continuously improving effectiveness and efficiency. While this has begun to be addressed more recently, the focus quite frankly has been on stemming the fires and crisis points. While we appreciate that this may always be a part of the milieu in the NWT and in social services particularly, it does not negate the need for continual improvements in the evaluation of results and a focus on targets and outcomes.

Most of the staff that we interviewed, reported not having had performance appraisals for years; and

Other than the new Child and Family Service Information System, performance data is not systematically captured and analyzed. As a result, most program policy and budget decisions throughout the system are made with little or no relevant data.

We conclude that the Department is not able to systematically measure most aspects of its performance, with the possible exception of expenditures at quite a high level.

Adaptability

Adaptability refers to the organization's capacity to respond to changes in the environment and adapt to the way in which supports and services are delivered in response to these emerging needs and circumstances.

Observations and Comments

Given all of the changes which have been the experience of the NWT at least over the past few years, it is obvious that the Department and Boards have had to be quite adaptable to changing circumstances.

Having said that, we also note that the Department lacks comprehensive, integrated measures to conduct ongoing, coordinated, territory-wide surveys in order to systematically collect data from the environment relative to the delivery of social services (e.g., population needs assessments). For example, neither the Department nor regional Boards have the capacity to capture data that would enable accurate projections of future social service needs. For the most part, budget projections appear to be based on last year's utilization data. The result has been inaccurate budget estimates and over-expenditures.

Although there has been progress reported, the Department does not appear to have sufficient research, development or program evaluation capacity to support its social service agenda; and

Several regional Board staff commented on the need to collect and share best practices across the territories. The Department does not have the capacity to do this at present.

We conclude, therefore, that if the Department is able to develop the

capacities identified above, increased economies of scale could potentially be achieved by having the Department and regional Boards share these resources.

10.4.4 Current Issues and Challenges

We were made aware of a number of either new or ongoing challenges facing the social services component of the overall delivery system. While these may be quite familiar to those involved in each of the Boards and the Department, we felt it to be useful to share our understanding of these, both in terms of what these are and possible next steps.

Linkages to the Non-Governmental Organizations

As we have mentioned several times in this Report, the system of delivery relies quite extensively on the involvement of the wide range of non-governmental organizations (NGOs). It is equally apparent, however, that little attention is paid to the this important group of partners in most of the H & SS Boards. Thus, we find:

- Evidence of NGO agencies seldom if ever meeting with members of the Board either at a Board meeting or at their own place of business
- NGO budgets being requested for submission with no guidelines on the Business Plan priorities or budget targets
- Senior management either unwilling or unable to take the initiative around the logic of establishing multi-year budgets in order to facilitate some longer range planning
- Staff at the H & SS office receiving salary increases but no additional funding for the same demands in the NGOs being considered or put forward for consideration
- Lack of involvement of NGOs when the Business Plan is being orchestrated
- Limited awareness to the prospect of NGOs taking on additional responsibilities at the community level
- Willingness of NGOs to take on added responsibilities including becoming involved in new programming, in order to grow their own niche in their marketplace.

Community Development

While not particularly innovative or new, one of the most overlooked aspects of successful change is the role played by the local community. Besides the primary role played by the family, this is the heart of where people co-exist and where behaviours are impacted. If the concentration of resources continues to be placed on the problems being experienced by individuals, the cycle is unlikely to change substantially. Poor behaviours will continue to be learned and personal health will be ignored until the only recourse is expensive and longer term care.

While our terms of reference do not encourage us to become involved in aspects beyond this specific mandate, it is impossible to ignore the obvious. There are major difficulties being experienced in the NWT relative to problems related to various types of dysfunctional behaviour patterns. While these same behaviours are also of concern elsewhere, they are simply not as visible nor as statistically compelling.

We do not question the best of intentions of those serving in a wide range of capacities in the north. There are many competent and caring people whom we met who are labouring under often difficult conditions in order to live out their calling. While this may be a temporary path for

some, it is a lifetime for others. There are very few simple or easy “cures”. Those who believe that this or that program or change in legislation will bring about vastly different circumstances are not conveying the truth. The path of change and improvement in the living conditions and social and personal well-being will be a prolonged one.

One of the keys, which will only become evident in the longer term, is the role played by the community in helping each of its residents to achieve a greater degree of personal well-being. The community as a whole unit has a vested interest in each of its residents. It recognizes that the strength of any community lies in the capacity of its citizens to live productive lives. Thus, we believe that the Department as well as the NWT Authority needs to encourage the investment of time and resources into helping the community to achieve its aims and objectives. While these may simply be more organized opportunities for interaction, the result will be citizens with a stronger sense that others care. Or, it may be the improvement of the community hall so that the youth and children have places to congregate where sponsored recreational activities can at least partially replace other more dangerous or less healthy pursuits.

We would encourage the leaders of community development strategies to keep working to improve the understanding of all stakeholders and community residents of the value of strengthening the capacity of the community to be an active participant. If this requires an interdisciplinary approach with several ministries becoming involved, progress will be made.

Addictions and Mental Health Framework

Addictions and mental health were identified as targets for strategic initiatives in the 2001-2004 Business Plan. The Minister’s Forum, referred to earlier, identified this area as one of the key four primary recommendations. The need for a comprehensive overall framework has been identified which examines these issues in a broader context, including the impact on wellness, family violence, suicide, healing and recovery.

The main objective seems to be to improve the treatment services and prevention programs offered by the Government, the Boards and NGO agencies. Funding has also been made available for Boards to deliver mobile adolescent addictions treatment. In addition, Boards can access additional funding through Brighter Futures and Building Healthy Communities. More work is needed in establishing a core of community level services which are readily accessible.

The Minister’s Forum, referred to earlier, stated the problem quite clearly relative to addictions and substance abuse. Its opening comment was as follows: “Put health and social service dollars where they are needed most. Concentrate efforts on reducing substance abuse which is responsible for increasing costs of health and social service programs, and drives up costs for education and justice (Action Priority Area # 3; Our Communities, Our Decisions).” The report echoes what we heard at the community level, that is:

- Involve the community in recognizing why the problems occur and what responses are not appropriate or acceptable
- Provide a higher level of support to those actually working in stressful conditions in the field
- Recognize that some communities are not a good fit for workers who are trained as para-professionals but who once lived in the same community

- Involve as many of the leadership of these communities in public meetings where the problems are discussed openly
- Send in specialist teams whenever the well-being of segments of the community (or age sectors) are at risk
- Provide strong and as consistent as possible back-up to the professional staff that does attend to tough situations
- Invest in NGOs which are focused on this area and which are developing confidence and acceptance in their treatment programs
- Ensure that each regional centre has comprehensive treatment facilities; provide such centres at the community level if the population or demand is there to support such facilities; create model "integrated community centres" which may tackle more than one issue at the same time recognizing the need for caution relative to age range and gender
- Involve the people of the community in the programs and facilities to the extent possible; create "normal" community supports

The Government has taken steps to put together a thoughtful plan "Working Together for Community Wellness". A Strategy for Addictions, Mental Health and Family Violence in the NWT" (March 2001). The Minister of Health and Social Services (as the lead department involved) has requested community input to the document. The Strategy appears to be directed at addressing some of the concerns as noted above and sets out the broad parameters (as well as certain specific actions) of what needs to be done. The key will be whether or not the Department is able to engage the cooperation of each of the regional Boards in involving the communities in this attempt to address a critical area of need.

Need to Address the Shortage of Social Worker Positions

As reported earlier, the NWT is experiencing a shortage in social services workers with a reported 8 vacancies in January 2001. While there is a general recognition of the much larger and more widespread shortage of health and social services personnel, this is not of much comfort for those who are working in over-stressed and under-staffed situations. A Social Work Mentorship Program is to be established in the expectation of creating an additional pool of potential northern workers in this demanding and challenging field. There are bursary programs available for those pursuing a career in social work.

As we note in our comments relative to recruitment and retention, the fact that there are shortages is an unfortunate yet predictable fact of life at the present time. These issues appear to be cyclical and may reverse with time. It will be the combined efforts of well-meaning people who are able to respond quickly to both problems as well as opportunities. Thus, we would expect to hear of some very innovative approaches to recruitment which may not bear immediate fruit; and some which do because the report of an opportunity is responded to without delay by Boards and senior staff who are alert to market changes and pockets of opportunity.

Children's Services

The system has been aware of the need to take the appropriate actions in strengthening the delivery of services for children. This is not of recent vintage. Since the takeover of social services by the NWT, ongoing improvements have been sought.

One of the steps forward was the introduction of a new piece of legislation "The Child and Family Services Act" (October 30th, 1998) and the "Adoptions Act" (November 1, 1998). Together these Acts replace the former Child Welfare Act. The new Act is the result of much consultation and research over the past few years. The Act deals with legal responsibilities for the protection of children up to 16 years of age. It is felt that the new Act is more responsive to the importance of the individual, family and community in taking responsibility for the young people of society.

There are a whole series of initiatives targeted at meeting some of the more pressing problems impacting those who are the most vulnerable. The Department and Boards are well aware of the issues and, in most instances, seem quite prepared to take what ever action possible to relieve the significant pressure points. The Standing Committee on Social Programs has provided some leadership as well through holding a meeting on Family Violence. As a result, the Committee has requested follow-up action by the Department to address the provision of safe houses for victims of abusive situations and to determine whether or not those children left with an abusive parent may be also at risk.

A Children and Youth Strategy has been drafted as a framework for the development and guidance of programs targeted specifically at the children and youth. This is expected to be one of the planks in assembling a platform or continuum of programs/services which will be part of the three year action plan. This builds on the earlier Strategic Plan and will presumably incorporate at least some of the 58 recommendations stemming from the Report by the Child Welfare League of Canada.

The Report from the Child Welfare League was tabled in the Legislative Assembly in June 2000. It was a broad-sweeping review "It Takes A Community" and has prompted the Department to develop an action plan towards addressing the report's recommendations. According to information from the Department, the number of children receiving services from Child Protection Workers is increasing (the Yellowknife Board reports that its child protection unit responds to over 60 reports of child abuse and neglect in the average month); the number of children being placed in the permanent care of the Director of Child and Family Services is increasing (there are over 100 permanent wards in the NWT, many with special needs); and the number of children requiring specialized residential care in the NWT and in southern Canada is also increasing. The NWT has 39.6 children in care per thousand, as compared to 10 per thousand in Alberta. There is a chronic shortage of foster placements, group home placements and northern treatment spaces. Over 90 % of those taken into protection were aboriginal. Many of these stem from problems due to family violence, gambling, alcohol and drug abuse and neglect.

These are obviously troubling statistics which the Department and Boards need to monitor, review on a regular basis and determine what action steps might help to address such a significant issue. We note that one of the recommendations in the afore-mentioned report by the CWLC recommended a Child and Family Advocate. This issue is being assessed by the Department although it is our understanding that no action has been planned at the present time. The Department has, however, began action on a number of fronts relative to the Report by CWLC, including: increasing

the number of social workers at the community level; building capacity at the community level; developing a comprehensive training program for social workers, foster families; and embarking on new program development. These are very positive and will need ongoing commitment by the GNWT.

Seniors Issues and Programs

The Department is aware that one of the growth population groups in the NWT is that of senior citizens. While we have read various statistics on the actual numbers, it would appear that the base population of 1350 seniors in 1996 will increase to 4471 by 2019, a 231% increase (**see Chart 6**). In 1997, the Seniors Advisory Council produced a Review of NWT Seniors Programs and Services which outlined the needs, circumstances and resources required for seniors to operate independently of increased Government resources. As well, a number of recommendations pointed to the need to harmonize seniors programming. A working group has been established by Government to address these issues and to ensure a coordinated approach to any new seniors programming.

The Department must ensure that each of the Boards has in place a policy and supportive procedures which support the concept of "aging in place" which has now been endorsed by the Department and some others, including the Yellowknife Health and Social Services Board. The fact that the seniors population is expected to grow substantially over the coming years requires that effective planning now occur which supports a step by step approach to a seniors-sensitive continuum of care, beginning in their own homes.

Persons with Disabilities

The NWT is recognizing the fact that there is a growing number of people in the system who are struggling with various forms of disabilities. A survey was conducted in 2000 which formed the basis of a "Count Me In" Conference in January of this year. While there is a general recognition that this is a problem area which is only going to get bigger if for no other reason than the number of cases of FAS/FAE coming down the road. There are other models of providing services to those with disabilities. These should be explored and funding made available to the proposed NWT Authority to examine this issue and develop a useful and factual base as to its extent; as well as a strategy for approaching this issue through the use of an NGO(s) (if possible).

11.0 STEPS TOWARDS A NEW LEGISLATIVE AND GOVERNANCE SYSTEM

The steps away from the status quo towards a new way of doing business is never as easy as it might seem at first glance nor, somewhat surprisingly, as difficult. It will require a thoughtful and committed approach based on ensuring that each of the key issues are addressed in an overall framework. We see the following as the key components of the total initiative:

- Sound Legislation (in this instance, a new Act)
- Clarity of Accountability
- Clear System Design Principles
- New Board Governance Model
- Clarity of Roles and Responsibilities
- Effective, Realistic, Sustainable and Comprehensive Delivery System
- Solid, Accountable and Systematic Business Planning
- Appropriate Management Systems
- Sound Financing Framework
- Ongoing Training and Development

11.1 The Legislative Framework

At the end of the day, we are left wondering what has been missed in this very complex and regulated environment. There is no question but that both health and medical services exist in a very structured environment not only in the NWT but also across Canada. Much of this is done to ensure adequate protection of the public and to ensure a certain degree of consistency in service and behaviour regardless of where the services are rendered. However, we

believe that the health and social services system of the NWT has become overly prescribed and thus overly complex.

Given the very small populations administered by Boards of Management (and even the Boards of the larger regions), it is highly unlikely that many of the governing members would understand the implications of this highly legislated and regulated environment. And yet, each of those members is expected to "govern" the system and ensure that their administrations are operating the system effectively and professionally. How? This is to be accomplished through the policies and resolutions established by the Board.

It seems to us that if this were really expected to happen, there should have been considerably more effort with regard to ongoing orientation and governance training. Board members should have been advised as to the questions which they ought to be asking and the type of policies which they ought to be establishing. Such an environment is necessary if the GNWT (through the Minister of Health and Social Services) is to be able to develop any degree of confidence that the appropriate oversight and accountability framework has been created.

A sound governance/management system must be based on developing, establishing and communicating a clear understanding of accountability. This recognition of who is accountable to who and for what is essential if full accountability for resources as well as results is ever to be achieved. It is our assessment that the current system is a considerable distance removed from such a goal.

We note that this issue of accountability and the need for clear roles is not only of recent vintage. The Report of the Special Committee of Health and Social Services, tabled in November 1993, titled "Talking

and Working Together", commented as follows:

> *"The role of regional boards should be reviewed…they require more certain plans and a better definition of their function."*

The Med-Emerg Report of 1997 states as follows:

> *"…the boards are micro-managing the community-based initiatives and not focusing on strategic and operational planning…If roles and responsibilities are not clearly defined at the Regional and community levels, a conflict will develop."*

The 1998 "Shaping Our Future: A Strategic Plan for Health and Wellness" made this its number one "strategic direction" and we quote:

> *"Improve management of the system by clarifying roles and responsibilities of the department, boards, private sector providers and nonprofit organizations".*

The Minister's Forum on Health and Social Services (January 2000) weighed in with the following observation

> *"The system, including the reporting relationships, has to be restructured, so that roles and responsibilities are clearly defined…"*

11.2 The Accountability Framework

The GNWT as well as the Department have been examining the important yet broad issue of accountability. While we commend that initiative, we wish to add some parameters to it through defining what key elements we believe need to exist.

11.2.1 The Guidelines for Accountability

The Auditor General of the Government of Alberta produced a report on "Government Accountability". In it, the Auditor General outlines certain guidelines for assessing the effectiveness of an accountability framework. We believe that these are useful here as a point of reference for the Government and its Boards.

The guidelines follow:

> *"Accountability is necessary when responsibility is assigned and authority is delegated.*
>
> *The basic characteristics of accountability information are understandability, relevance, reliability, and comparability. Also, the cost of providing accountability information should not exceed the expected benefit.*
>
> *All forms of accountability reporting should present information on outputs.*

- *Expected results need to be clearly expressed and must be measurable.*
- *Accountability reports should link information on the costs of outputs with information on their effects.*
- *A Department accountability report should include all organizations accountable to a Minister.*
- *Each organization and fund accountable to a Minister should prepare plans (including budgets) and performance reports.*
- *Plans should be prepared by those who have been assigned responsibility. The plans should state results to be achieved, actions to be taken and by whom, estimated costs and performance targets. Those who assign responsibility should agree to the plans.*
- *Performance reports (such as financial statements and annual reports) should compare actual to planned results.*

- *Key accountability reports, including plans, budgets, financial statements and annual reports should be made public.*
- *Published performance information should be audited.*
- *Accountability processes within (Territorial) organizations should be consistent with, and support, accountability to the Minister and the Legislative Assembly.*
- *The main elements of an effective accountability framework should be legislated."*

11.2.2 The Necessary Elements in an Accountability Framework

A framework for accountability should be outlined for all of the players to view, understand and accept. Such a framework, in this instance, should include:

the responsibility of the Government to establish who is accountable to who and for what

the authority of the Government, within its jurisdiction, to establish and articulate the goals and priorities of the residents

the authority of the Government(s) to determine what authority it will devolve and to whom

the responsibility of the NWT Authority and the Regional Services Authorities to develop service plans within the parameters set by the GNWT 's vision and Department's business plan/priorities

the responsibility of the NWT Authority and RSAs to conduct their programs in such a manner as to achieve the goals and targets articulated in their respective and approved plans

the authority of the NWT Authority to request the RSAs to report on those achievements and targets

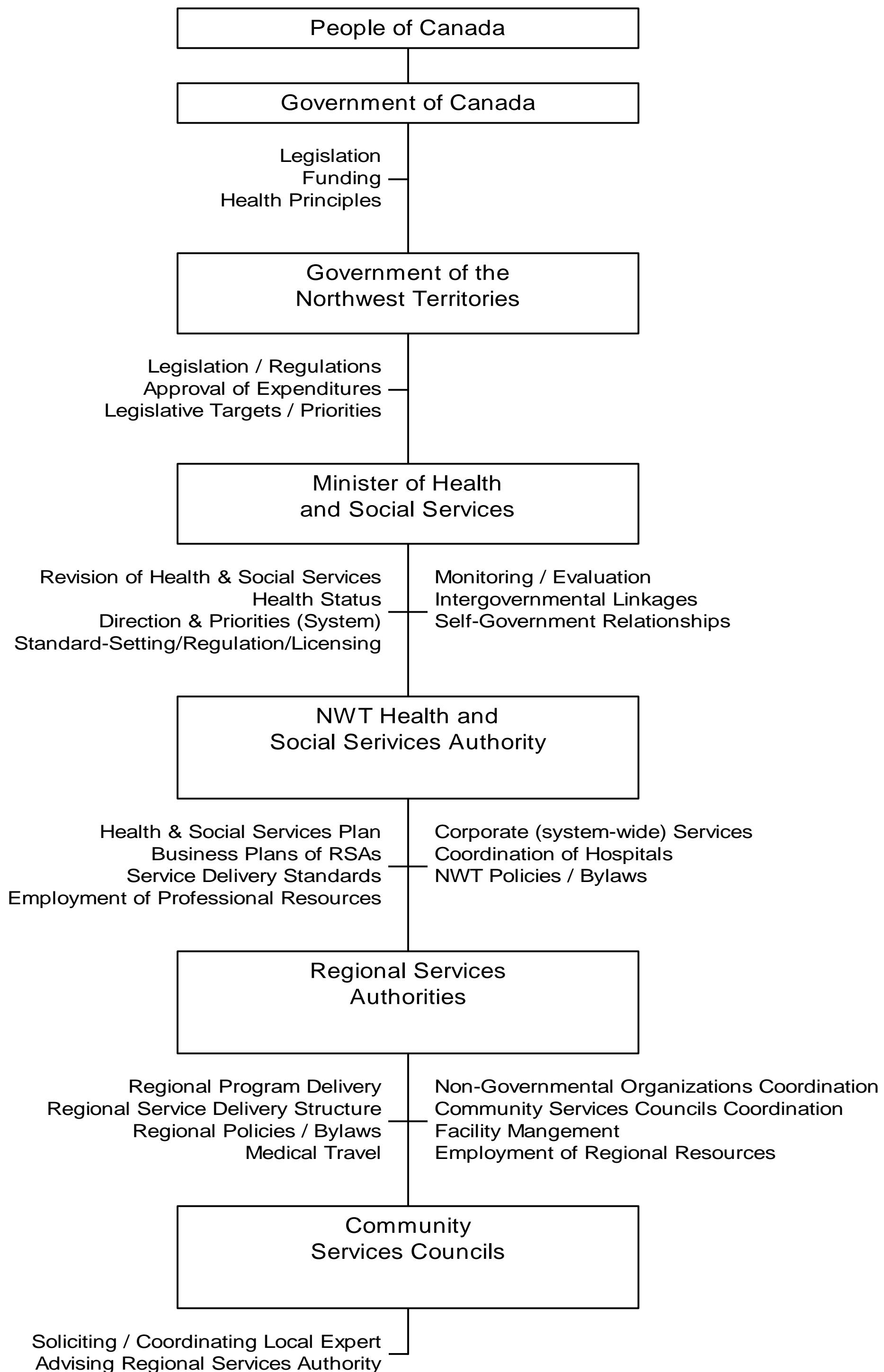
the authority of the Department to request an amalgamated reporting of the results achieved; and the authority to share this information widely across the NWT.

Such an Accountability Framework should be made available as widely as possible so that the public is better informed as to how the system is supposed to be run and the steps being taken to improve the results. It is our view that a more publicly accessible system and the reporting of results, will achieve more support by the public.

While we recognize that there are those who will wish to eliminate structure and simply delegate both the authority as well as the resources down to the community level, it is our view, and substantiated by events thus far, that in doing so, there may be very short term political gain but very significant and much longer term losses to the ability of the health and social services system to deliver on its vision, mission and goals.

While our chart outlines the fact that the Federal Government has a role to play in this accountability framework, for the purposes of this Report, we have chosen to focus on the NWT and its respective players.

Elements for Accountablity Framework



The Government of Canada

Responsibility for:

- Empowering the GNWT to make laws respecting health
- Making laws relative to certain federal health issues and national health concerns
- Designating funding to the GNWT (and the Provinces) through the Canada Health and Social Transfer (CHST) in order to provide the health services envisioned by the Canada Health Act
- Setting forth the broad principles which guide the delivery of a public health system
- Managing the delivery of health on federal lands and to specific groups
- Providing specific targeted grants including that aimed at designated research focus areas

Accountability to:

- The people of Canada through the Parliament of Canada

The Government of the Northwest Territories

Responsibility for:

- Establishing the Legislation which gives powers and authority to those designated to provide certain health and social services
- Approving the departmental estimates which direct the expenditures of the Department of Health and Social Services
- Establishing broad legislative targets and an agenda for services to the people of the NWT
- Receiving an annual report

Accountability to:

- The people of the Northwest Territories
- The Government of Canada

The Minister of Health and Social Services

Responsibility for:

- The provision of health and social services to all residents of the NWT
- The health status of residents of the NWT
- Establishing the overall direction, priorities and goals for the health and social services system
- Promoting wellness programs and initiatives
- Monitoring and evaluating the well-being of citizens
- Administering health and social services legislation/regulations
- Ensuring an appropriate system of measurement
- Registering and licensing the professions
- Protecting children and families
- Recommending the budget allocation; allocating resources to those charged with delivering the services

Accountability to:

- The Legislative Assembly of the Northwest Territories

The Department of Health and Social Services

Responsibility for:

- Recommending to the Minister the overall direction, priorities and goals for the health and social services system
- Ensuring the promotion of wellness programs and initiatives

- Monitoring and evaluating the well-being of citizens
- Administering health and social services legislation
- Ensuring the protection of children and families
- Advising the GNWT (through the Minister) on any new or revised legislation/regulations
- Advising the Minister of any emerging issues which may need the response of the GNWT
- Developing Budget estimates for the Department and Authority
- Monitoring compliance with legislation/regulations/standards
- Investigating complaints relative to the system
- Liaising with the NWT Authority and Regional Services Authorities
- Dealing with any issues relative to self-government
- Providing the services of the public guardian
- Monitoring the health status of residents of the NWT
- Recommending the budget allocation; allocating resources to those charged with delivering the services

Accountability to:

- The Minister of the Northwest Territories

<u>The NWT Health and Social Services Authority</u>

Responsibility for:

- Developing and submitting an NWT Health and Social Services Business Plan for approval to the Minister (such a plan will provide direction for the delivery of services across the NWT)
- Reviewing and approving (or amending) the Business Plans of the RSAs (these will focus on their specific region and must be in compliance with the guidelines provided by the NWT Authority and will tend to reflect the general directions contained within the NWT Plan)
- Establishing service delivery standards subject to veto by the Minister (with the input of the key stakeholders e.g. the medical community, the professions, the Authorities, relevant others)
- Operating a range of clustered or pooled resources and services e.g. budget review/allocation; financial management transactions; information technology systems; human resource plans and policies; payroll and benefits management; records management; communications; health insurance program
- Ensuring the provision of governance training and support to the Authority, Regional Services Authorities (RSAs) and Community Services Councils (CSCs)
- Overseeing a planned program of professional development
- Authorizing contractual arrangements between RSAs and self-governing bodies for service delivery
- Overseeing the recruitment and retention initiatives; employing professional resources; assigning to RSAs; coordinating locum services and assigning
- Coordinating and ensuring the most effective and efficient delivery model for medical travel; setting the framework and policies

Coordinating and supervising the delivery of NWT-wide services e.g. laboratory analysis

Reallocating services to address crisis areas

Coordinating service resourcing from outside the NWT

Establishing policy committees as needed (e.g. Corporate Services (Planning, IT, HR and Budget); Health Services; Social Services; Audit

Submitting an Annual Report to the Minister

Accountability to:

The Minister of Health and Social Services

<u>President of the NWT Authority</u>

Responsibility for:

Developing and submitting an NWT Health and Social Services Business Plan to the Board of the Authority for approval; ensuring that this has been the product of the key stakeholders and reflects the input of the Department as appropriate

Reviewing and commenting to the Authority Board on any recommended changes to the Business Plans of the RSAs

Establishing service delivery standards in conjunction with the Board (and as approved by the Board)

Directing a range of clustered services e.g. budget review/allocation; financial management transactions; information technology systems; human resource plans and policies; payroll and benefits management; records management; communications; health insurance program

Overseeing the operation of health and social service facilities; setting the standards, budget and expected results (in accordance with the policies and guidelines as approved by the Board)

Managing the approved budget of the Authority within the expenditures approved by the Board of the Authority and subject to Board-designated expenditure limitations

Planning, guiding and overseeing a planned program of professional development

Administering the recruitment and retention initiatives; employing professional resources; assigning requested resources to RSAs as approved by their approved budgets; coordinating locum services and assigning

Coordinating medical travel; ensuring the cooperation and support of the RSAs

Reallocating services to address crisis areas

Coordinating service resourcing from outside the NWT

Reporting to the Board on all matters deemed to be substantive or key to the organization's operations and continued functioning

Establishing administrative committees as necessary (e.g. Placement, Planning, Review Committee; Child Abuse Review Team; Communications; Business Planning; Integrated Case Management; Community Development; Legislative Review); assigning applicable staff to assist the Board and its policy committees as needed (e.g. Corporate Services -Planning, IT, HR and Budget; Health Services; Social Services; Audit)

Accountability to:

The Board of the NWT Health and Social Services Authority

The Regional Services Authorities

Responsibility for:

Coordinating regional program delivery (e.g. children and family services; mental health services; wellness programs; services to the disabled)

Establishing the appropriate service delivery structure any hospital or health clinics in the region

Approving regional policies and bylaws; submitting these to the NWT Health and Social Services Authority for review and approval

Authorizing medical travel within NWT Authority-approved guidelines; referring non-emergency cases to the Medical Travel Coordinator for the Authority

Providing a full range of public health programs and services; ensuring that all MHO directives are promptly communicated to the applicable professional staff and to community contacts; working with communities in developing a keen awareness of health promotion and prevention programs

Encouraging compliance with all environmental health protocols

Allocating regional resources as promptly and equitably as possible; working with local groups, individuals and authorized organizations relative to determining their needs; organizing regular surveys of local needs

Liaising with non-governmental organizations; reviewing their plans and budget requests; allocating appropriate resources within approved budgets; advocating on their behalf with the NWT Authority and Department

Entering into contractual arrangements with self-governing bodies for service delivery (subject to the prior approval of the NWT Authority)

Employing regional staff; planning for and allocating resources for the training and development of regional staff

Coordinating input from community services councils

Developing regional delivery policies

Management of regional facilities as designated by the NWT Health and Social Services Authority

Accountability to:

The Board of the NWT Health and Social Services Authority

The Chief Executive Officer of the Regional Authorities

Responsibility for:

Providing policy advice to the Board of the RSA

Directing the organization according to the direction of the Board, the legislation, bylaws and policies

Managing the day to day operations; establishing administrative goals and objectives; providing guidance to the senior staff in the performance of their duties

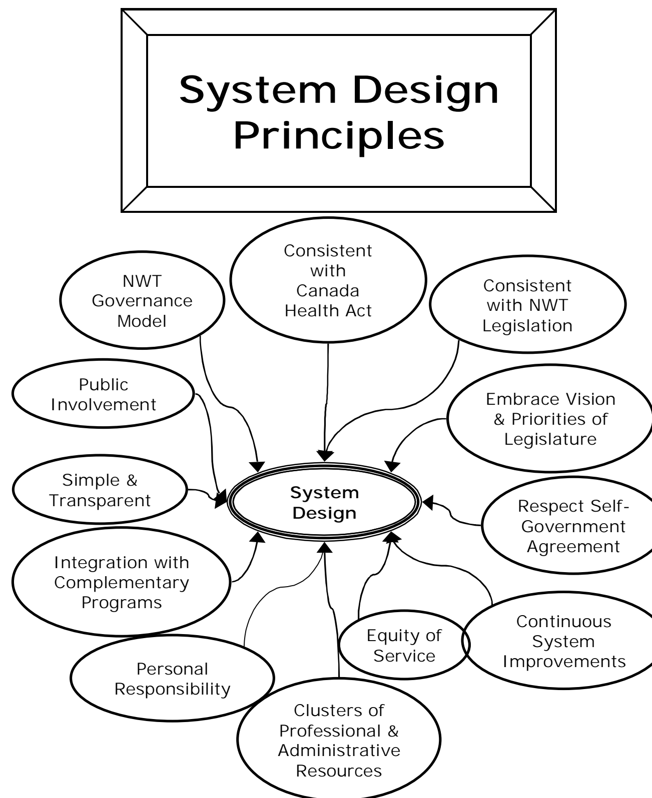
Guiding the development of the Business Plan and budget; managing the expenditures of the RSA within the budget approved by the NWT Authority

Ensuring appropriate and ongoing involvement by the Board in the development of the Business Plan and budget; reporting on the financial health of the organization

- Reporting to the Board on all matters deemed to be substantive or key to the organization's operations and continued functioning
- Developing effective mechanisms for communicating with the key stakeholders and public
- Performing all the requirements directed to the CEO by legislation and regulation.

Accountability to:

- The Governing Board of the Regional Services Authority



11.3 The Principles of a New System

It is our view that the only way to approach the creation of a new system or to evaluate an existing set of arrangements is to see how they line up with the principles upon which the system is being based. For this reason, we put forward those principles which we believe from the basis of a sound and defensible system and those which would best address the concerns and observations which we heard throughout the course of this exhaustive study.

The proposed **Principles for the Design of a New Health and Social Services System** are recommended as follows:

1. That the health and social services offered to the residents of the NWT meet the test of the Canada Health Act and thus that they reflect:
   - Universality of coverage
   - Comprehensiveness of coverage of health services provided by hospitals and medical practitioners
   - Accessibility without barriers
   - Portability of coverage

Public administration on a non-profit basis.

2. That the health and social services offered to the residents of the NWT be integrated with other complementary programs and services offered by allied agencies and other private/public health and social services initiatives.
3. That the health and social services offered to the residents of the NWT reflect the approved vision, goals and priorities of the Government of the NWT.
4. That the delivery of the health and social services offered to the residents of the NWT reflect, and be in the spirit of, the legislation and agreements entered into by the Government of the NWT.
5. That the health and social services be offered to all residents of the NWT in as equitable a manner as possible, while being mindful of the constraints imposed by geographical distances.
6. That the delivery system be reflective of the principles of seamless delivery; simplicity in design; and transparency in decision-making.
7. That the people of the NWT be encouraged and supported to take on personal responsibility for their own health and physical, mental, social and spiritual well-being.
8. That the delivery system be reflective of both the importance as well as the scarcity of qualified professional resources and that sufficient resources be available at each service center so as to ensure adequate back-up to those delivering such services in the various communities.
9. That the governance model which guides the delivery of services be designed in such a manner so as to ensure clarity of roles and responsibilities as well as a clear understanding by those governing of the key components of the services.
10. That continuous improvements be sought and that changes to the system only be made when it is evident to those charged with governing the system that such changes are essential to bring about desired improvements.

11.4 New Model of Board Governance

11.4.1 An Overview

It is our assessment that mere tinkering with the present system will not suffice. As a result, we are recommending a comprehensive revision of the governance models employed by the system.

11.4.2 Why Boards?

At the outset of our review, we asked a number of those whom we interviewed the question “Why Boards?” As reported to us, it would appear that the most likely reason for their creation was the expectation, as cited by the Federal Government, that local communities would be encouraged to become involved in the governing and managing of their own health and social service requirements. As well, the move towards Boards was viewed as a national trend which appeared to have found merit in terms of encouraging local and regional input to the decision-making process.

At the end of the day, we are still left questioning what value Boards offer to the system. We have sat through at least one meeting of virtually all of the present Boards and have frequently been left with the seminal question: what difference did that meeting of the Board make to how the health and social services system is

being managed or governed? If it was felt that Board governance as a construct was of importance, then surely there must be some observable benefits to this style of operating. Otherwise, why not simply have the GNWT offer the services within their own bureaucracy?

We also have some questions as to why the Boards which were established are referred to as "boards of management" when, in fact, the onus has clearly been placed upon them to govern. These Boards do very little in terms of actual "management" and, in fact, are vigorously encouraged in most places to stay away from anything to do with any administrative responsibilities as those functions have more properly been delegated to the chief executive officers. It may well be that some of the frustration which we heard expressed by these Boards may be due at least in part to their own expectation of being "managers" of the system when it has apparently been made clear that their roles were to be far more focused on governance (as witnessed by the focus on the Carver model).

11.4.3 What Has Happened with the Present Model?

It is our observation that the present model of devolution of authority to Boards has resulted in a system which:

- Has stretched the capacity of the system to be effectively governed beyond the breaking point
- Has hindered rather than helped the access of individual residents to necessary health and social services
- Has utilized local and regional political considerations as a much stronger argument in defending the status quo than access to decent services
- Has enabled Boards to make decisions based on factors relating to local economic considerations rather than on what is in the best interests of health and social services in our area
- Has encouraged the flow of qualified human resources out of the various Board jurisdictions
- Has led to situations wherein adequate staff back-up are unavailable in times of emergency
- Has left Boards with inadequate expertise being available to operate essential information systems
- Has led to a complete financial breakdown in certain jurisdictions and poor reporting in others
- Has enabled local politics to rob the system of independent, committed leadership
- Has resulted in rapid turnover of Board members and thus little stability
- Has resulted in some Boards being virtually excluded from the decision-making process in any meaningful way whereas other Boards have become so involved that their status as Board members is not that distinct from those of senior staff.

11.4.4 The Need for Clarity and Effectiveness in Board Roles

If Boards are to be retained in a similar role in the future, there will need to be changes made to the current governance model. In some instances, Board members seemed to understand the objectives of the presently deployed "Carver" model. This appeared to us to have some relationship to the experience level of Board members; their degree of confidence in the CEO; the willingness of the CEO to respond to Board member questions on topics which might have been more operational than governance; the frequency of training; and so on. In most instances, however, we were

impressed by the inability of Board members to grasp the significance of what was being presented and thus the lack of solid, probing questions relative to central issues.

If the governance model is to be effective, then Board members must have a comfortable understanding of their roles as well as a reasonable degree of familiarity with the topics at hand. The conduct of a meeting should similarly be well-understood as should the respective spheres of authority of the Board and the CEO. While these areas of Board member responsibility may appear to be relatively straight-forward, they are an essential part of the underpinning of a healthy governance-management relationship.

We recognize that the Board members interviewed and observed at Board meetings were generally knowledgeable about the needs of their communities and appeared to be conscientious and dedicated. The lack of a solid grasp on their own roles has rendered, however, the system into a CEO-driven and lead enterprise with virtually all of the key decisions being made in the office of the CEO. The Board, in some instances, appears to be brought together to baptize the decisions of the CEO and to ratify the minutes of the most recent meeting.

Given that most Boards seemed to lack a clear understanding of their governance role and of their responsibilities and accountabilities relative to the GNWT, the Department of Health and Social Services, and to their communities, it is apparent that a consistent, thorough orientation is needed: firstly as a condition of appointment and, secondly, as an ongoing refresher for all board members, e.g. an annual conference format which could integrate board responsibilities with the annual business planning requirements of the Government.

We are mindful of the fact that there are both proponents and opponents of the present governance model, commonly referred to as the “Carver Model”. We also respect the fine work which this leading expert on corporate Board governance has done and has contributed to the thinking and practices in this field. Unfortunately, the model has either not been well-understood or has been wrongly applied. As a result, it is our view that:

- Boards as a whole, with some exceptions, lack a good grasp of their roles
- Board members do not understand how the Board is expected to add value to the system
- Key issues and concerns may either go unheard or poorly discussed resulting in little or no direction to the CEO
- The CEO’s power and authority has generally increased in response to the vacuum created by a non-involved Board
- The responsibility for Board involvement and understanding is a two-way street: the lack thereof is a function of a poor or inadequate advisory role played by the CEO as much as it is a result of Board members who are not involved or apparently interested.

While we have questioned why Boards exist if they offer so little of value to the decision-making requirements of the system, we still believe that the potential is there but must be actively and aggressively addressed.

Effective Board governance is an absolute requirement for the delivery of health and social services to be successful. In many ways, the quality of governance at the local level will determine other qualities of

the health and social service system "down the line". Consequently, efforts to continually assure that Board education occurs at a regular and high quality level are necessary.

One of the most important factors that can determine the success of a Board governance system is the degree to which Boards and the Government understand their respective roles. Simply put, Board effectiveness will deteriorate unless there is a regular and concerted program for regular training and education. Such a program will be difficult to achieve unless one organization or agency is mandated to provide this service for the long term.

Board education should involve the following components:

- Orientation of new board members regarding roles, responsibilities, board governance through policy, communication policy, etc.
- Annual education events on key aspects of board education including board governance.
- Regular education sessions on board governance, preferably at the local level.
- Supporting and assisting local programs regarding board self-evaluation.
- What is policy, and what are "operations"? What should board members do, and what should they stay away from? These and other questions need to be addressed.

There should be a checklist for every board and every board member to assure the program is as effective as possible. This checklist system should accomplish the following objectives:

- Effective monitoring of board education programs. This monitoring should include tracking the type of education program each board receives and when it was received.
- Provision of effective board member orientation.
- Monitoring who is on each board at the time of the education program being delivered.
- Assurance that evaluation is done at the conclusion of each education session.
- Assurance that training needs are regularly being assessed.

In addition, an effective Board education program should include a registry of the type of education that will be required, what was delivered, and what were the results. This registry should be maintained for each Board. The range of Board education programs should be comprehensive including:

- **Orientation sessions** that are "common" or consistent with those provided to each board.
- **Education sessions** that are "common" or consistent with those provided other boards perhaps around a particular or key theme.
- **Unique local education sessions** that are designed around the needs and concerns of the local boards. Examples of such a program would be a session on board/staff relationships.

11.4.5 Coordination and Responsibility for Board Education

Because of the importance of a well-planned, coordinated, and resourced program of Board education, it is important to place this function within one organization or agency. This organization would have the full responsibility of working with the various Boards in developing, implementing, and evaluating an effective Board education program.

There are two main options that can be considered to achieve this goal:

A Branch, Unit, or Division within the Department of Health and Social Services

It may be possible and worthy of consideration to place this important responsibility with the Department. More and more, this Unit has been attempting to fulfill the expectations of Boards and their administrations. It is recognized, however, that the Unit would require the addition of more experienced resources who would carry added credibility in the field. Thus, if this option were to be selected, it is recognized that there will need to be appropriate resources and direction given to this Unit so that it can adequately carry out these additional functions.

A Central Agency

The second option, and one which we will be recommending, is to have the majority of the functions of Board support attached to the proposed new NWT Authority. Such services would be a natural fit with many of those which we are recommending to be transferred over to the Authority. These services would include: human resources, information technology, records management, finance, etc. These functions are often called "business centres", "shared support services" and so on.

Regardless of the approach taken, it is essential to have one organization with the clear responsibility and adequate resources to develop and implement an appropriate Board orientation and education program.

11.4.6 A Suggested New Model

In order to obtain a fresh start, it is our view that the Boards which we recommend be established as a result of the implementation of this Report be the recipient of a two day session on Board governance according to the **"NWT Model".** Some of what such a session should address is reflected in the Appendices to this Report. The key elements of the new Model are the following:

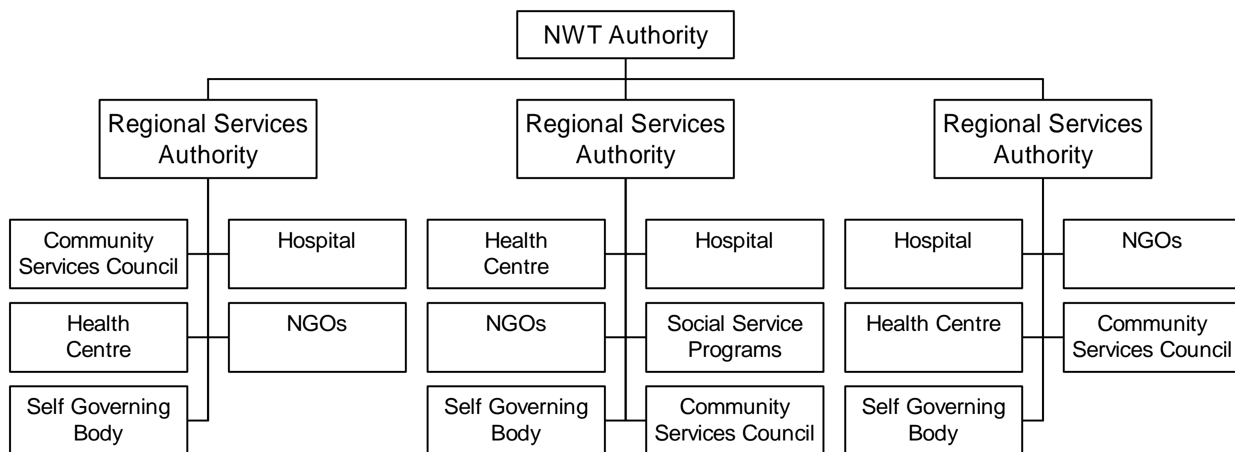
- Clarity of mandate of the Board and of the Authority
- Clarity of Board powers
- Clarity of powers of the Minister (and Department) and the proposed NWT Health and Social Services Authority
- Access to a central bank of professional resources and support services
- Board governance principles
- A description of the roles of the Board vis-à-vis the CEO
- An understanding of the type of questions to be addressed on a regular basis by the Board
- A template of a Board agenda format
- A template of a "Request for Decision" to be used by the CEO on all business items of the Board
- A new format and template for policy development and training in the use of this model
- Guidance to service delivery (policy; budget; standards)
- Techniques to establish and resolve:
- Key Issues
- Priority-Setting
- Agenda Development
- Business Planning/Budget
- Reporting Requirements
- Linkages to Partners
- Professions and Staff Relationships
- Procedural Guidelines/Bylaw

Development & Training

11.5 Clarity of Roles and Responsibilities

A continuation of the current system would continue the consumption of valuable resources rather than designating these in such a way as to reach those in most need. As a result of this and other related observations which we have documented in this Report, we are convinced that a new system is essential if the people of the NWT are to be confident of receiving the best possible care and services within the overall funding allocations which are designated for the delivery of health and social services. Part of the effectiveness of any new system will be predicated on how clear the designated new roles are and how long it takes the new system to sort out the new arrangements. Let there be no misapprehensions: the development of the new system will take some time in the initial months to bring about the changes which we have reported on and which will inevitably result in a much more focused delivery of services.

Illustrated Flow of Representative Linkages in the Proposed Structure



11.5.1 Involvement of the Local Community

There is little question in the minds of most of those with whom we discussed this matter of the value of some mechanism to encourage public input. Thus, while we see absolutely no reasonable justification for a continuation of the present system of nine Boards, there is good reason to maintain some form of local input. It is our view, based on the extensive work which we have done, that the responsibilities of managing the business affairs of the current Boards has caused substantial problems, mainly due to the non-availability of qualified resources. We do not see any need for such services to be provided locally within the smaller centres nor do we feel that the control of professional resources has been in the best interests of personal care and service.

The bottom line for local residents is the desire to provide their input as to how best the services can be designed so as to meet local needs and conditions. While we applaud the this desire for local input into what and how services are delivered,

it is our view that this can be accomplished through a series of **"community service councils".** These have been designed so as to fit within all of the communities as a forum for input and discussion with regard to service delivery. What might these accomplish? We see the following functions:

Functions of Community Service Councils

The following are examples of the functions which we envision for the Community Services Councils:

- A consultative mechanism to provide input and advice to the Regional Services Authority relative to the provision of local health and social services
- Forwarding any issues and recommendations to the Regional Services Authority
- Authority to hold monthly meetings with the residents of the community in order to seek input on any matter deemed relevant to the delivery of health and social services at the local level
- Such community service councils may be incorporated within a larger community framework (e.g. a community services board) provided that the community health council continues to function in an advisory capacity or the council may be a stand alone entity
- The community services council will be consulted with by the Regional Services Authority to propose changes in service delivery to the RSA and/or a re-allocation of current budget dollars
- The community services council will be granted the authority to provide input to the annual budget process of the RSA and/or to the Business Plan process
- The community services council will have no authority to direct staff or to authorize expenditures.

Values of Community Services Councils

There are several potential benefits to establishing community service councils at the local level. These include:

- Access to the concerns of community residents relative to service delivery/facilities/priorities
- Opportunity to have a local body act as an arm of the regional governing authority and provide it with immediate feedback on key decisions
- An avenue to spread the word about new health and social services initiatives and provide education on existing initiatives
- A forum for exchanging views on the most viable way to tackle a particularly sensitive local concern
- A forum to serve as the key distribution point for new material relative to a health promotion campaign

The 1993 Report "Talking and Working Together" which was cited earlier speaks to the need for involvement at the community level. Their Recommendation # 4 states: "Local health and social services committees must be recognized as essential to the delivery of these programs. The development of local committees should be encouraged and progress reported to the Legislative Assembly during each budget session."

Who Sits on Community Service Councils

The Regional Services Authority (for each designated region or cluster of communities) should decide who is entitled to serve on these community service councils. Whereas we do not see the need to have these as elected

positions but rather, honorary appointed ones, the RSA could seek the input of the local community as to the fair method of appointment. This could be by appointment by the local governing body (s) or, if there are problems in filling such advisory positions, the Regional Services Authority Board will be charged with making those decisions.

We believe that the criteria for such positions should include:

- Agreement to the functions and purpose of the community services council
- Availability to attend once monthly evening meetings
- A personal lifestyle which is recognized in the community as healthy and a model for others
- An awareness of the policies, services and facilities of the community relative to health and social services
- A willingness to accept the democratic decisions of the community services councils (without the need to subject such decisions to the approval of any other governing or advisory community agency save and except the Regional Services Authority)

<u>Tenure of Members on Community Service Councils</u>

Members should be appointed to serve for a term of three (3) years before they must step down from the council for a minimum of one (1) year so as to always allow new people and new ideas to serve. If there are no new people stepping forward for appointment, then the Board of the Regional Services should be asked to re-appoint the current members.

<u>Honoraria for Members</u>

Whereas these positions are advisory in nature, we believe that their volunteer nature should be considered as the basis for determining any degree of honoraria. If the Department feels that some degree of payment for service is necessary, we would recommend that it be no more than $75 per meeting with a maximum of one meeting per month. Any payment to individuals for honoraria should be made either monthly or quarterly by the Regional Services Authority.

11.5.2 Regional Services Authorities

The only way by which the residents of the NWT will be guaranteed of a quality system of health and social services is to ensure that key resources are clustered in certain locations, with a mandate to reach out to the surrounding communities. While the location and thus the number of these clusters will likely be open to some question, it is our view that the present number of Boards should be reduced from nine to four, with three of these serving as Regional Service Authorities, reporting to a NWT Health and Social Services Authority.

We deal first with the establishment of the three “regional services authorities” (referred to as “the Region”). These are expected to be multi-disciplinary in scope, acting as the key centres for services within the described geographical area.

<u>Functions of Regional Services Authorities</u>

The following are examples of the functions which we envision for the Regional Services Authorities :

- Coordination and delivery of community health and social services to all residents within the region; determine community priorities in the provision of services to those living in the region and allocate funding accordingly

- Assurance that all residents of the region have adequate and timely access to necessary medical services
- Coordination of the community health and social services providers within the region
- The development, in accordance with the regulations and subject to the approval of the Board of the NWT Health and Social Services Authority, of a plan for the delivery of services; the responsibility to oversee and evaluate the implementation of the plan
- The assessment, on an ongoing basis, of the needs of the region for services
- Collaboration with appropriate non-governmental agencies which offer services within the range of responsibilities of the regional authorities
- Consultation with all community health and social services councils and communities served by that regional authority
- Development of detailed budget submissions for approval by the NWT Health and Social Services Authority (NWT HSSA)
- Approval of expenditures within the NWT HSSA budget allocation
- Authority to delegate the approval of budget allocations within specific program areas to the CEO
- Authority to delegate other operational issues to the CEO (within the policies as approved by the Board or as established by legislation
- A consultative mechanism to collect and operationalize the advice and input received from the Community Services Councils relative to the provision of local health and social services

Values of Regional Services Authorities

There are real advantages in designing a system which is focused around the establishment of **Regional Services Authorities**. These include:

- Access to the concerns of residents living in the jurisdiction ascribed to the Regional Services Authority relative to service delivery/facilities/priorities in their community or region
- Opportunity to have a regional body function in the capacity of "host" of a broad range of health and social services on behalf of the communities served by that region
- A decision-making body (subject to its terms of reference and powers) with authority to make meaningful choices which will impact the residents of the region
- A body which can orchestrate the placement of professional resources into communities where the need is most urgent and able to respond to changing conditions quickly and effectively
- The forum for ensuring a reasonable degree of consistency and equality of services being delivered
- An avenue to spread the word about new health and social services initiatives within the region
- A forum for exchanging views on the most viable way to tackle a particularly sensitive regional concern(s)
- A forum to serve as the key regional distribution point for new material relative to a health promotion campaign
- A natural mechanism for any self-governing bodies to contract with in

order to have either services provided in that particular community by the regional authority or to take on the obligation/responsibility as a separate body.

The following excerpt from a recent review states: “We believe that Regional Boards throughout the NWT should be given greater authority and responsibility by the Department and be held accountable for their actions. There is also a need to empower Regional Boards within the system in a manner consistent with the risks they assume….if the transfer of risk to agents is not accompanied by effective control over outcomes on the part of the agent, dysfunctional behaviour will result” (Med-Emerg). This current review supports this conclusion that was reached in previous consultations.

Who Sits on Regional Service Authorities

The present system of appointing Board trustees appears to be somewhat helter skelter across the system. That is, there are various mechanisms utilized in having members appointed to Boards of Health and Social Services including:

- Recommendation from the local community council
- Election within the First Nations settlement and subsequent nomination by the First Nations Council
- Direct appointment by the Minister upon recommendation from the current Board and MLA

While we are cognizant of the fact that one size fits all may not be totally acceptable or perhaps even appropriate in all instances, we note that, given the significant changes being recommended across the system, that ensuring some stability in the appointment process will allow the system to add increased consistency in its governance structures.

At the moment, of the nine Boards in existence, two are consistent in jurisdiction represented with cultural/claimant groups (Deh Cho, Dogrib); two represent very small communities (Fort Resolution, Lutselk’e); two represent somewhat larger (neighboring) communities (Hay River, Fort Smith); one represents the largest NWT community and two satellite communities (Yellowknife); and one is territorial in scope albeit providing most of its services to the largest community (Stanton).

Thus, we are recommending that the Minister of Health and Social Services make all appointments to the resulting Boards. This appointment by the Minister should be based on the need for:

- Balance in representation for the key elements of the region being represented
- Recognition of the need for increased consistency in Board membership
- Balance of gender and age
- Understanding of the type of system and the health needs of the people.

The membership of a Regional Services Authority (RSA) is expected to be the purview of the Minister of Health and Social Services. While the mechanism for how names are solicited and forwarded in each instance may vary, we would expect the Minister to establish a Nominating Committee charged with soliciting such nominations.

We believe that the criteria for such positions should include:

- Agreement to the functions and purpose of the Regional Services Authority
- Availability to attend meetings which will not exceed 1-2 meetings (days) per

month, plus any approved conferences or seminars

A personal lifestyle which is recognized in the community as healthy and a model for others

An awareness of the policies, services and facilities of the NWT Health and Social Services Authority and Department

A willingness to accept the democratic decisions of the RSA (without the need to subject such decisions to the approval of any other governing or advisory community agency save and except the Regional Services Authority)

Tenure of Members on Regional Services Authority

The appointments should be for a three year term with eligibility for a second three year term. Thereafter, any member wishing to be re-appointed must be absent from the Board for a minimum of one year before being eligible for re-appointment by the Minister. If there are no new people stepping forward for appointment, then the Minister should be asked to re-appoint the current members.

Honoraria for Members

While any position such as these is designed to appeal to those with a "volunteer" spirit, there must be some recognition as to the amount of time which may be expended by each member which may be time away from personal employment or business obligations or time away from family obligations.

Regardless of personal circumstance, the compensation provided for such duties should be the same for all members, save the additional honoraria paid to the Chair by virtue of somewhat greater expectations in terms of time commitment. While we realize that various practices have crept into the present system relative to paying Board members on a per hour basis for background research/reading; independently held meetings; and the like, we are not supportive of this practice. Unfortunately, this practice enables the notion of "fee for service" for Board members to enter the system as though Board members were to be paid on a similar basis as the staff. This was never the intention, as we understand it, of the Department nor those who established the governance model.

It is our view that the Minister should establish a "compensation and expense policy" which will apply to all Boards. Such a policy should include such provisions as:

A basic member meeting honoraria of $ 125 per half day (4 hours or less) meeting; $265 per full day (greater than 4 hours)

A maximum of $530 per month in honoraria for Board member honoraria

An additional stipend of $250 per month for the position of Chair; $100 for the position of Vice Chair

A per diem honoraria for conferences, seminars, meetings of the Leadership Council, etc. of $265 per day plus expenses at cost (as per actual receipts) or as per the GNWT travel expense guidelines as may be applicable to Deputy Ministers or other senior appointed staff

Any payment to individuals for honoraria/expenses should be made monthly by the Regional Services Authority.

11.5.3 NWT Health and Social Services Authority

We also see the need for one NWT-wide Authority which would act as a support mechanism for the other Regional Services Authorities; a control agent on

behalf of the GNWT (and Department of Health and Social Services); and as a coordinating body for the three principal hospitals and various health centres. This Territorial Authority is necessary to ensure that all health and social services are effectively coordinated between the various authorities and that resources are being placed (or rotated) as efficiently and effectively as possible.

Functions of the NWT Health and Social Services Authority

The following are examples of the functions which we envision for the NWT Health and Social Services Authority:

- Coordination of delivery systems within and between all hospitals and health centres
- Coordination of the provision of social services to all residents of the NWT
- Coordination of all recruitment and placement activities for medical/social services professional staff
- Provision of short term professional staff replacements
- Overseeing the licensing and registration processes; seeking the input of the professions
- Delivery of coordinated non-management support services functions including: finance; information technology; human resources; records management; NWT-wide communications; health insurance program
- Development of the framework and policies governing the medical travel system
- Coordination of services provided by non-governmental organizations
- Back-up support to the regional health and social services authorities
- Supervision of health and social workers and other child care professionals
- Training for health and social workers throughout the NWT
- Submission of three year Business Plans to the Department of Health and Social Services
- Approval of annually submitted budgets from the RSAs; allocate funding in a manner approved by the Minister and allocate resources to the Regional Services Authorities
- Development of a Plan, in accordance with the regulations and subject to the approval of the Minister, for the delivery of services
- Oversee and evaluate the implementation of the approved Plan
- Co-ordination of the activities of Regional Services Authorities
- Development of policies for the provision of health and social services to those being served by the NWT; ensure consistency of services
- Monitor and assess the Regional Services Authorities in the carrying out of their activities
- Work with the GNWT and public and private bodies to co-ordinate the provision of services to residents of the NWT.

Values of the NWT Health and Social Services Authority

There are several potential benefits to establishing **a NWT Health and Social Services Authority**. These include:

- Opportunity to have a Territorial body coordinate the delivery of health and social services so as to ensure consistency and a uniform level of service as much as is reasonably possible

- Ensure that the key decisions relative to budget allocations and standard setting are made at a level which reflects and indeed represents the regional and community needs
- Ensure that outstanding issues relative to the allocation of professional resources are addressed on an "as needed" basis within a reasonable timeframe
- A service delivery concept which clusters service components and is better able to find qualified resources and encourage skills upgrading
- A forum for providing adequate supervision of field resources so as to ensure that professional concerns relative to sensitive service issues are being responded to promptly
- An avenue to coordinate the dissemination of information relative to new health and social services initiatives
- A forum to serve as a "lobbying voice" to the Minister relative to NWT-wide issues which require recognition and/or intervention by the Legislature.

Who Sits on the Board of the NWT Health and Social Services Authority

The Minister should be charged with making the appointments to the Board of the NWT Health and Social Services Authority. The Minister represents the powers and duties of the Legislative Assembly, which is the elected body representing all residents of the NWT.

The Board of the Authority should consist of:

- the three chairs of the Regional Services Authorities (RSA)
- and four members at large as designated by the Minister, one of whom should be appointed from Nunavut based on the number/percentage of use of the Stanton facility
- The Minister may seek nominees from the Regional Services Authorities but may also simply advertise and/or solicit nominees (the involvement of the proposed Board Member Nominating Panel could be considered)

Tenure on the NWT Health & Social Services Authority

Members, except for the chairs, should be appointed to serve for a term of three (3) years, to a maximum of two consecutive terms. At that stage, members should be required to have been off the Board for a minimum of one (1) year in order to be re-considered for appointment.

Honoraria for Members

Given the considerable importance to the system of these positions, we believe that the time should be recompensed accordingly. We expect this Board to meet no less than 10 times annually with the potential for an additional 6-10 days of conference and seminar time committed to this endeavour. There must be some recognition as to the amount of time which may be expended by each member which may be time away from personal employment or business obligations or time away from family obligations.

Regardless of personal circumstance, the compensation provided for such duties should be the same for all members, save the additional honoraria paid to the Chair by virtue of somewhat greater expectations in terms of time commitment.

It is our view that the Minister should establish a "compensation and expense policy" which will apply to all Boards. Such a policy should include such provisions as:

A basic member meeting honoraria of $ 125 per half day (4 hours or less) meeting; $265 per full day (greater than 4 hours)

A maximum of $750 per month in honoraria for Board member honoraria

An additional stipend of $250 per month for the position of Chair; $100 for the position of Vice Chair

A per diem honoraria for conferences, seminars, meetings of the Leadership Council, etc. of $265 per day plus expenses at cost (as per actual receipts) or as per the GNWT travel expense guidelines as may be applicable to Deputy Ministers or other senior appointed staff

Any such payment(s) to individuals for honoraria/expenses should be made monthly by the Board.

11.6 Effective, Realistic, Sustainable and Comprehensive Delivery System

11.6.1 Background and Observations

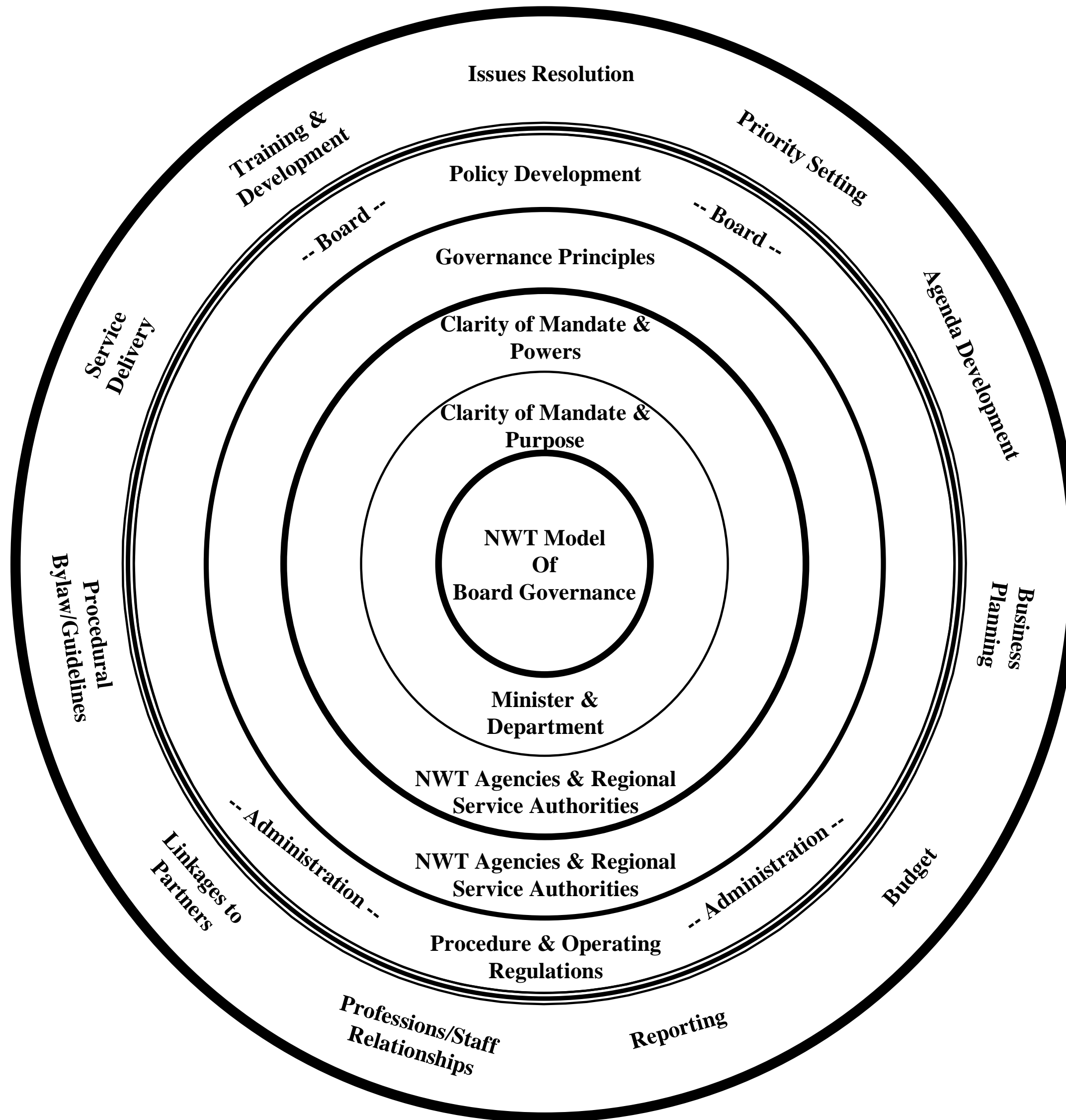
It is our view that the proof of whether or not any new system of health and social services actually works will be decided by those who make use of the system. That is, regardless of whether or not this design, or some modification thereof, is actually put forward and approved by the Legislative Assembly, the key question to be answered is: “Has the new system enabled the residents of the NWT to have an improved health and social services system which meets their needs?

It is our view that any system which we design must be capable of meeting the needs of the residents of the NWT. This requires reasonable answers to the following types of questions:

> *“Will I get access to the appropriate professional resources who are able to properly diagnose and treat (or help me address) my situation?”*
>
> *“Is the distance which I have to travel for services reasonable based on where I have chosen to reside?”*
>
> *“Can I be confident that the care provided is what I need and that, if such care is not available locally, that those in charge will ensure that I am transported to where I can get the necessary care?”*
>
> *“Are the people who serve our community aware of our local conditions and culture? Do they show respect for our differences? Are they concerned with me as an individual?”*

Is the level of service adequate for our region? Is the time which I must wait for someone to attend to me reasonable? If I am elderly and frail, will the staff attend to me with due care and attention? If I do not speak their language, will they try to find someone who does?”

Northwest Territories Health & Social Services A Model of Board Governance



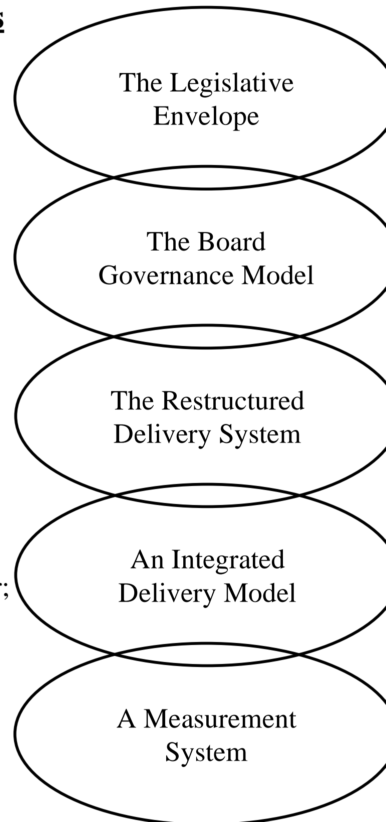
11.6.2 Development of an Appropriate Service Delivery Structure

The Service Delivery Structure

Key Elements

Answers the Questions

1. What is the basis of our authority? What are our goals & objectives?
2. How will the interests of those living in our region be reflected?
3. How will the decision making and resources be channeled to the community level?
4. How will services be delivered; in what manner; with what resources?
5. How will we know what we have achieved? Were our targets met? Did we report; to whom?



The key elements of the recommended approach to Service Delivery are as follows:

- A Clearly Articulated Legislative Envelope
- A New Act
- Streamlined Legislation
- A Clear Statement of Regulations/Directives/Policies
- System Goals and Priorities
- A Re-Designed Board Governance Model
- A New "NWT Model of Board Governance"
- Effective and Ongoing Training for Governing Boards
- Elimination of Boards of Management; Replacing Those with Boards of Governance
- Clear Role Statements for the Key Administrative and Governing Positions
- A Restructured Delivery Structure
- The Creation of a Comprehensive Delivery Mechanism—The NWT Health and Social Services Authority
- Clear Designation of Responsibilities to the Authority (as described herein)
- The Creation of Three Regional Service Authorities—North, Central, South (together with the elimination of Board status of any other present Boards)
- Clear Designation of Responsibilities to the RSAs (as described herein)

Contractual Arrangements with Self-Governing Bodies

The Creation of Community Service Councils (one per each community) with responsibilities as described herein

An Integrated Service Delivery Model

A comprehensive, patient/client based "Integrated Service Delivery Model" wherein all related aspects of service provision are linked so as to achieve the right support base and access to all of the appropriate skill base which the patient/client may require; a high degree of patient sensitivity and understanding of the principles of collaboration and coordination will need to be exhibited

A "continuity of care model" wherein the individual and his/her needs are the key component of how care is delivered

A patient-focused multidisciplinary team delivery mechanism which includes physicians' services, home care, community care, social services support and counselling, access to emergency and acute care, assisted living arrangements, specialized care for persons with developmental disabilities, long term care

A community-focused support network which meets frequently and discusses what community supports are in existence and what supports are needed; the network identifies what services are needed and establishes a gameplan to make it work

Services which reflect the goals of the organization

Services based on evidence that they work towards, and provide, the health and social service outcomes desired

A Measurement System

Clear targets established on an annual basis

Definition as to how and when targets are to be measured

Results measured and reported

11.6.2 Key Service Components

The Future Social Services Model

In our view, the Department is at a critical stage, relative to the delivery of social services. Although the organization has strengths, it also has significant and serious weaknesses. As is evident from our analysis (see Section 10.3), there are considerable stresses in the system which require the attention of the key decision makers. In order to address the challenges of the social services system, the following must be addressed:

Identification of social services priorities must be seen as the mandate of the full range of players involved in the delivery system

Development of the vision, goals, objectives and priorities must be considered the mandate of the Authorities and any bodies as identified by the RSA which participate in the delivery of the actual services

Ongoing formal as well as informal mechanisms for communication must be designed; essential in a small system and thus critical to further system improvements.

Recognition of the significant demands placed on the professional resources

Development of a user-friendly community survey instrument to adequately measure needs in order to plan for future programming

Ongoing increases as appropriate in the number of qualified resources

Performance measurement systems and ongoing individual appraisal reviews

- A priority listing of issues and intervention strategies which are regularly brought forward to the hierarchy of the organization for review
- Sound monitoring and evaluative functions; systematic collection of performance data as well as clear timelines for reporting

The Key Priorities of the Social Services Delivery Model

There are a number of key priorities facing the social services delivery system. These include:

- Development of a children and youth strategy
- Implementation of recommendations relating to the Child and Family Services program review
- Respond to the recommendations stemming from the Child Welfare League of Canada report
- Development of a seamless delivery system for continuing care/home care
- Response to the growing needs of persons with developmental disabilities
- Gain feedback and draft a strategic response to the draft Strategy for Addictions, Mental Health and Family Violence; determine ways by which the mental health strategy can be linked to other priorities
- Promote the need for
  - Coordinated, community-based services for trauma survivors, families at risk of violence, and people with mental illness and addictions
  - services for children and youth
  - case management to coordinate services
  - prevention and promotion programs
  - culturally-relevant services.

In order for the social service organization to function effectively, all of the interdependent functions and priorities described above must be carried out effectively. If one or more of these functions are not well executed, the performance of the system is compromised.

In the document, *It Takes A Community*, the Child Welfare League of Canada concluded that "child welfare services are functioning precariously close to the edge". We agree. We also believe that other social services are in a similar position. During our analysis, we were asked several times if a fundamentally different model was needed for child welfare and other social services. In our opinion, the simple and most direct answer is no. This is a step-by-step process of learning what works and what the impediments are. It has been our hope that the new model of governance and service delivery will rationalize the overall system and ensure that the services which are needed in the communities actually get to those for whom they are intended.

Key Elements of a New Social Services Delivery Framework

As we see it, and based on our assessment of what has been the basis of service delivery problems to date, it is our opinion, that the key issue which needs to be resolved, is the effective use of the resources which are available. These, we believe, are sufficiently stretched so as to make meaningful performance and personal follow-up very difficult to achieve.

The present philosophy appears to be driven principally by the demands of the

day as opposed to a strategy-driven approach. That is, we have been unable to find much evidence to support the notion that services are being guided in an even-handed manner based on performance indicators and program priorities. The fact that this is the main approach is driven by need rather than a lack of attention to what might appear to be obvious. In our view, the status quo will prevail as long as the managers of the system are expected to operate within the same Board structure. It is not realistic, in our view, to consider placing full-time staff within the structure of a small Board wherein the staff member lacks adequate back-up and supervision. This is a recipe for failure despite the best efforts of the local staff, Board and CEO. The quaint notion that each community should have their own social worker makes as little sense as each community, regardless of size, having their own doctor. The supporting cast which both professions depend so much upon, is simply not available.

Any framework, which we would propose, will look much like the one that expert observers would argue is in place at present. Having said that, it is our view that the **new Model should be based upon:**

- A Common Vision by all Stakeholders
- Need for Comprehensive Input
- Need for Input/Revision at Regular Intervals
- Access to a Body of Expertise
- Professional Resources located at Regional and NWT Authority
- Communities Access Resources as Needed
- Resource Teams Available Quickly
- Integration of Services at the Front-line (removal of obstacles relative to sharing of information about individual clients)
- Service Teams Established; All Members Must "Buy In" to Model
- Case Management Clinics Held to Review Each Patient
- Development of Community Capacity
- Innovative Community Linkages Established
- Community "Buy In" Encouraged
- Development of Partner Capacity (Involvement of the NGOs, etc)
- Priority Placed on Finding and Developing Strong NGO Partners
- NGO Capacity Monitored and Resourced
- Early Intervention (Capacity to Monitor and Intervene)
- Strategies Developed to Become Aware of Difficult Situations Early)
- Region-Based Services (Need for Sufficient Capacity for Proper/Comprehensive Service Delivery)
- Full Range of Services Established at RSA site
- Specific Community Resources Designated as Required
- Effective Coordination of Key Policy and Procedural Issues (e.g. Children's Services, Adoptions, Mental Health, etc)
- Department Provides Overall System Guidance
- One Authority Unit Assigned Responsibility for Policy Coordination
- Balance in Service Delivery (Adult vs. Children's Services/Maintain Reasonable Balance)

Senior Management Teams Monitor the Weight Placed on All Service Components

The Guiding Principles

The model must be tied into the overall system and thus be framed by the same set of principles as any other component. These we outlined in Section11.3.

Key Elements of a New Health Services Delivery Framework

As we noted in our comments relative to the Framework for Social Services, "it is our opinion, that the key issue which needs to be resolved, is the effective use of the resources which are available. These, we believe, are sufficiently stretched so as to make meaningful performance and personal follow-up very difficult to achieve".

For whatever reasons, mostly historical and based on the wishes and needs of that day, hospital facilities were constructed and services promised to small and remote communities. While obviously well-intentioned, the promises made have been very difficult to service. Quite simply, the cost of those services has risen (and still continues to rise) and the access to professional resources becomes increasingly scarce (and not projected to improve substantially for some time yet).

We agree that all residents of the NWT deserve a decent level of service and access to those health and social service professionals (and related facilities/equipment) which their needs might warrant. This reflects the intention of the Legislature as conveyed in their annual priorities and plans. What has become very apparent, however, is the inability of those in the allied fields of health and social services to deliver all services on site. Quite simply, the threshold levels required for local services drive their availability.

Again, the Framework for a new Model of Health Service Delivery should reflect the principles referenced earlier as well as certain criteria. Similar in many ways to those which guide the Social Services field, we believe that the **new Model should be based upon:**

A Common Vision by all Stakeholders

Need for Comprehensive Input by the Medical Profession and Allied Professions

Need for Input/Revision at Regular Intervals

Access to a Body of Expertise

- Professional Resources located at Regional and NWT Authority
- Communities Access Resources as Needed
- Resource Teams Available Quickly
- Integration of Services at the Front-line (removal of obstacles relative to sharing of information about individual clients)
- Service Teams Established; All Members Must "Buy In" to Model
- Case Management Clinics Held to Review Each Patient
- Development of Community Capacity
- Innovative Community Linkages Established
- Community "Buy In" Encouraged
- Preventive Health Practices Promoted
- Use of Community Health Representatives Encouraged
- Development of Partner Capacity (Involvement of the NGOs, etc)

- Priority Placed on Finding and Developing Strong NGO Partners for Long Term Care and Assisted Living

  NGO Capacity Monitored and Resourced

- Early Intervention (Capacity to Monitor and Intervene)

  Strategies Developed to Become Aware of Difficult Situations Early

- Region-Based Services (Need for Sufficient Capacity for Proper/Comprehensive Service Delivery)
- Full Range of Services Established at RSA site
- Specific Community Resources Designated as Required
- Effective Coordination of Key Policy and Procedural Issues
- Department Provides Overall System Guidance
- One Authority Unit Assigned Responsibility for Policy Coordination
- Input from Professions Sought
- Use of Medical Travel Coordinated Regionally; Guided from the NWT Authority

<u>The Guiding Principles</u>

The model must also be tied into the overall system and thus be framed by the same set of principles as any other component. These we outlined in Section 11.3.

<u>Proposed Health Care Model</u>

By simply adding more money to the present system and not changing the way in which health care is presently being delivered, there will be little overall improvements in health care.

The NWT has been innovative in the past, and it can continue to be innovative in the future when designing a future health care system. In addition to some new funds required for the health and social services system, there will need to be open discussion, dialogue, and decisions made concerning a more equitable base for regional board funding and less expensive ways of delivering health care.

Our view of the future healthcare delivery system envisages a primary care service delivery model for health and social services supported as needed by a regionalized system of emergency, diagnostics, acute care, continuing care, rehabilitation, mental health, and addiction services. The determination of the actual service components and service locations requires a detailed assessment of demographics, population age density and growth, transportation, industrial development, and the availability of skilled human resource, etc., plus a detailed cost analysis to determine the cost impact/benefit of taking the client to the service versus bringing the service to the client.

Above all, these decisions have to be made with the input of the local communities, the local health and social services professionals, and ultimately, the governing and funding bodies. While this type of needs assessment goes far beyond the terms of reference of this review, there are the following components that should be considered in the refinement of health and social services in the NWT.

1. Primary Care

   Health care in the NWT is built upon a network of approximately 30 community health centres that can be enhanced/consolidated to function as primary care centres that offer the following services that include but are not limited to:

   screening

health information - promotion and prevention

eye exams

physical examinations

medical treatment

vaccination

hearing exams

home visits

nutrition counselling

mental health services/addictions

rehabilitation (physiotherapy, occupational therapy, speech therapy)

- drug dispensing and information
- palliative care
- child protection, guardianship, and trusteeship
- medical transport
- diagnostic - basic laboratory and x-ray capabilities (depending upon distance to nearest hospital)

It is recognized that some very isolated communities are staffed by "lay dispensers" and that this service needs to continue, providing that ongoing supervision and consultation is provided from the nearest primary care centre.

One person nursing stations/social worker stations should be discontinued wherever possible.

Primary care is a system whereby services are mobilized and coordinated to promote health and well-being, prevent illness, care for illness, and manage health and social services problems. It is a comprehensive approach that addresses not only illness and injury, but also prevention programs, promotion of good physical and mental health, social well-being, and strategies to improve the health and well-being of the population. Primary care is built around the concept of a multidisciplinary team wherein health and social service professionals are brought together as equal partners.

Primary care can also be provided as an outreach service – in some instances it is more cost effective to take the service to a community on an as-need basis rather than establishing a permanent service in a small community.

2. Continuing Care

The NWT, like the rest of Canada, is experiencing an ageing population. Demands will continue to grow for continuing care services. Coupled with this growth for more continuing care services is an increasing focus on the desire of seniors to remain in their homes as long as possible.

the focus will be on bringing services to people not bringing people to service

home care services will have to be increased–however, in most cases the cost will be less than the cost of a regular "nursing home bed."

People with complex and chronic health needs will still need to live in a continuing care centre of some type – enhanced care lodge, assisted living, nursing home, etc.

- people usually prefer to remain in their own communities where they have family and friends and Regional Service Authorities will be challenged to provide efficient and effective continuing care services in rural NWT.
- Fort Simpson is a good example of a community where an existing hospital was converted to a community health centre and a nursing home unit was attached

which enabled the sharing of common services such as heating, laundry, food services, administration, maintenance, and other support services. There are other opportunities such as Fort Smith where hospital space could be converted to usable continuing care space. Indeed, we believe that these two centres could become the "Centres of Excellence in Long Term Care".

In other communities, it may be cost-effective to add some continuing care spaces to community health centres or to contract with private developers for services.

In the larger centres there is an opportunity to construct larger and perhaps free standing innovative and creative continuing care spaces.

Note: as a reference for new alternatives in continuing care, the Alberta Minister of Health and Wellness has just completed an extensive two-year Long Term Care Review and has published a report titled "Healthy Ageing: New Directions" which is available from:

Communications Branch
Alberta Health and Wellness
22 Floor, 10025 Jasper Avenue
Edmonton, Alberta T5J 2N3

3. Emergency Services

Emergency care will continue to be provided at the following levels:

- by on-site physicians at the Yellowknife Regional Hospital
- by on-call physicians at hospitals and community health centres that have resident physicians
- by nurses in remote areas that do not have resident physicians
- in all or most all instances, the nurse will continue to be the first contact/provider for emergency care and it is most important that the nurse practitioner's program at the Aurora College be supported and expanded. Nurses in remote areas have traditionally been called upon to suture wounds, splint broken bones, function as midwives, etc., and it is not expected that these duties will decrease.
- a speedy and efficient medevac transport system will continue to play a vital role in providing emergency care.

4. Acute Care

Acute hospital care is becoming increasingly complex and costly. No longer does the formula of a doctor + a nurse = a hospital. Acute hospital care is built around an extensive and diverse team of health care professionals supported by very complex and expensive array of diagnostic tools. Repetition improves practice and for this reason a certain volume of patients is required to maintain the skills and expertise of all staff. The trend across Canada is to perform more services on an out-patient/day procedure basis and to utilize fewer inpatient hospital beds, which are used primarily for advanced or traumatic conditions that often require specialty services. Acute hospital care is provided by physicians who, in the main, work in a team environment and require the back-up of colleagues, e.g., surgeon requires the anaesthetist, family physician requires the internist, etc. - all require the diagnostic backup of pathology and radiology.

- with approximately 30 physicians in the NWT, it is important that acute care services be structured and consolidated to most effectively utilize the limited medical resources (including the concentration of acute care services in the three communities of Yellowknife, Inuvik, and Hay River).
- medical resources should be shared wherever possible and the role of visiting consultants should be expanded.
- to further facilitate the sharing of medical resources, there should be one medical staff organization for the NWT for the purposes of credentialling and privileging physicians and for the general organization and management of physician services.
- a single medical staff organization with one master set of bylaws would offer the following benefits:
- reduce medical administration and bureaucratic duplication
- improve referrals and consultations
- streamline the process of visiting privileges
- expand opportunities for medical rounds and educational opportunities
- retain local control through site medical chiefs while bringing collective assistance to those site chiefs from a consolidated medical staff organization
- provide backup and support to those physicians who are working in communities served by community health centres.
- as with emergency services, an organized referral system with a speedy and efficient medevac transport system will continue to play a vital role as transfers within the NWT and transfers beyond the NWT to a higher level of care, for advanced and tertiary care will always be required.

5. Diagnostic Services

While timely and definitive diagnostic services are essential to the practice of good medicine, the health care industry is constantly being challenged by the growth (and often very high cost) in the availability of new diagnostic tools e.g., MRI units that cost upwards to 2 million dollars to purchase and a 1/2 million dollars a year to operate. Nevertheless, diagnostic services are essential and have to be provided. The question then, is at what level should they be provided.

- professional advice needs to be sought in this regard; however, as a minimum, physicians need basic on-site laboratory and x-ray services
- most laboratory specimens can be referred out to a more complex central laboratory and some radiology film can be sent out for interpretation
- telehealth technology is enabling the transfer electronically of certain radiology information to remote specialists to help diagnosis and prescribe appropriate treatment methods. Similar technology is being used for the interpretation of ECGs, etc.
- beyond the transfer of specimens or electronic data, it then becomes

necessary to transfer the patient to the appropriate diagnostic centre

- the planning question then becomes an economic equation as to when the cost of referral (transport) exceeds the cost of providing the service locally
- the cost equation, however, is further compounded by the realities that physicians recruitment and retention are often predicated by the availability of diagnostic services and equipment. Planners, therefore, must be cautioned to plan around service needs rather than individual physician's needs.

6. Rehabilitation Services

Rehabilitation Services such as physiotherapy, occupational therapy, and speech therapy services are gaining recognition as to their important contribution to health care. Services that were traditionally hospital-based, and focused on short term restorative therapy following injury, are now being expanded into long term continuing care and in prevention and promotion, e.g., back care, work environment, job site sound attenuation, etc.

- rehab services can be offered through hospitals, community health centres and through travelling services wherein the therapeutic services are taken to the client in their own home or into other communities that are not served by community health centre complexes.

7. Mental Health and Addiction Services

Mental Health and Addictions Services that were traditionally provided in specialized institutional settings has gained much success by offering community based programs

- these programs have a natural home in the primary care model and emphasis should be placed on the expansion of these community-based programs (there is a natural expansion of service opportunity here which could be assumed by sites such as Fort Simpson and Fort Smith
- specialized institutional services for mental health and addictions will continue to be needed for more severe cases and these can be centralized in the three Regional Services Authorities with the principal units being located in Yellowknife.

8. Social Services

We believe that the integration of health and social services should be continued, however, the integration is only partially working and case management involving health workers and social workers' needs further collaboration and teamwork in most communities. We visualize social services as an essential component of primary care and recommend that the Regional Services Authorities work diligently to bring about this integration that will ultimately better serve the people of the NWT.

Public Health Programs in the New Health Model

The GNWT does have some basic overall responsibility to assure basic public health programs are carried out. It is suggested that this Departmental responsibility can be carried out in the following ways:

An NWT-wide board or committee can be formed to advise the Department and the Chief Medical Officer of Health on relevant programs and needs.

The Department can recommend the designation of one or two full time

nurse positions to each of the new Authorities to work with the Department and NWT Authority under the guidance of the Chief Medical Officer of Health to help carry out basic public health programs. Fundamental to their duties would be TB surveillance and communicable disease, however, they would be able to assist in various other public health campaigns as necessary.

Each of the Regional Services Authorities should appoint a person to be their Deputy Medical Officer of Health. These persons would have a professional reporting linkage to the Chief Medical of Health Officer in the Department while reporting administratively to their own CEO. This system would help prevent fragmentation and breakdown with regard to wide range population health-related programs.

Under public health legislation, there are certain responsibilities relating to, but not limited to the:

- Discovery and treatment of communicable disease including immunization, isolation and quarantine.
- Surveillance of water and air quality, and sewage and garbage disposal to assure public safety.
- Surveillance of public food outlets and food production to assure public safety.
- Inspections of above public services with authority to regulate, control and quarantine (including access to private property).
- Public education and promotion of healthy living.
- Healthy childhood development – pre and post natal services
- Supporting seniors through the aging process to reduce health problems and injury.
- Development of young adults enabling them to lead a healthy lifestyle.
- Prevention of injuries and chronic disease in the general population.

Public health responsibilities cross the boundaries of the Department of Health and Social Services and the Health Authorities and other government departments such as environment and education, etc. From our many interviews, it appears that pubic health programs occasionally “fall between the cracks” and that roles and responsibilities between the Department and the Health Authorities are not clear.

During the past three years, when major public health programs were being organized and promoted, there was not any assurance that they would be delivered in the desired time frame because of emergencies and daily demands being experienced at the local level.

Operational issues arise in inspection and surveillance in that all “orders” have to be issued under the authority of the Chief Medical Officer of Health who is employed by the Department of Health and Social Services while some of the inspection officers are employed by the local boards. Similar jurisdiction concerns arise in the areas of immunization, isolation and quarantine orders in the discovery and treatment of communicable diseases.

The GNWT has the overall responsibility to establish basic public health programs and to assure that they are carried out. It is suggested that this GNWT responsibility can be carried out in the following ways:

The Department of Health and Social Services would have the responsibility

to develop the regulatory framework and the territorial wide program standards and regulations.

Programs and services would be administered directly by the three regional service authorities under the direction and guidance of the NWT Health and Social Services Authority and the Chief Medical Officer of Health (for those duties mandated to the Chief Medical Officer of Health under the public health legislation).

A joint NWT Health and Social Services Authority and Department of Health and Social Services (Chief Medical Officer of Health et al) committee be formed to provide program direction and to advise the Department of Health and Social Services and the NWT Health and Social Services Authority on relevant programs and needs.

Each of the Regional Services Authorities would appoint a member of their medical staff to be their Deputy Medical Officer of Health. These persons would have a professional reporting linkage to the Chief Medical Officer of Health in the Department while reporting administratively to their own CEO. All public health inspectors, public health nurses and operative staff will be employed by the RSAs. This system would help prevent fragmentation and breakdown with regard to wide range population health-related programs.

- It will be necessary to designate permanent positions in each of the RSAs for inspections, surveillance duties and for the discovery and treatment of communicable disease such as TB surveillance and for ongoing immunization. Additional staffing will have to be designated and provided for ongoing prevention and promotion programs. Most of these programs fit nicely into the primary care model of care and should be offered through that system (e.g. pre and post natal programs, supporting seniors and young adults in healthy lifestyles, health promotion, prevention, etc).

Health Centres in the New Health Care Model

This proposed health care model is still founded upon the care offered through the health centres. There needs to be a clear vision articulated for the community health centres that is built upon various programs and practices now in place. This vision should incorporate the following philosophy:

Orientation to community wellness.

Adopting a multi-disciplinary approach: working closely with other professions and groups such as alcohol and drug workers, social workers, community development workers, school teachers, medical specialists, and so on.

Working closely with social service workers through a fully integrated case management approach.

Effective linkages with community leadership including the proposed community health committees or councils.

Exploring and incorporating innovative models of health education and health care delivery.

11.7 Clarity of Business Planning

One of the critical components of any sound system is its focus on its future. Without such a focus, any future planning lacks an overall framework. Such a framework is provided by: a sense of purpose (vision); long range goals; shorter term objectives; 1-3 year budgets; stated

priorities on annual basis; and
measurable targets.

In order to achieve a well-rounded view of something as complex and as important as personal health and sense of well-being, a series of discussions are required with people who are often referred to as the key stakeholders. In this instance, many of those discussions have been held as a result of the recent Minister's Forum which resulted in a well-crafted response to what the members of that body heard in their discussions with the residents of the NWT. That was complemented by the other recent consultative exercises which have been orchestrated by the Department relative to its own strategic planning cycle. As well, there are numerous ongoing consultative mechanisms involving the professions and the Northern Workers Union and others which ensures that some degree of informal exchanges of ideas are possible. This does not supplant the need for an orderly way of establishing the goals and objectives for the entire system. Thus, while there will always be criticism of "too much consultation-not enough action", the scope and significance of these two allied fields requires opportunities for those most affected to provide input. In many ways, such input works towards ensuring an ongoing focus on continuous improvement.

The **Business Planning Cycle** refers to the steps through which an organization ought to proceed in terms of establishing a clearly-defined Business Plan. Thus, while the Business Plan itself must result in certain issues being addressed, as noted below, the Planning Cycle identifies those steps through which the Plan must proceed. We have outlined our expectations in a broad framework (see Exhibit below) as well as the actual Business Plan Components (see Exhibit below).

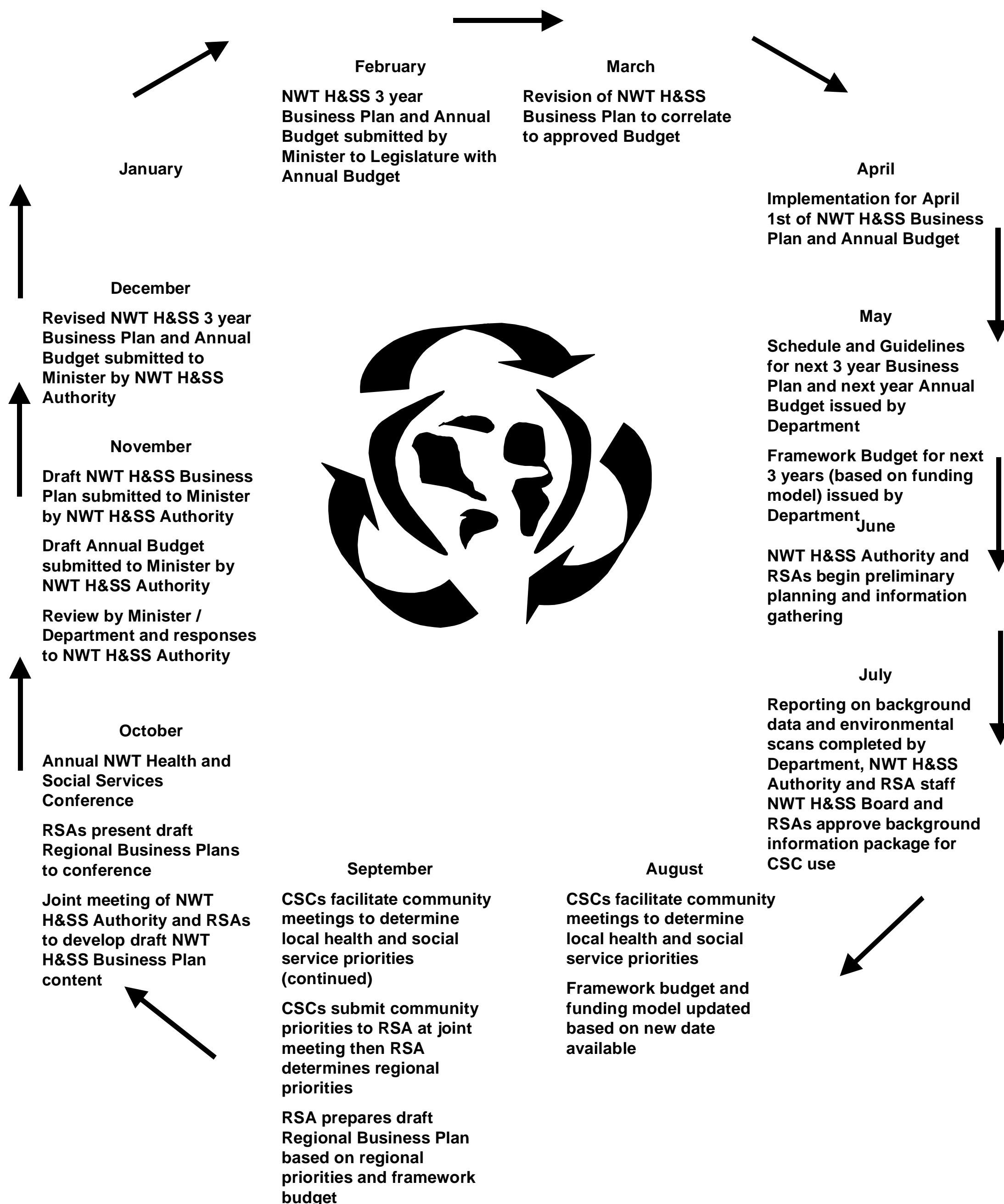
The **Business Plan** for each Board must result in:

- Opportunity for planned public input
- Identification of local and regional needs & aspirations
- A description of the vision and mission of the organization
- A clear statement of mandate
- A set of governing and operating principles
- Broad goals and specific objectives
- A description of each service area and a description as to where the area of responsibility lies i.e. the Board and its administration; a non-governmental organization; or other
- An outline of the perceived priorities for that Board
- A description of how these priorities are to be addressed
- A review of the human and financial resources needed to accomplish these objectives
- An outline of how these targets (goals, objectives and priorities) will be measured, when and by whom

Business Plan Components

Territorial-wide
Guidelines
Meetings by Community
Services Councils and
Local Public
Local / Regional
Needs and
Aspirations
Measurement of
Results
Action Plan
Business Plan
Vision and Mission
Reviewed /
Established
Priorities of the
Board
Clear Statement
of Mandate
Service Areas
Described
Goals / Objectives
Governing and
Operating
Principles

Business Plan Cycle



11.8 Appropriate Management Systems

Some of the problems encountered as a result of our extensive round of interviews pertained to the understanding of management processes by those appointed to fairly senior positions. While some of the senior staff are obviously well-qualified for their respective positions, there is still the need to ensure that a common body of knowledge is developed relative to what constitutes effective Board management and supervisory skills.

We also recognize that simply saying what we have identified these practices to be does not mean that sound business management skills are readily assumed by those holding senior or supervisory positions. While we have included herein a first cut at such a description of key supervisory and management systems and related skills, the only way by which these will be fully absorbed is through a process of ongoing training. Thus, we believe that an effective organization reflects:

A Sense of Future Vision

> Is involved in contributing ideas to a board-driven business planning process which seeks to set forth a future vision of the region and organization.
>
> Establishes its own internal mechanisms(s) to develop an administrative sense of the future; ensures that all levels of personnel, if not all staff, have the opportunity to contribute ideas.
>
> Is knowledgeable regarding the priorities of the Board and the organization.

Clear Statement of Mandate

> Has a clearly articulated written statement of mandate which sets out its principal functions and expectations.
>
> Has well defined and broadly-written position descriptions which focus on key tasks and expectations.
>
> Possesses basic policies to guide all key aspects and drafts procedures to support the Board-approved policies.

Organization Structure

> Is clearly defined so as to ensure that all staff are aware as to their direct lines of reporting and accountability.

Sound Recruitment and Retention Policies

> Recognizes that to do its best it needs to recruit the best person for any position.
>
> Ensures that both internal and external candidates are equally considered.
>
> Ensures that the compensation package is appropriate for each position.

Orientation of New Employees

> Sees the value in having all employees well-versed in the role, functions and personnel of the entire organization.
>
> Ensures that any new employee is fully introduced to the organization, its people, policies and procedures.

Effective Leadership

> Is blessed with a leader who has a clear sense of direction; is committed to the organization and its mandate; is respected by those in authority.
>
> Lead by someone who communicates well; adheres to policies but is able to innovate as necessary; mixes well with

his/her employees and is respected by them; sets standards and then provides feedback on performance; encourages constructive feedback on problems and challenges.

Sense of Collaboration and Cooperation

Understands that its first loyalty is to the needs of those being served rather than to its own self-interests (i.e. Maintaining its own turf).

Finds ways to collaborate with other organizations/departments to make better use of resources and to encourage the notion of cooperation amongst employee groups.

Maximizes the use of shared human and physical resources.

Communication

Recognizes communication as the lifeblood of an organization and seeks to remove any impediments to its flow.

Meets in small groups regularly and as a larger department (less often) to discuss plans, issues, opportunities.

Planning and Standards

Appreciates the need to plan ahead in order to make the best use of all resources.

Sets targets and deadlines and monitors regularly and openly.

Informs staff as to desired standards of performance and regularly evaluates.

Training and Development

Views people as its most valuable resource and establishes policies/procedures which recognize that value.

- Ensures that all new staff are appropriately trained for their tasks and then updates skills on a regular basis.
- Affords older staff the opportunity to upgrade their skills to ensure their continued relevance.
- Plans training in advance of each budget year and targets the program to needs identified by the job and by performance reviews.

Morale

- Seeks to monitor and improve employee morale through:

open communication of plans and board decisions

regular employee appraisals

complimentary comments on a job well done

formalized recognition programs

fair compensation.

regular team-building opportunities.

Facilities and Equipment

Occupies space which is well-planned, functional, attractive.

Has access to up-to-date equipment, technology and work processes.

Issues Management

Understands the key issues facing the Authority and the department.

Provides ongoing feedback to the public, the Board and management on the status of those issues.

Decision-Making

- Understands how decisions are to be processed.
- Respects the need for collaboration and cooperation.
- Provides for clear levels of decision-making authority and responsibility.
- Implements authority decisions quickly.

11.9 Ongoing Training and Development

Thus, we are recommending that the Department not only work actively towards an ongoing process of **Governance Training** but that it also work with the Boards and CEOs in designing **Senior Management Training** opportunities for senior level staff and supervisory staff. Training opportunities also need to be made available for professional and support staff, a topic which we deal with in more depth in this Report.

The need for appropriate governance training is absolutely essential if the proposed system of governance is going to function as intended. While we appreciate the intent of the former approach, it is our opinion that, for a variety of reasons, it did not result in a strong system of Board governance.

It is our understanding that the former NWT Healthcare Association was given this responsibility. That mandate lapsed, of course, with the shutdown of the Association. While we do not comment relative to the worth of the Association, this was obviously one of its important functions.

In light of the Association folding, we believe that this should be a shared function between the Department and the recently constituted **Leadership Council of Chairs**. The **Department** has the following important roles to play:

- Coordinating the training program and activities
- Assisting with program content
- Advising as to their areas of concern and/or recent initiatives
- Providing some of the expertise for training programs
- Providing advice on others who may be suited for training activities
- Hosting a once annual conference of the NWT Health and Social Services Authority and the Regional Services Authorities, wherein at least one day will be given over to the training of all Board members (note: additional training on an ongoing basis would be the mandate of the Authority)
- Funding the annual training program/conference and the tri-annual conference of new Board members

The **Leadership Council of Chairs** has the following roles to play:

- Providing input to the training program
- Advising as to appropriate speakers/facilitators
- Encouraging full involvement by all Authorities
- Ensuring that the community services councils training requirements are also met
- Deciding upon a suitable location(s) for the training.

11.9.1 Senior Management Training

Similarly, there is a growing recognition of the need for an adequate training program for chief executive officers and their staff. This needs to be given a strong impetus by the Department and by the Boards. It too should include involvement by both the Department and the CEO Leadership Council. Again, the following division of duties is recommended:

The **Department** has the following important roles to play:

- Coordinating the training program and activities
- Assisting with program content
- Advising as to their areas of concern and/or recent initiatives

- Providing some of the expertise for training programs
- Providing advice on others who may be suited for training activities
- Hosting a once annual conference of the NWT Authority and the Regional Services Authorities, wherein at least one day will be given over to the training of all CEOs and senior staff members
- Funding the annual training program/conference.

The **Leadership Council of CEOs and Senior Managers** has the following roles to play:

- Providing input to the training program
- Advising as to appropriate speakers/facilitators
- Encouraging full involvement by all senior staff and the professions
- Ensuring that the training requirements of subordinate staff are also met
- Deciding upon a suitable location(s) for the training.

We do not presume, nor are we recommending, that this is the only training or development program which the CEOs should be pursuing on an annual basis. It is important that these senior executives continue their learning through applicable conferences with other executives in the health professions. The foregoing is presumed to be one element of that learning contract.

12.0 KEY ROLES AND PROPOSED STRUCTURES

If our proposed changes are adopted by the Legislature and thus by the Department, there will be considerable change to the make-up of the Department and the deployment of resources. The roles of the Department will by necessity, be much more focused in the areas of:

- Legislative renewal and policy leadership
- Strategic goal-setting
- Allocation of global budget(s) and reporting requirements
- Description of core services
- Measurements and standards for determining health status
- Monitoring of public health requirements; ensuring standards are being met
- Coordination of Territorial response to new federal initiatives; intergovernmental relationships
- Monitoring performance of the NWT Health and Social Services Authority
- Acting as the backstop to any significant problems encountered by the new system in achieving performance targets and/or delivering a reasonable and consistent level of service.

12.1 Criteria for Establishing a Regional Services Authority

In order to fully understand the philosophy which underlies this proposed change in service delivery structure, it is imperative to establish the criteria which we used for designating the three Regional Service Authority areas of jurisdiction. Further, we herein outline our thinking relative to where these Authorities ought to be physically located and how this will affect the present arrangements.

The recommended criteria as to what regional authorities ought to be established and where are as follows:

- The most effective and comprehensive range of professional services available together with the back-up support to that service
- Scope of the geographic area; accessibility; normal traffic patterns
- Recognized hub community for at least the majority of the region it serves
- Number of people likely to be served; actual population base
- Accepted as the current “home” of many of those who are likely to work for that Authority.

The Med-Emerg Report of 1997 pointed to the need for sufficient resources to be available which necessitates a broader-based approach. That Report states, and we quote

> *“It is important that the Regional Boards represent an entire region and not the interests of any one community.”*

Similarly, the Department’s own documents refer to the problems encountered in trying to provide services out of a multiplicity of Boards. Their plan “Shaping Our Future: A Strategic Plan for Health and Wellness (1999) states:

> “*The number and variety of boards can make it difficult to coordinate or develop services that are shared by more than one board. It can also be difficult, particularly for small boards, to maintain expertise and stability in*

management, administration and service delivery."

12.2 Board Member Recruitment and Retention

At present there are various ways by which a Board member is appointed to one of the nine Health and Services Boards. Some members have been nominated by the local community council; some have been elected within the community and appointed to the Board; others have been nominated by various councils within their local community; and some are direct appointments of the Minister.

It is our view that the Minister should standardize the system of appointments through establishing a **Board Member Nominating Panel** which is charged with seeking nominations to these recommended Boards for a term which should begin no later than October 1, 2001 and should carry on for the three year period to October 1, 2004. The panel should stay empowered by the Minister to advise on ongoing appointments which are necessary by virtue of those stepping down from their appointment or whose position has been revoked for one reason or another.

12.3 Election of Board Members

We briefly examined the issue of electing Board members to either the Regional Services Authorities and/or the NWT Authority. It is our view that the present method of appointing Board members is suitable. We base this argument on the following rationale:

- The notion of having public interests served by elected representatives is accounted for by the fact that the NWT has 19 elected Members of the Legislature
- The fact that health and social services are high profile as service areas of the Government means that there is a constant spotlight on this Department
- Additional elected spokespersons/representatives would not necessarily achieve any greater focus on these services than is currently the case
- If local groups/Band Councils/Metis Councils want to be assured of being represented at the Board table, that is more likely to happen by way of appointment through the Minister's office
- The system is going through considerable change as it is with the potential implementation of all or much of this Report; electing Board members simply adds an additional dimension of change
- The system is funded through the revenues of the GNWT; if there are concerns about the lack of spending on a particular perceived local priority, direct contact will still be made with the Minister, Cabinet and MLAs.

12.4 Selection and Appointment of the Chairs

The issue of how the Chair for each of the NWT Authority and the three RSAs is selected was brought forward as an issue. There is merit in either option: either electing the Chair from within the Board; or having the Minister make the appointment from all those appointed to by the Minister to serve on the Board (i.e. either candidates recommended through a nomination panel or through other mechanisms e.g. from community councils, MLAs, etc.).

In this instance, we believe that there would be real merit in having each of the

Boards choose their Chair from the members of the Board on a secret vote and on an annual basis. This will ensure that there is a need by the Chair to maintain a decent professional relationship with his/her colleagues and the communities represented.

We recommend that the Department draft the regulations such that the Chair of each of the four Boards is elected by secret ballot from within the members; with the proviso that the Minister can, with reason, dismiss the Chair, individual members of the Board; or the Board as a whole and that the Minister may appoint the Board if conditions so warrant and may refuse (with reason) to accept the name of the person elected from amongst their members.

12.5 Location of the Regional Services Authorities

We recognize that there is likely to be considerable sensitivity to the recommended placement of the proposed Regional Services Authorities (RSAs). At the heart of the matter is one seminal or key question:

> "do the changes to the status quo enable the residents of the NWT to have a more stable and sustainable health and social services system such that not only the present population but also future residents are able to access quality services which meet the needs of the population of the NWT?"

We have given much thought to the question of where to recommend the placement of the four bodies which we recommend to replace the current nine. The designation of specific locations (and alternatives) has been based on the following considerations:

The NWT Authority

- Access to the necessary professional resources to staff the Authority
- Site of significant social, educational, cultural and recreational amenities (ease of attracting new or replacement staff)
- Cost efficiencies for staff travel
- Quality accommodations
- Accessible by ground and air transportation
- Central to the communications hub of the NWT
- Ease of transition from the current arrangements to the new structure
- Ability to attract the right resources quickly to replace any that leave the Authority
- Cost of holding meetings of staff and the Board
- Access to the leadership of other organizations for key meetings
- Will reflect and represent the seat of Government
- Ease of access to the Minister and Deputy Minister

The Regional Services Authorities

- Recognized as a natural centre for the region
- Consistency with broad regional groupings
- Accessible by ground and air transportation
- Site of a major hospital
- Reasonable range of professional resources
- Access to trained support staff
- Presence of a solid core of qualified health and social service professionals

- Quality accommodations
- Recognition of current boundaries of self-government groups and a preference to keep these in one RSA if possible
- Ease of transition from the current arrangements to the new structure
- Complementary range of non-governmental organizations
- A balanced system

As a result of our assessment of a comprehensive range of options relative to locations for each of these Authorities, we have decided to recommend that the NWT Health and Social Services Authority be based in Yellowknife. This will likely come as no surprise to most although we did give consideration to one other community (Hay River) for some of the same reasons. At the end of the day, it was our view that there was significantly greater likelihood that the new Authority would be able to access the necessary human resources more quickly and assuredly in the capital city. It is also true that some of the staff who are presently employed by the Department (and resident in Yellowknife) may have their positions allocated to the NWT Authority.

The second decision(s) was more difficult to resolve. Much of our hesitancy has been simply a reflection of the population distribution of the NWT. It would be much simpler if there were natural core communities with a sufficient threshold population which would support a comprehensive service hospital facility as well as being home to a wide range of skilled health and social services employees. The reality is much different.

Thus, while we have explored a variety of options and have reviewed the existing literature relative to regional servicing issues, we are charged with recommending a system which is sustainable over the foreseeable future and sufficiently flexible so as to accommodate future shifts in governance arrangements (for example, that which might evolve due to current self-government negotiations).

The very significant population difference between Yellowknife and the other NWT communities makes the choice for any of these locations a rather difficult exercise. However, after giving this some thought, we believe that there are quite sound reasons in favour of placing the headquarters of the three regional services authorities as follows:

Northern Region	**Inuvik**
Central Region	**Yellowknife**
Southern Region	**Hay River**

While we gave consideration to the location of the Central Region in at least one other location, the overwhelming impact of the Stanton Hospital and the Yellowknife Health and Social Services would bring any other headquarters into real question as to its viability and logic. While one could argue that a site other than Yellowknife for the Central Region would add balance to the overall distribution of resources, our task was not to “spread the resources around” as though that was as easy to achieve as it sounds. Rather, the health and social services system must be reflective of a good degree of common sense if it is to serve the residents in an optimal fashion.

Our recommended sites, which ought to be designated for each Regional Services Authority, are as follows:

<u>Northern Regional Services Authority</u>

Headquarters: Inuvik

Regional Services Centres: Aklavik, Holman, Paulatuk, Sachs Harbour, Tsiigehtchic, Tuktoyaktuk, Fort McPherson

Central Regional Services Authority Headquarters

Headquarters Yellowknife

Regional Services Centres: Norman Wells, Fort Good Hope, Colville Lake, Deline, Tulita, Fort Simpson, Wrigley, Fort Liard, Jean Marie River, Trout Lake, Nahanni Butte, Yellowknife, Detah, Rae Lakes, Edzo, Rae, Wha Ti, Gameti, Wekweti, Kakisa, Hay River Reserve

Southern Regional Services Authorities Headquarters

Headquarters: Hay River

Regional Services Centres: Fort Smith, Fort Resolution, Enterprise, Fort Providence, Lutselk'e

12.6 Support Services for Boards

If the proposed Board structure is to work as intended, several key elements must be in place. These include:

- A comprehensive background briefing on the purpose of Boards
- Orientation for all new members on an ongoing, regularly scheduled basis
- A thorough briefing with respect to the key components of the Board's business
- Clear protocols which state the prerogatives of the Minister (and Department) as well as their obligations
- Access to expertise from the Department and/or external advisors on topics central to the core businesses of the Boards
- Appropriate and thorough briefings of the Board by their Chief Executive Officer
- A clear understanding of the fiduciary responsibilities of a Board

12.7 Proposed Organization Structures

In order to accomplish the changes in the delivery system which we are recommending in this Report, there must be significant change to the way in which the health and social services components in the NWT are presently structured. While we realize that what we are recommending is very significant and a marked departure from the current delivery system, it is our view that the current structures have hindered the system and will threaten its very survival if not radically changed.

As a result of our perceptions that change is necessary if the health and social service needs of people are to take precedence to the aspirations for local community control of the delivery of services, we believe that the re-design of the system is essential.

We recognize that the changes recommended are significant. Not only are we recommending changes to the structure (and thus staffing) of the nine Boards but so too are we recommending a rather significant change in the roles and functions (and thus staffing) of the Department. We would presume that the Department would act quickly to assure employees of their future employment status and potential career opportunities once the Government has decided how to proceed with this Report. It is our view that any current employee wanting to stay in this challenging field would have increased opportunities to do so.

The recommended design is shown as: **Exhibit # 1 (Proposed Departmental Structure); Exhibit # 2 (Proposed NWT Health and Social Services Authority); Exhibit # 3 (Proposed Regional Services Authorities) (see opposite).** These three structures are interdependent, that is, they are intended

to complement each other with a minimal degree of overlap and a significant degree of clarity as to responsibility and accountability.

The following outlines our description of the anticipated roles, responsibilities and functions of each of the three new structures:

Exhibit # 1

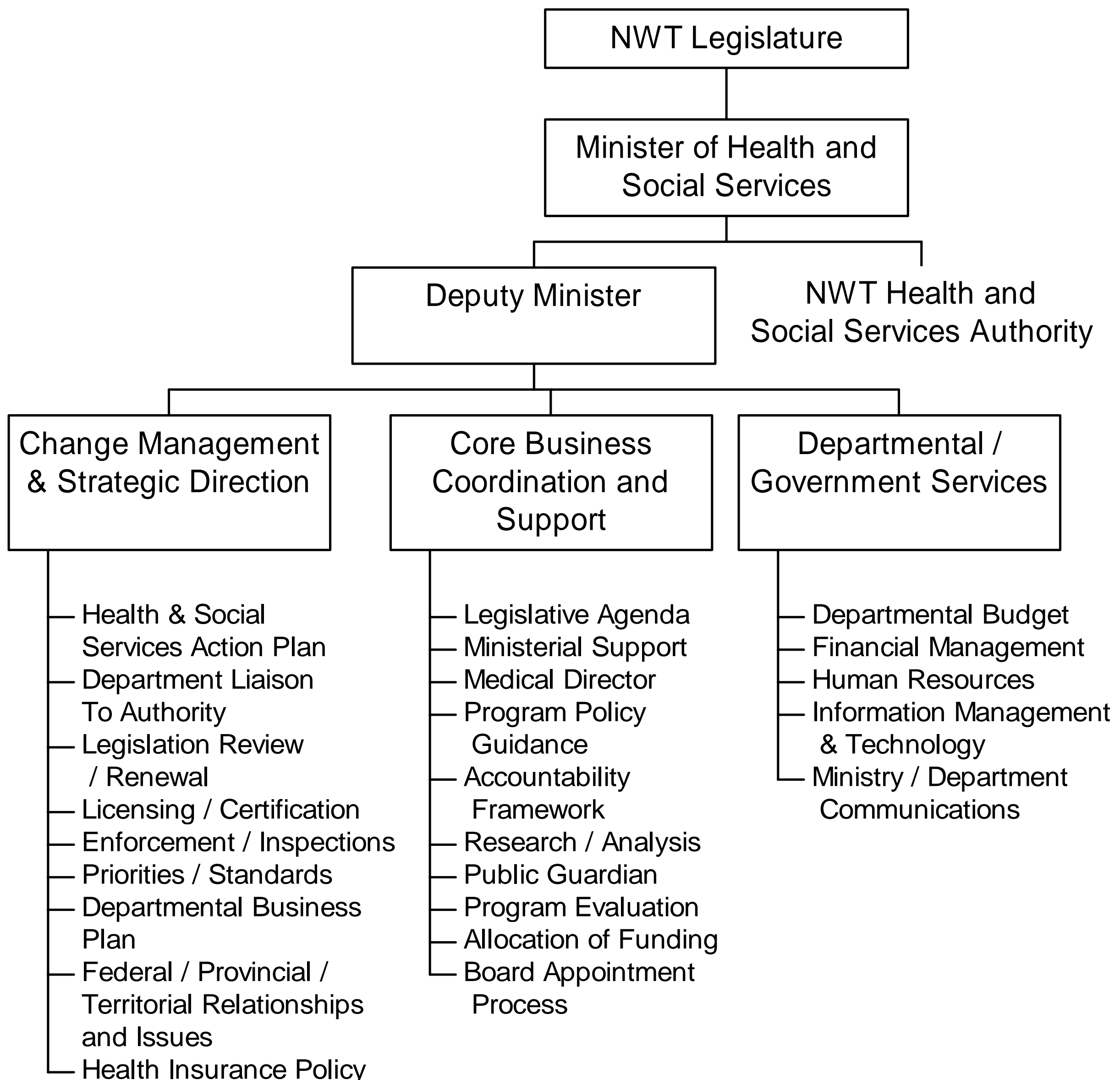


Exhibit # 2

Proposed Organization Structure for
NWT Health and Social Services Authority

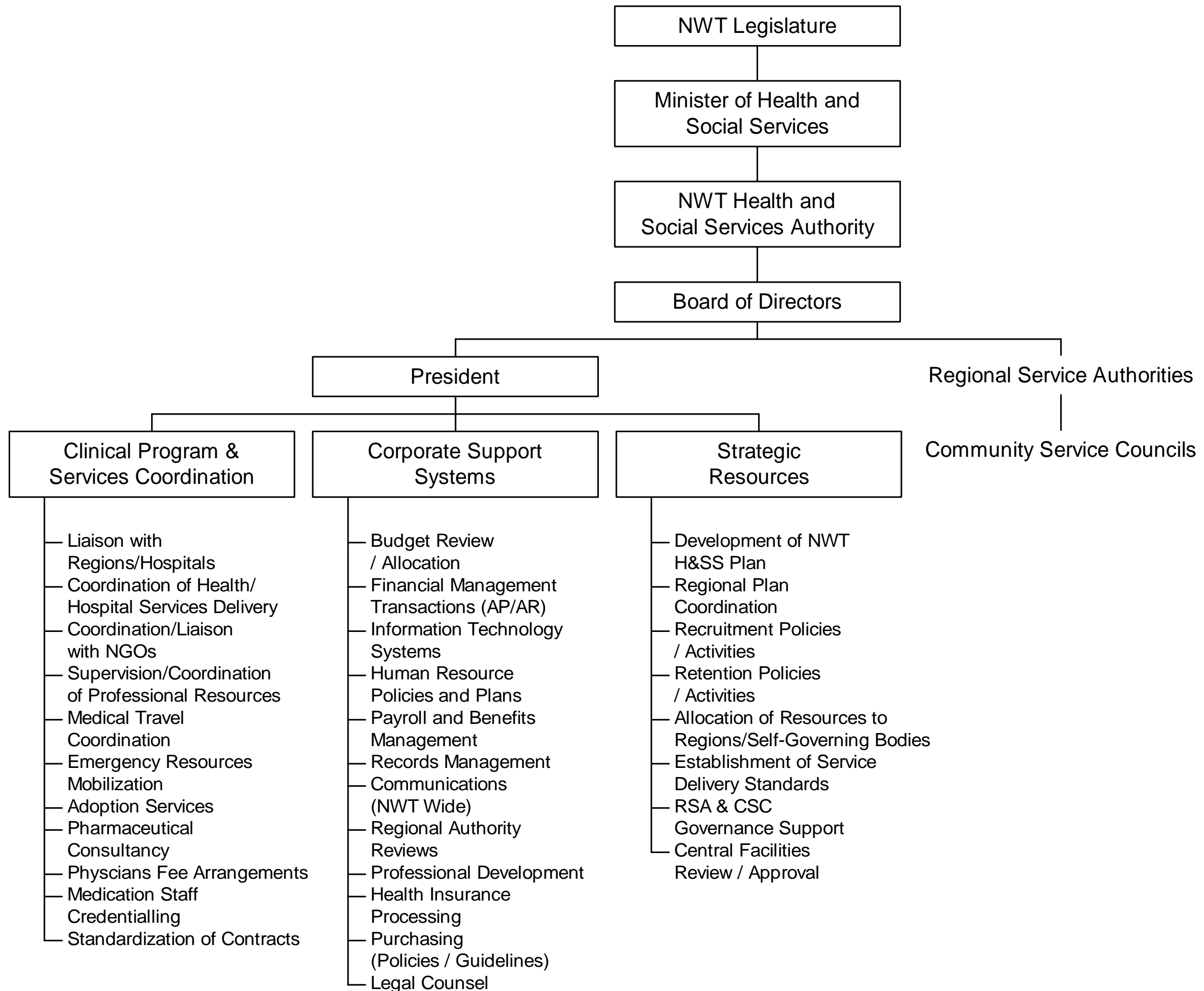
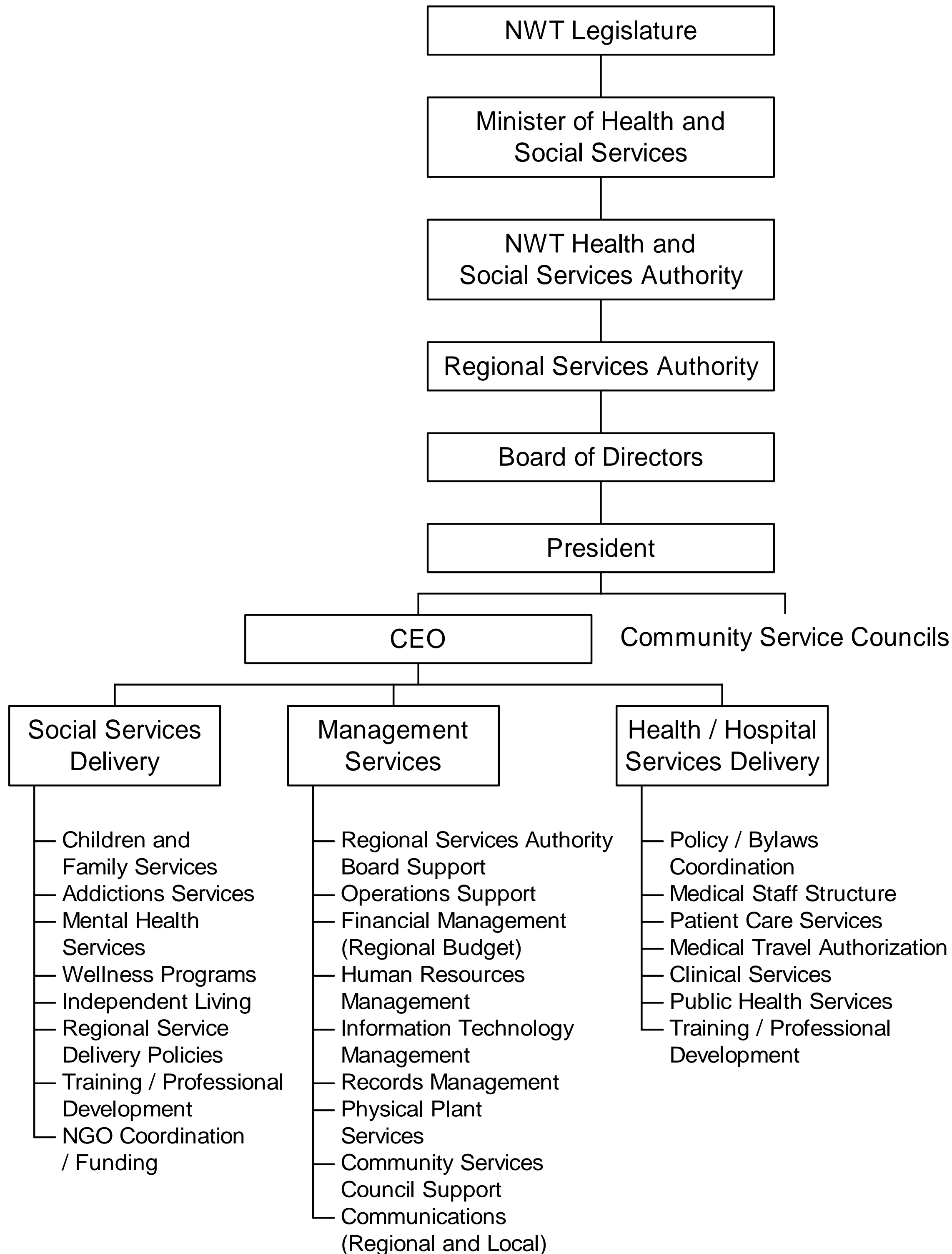


Exhibit # 3

Proposed Organization Structure for each Regional Services Authority



Level 1 Deputy Minister

Main functions include:

Management: directing the staff of the Department of Health and Social Services

Legislative: responding to inquiries from the Minister and/or other members of the Legislature; briefing the Minister on key and/or emerging issues; briefing the Legislature and its committees; providing budget estimates; defending expenditures; initiating new legislation/regulations; evaluating existing legislation/regulations

Strategic Leadership: developing territorial strategic directions based on health and social needs

Monitoring: developing and monitoring core services and population health/social status; monitoring programs and services to ensure that they are integrated and coordinated with other GNWT services wherever possible; monitoring boards to ensure that they meet territorial legislation, policies, standards, utilization management, quality assurance, and performance requirements

Consultation: consulting with the NWT Authority principally regarding legislation, policy and direction pertaining to the Authorities powers, responsibility and

Base Level of Services: developing the framework which determines a defined base level of services

Investigative Role: responding to public, Board or administrative concerns relative to the delivery of services or actions of the Department and Authorities which are not perceived as in keeping with the agreed upon mandate; where conditions so warrant, taking corrective, remedial action to address perceived inequities or an inability to deliver the agreed upon services and programs to an acceptable standard.

Level 2 Functional Responsibilities

Main functions of the **Board/Authorities Coordination & Support** may include:

Developing clear reporting requirements including type of content, timing of reports

Advising the Minister of an appropriate process for Board member selection and appointment

Developing an accountability framework; ensuring that all stakeholders are familiar with the concepts

Coordinating a conference of all Board members and senior staff once annually to discuss the latest emerging issues; review any recent legislative changes; discuss recent public health initiatives; meet with experts on the issues from across Canada

Promoting interagency cooperation between the Authority, RSAs and any relevant NGOs

Main functions of the **functional responsibilities: Programs Support** include:

Providing policy to related aspects of Patient Care services and programs

Providing policy leadership to the services of Population Health

Providing policy leadership to the area of Health Information Services

Providing policy leadership to the broad area of Social Services

- Providing policy leadership to all NWT Wellness programs
- Providing policy leadership to the functions of Children and Family Services
- Providing policy leadership to Health Protection and Prevention Services
- Providing policy Health Promotion programs and services
- Providing policy leadership to Independent Living programs and services
- Liaising with the professional associations involved with each of the professions which are involved with health and social services

Main functions of the **functional responsibilities: Corporate Services (Territory Wide)** include:

- Preparing the budget estimates for the Department
- Overseeing and being responsible for all Departmental financial management procedures and activities
- Preparing the Departmental Business Plan; providing input and advice to the NWT Authority relative to Business Plan preparation
- Overseeing the policies and plans for the Departmental human resources; liaising with the Union of Northern Workers; advising the NWT Authority in their recruitment activities
- Coordinating the development of a Departmental communications approach and plans
- Ensuring the development and coordination of Departmental information technology functions; liaising with applicable GNWT officials relative a coordinated strategic IT Plan

Main functions of the **functional responsibilities: Strategic Directions** include:

- Coordinating the legislative renewal process; ensuring that all applicable legislation and supporting regulations are placed in an appropriate framework and that they are streamlined in keeping with the tone of this Report
- Enforcing the legislation and regulations; conducting inspections from time to time to ensure their effective enforcement
- Developing Departmental and Ministerial Directives in support of the legislation in order to bring about increased understanding and therefore compliance
- Establishing Departmental and program standards in conjunction with other senior officials and relevant professions
- Overseeing the creation of Departmental goals and objectives relative to the Business Plan; developing policies which support the Plan
- Acting as the lead Division relative to any federal/provincial/territorial relationships and initiatives; ensuring that any such initiatives as they affect the NWT Authority and RSAs are communicated promptly

Level 1 President & Chief Executive Officer

Responsibility for:

- Developing and submitting an NWT Health and Social Services Business Plan to the Board of the Authority for approval; ensuring that this has been the product of the key stakeholders and reflects the input of the Department as appropriate

Reviewing and commenting to the Authority Board on any recommended changes to the Business Plans of the RSAs

Establishing service delivery standards in conjunction with the Board (and as approved by the Board)

Directing a range of clustered services e.g. budget review/allocation; financial management transactions; information technology systems; human resource plans and policies; payroll and benefits management; records management; communications; health information program

Overseeing the operation of health and social service facilities; setting the standards, budget and expected results (in accordance with the policies and guidelines as approved by the Board)

Managing the approved budget of the Authority within the expenditures approved by the Board of the Authority and subject to Board-designated expenditure limitations

Planning, guiding and overseeing a planned program of professional development

Administering the recruitment and retention initiatives; employing professional resources; assigning requested resources to RSAs as approved by their approved budgets; coordinating locum services and assigning

Coordinating medical travel; ensuring the cooperation and support of the RSAs

Reallocating services to address crisis areas

Coordinating service resourcing from outside the NWT

Reporting to the Board on all matters deemed to be substantive or key to the organization's operations and continued functioning

Establishing administrative committees as necessary (e.g. Placement, Planning, Review Committee; Child Abuse Review Team; Communications; Business Planning; Integrated Case Management; Community Development; Legislative Review); assigning applicable staff to assist the Board and its policy committees as needed (e.g. Corporate Services -Planning, IT, HR and Budget; Health Services; Social Services; Audit)

Accountability to:

The Board of the NWT Health and Social Services Authority

Level 2 Functional Responsibilities: Service Delivery and Coordination

Responsible for:

Liaising with the RSAs relative to the effectiveness and accessibility of services offered by the hospitals and health centres operated within each region

Ensuring that the services provided are coordinated to the extent possible with other allied health facilities and professionals; ensuring that all health center and hospital services meet expected standards; acting as a team leader to the RSAs

Ensuring that the social services offered within each of the regions meets standards and expectations; acting as a clearing house of concerns for the regional senior staff; acting as a team leader to the RSAs

Ensuring that appropriate coordination occurs between the regions and the NGOs which function in each region;

seeking opportunities for enhanced collaboration

Oversees team leaders charged with providing a supervisory role for the professional staff

Establishing a centralized and responsive medical travel coordinating and administration unit; developing appropriate policies and procedures; ensuring that these are being followed

Mobilizing key resources as necessary in response to acute shortages in the regions or in response to perceived areas/issues of crisis

Overseeing the Adoption Services functions and applicable record-keeping

Ensuring that an appropriate policy and procedural regime is established and maintained relative to a pharmaceutical consultancy

Level 2 Functional Responsibilities: Corporate Support Systems

Responsible for:

Reviewing all RSA budgets and directing the allocation of funding in accordance with Board-approved funding allocations

Providing all financial transactions on behalf of RSAs including the accounts payables and receivables

Directing the IT systems; ensuring that any systems in place at the RSA level are effectively linked to the Board system; overseeing any updates or system repairs

Directing the provision of all NWT Authority and RSA human resource plans and policies; establishing the appropriate linkages with the regions

Providing each with guidance relative to the availability of benefits; coordinating all payroll and benefits procedures

Ensuring that a centralized records management system is in effect; developing policies and procedures which ensure safeguarding of the system's essential documents; complying with any legislated direction regarding freedom of information and privacy

Guiding the development of an Authority/RSA communications strategic plan; employs the appropriate resources or contracts as necessary

Conducting or overseeing the conduct of regular and comprehensive corporate/operational reviews of RSAs as per the legislation/regulations

Establishing a comprehensive professional development program for applicable staff; encouraging the staff to attend regular upgrading opportunities which are available and approved

Level 2 Functional Responsibilities: Strategic Resources

Responsible for:

Developing a comprehensive Health and Social Services Plan which outlines the proposed approach taken to addressing perceived needs/expectations of the residents served by the health and social services system

Working with the RSAs in the development of such a Plan; coordinating their input and providing leadership to the compilation of this key document

Overseeing and directing the recruitment activities and polices designed to enable a reasonable degree of access to the required professional resources for each RSA;

- working with the appropriate people at the RSAs to ensure a solid level of understanding of needs
- Developing the policies and approaches to retaining quality staff both at the NWT Authority and RSA levels; bringing to the attention of the Department any new ideas or initiatives which may show some results
- Allocating professional resources to the regions based on their needs and the priority attached to each area of need based on an NWT-wide perspective
- Liaising with the appropriate officials of any self-governing body relative to contracting for services or the devolution of services to such bodies; ensuring that all legal requirements are met
- Establishing service standards in each of the key service delivery areas; seeking the input and cooperation of the RSAs in developing these standards; overseeing any accreditation activities on behalf of the NWT Authority
- Providing ongoing support to those charged with governing the RSAs and the NWT Authority; ensuring that they have access to available training personnel and resource materials; coordinating these initiatives with the appropriate Department personnel

Level 1 Chief Executive Officer

Responsibility for:

- Providing policy advice to the Board of the RSA
- Directing the organization according to the direction of the Board, the legislation, bylaws and policies
- Managing the day to day operations; establishing administrative goals and objectives; providing guidance to the senior staff in the performance of their duties
- Guiding the development of the Business Plan and budget; managing the expenditures of the RSA within the budget approved by the NWT Authority
- Ensuring appropriate and ongoing involvement by the Board in the development of the Business Plan and budget; reporting on the financial health of the organization
- Reporting to the Board on all matters deemed to be substantive or key to the organization's operations and continued functioning
- Developing effective mechanisms for communicating with the key stakeholders and public
- Performing all the requirements directed to the CEO by legislation and regulation.

Accountability to:

The Governing Board of the Regional Services Authority

Level 2 Functional Responsibilities, Social Services Delivery

Responsible for:

- Directing the staff who provide the services and conduct the Children and Family Services programs
- Directing the staff who provide the services and conduct the Mental Health Services programs
- Directing the staff who provide the services and conduct the Addictions programs
- Directing the staff who provide the services for the Wellness programs

Directing the staff who offer services to for the Independent Living program

Developing regional service delivery policies and procedures for each of the foregoing programs and any programs which may be added to the RSA Business Plan

Ensuring that the training and development requirements of the staff are being addressed by the NWT Authority; communicating any suggestions and feedback to the CEO of the Authority

Working with and coordinating the work of the NGOs in delivering family and social services to the residents of the RSA; reviewing budget requests and evaluating before submitting for approval (to the CEO of the NWT Authority) as part of the annual RSA funding requirements

Level 2 Functional Responsibilities: Management Services

Responsible for:

Providing ongoing secretariat support services to the Board of the RSA

Developing the RSA budget with the input of the administration and the guidance of the Board of the RSA; liaising with the functional head of Corporate Support Systems at the NWT Authority

Advising the CEO on an ongoing basis as to the status of expenditures and revenues; ensuring that appropriate policies and procedures are being followed

Overseeing the human resource issues of the regional staff; employing, training and dismissing any regional support staff

Overseeing the utilization of IT services by the RSA; ensuring that any concerns relative to service availability and performance is communicated to the functional head of Corporate Support Systems at the NWT Authority

Maintaining RSA records as required by legislation and policies; ensuring that any records which are so designated are forwarded to the NWT Authority office

Overseeing the operation of all physical plants managed and operated by the RSA; retaining and training the plant personnel

Providing support to the Community Services Councils in the region served by the RSA; attending meetings as requested or as available; acting as an advisor to the CSCs

Level 2 Functional Responsibilities: Health and Hospital Services Delivery

Responsible for:

Developing hospital/health centre bylaws and policies; coordinating this work with the functional head of Service Delivery/Coordination at the NWT Authority

Coordinating and directing the operational support functions for the hospital/health centres

Putting in place the medical staff structure; liaising with the Medical Staff Director so as to structure the appropriate bylaws and committees

Designating one of the Medical Staff to act as the liaison with the Deputy Medical Officer of Health at the NWT Authority level

Working with the Patient Care supervisor to ensure an appropriate roster of patient care staff is maintained; coordinating any requests for additional professional personnel

through to the functional head of Strategic Resources at the NWT Board

Authorizing emergency medical travel in accordance with the policies of the NWT Authority; referring any ongoing requests for medical travel to the office of Medical Travel Coordination at the NWT Authority and handling according to policy

Overseeing the operation of all medical clinics which are the responsibility of the RSA; establishing operational policies and procedures

Guiding the delivery of all RSA public health services; ensuring that such services are in keeping with the guidelines and policies of the NWT Authority; liaising with the functional head of Service Delivery/Coordination in this regard

Encouraging the ongoing training and development of all staff of the RSA; ensuring that reasonable opportunities are made available for regional staff (i.e. non-professional); referring professional training requests and requirements to the functional head of Corporate Support Systems.

12.8 Professional Staff Recruitment

This issue has produced considerable comment and research over the past 24 months with less than desired results. The Department and various Boards have put both individual and collective resources to work in trying to find solutions to the ongoing need for qualified resources, particularly medical staff and specialists but also many of the other professions as well.

The fact that recruiting professional resources has become an increasing challenge should come as no surprise. As we understand it from our sector contacts and from the media sources, there is a growing shortage of many of the related professions right across Canada. Unfortunately, this has not been well-understood by the Governments and the health professions and has been the result of a combined failure to address this issue at the outset.

The most significant of these, in our opinion, is the need for one office to maintain the centralized control of this initiative. The problems encountered in not having this function decentralized out to the regions pale in significance to the potential loss of quality candidates who are falling through the cracks at present due to a lack of coordination. This notion of "turf control", which we note in reference to other aspects of the system as well, has and will negate progress in this critical area of responsibility. If the health and social services system is incapable, for whatever reasons, of finding and retaining quality professional resources, then the health of the residents will be put at unnecessary risk. Future studies and reports on this system will point to any inability to act on this finding as one of the critical faults in overall system performance.

Our general assessment of the work to date by the Department in this regard is likely more complimentary than the feedback which we heard from the regions. This is a relatively new Unit with limited resources of moderate tenure. The direction provided has been somewhat lacking, again due in large measure to the newness of the program and in part due to a lack of clarity of definition of roles. In many ways, however, the initiative has been successful in terms of highlighting the need in this key area and in terms of launching a number of related concepts and programs which have considerable potential of bearing positive results.

Two things must happen:

- An increased degree of focus on retention strategies
- Coordination of this effort in one shop and not dispersed to the field. Moving this initiative out to the regions has been and will be a major mistake.

Much of the dilemma to date has been the overall lack of focus and coordination which we believe we have addressed in our recommended service delivery model. This function must be seen as one of the key building blocks in a long term effort to continuously find ways of attracting and retaining quality people.

While we commend the efforts to date, it is obvious that continuing down the present path is likely to be less than fully productive. As a result, we believe that a somewhat different approach should be taken which combines the following elements:

12.8.1 Professional Resources Recruitment Team

This should be headquartered and coordinated through the NWT Health and Social Services Authority with a specialist team chosen under that umbrella.

The team should consist of: a Territorial Recruitment Specialist; a representative of the NWTMA; NWT Nurses Association; 2 Regional Services Authorities; Stanton executive.

The team should meet no less than 10 times annually to discuss objectives, targets and progress.

The team should develop a person and professional profile of what resources are needed and for what specific areas of the NWT; consideration should also be given to developing the type of employment agreement which permits some degree of transfer within the whole NWT system.

The team should report no less frequently than twice annually to the Leadership Council of Chairs

12.8.2 Departmental Assistance and Funding

The Department presently has a small unit working on this function of recruitment/retention. Those resources should be transferred to the NWT Health and Social Services Authority as a support core there. The Department's role is to oversee this process and to vette its degree of success. The Department also has a role in providing specific funding on an annual basis to ensure that the unit has sufficient funding to attack this issue with vigour.

12.8.3 External (and Industry Experienced) Consultants

We are aware of the fact that there are professional resources available through the management consulting profession who have had considerable success in recruiting to other Authorities in western Canada. While this may appear at first glance to be more extensive an approach than is required, we would argue that "tough times demand tough measures". There is little doubt but what other areas of this country are experiencing similar shortages of skilled employees. They will be targeting the north, taking advantage of the normal north-south flow of professional staff.

We have made the appropriate people in the Department aware that this mechanism should be explored at least on a trial/pilot basis. The reputation of such firms is that they do get results providing that the client has been specific in terms of describing the needs. As noted earlier, this is the mandate of the Professional Resources Recruitment Team.

12.8.4 Professional Staff Retention

The flip side of the recruitment issue is that of retention. It has become increasingly apparent that at least of equal importance to the flow of professional resources to the north, is the seeming inability to retain such resources for longer than a nominal period.

We have asked many of those whose futures will directly impact the ability of the NWT to deliver quality services as to why they would consider leaving and the answers prove to be quite revealing. We heard the following:

> "There is insufficient demands for my areas of specialty here so I am in danger of losing my skill level
>
> The lack of potential to travel the whole of the NWT is limiting my degree of interest; I am stuck in one small corner of the world; even the potential of travel to other Boards would be appealing
>
> There are not enough of us here; the lack of adequate back-up results in me having virtually no personal life; I am always on call
>
> Once they succeed in getting you here, it seems that they spend their resources and energy on finding your replacement rather than focusing on what could be done to make me somewhat happier and contented
>
> The housing conditions in my apartment are quite poor; why not do something about the quality of the furnishings?
>
> Whenever problems occur, I'm the only one here. Who am I supposed to turn to?"

It seems to us that many of these problems, albeit not all, are resolvable. Given the costs involved in recruiting new doctors and nurses, why not spend additional time and resources on developing a proactive gameplan for their retention. Involve the doctors and nurses in such discussions. We did and they were quite willing to identify areas which could be addressed with minimal resources.

One of the tasks of the CEO should be to hold regular, at least monthly, discussions with the relevant medical and social services staff and seek their input as to what steps could be taken.

13.0 The Impact Of Self-Government

A significant factor, which is likely to impact the implementation of our study at some stage over the next few years, has been the land, resources and self-government negotiations currently underway between the Federal Government, GNWT and aboriginal governments. The ongoing talks relative to self-government and the related issue of land claims are complex and certain to have an impact on how the NWT is both governed and managed in the future.

While we are not the experts in this delicate and highly specialized process, there is no question but what the outcomes of these negotiations will have an impact on the future design and delivery of health and social services. A part of our hesitation in commenting on this significant NWT issue lies in the fact that negotiations are ongoing and we are reluctant to allow our lack of familiarity with the issues to somehow, regardless of how inadvertently, interfere with the process. On the other hand, our task (as guided by our terms of reference) is to provide the framework of a system for the future delivery of health and social services which is sustainable.

It is our view that there are really two distinct issues which impact our Report; the first is that of governance (who determines what services are to be delivered to what areas) and, secondly, service delivery (who has responsibility for actually getting the services to where they are most needed). From a quality control perspective, it may be that the latter is more critical. That is, our Report has argued that it is far more preferable for citizens to have access to quite a range of specialized resources on an “as needed” basis rather than to have sole control over minimal resources (i.e. the less than satisfactory person years of one or more employees who will inevitably need time off, vacation period, supervision, training, etc).

As we understand it, and recognizing the problems which can be encountered in over-simplifying such issues, the following key points are significant:

> We do not want to infer that the processes of land claim settlements and that of self-government will not have an impact on the delivery of health and social services. Obviously these will likely have a significant impact and will need to be reviewed in light of how these issues will impact the overall delivery system. It is our hope that people of wisdom will recognize the need for a solid, rational basis for the delivery of these critical services.
>
> These two key areas of health and social services appear to be recognized as distinct and separate by those in the negotiation processes. It has been argued and, we understand, at least tentatively accepted by some, that health is a very complex and vertically-integrated service that requires a territorial-wide legislative and policy framework and which transcends local and indeed regional boundaries and thus is perhaps best left at a more territorial level.
>
> Given the highly specialized nature of health services, much of its delivery system will need to be retained in a very few centres. Indeed, we would argue that trying to provide some of these highly specialized services in more than three core centres has reduced the overall viability of the delivery system. The desire for local control over the delivery of key

services should not be mistaken for the need to recognize that certain services, by their very nature, need the threshold size which is only possible at a larger, more regional level.

In certain instances, particularly where the population level is quite small, the governance of services locally may be achieved most successfully in a contractual environment whereby necessary services are obtained via contract with another agency in a partnership agreement. Thus, it may be that a self-government body which negotiates for the authority to establish the laws and delivery structure of certain social services may, for example, recognize that it would be preferable to contract with the proposed NWT Health and Social Services Board to have the local Regional Services Authority provide the human resources for such services. In that way, the self-government body would be able to negotiate access to a much wider array of needed specialty skills without having to find the financial resources to pay for services which are only required on a part-time or “as needed” basis. If negotiated by people of goodwill and common sense, such a partnership can be beneficial to both parties.

Based on our limited understanding of the agreements being negotiated in the Beaufort Delta and Dogrib jurisdictions, self-governments may have quite broad authority relative to social services and less relative to health services. In the instance of social services, the concept of a shared jurisdiction and partnership relative to the delivery of culturally-sensitive services may be a realistic option. (It was recognized that some of these services may well become part of the devolution of authorities during the self-government process. In fact, it is our understanding that the delivery of some or all aspects of social services are “on the table”, or have already been agreed to, in the various discussions and negotiations relative to self-government).

An authorized aboriginal self-government may determine to continue on a present arrangement relative to service provision or may decide to contract with the proposed NWT Health and Social Services Board for the services and present level of funding to be transferred to the self-government body via the Regional Services Authority (an intergovernmental services agreement).

To the extent possible, each of the communities should be consulted as to which Regional Services Authority best represents their “home” region and thus where they would expect much of the services to be coordinated and/or delivered.

Local aboriginal customs and interests should be reflected to the extent permitted or encouraged within the prevailing laws in how services are delivered; for example, a Regional Services Authority may be delegated authority to enter into an agreement with a self-governing body relative to the establishment and regulation of traditional healers.

If the question becomes one of local control for political or economic reasons versus the delivery of quality health and social services which are essential to individual well-being, it is our view that the latter must be accorded the primary rationale and role.

At the end of the day, we are striving to recommend a system which:

- Is respectful of any existing laws insofar as they impact the delivery of health and social services
- Respects the rights both of aboriginal peoples and all residents of the NWT
- Results in a system of service delivery which is defensible from the standpoint of effectiveness, efficiency, transparency, quality, consistency, accurate and useful reporting, timeliness of service, equity of service for all, measurable results
- Is enveloped in a governance structure which is open to all citizens; is responsive to the pressures which it will face; assists rather than hinders good decision-making; and enables citizens to participate in the decisions respecting their own health care and use of social services such that lives are enriched and individual responsibility for managing personal care is respected
- Is stable during the next decade of change resulting from the implementation of self-government agreements.

14.0 SOME SUMMARY COMMENTS

This has been a comprehensive exercise on behalf of the Department of Health and Social Services. We have appreciated the opportunity to provide an independent and unbiased view of the present system and how we believe it could be enhanced. We have not answered all of the potential questions and thus some will feel disappointed that their area of concern was not addressed. Further, we realize that in singling out any one part of the system, we run the risk of missing other important elements. It is not that they are not important-simply that they were not addressed to us as issues at this time. We apologize for any oversight and assure anyone so impacted that this was entirely unintentional.

There are many components of health and social services which still must be addressed. However, it would be a significant mistake, in our view, for the Department to delay making the necessary structural changes as are recommended herein. This system, which we have designed, will be a significant element in rationalizing the entire style and method of delivering services.

One note of caution may be helpful to those whose livelihood is impacted by the recommendations and philosophy contained in this Report. Change is always of concern to anyone who serves in or with the organization undergoing a transformation. It will take some time for these changes to be thought through and acted upon by the leaders of the NWT. If the work which is being done currently is of value to the system, then that component has every possibility of being there at the end of this process. We are confident that the Department and Boards will ensure that their employees are treated fairly.

We believe that there are two other steps which the Department should take which will assist in ensuring the appropriate follow-up to this Report. These are: an Action Plan Monitoring Team and a Professions Advisory Council. Both should be important in assisting the Department and the Boards in addressing the changes noted herein.

14.1 Action Plan Monitoring Team

We believe that one of the keys, in addition to the commitment to action by the Members of the Legislative Assembly, to making any real change or progress as recommended by this Report, is to appoint an Action Plan Monitoring Team to:

- Ensure that the Report Recommendations as approved are acted upon within the timelines as established
- Report to the Legislative Assembly (or a Committee thereof) on the progress made relative to the Report
- Recommend to the Deputy Minister what actions should be taken and in what sequence.

14.2 The Professions Advisory Council

It is apparent to us that the concept of service integration is widely accepted among members of the professions involved in these broad endeavours of health and social services. Unfortunately, we note that seldom do the professions find cause to actually work together to achieve real progress in part because the gameplan may not be clear, and, in part because the advantages in doing so may be less observable than the impediments. Thus, we believe that the establishment of a formalized mechanism for collaboration may be beneficial in terms of translating the best intentions into action. This recommended Council would be established under the guidance of the Deputy Minister and would consist of representatives of each of the professions who are involved in the delivery of services to patients/clients. The representatives should be nominated to this Council by their respective organizations. The Council's terms of reference should include:

Assessment of the current approaches to service collaboration and integration

Review of those factors which are viewed as impediments to effective service integration

Review of the breadth of professions and technical groups whose mandates may be impacted by service integration; recommendation as to their role in relation to this Council

Recommendations to the Deputy Minister as to what administrative resources will be required by the Council to assess this mandate

Regular reports to the Deputy Minister (3 times annually) on steps towards improving service integration.

15.0 THE ACTION PLAN

The Legislative Environment

1. We recommend that the Government approve a new piece of legislation "An Act to Establish the NWT Health and Social Services Authority and Regional Services Authorities" which clearly outlines the roles and responsibilities as recommended herein for the proposed new system.
2. We recommend that the Department develop a "Legislative Review Team" to review and recommend revisions to the present legislation with the objectives of:

   Simple language (user friendly)

   Clarity of roles; elimination of any overlaps

   Reduction in the number of pieces of legislation.
3. We recommend that the Department contract with experienced external legal counsel to conduct the above review and to recommend changes to the legislation in keeping with the tenor of this Report. "An Act to Establish the NWT Health and Social Services Board and Regional Services Authorities" should be the first order of priority.
4. We recommend that a new Public Health Act and a Health Disciplines Act be considered as top priorities by the proposed Legislative Review Team.
5. We recommend that the requirements for the registration of Authorities, and previously the Boards, under the Societies Act be eliminated.
6. We recommend that the document *Core Services of the Department of Health and Social Services* be reviewed and amended to provide greater flexibility for the Authorities in the level of service provided for individual core services, in order to operate within approved budgets.

Principles Guiding The New Health And Social Services System

7. We recommend that the Government endorse the proposed "System Principles" which guide the design and implementation of a new way of providing health and social services to the residents of the NWT.

Department Roles And Structure

8. We recommend that the Government endorse the need for a more streamlined and focused role for the Department of Health and Social Services which concentrates its resources in the areas of strategic leadership, goals and priorities, monitoring and measurement and endorse the proposed Statement of Departmental structure, roles and responsibilities.
9. We recommend that the NWT Authority engage in a process to develop an NWT Health and Social Services Plan for submission to the Minister; and that this Plan involve the participation of all relevant stakeholders.
10. We recommend that the Regional Services Authorities engage in a process of consultation with their regional partners and develop a regional strategic plan.
11. We recommend that the Department submit a restructuring and revised staffing plan to the Minister.

Governance Structure

12. We recommend that the present delivery system model and resulting boundaries (which reflect nine (9) Boards of Management) be rescinded.

13. We recommend that a new model of providing health and social services be established based on the following key components:

    An NWT Health and Social Services Authority

    Three Regional Services Authorities as follows:

    Northern Regional Services Authority (based in Inuvik)

    Central Regional Services Authority (based in Yellowknife)

    Southern Regional Services Authority (based in Hay River)

    Local Community Services Councils as approved by the Regional Services Authorities

We note and wish to underline that nothing in our Report and recommended restructuring of the health and social services system is intended to detract from either the land claims or self government processes which are in their various stages of negotiation. Rather, we are intent on designing a system approach which can work and can allow for the Department through the established mechanisms to enter into an agreement to contract for certain services to any legitimate third party, including a self governing authority.

14. We recommend that the principal function of these bodies be as follows:

NWT Health and Social Services Authority

Coordination of delivery systems within and between all hospitals and health centres; coordination, supervision and direction of the acute care services including where and how these are delivered

Coordination of the provision of social services to all residents of the NWT

Coordination of all recruitment and placement activities for medical/social services professional staff; authority to enter into secondment arrangements with the Regional Services Authorities for all professional staff

Provision of short term professional staff replacements

Delivery of coordinated non-management support services functions including: finance; information technology; human resources; records management

Coordination of services provided by non-governmental organizations

Back-up support to the regional health and social services authorities

Training for social workers throughout the NWT

Submission of three year Business Plans to the Department of Health and Social Services

Approval of annually submitted budgets from the RSAs

Three Regional Services Authorities

Coordination and delivery of community health and social services to all residents within the region

Assurance that all residents of the region have adequate and timely access to necessary medical services

Coordination of the community health and social services providers within the region

Supervision and direction of all staff working in the region (except as otherwise delegated to the NWT

- Health and Social Services Authority) including those on a secondment arrangement from the NWT Authority
- Collaboration with appropriate non-governmental agencies which offer services within the range of responsibilities of the regional authorities
- Consultation with all community health and social services councils and communities served by that regional authority
- Development of detailed budget submissions for approval by the Board of the NWT Health and Social Services Authority
- Approval of expenditures within the NWT Health and Social Services Authority budget allocation
- Authority to delegate the approval of budget allocations to the CAO
- Authority to delegate other operational issues to the CAO (within the policies as approved by the Board or as established by legislation)

Local community services councils

- A consultative mechanism to provide input and advice to the RSA relative to the provision of local health and social services
- Authority to hold bi-monthly meetings with the residents of the community in order to seek input on any matter deemed relevant to the delivery of services at the local level
- Such community services councils may be incorporated within a larger community framework or may be a stand alone entity
- Authority to propose changes in service delivery to the RSA and/or a re-allocation of current budget dollars
- Authority to provide input to the annual budget process of the RSA and/or the Business Plan process

Accountability In The System

15. We recommend that Government ensure the establishment of clear lines of accountability in the system. Thus, we recommend that:

    The Minister of Health and Social Services be accountable for the following:

    - establishing and enforcing the legislation
    - ensuring the overall quality of health and social services in order that the needs of residents are met
    - ensuring access to services
    - promoting health and wellness
    - monitoring and evaluating programs and outcomes
    - working with professional organizations
    - administering the legislation
    - sharing information with other departments within the GNWT and other Governments.

16. We recommend that the Board of the NWT Health and Social Services Authority be held accountable to the Minister of Health and Social Services with responsibility for the functions as outlined herein.
17. We recommend that the Regional Services Authorities be accountable to the Board of the NWT Health and Social Services Authority with responsibility for the functions as outlined herein; and that, in the case of any conflict or confusion as to approvals sought and gained, that the RSAs recognize that they are

ultimately accountable to the Minister of Health and Social Services.

18. We recommend that the community services councils with responsibility for the functions as outlined herein, be deemed accountable to the RSA for that region and, in the case of any conflict or confusion, an appeal with respect to roles or authority would be resolved by the NWT Health and Social Services Authority.

Clusters Of Service

19. We recommend that the NWT Health and Social Services Department ensure that the NWT Authority has adequate resources to carry out its assigned functions.
20. We recommend that the NWT Authority utilize a **cluster method of service delivery** as the most practical method of ensuring the availability of professional and key administrative resources where they are in greatest need.
21. We recommend that the NWT Authority delegate to each Regional Services Authority sufficient resources to adequately meet the needs of those residents of that region.

Board Governance System

22. We recommend that the Department and the NWT Authority endorse the proposed NWT Model of Board Governance as outlined herein.
23. We recommend that the Department (through the NWT Authority) arrange for training of all Board members in this proposed model and that such training be made available to all members of the Board of the NWT Health and Social Services Authority and the members of the Regional Services Authorities.
24. We recommend that the membership of the new Boards (as recommended) be appointed by the Minister; and that all members of the current Boards be deemed eligible to apply to the Minister for membership on the new Boards.
25. We recommend that the Minister take steps to standardize the system of appointments through establishing a Board Member Nominating Panel which is charged with seeking nominations to these recommended Boards. The panel should stay empowered by the Minister to advise on ongoing appointments which are necessary by virtue of those stepping down from their appointment or whose position has been revoked for one reason or another.

Board Management Systems

26. We recommend that the Department approve the proposed structure of the NWT Health and Social Services Authority (**See Exhibit 1, Item 12.7**) insofar as the functions of that Authority are identified.
27. We recommend that the proposed structure of the Regional Services Authorities (**See Exhibit 2, Item 12.7**) be approved insofar as the functions of the Authorities are identified.
28. We recommend that the proposed functions of the President and CEO (chief executive officer) of the NWT Authority be endorsed in principle and conveyed to the first Board of Directors of the NWT Health and Social Services Authority for their consideration and adoption.
29. We recommend that the contract of the President and Chief Executive Officer be the responsibility of the NWT Authority.

30. We recommend that the proposed functions of the chief executive officer (CEO) of the Regional Services Authorities be endorsed in principle and conveyed to the first Board of Directors of the respective Regional Services Authorities.

31. We recommend that the contract of the Chief Executive Officer be the responsibility of the Regional Services Authority.

System Financing

32. We recommend that the revised Business Planning Process as outlined by this report be adopted.

33. We recommend that the directions included in the Sierra Systems Consultants report titled *Information Management / Information Technology Strategic Plan* be applied within the governance structure and priorities of this Action Plan.

34. We recommend that financial and operational information systems be developed through a step-by-step basis based on utilizing the Financial Management Capability Model published by the Office of the Auditor General of Canada.

35. We recommend that financial information and transaction systems, chart of accounts, operational data collection systems, and payroll systems be standardized across the Department and the Authorities.

36. We recommend that the Department provide guidelines for the auditors appointed by the Authorities, with the guidelines standardizing the minimum content of financial statements and areas required to be covered by management letters.

37. We recommend that funding of health and social service programs be undertaken on the basis of the funding model and principles included in this Action Plan.

Recruitment And Retention

38. We recommend that a Professional Resources Recruitment Team be established and that the following terms and conditions apply:

    This should be headquartered and coordinated through the NWT Health and Social Services Authority with a specialist team chosen under that umbrella

    The team should consist of: a Territorial Recruitment Specialist; a representative of the NWTMA; NWT Nurses Association; senior staff of two Regional Services Authorities; and a cross-section of representatives of the other professions

    The team should meet no less than 10 times annually to discuss objectives, targets and progress

    The team should develop a person and professional profile of what resources are needed and for what specific areas of the NWT; consideration should also be given to developing the type of employment agreement which permits some degree of transfer within the whole NWT system

    The team should report jointly and no less frequently than twice annually to the President and CEO of the NWT Authority and the Leadership Council of Chairs

39. We recommend that a benefit package for professional staff (including a review of housing, vacation, and travel benefits) be reconsidered in the overall context of a recruitment and retention policy framework.

Service Delivery

40. We recommend that the integration of health and social services continue to be promoted at all levels, and that more emphasis be given to an Integrated Case Management approach at the regional level.

41. We recommend that any self-government bodies which negotiate for the authority to establish the laws and delivery structure of certain social services be encouraged to contract with the proposed NWT Health and Social Services Authority to have the local Regional Services Authority provide the human resources for such services.

42. We recommend that The Professions Advisory Council be established under the guidance of the Deputy Minister and consist of representatives of each of the professions who are involved in the delivery of services to patients/clients. The representatives should be nominated to this Council by their respective organizations. The Council's terms of reference should include:

    Assessment of the current approaches to service collaboration and integration

    Review of those factors which are viewed as impediments to effective service integration

    Review of the breadth of professions and technical groups whose mandates may be impacted by service integration; recommendation as to their role in relation to this Council

    Recommendations to the Deputy Minister as to what administrative resources will be required by the Council to assess this mandate

    Regular reports to the Deputy Minister (3 times annually) on steps towards improving service integration.

43. We recommend a more concerted effort be taken to address the public health concerns and issues of NWT residents. To this end, it is recommended that a NWT Public Health Advisory Committee be established to assist and advise the Minister and the Chief Medical Officer of Health by advising as to key areas of concern; potential public health strategies; and methods of increased communication.

44. We recommend that the position of Chief Medical Health Officer be retained in the structure of the Department; that one of more Deputy Medical Officers of Health positions be established within the structure of the NWT Authority; and that public health responsibilities be delegated to senior public health staff in each of the RSAs.

45. We recommend that health centres employing only one nurse either be closed or be expanded to a minimum of at least two nurses plus other professional and/or support staff. If they are closed, a concurrent strategy will be required to announce how health care will be available to those communities involved.

Non-Governmental Organizations

46. We recommend that the NWT Authority develop a series of policies and protocols with regard to its proposed relationships to Non-Governmental Organizations. These policies and protocols should address:

    Areas of service delivery

    Reporting relationships

    Budget process (financial and program accountabilities)

Business planning

Lines of Communication

Performance measures

47. We recommend that increased attention and resources be placed in a "community development strategy" which has as its goal "a caring community".

Training And Development

48. We recommend that the NWT Health and Social Services Authority develop a high quality board orientation and governance orientation program for all Board members who are appointed to the first Boards of the four Authorities.

49. We recommend that the NWT Authority develop and oversee an ongoing training program for Board members based upon the philosophy and principles included within the NWT Model of Board Governance. A part of this training should include sessions on:

    Principles and Practices of Governance

    Conduct of Board meetings

    Policy Development (The Role of a Board)

    Business Planning (The Role of a Board)

    Decision-Making (The Role of a Board)

    Performance Assessment (The Role of a Board)

50. We recommend that the nurse practitioner program at Aurora College be supported, and that appropriate designations and compensatory recognition of graduates be considered as essential aspects of the process.

The Action Plan

51. We recommend that the Deputy Minister appoint an Action Plan Monitoring Team to:

    Ensure that the Report Recommendations as approved are acted upon within the timelines as established

    Report to the Legislative Assembly (or a Committee thereof) on the progress made relative to the Report

    Recommend to the Deputy Minister what actions should be taken and in what sequence.

52. We recommend that the current staff be regularly updated with regard to how present functions will be deployed under the new model and where senior management expects to place their specific responsibilities.

53. We recommend that an orientation process for all staff into their proposed positions be held immediately after the new structure is announced.

54. We recommend that the Department ensure that it publicizes, on a monthly or bi-monthly basis the status of these recommendations until such time as they are officially approved and implemented, or dismissed outright or deferred to a later date.

55. We recommend that a Forum on Personal and Community Well-being be held within 90 days of the adoption of this Report to begin the drafting of an NWT Health and Social Services Plan setting out the respective roles and commitments of each of the stakeholder groups. We envision a small, select and representational group who will be empowered with the task of drafting principles and action steps for not just individual groups,

non-governmental organizations and the private sector, and communities, but for the NWT as a whole. Such a task force should be placed under the guidance of the proposed new NWT Authority.

56. We recommend that Annual Minister's Forums should be scheduled thereafter which are focused on identifying areas of progress, best practices and challenges. One of the values of such a Forum will be the recognition that, in spite of the many challenges and even setbacks, that real progress is being made on many fronts. Forums should be scheduled thereafter which are focused on identifying areas of progress, best practices and challenges. One of the values of such a Forum will be the recognition that, in spite of the many challenges and even setbacks, that real progress is being made on many front