APPENDIX B

REGINA HEALTH DISTRICT REVIEW

Prepared for the Saskatchewan

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EXECUTIVE SUMMARY

In 1998 the Regina Health District began to encounter significant financial difficulties, with a year-end operating deficit of $4.7 million. In the 1999/2000 fiscal year the District Board approved a health plan and operating budget that was projected to result in an operating deficit of $22.5 million.

The Saskatchewan Department of Health decided, in the fall of 1999, that a review of the District's activities had to be undertaken to determine the steps required to return it to financial sustainability. Therefore it engaged the services of a three-person Review Team experienced in hospital management, medical administration and patient services administration, to undertake this Review and provide recommendations to both the Department and the District. The Review Team was requested to determine what the District must do to ensure that it can effectively manage its resources, and what would be required for the District to operate within available revenues and continue to provide quality services.

This Review has determined that the District, with careful planning and strong financial management, should be able to reduce its current operating expenditure levels over the next three years by approximately $12 million without impacting its ability to provide timely access to appropriate care. This Review has also identified approximately $10 million in ongoing operating costs that are considered to be outside the direct control of the District, and that should be considered by the Department of Health in future funding allocations.

This Review has also identified the need for the Department and the District to agree to a strategic financial plan, which would include:

- Establishment of a contract between the District and the Department outlining the expectations of the Department with respect to the District taking appropriate actions to return it to financial sustainability.
- Development of strong leadership within the District, both at the Board and Senior Management levels.
- Introduction of a three-year financial recovery plan.
- Development by the District of a strategic longer-term planning and resource allocation program that will ensure that the current financial difficulties are not repeated.

It is suggested that as part of the development of a contract between the Department and the District relating to the District receiving financial support from the Department, the Minister appoint a special representative to monitor, on her behalf, the steps being taken to return to financial sustainability. It will be critical that there be strong communication and understanding between the parties during this time of restructuring, and this could be enhanced by the presence of this "third-party" individual.

The Review Team has identified that it will be essential to have strong leadership within the District if a financial recovery plan is to be successfully implemented. Changes in the composition of the Board of Directors are being recommended to ensure that it has sufficient members with a strong business orientation to enable it to successfully carry out its fiscal responsibilities. The Board must also ensure that the management team, led by an experienced Chief Executive Officer (CEO), can provide coordinated leadership in directing the activities of the District. The Board must provide appropriate direction to the CEO and management team, and must receive the reports and information required to allow it to effectively monitor the financial performance of the District.

1.0 INTRODUCTION

The Regina Health District (RHD) was formed in 1993 as part of the introduction of health service delivery "reform" in the province of Saskatchewan. Since that time it has been actively involved in developing an integrated approach to the delivery of health services to the residents of Regina and South Saskatchewan.

The Regina Health District currently provides a full range of health care services to the residents of the Regina area, including:

- Acute care services, at primary, secondary and tertiary care levels.
- Rehabilitation, long term institutional support, mental health, and home and community based services.
- Public health services.

The majority of health care services are provided by staff of the Regina Health District, and in facilities operated by the RHD (including two acute care hospitals, the rehabilitation centre, community health clinics, and facilities at Imperial and Cupar). In addition, the RHD contracts with (and provides funding to) other agencies to provide care and services – primarily for the provision of institutional support and a number of community based services.

In addition to its mandate to provide health care services to the residents of the District, the Regina Health District also serves as a referral centre for residents of southern Saskatchewan. As such, it plays an important role in providing specialized acute care services to residents of other districts where such services are not available locally.

The Regina Health District is one of only two referral centres for the provision of tertiary, or highly specialized, care in the province – the other being the Saskatoon Health District (SHD). In general the two centres offer a similar range of services, with some exceptions. Services not offered by the RHD include:

- Pediatric neurosurgery and cardiac surgery (which are provided by the SHD).
- Highly specialized, but low volume services, for which the provincial population is too small to support a cost-effective service.

In 1998 the District began to encounter significant financial difficulties, with a year-end operating deficit of $4.7 million. In the 1999/2000 fiscal year the District Board approved a health plan and operating budget that was projected to result in an operating deficit of $22.5 million. In addition, the Health District had incurred significant capital debt as a result of greater than anticipated spending in their recently completed major redevelopment projects.

In the fall of 1999, the Department of Health decided that it was imperative to conduct an assessment of the District's activities, to determine what steps were required to return it to financial sustainability. Therefore it engaged the services of a three-person Review Team experienced in hospital management, medical administration and patient services administration, to undertake this Review and provide recommendations to both the Department and the District.

1.1 Scope of the Review:

The Department of Health identified the purpose of the Review (as delineated in the Terms of Reference) "to make recommendations that will support the delivery of appropriate health services within a framework of balanced budgets" for the Regina Health District. It was agreed that the Review should focus on answering two questions:

1) How can the District ensure that it can effectively manage its resources?

2) Given Regina Health District's responsibilities to respond to the District's residents and to provide tertiary care for southern Saskatchewan, what would be required for the District to operate within available revenues and continue to provide quality services?

It was agreed that this Review would focus on the major issues and strategic requirements facing the District and would not become involved in any in-depth operational assessment.

1.2 Review Methodology:

The Review Team conducted over 80 interviews with members of the District and the Department of Health. In addition, group meetings and focus group sessions were held with representatives from various functional areas in the District.

The Review Team also reviewed Board and committee minutes, financial statements, relevant reports, and any other data pertinent to the Review.

In establishing this Review, it had been agreed that financial support and analysis would be provided to the Review Team from the Department. Throughout this review the Review Team found that both the Department and the District were extremely helpful in providing financial and statistical data, and in undertaking analyses as requested. The Team established a working group with representation from senior staff at both the Department and District to coordinate the review of the financial situation of the District. This group certainly facilitated dialogue between the parties and ensured that the financial information was being presented in a manner acceptable to both parties.

When agreeing to undertake this Review the Review Team indicated that, although the Department was the "client" for the study, it would be critical to have both the Department and District work with us in a collaborative manner. This premise was accepted by the Department, endorsed by the District and incorporated into all subsequent activities. The Review Team greatly appreciated this collaborative and cooperative approach taken by the participants and thanks all those who assisted us throughout the course of the Review.

1.3 Organization of the Report:

This report has been developed in three major sections, designed to answer the questions posed by the Department about the steps necessary to ensure that the District can return to financial sustainability:

- **An Overview of the District**

  This section provides a brief synopsis of the programs and services being offered by the District, its current financial position, and an assessment of some of the key factors contributing to its financial difficulties.

  The intent of this section is to "lay the foundation" for an analysis of the opportunities available to the District to work towards financial sustainability.

- **Addressing the Key Issues**

  This section identifies those steps that can be taken by the District, with support from the Department, to address its current financial difficulties. The first part of this section addresses the need to ensure that the District has a strong governance and senior management team, with human resources, financial, and utilization management systems in place to provide leadership and direction to the organization. The second part of this section focuses on eight key areas where targeted savings can be identified within the District and actions taken to improve the District's "bottom line".

- **Strategies to Return to Financial Sustainability**

  This section summarizes the findings of the Review and delineates a three-year financial recovery plan that is recommended for adoption by the District and the Department. It also addresses some of the longer-term strategies involving both provincial and region initiatives that should be considered by the two parties.

2.0 OVERVIEW OF THE DISTRICT

2.1 Overview of Health Service Delivery

Health service delivery in the province of Saskatchewan has changed significantly in the past few years, with the amalgamation of individual health service providers into thirty-two health districts. This restructuring into a regional framework is consistent with approaches being taken in most of the provinces in Canada, where governments are looking for the most effective manner to allocate health funds to ensure that services are being provided in an integrated and accessible framework.

The creation of the Regina Health District in the early 1990's provided the opportunity to integrate the various health services being provided in Regina and to restructure the system to eliminate duplication of services. As part of this restructuring, the District decided that the Plains Health Centre should be closed and acute care services distributed between the Regina General and Pasqua Hospitals. This led to the development of a major capital project known as Project '98, which initially included the closure of the Plains, major capital development at both the General and the Pasqua, and realignment of many of the acute care services. This project eventually expanded to include a number of other initiatives within the District.

The closure of the Plains Health Centre and redistribution of a number of programs and services caused significant upheaval in the District and resulted in many transitional costs being incurred. In addition, these changes caused additional workload pressures and stress upon the staff and medical community, who were forced to deal with the changes being implemented while still trying to respond to the health needs of the community.

At the same time that the District was developing and realigning its programs and services it was also undergoing significant changes in its senior management team. The original District management group was composed of an amalgamation of many of the functional officers from the individual organizations amalgamated into the District. Over the past few years a number of changes were made in the District Management Team. A new CEO was appointed in 1996 who subsequently appointed new Vice Presidents in the key program portfolios. This new CEO and team developed their management style and approach to program development, decision making and financial controls and monitoring.

2.2 Clinical Programs and Services

As part of the move to regionalization there have been over the past five years, major changes in the number of clinical services provided, and the manner (and location) in which they have been provided. Appendix A (attached) provides selected data on clinical volumes and trends.

Acute Care

It is well recognized that major changes have occurred in the delivery of acute care services. The major focus has been the "down-sizing" of acute care beds from 1,100 in 1993 to 800 in 1996, and a further reduction to 675 (including 50 acute mental health beds) at present. Concurrent with the downsizing was a reduction in inpatient volumes. A corresponding volume increase in some ambulatory and diagnostic services has occurred, but service volumes in the majority of identified ambulatory programs have remained stable or decreased.

Program reconfiguration resulting from the closure of the Plains Health Centre in mid 1998/99 has also had a major impact. Most of that impact has been felt at Regina General Hospital (RGH), and since the closure, there has been intense pressure on a number of clinical programs at that site. The impact at Pasqua Hospital (PH) has been significantly less. Discussions have recently been initiated to reconsider the current configuration of services, with a view to moving more services to the PH site.

Major facility changes have been undertaken, mainly at the RGH site, to support the closure of the Plains Health Centre and to provide for upgrading of some clinical services. Most notably, the creation of expanded, and purpose-designed, ambulatory care facilities has allowed for more efficient organization and delivery of care, although the full impact of these changes has not yet been fully achieved. Project '98 and the other related capital projects resulted in the addition, (even after the closure of the Plains Health Centre) of approximately 110,000 square feet of space.

Non-Acute Care Programs

Institutional Support services have slightly downsized in terms of the number of Long Term Care (LTC) beds in operation (from 1,535 beds in 1996 to 1,500 at present). Significant changes in utilization of beds, and the initiation of alternative service options, have resulted in improved (and more timely) access to required care for those in need.

Home Care services have expanded, with major growth in the provision of professional care in the home. Similarly, Palliative Care services have developed and expanded to provide improved access to, and quality of, appropriate care in the most appropriate setting.

Mental Health services have formally integrated acute and community-based services; downsized acute care psychiatry beds (from 64 to 50), and enhanced community and ambulatory care services.

A major focus of development and growth in the provision of all of the services noted above has been to provide more timely access to appropriate care/support, and to support the optimum utilization of higher cost acute care services.

Public Health services have, with limited increases in resources, increased the number of immunizations provided to residents, and increased health promotion activities, particularly for school aged children. Two community health centres have been opened, offering a range of services to residents in neighbouring areas.

The Emergency Response Service has been incorporated in the District's mandate, and a coordinated ambulance service has been established across the District. The RHD is one of only two Districts in the province (along with Saskatoon) that has specialized emergency response services (such as the neo-natal transfer team). Current priorities of the Service relate to ensuring that ambulances are utilized appropriately (i.e. not over-used) by those requiring/desiring medical attention.

Diagnostic and Therapy Services

Integration of diagnostic and therapy departments at the individual hospital sites has occurred over the past five years for most departments, coincident with the closure of the Plains Health Centre and reconfiguration of clinical services. Integration of Laboratory services, including community laboratory services, occurred in 1996/97, and has resulted in significant efficiencies. More recently, integration of Diagnostic Imaging services has proven to be more problematic, and a number of challenges face the newly integrated Department. A detailed operational review utilizing external consultants and expertise is currently underway.

Increasing service pressures in a number of diagnostic and therapy services have resulted in both cost pressures and lengthening waiting lists.

2.3 Funding and Resource Utilization

Historical: The District, in the aftermath of its creation in 1993, was faced with the necessity of attempting to respond to the identified health needs of its catchment area, while living within its economic means. In its first four years following 1993 it managed to operate within 0.75% of its available funding, but in the 1998/99 fiscal year its operating deficit grew to $4.7 million, or 1.7% of its operating base. Much of this operating deficit occurred in the latter part of the fiscal year, following the closure of the Plains Health Centre in November 1998 and the concurrent realignment of programs and services.

During this period after the creation of the District in 1993 the Department provided increases in operating funds to the District, both to respond to ongoing operating funds, and to address identified program and clinical needs. In the most recent three fiscal years the Department provided a cumulative increase of

17.0% in its funding grant:

Year	Departmental Funding	Increase in Departmental Funding	% Inc.
1998/99	$272,627,185	$13,009,416	5.0
1997/98	$259,617,769	$ 7,629,830	3.0
1999/00	$294,886,611	$22,259,426	8.2
Total Increases		**$42, 898,672**	**17.0% cum.**

These increases included significant funding adjustments for clinical activities, including surgical wait lists ($5.5 million), front line nursing staff ($3.0 million) and physician remuneration ($3.0 million). Furthermore, in addition to these operational funding increases, specific one-time funds were provided to the District (e.g. Y2K funding, etc.).

Revenues from other sources have remained constant over the past three years at approximately $27 million per year.

Current Financial Position: As mentioned previously, the District began to incur significant operating deficits in the months immediately prior to the current fiscal year, which commenced on April 1, 1999. In the summer of 1999, the District Board approved in principle a 1999/2000 operating deficit of $22.5 million, which was subsequently incorporated in the Board approved Health Plan.

The Department has completed an analysis of this Board approved budget, which involved gross expenditure changes of $24.7 million, with input from the District. As part of this analysis the approved budget changes have been classified into a number of distinct groupings, as outlined in Exhibit 1.

This summary identifies whether the approved budget changes reflect costs which, in general, are considered to be “controllable” by the District (i.e. based upon decisions made by the District) or “non-controllable” (i.e. costs externally imposed upon the District e.g. inflation, the impact of applying all costs associated with meeting negotiated contracts, and in some cases the increased costs of meeting approved standards of care).

Exhibit 1
Regina Health District
Analysis of Budgeted Increases
1999/2000 Fiscal Year

Category	Amount	"Non Controllable"	"Controllable"
Salary Rates and Benefits	$ 2,497,003	$ 2,497,003	
Union/Management Issue Resolution	1,603,173	1,603,173	
Inflation	3,111,401	3,111,401	
Physician Remuneration	3,316,441		3,316,441
Barriers to Access	1,458,590	341,850	1,116,740
Tertiary/Provincial Program Changes	1,014,000	1,014,000	
Government Mandated Services	542,650	542,650	
SWADD	911,652		911,652
Information Technology Changes	1,660,863		1,660,863
Ongoing Impact of capital projects - net cost	1,282,557	650,000	632,557
Major Revenue Changes	Nil		
Major Supply Changes	323,000		323,000
Response to Workload Pressures	2,237,608		2,237,608
Enhancement of Programs and Services	3,418,608		3,418,608
Enhancement to Corporate/District Support	1,290,232		1,290,232
Miscellaneous	78,645	78,645	0
Total	$24,746,423	$9,838,722	$14,907,701

This analysis indicates that the increased budget in the current fiscal year was distributed over a number of functional areas, encompassing both clinical and support activities. It also indicates that approximately $10,000,000 of these budgeted increases could be considered to be outside the control of the District.

2.4 Funding and Utilization Comparison to Saskatoon

RHD Board members and staff have expressed concerns that the RHD may not be receiving an equitable share of provincial funding available for the provision of health services. More specifically, the concern is focused on whether RHD is receiving comparable funding levels relative to the Saskatoon Health District (SHD) – the only other district in the province that serves a similar population base and provides a similar range of services. In fact, SHD provides a

somewhat greater range of services, and serves a larger population than does the RHD.

While not formally a part of the mandate of this Review, the questions regarding funding equity expressed by Board members and staff of the Regina Health District (and the belief held by them that the RHD is "under-funded" relative to Saskatoon) are relevant to the outcome of the Review. Hence, this issue was examined – albeit at a high level only (see Appendix B).

Our examination was based only on the Department's annual budget allocation process, as delineated in the 1999/00 budget letter – and concluded that, overall, RHD and SHD receive comparable funding.

There are some significant exceptions. Funding for Mental Health Services and Rehabilitation Services are clearly not equitable (within the context of a population need based concept of equity). In the case of Mental Health, Saskatoon appears to be favorably treated. In the case of Rehabilitation, Regina appears to be. In our view, the large differences raise questions about the respective roles of these important clinical programs, and about possible differences in accessing these services by residents relying on these services. Funding differences are secondary to these fundamental questions.

Finally, a comparison of funding equity for remuneration of physicians is simply not possible based only on examination of the Department's grant to each of the Districts.

2.5 Physician Remuneration

Payments to physicians represent a significant, and rapidly increasing, expenditure item. Amounts paid to physicians have increased by about $6.5 million over the past two years (from $17.7 million in 1997/98 to a projected $24.2 million in 1999/00).

Most of these expenditures have offsetting revenues, in recognition of the services being provided. However, because of the various ways in which funding for medical remuneration is received by the District, it is somewhat difficult to precisely determine the "gap" between revenues and expenditures for physician remuneration.

There are several "sources" of funding for physician remuneration, including:

1. Department of Health Global Grant
   - Acute Care Services (identified as "Medical Remuneration")
   - Mental Health Services (e.g. psychiatrists)
   - Community Health Services (e.g. Public Health physicians)

2. Medical Care Insurance Branch
   - Contracts for Intensivists and 2 FTE psychiatrists
   - Fee-for service funding to support contracts between RHD and some physicians (e.g. Emergency physicians)

Regina Health District budget documents indicate the following:

Expenditures		
• Remuneration – salaries/benefits		$ 9,021,764
• Remuneration – medical fees		15,501,577
• Other costs		173,336
	TOTAL	$24,696,677
Revenues		
• Medical Care Insurance Branch		$ 3,665,189
• HSB		18,609,605
	TOTAL	$22,274,794
Shortfall (based on 1999/00 budget)		$ 2,421,883

The majority of the expenditures relate specifically to the provision of professional (medical) services. A smaller portion reflects remuneration to physicians for participation in the RHD organizational structure, including:

• Vice President Medical		$ 74,000
• Medical Department Heads		480,000
• Admission/Discharge Screening		625,000
	TOTAL	$1,179,000

Recognizing that these expenditures represent part of "corporate" overhead (and are comparable to expenditures for management/administration provided by other professionals), the actual budgeted shortfall in revenues for 1999/00 is likely in the $1.2 million range.

The substantial increase in physician remuneration ($6.5 million over the past two years) results from a combination of increased "rates", and increased numbers of physicians supported by contracts with RHD. Rate adjustments have, in turn, been driven by:

- Upgrading of rates, through renegotiation, many of which have not been adjusted for several years.

- Competitive pressures, mainly due to the fact that compensation levels in other provinces (or in the U.S.) are, in many cases, substantially higher than in RHD – resulting in significant challenges in recruiting necessary physicians (and even retaining existing physicians). In some cases, rate adjustments offered in Saskatoon have resulted in the need to renegotiate rates in RHD (and apparently, the opposite is also true, in some instances).

In selected areas, the numbers of positions have increased (examples include ICU, Neonatology, Infectious Diseases, Emergency, Physiatry). Several of these positions have not yet been filled, in addition to a number of existing positions that are currently vacant.

In renegotiating contracts, and establishing new contracts, the Regina Health District has communicated with Department of Health officials (and with SHD) in an effort to ensure some level of consistency in payment levels and contract terms – although, in fact, there is little consistency across the province, or even within the RHD. Most contracts are based on historical precedent, rather than on agreed upon strategies. There is no mandate to pursue provincial policies or guidelines, and each District apparently is free to individually negotiate non fee-for-service arrangements. A Framework Committee (with participation of the Department of Health, SAHO and SMA) has been established to identify policy issues and, through a consultation process, develop standards for non fee-for-service payment arrangements. The Committee has not been active in the past two years.

2.6 Deployment of Human Resources

Over the past two years, there have been significant changes in the deployment of staffing resources throughout the District. With the closure of one hospital, relocation of many services, expansion of other services, and reconfiguration of most of the management structure within portfolios and departments, the pace of change has basically exhausted the resiliency of the most valuable resource – the people working in the system. Substantial staffing increases (in excess of 200 FTEs in the past year alone), combined with staffing shortages in nursing and other departments have exacerbated the problem.

Much of the impact of the changes noted above has been felt in the ICS-A portfolio (acute care programs). Changes over the past two years have included:

- Consolidation of three emergency departments into two (with significant expansion of the RGH facility).
- Development of new Ambulatory Care services at both acute care sites.
- Implementation of a provincial strategy to increase the number of nursing positions at the direct care level.
- Transfer of clinical services from the Plains Health Centre.
- Expansion of capacity through reversal of the 5-5-4 staffing patterns, and reduction of the seasonal closures of ORs and surgical beds.
- Addition of service aide positions (and increased dietary and portering support) to reduce nursing workloads.
- Resolution of Union/Management staffing “issues” related to four specific services.

It should be noted that a review of staffing levels, and the appropriateness of current “base” staffing levels in nursing and/or other functional areas was not included in the mandate of this Review. However, a recommendation that this exercise be undertaken is included in a later section of this report.

In addition to these changes, the ability of the organization to effectively deploy staffing resources has been limited by two separate (but related) developments – staffing shortages (especially in nursing) and increased sick time and overtime.

Recruitment/Retention

With the large number of new nursing positions added (particularly in ICS-A), and the ability of staff to transfer to new areas of work, a severe nursing shortage arose in 1999 that required a temporary closure of nearly 60 beds. Extraordinary nursing recruitment efforts have been successful at reducing the number of vacancies – but approximately 60 vacancies still exist and, in many areas, casual relief pools remain depleted.

Note: The Regina Health District is experiencing nursing shortages similar to those being dealt with by all provinces. Analysis by both the provincial and national nursing organizations has shown that these shortages are largely due to repeated downsizing in the nursing workforce, lack of adequate education seats in the schools of nursing, and increased job stress in the work environment. Without significant changes to the number of nurses graduating each year, a reduction in the number of nurses leaving the workforce or going from full to part time, and an influx of nurses from outside of Saskatchewan, the shortage of nurses will be an ongoing problem.

Staffing shortages are not limited to nursing. A number of other departments/programs are experiencing shortages of professional staff, and increased vacancies – for many of the same reasons noted above. In some cases, a competitive environment (with other agencies and provinces offering greater compensation and/or opportunity) has also contributed to increased turnover and difficulty filling vacancies.

While the hiring of new staff has substantially reduced the number of vacancies in the "base" rotations for many units, there are still some vacancies in areas requiring specialized training or education. The costs for specialized education in the OR was budgeted at over $200,000 for each of the past two years and will likely continue over the next three to four years as staff retire. Other areas such as Emergency, Critical Care, and Labour/Delivery require extended orientation and will likely be involved in specialized education course requirements in future (as is the practice in other provinces). A conservative estimate of specialized education support costs would be $500,000 yearly. If the District does not plan to support nurses in gaining this specialized education, vacancies in the specialty areas could cause significant service closures to occur.

Another cost of the high vacancy and turnover rate is the orientation of new staff. Over the past two years some units have experienced a 50-70% turnover of staff as staff members accessed other positions in the District that were previously unavailable to them. Although detailed tracking of actual orientation costs is not possible via the current payroll system, the directors estimate that four to five times the budgeted allocation for orientation was used and this was only partially covered by the one-time funding for new staff. As the turnover and vacancy rate decreases, the orientation costs should reduce back to the previous budget, which is set as a percentage of FTE's within each cost centre.

Sick Time and Overtime

Sick time and overtime costs have risen significantly over the past two years largely due to number of vacancies in the nursing areas. While 5% vacancy on most units can be managed with casual relief staff, in many areas the vacancy rate has reached 25-50% at times. This lack of baseline staff has been further compounded by lack of casual staff so that even if a vacant rotation is filled with casual relief, regular staff are called back on overtime for any other relief needs (particularly sick calls or additional workload). In acute care nursing alone, year-end projections suggest that overtime will exceed initial budget projections by over $1,000,000 and sick time by nearly $2,000,000**.**

3.0 ADDRESSING THE KEY ISSUES

This section addresses the two key questions that the Department requested the Review Team to consider:

1) How can the District ensure that it can effectively manage its resources?

2) Given Regina Health District's responsibilities to respond to the health needs of the District's residents and to provide tertiary care for southern Saskatchewan, what would be required for the District to operate within available revenues and continue to provide quality services?

These questions recognize the need to consider not only those specific actions which might permit the District to "balance its books" but also to assess the impact of such actions on its ability to provide acceptable levels of care. Of equal importance is consideration of the District's ability to successfully manage the cost-savings process.

3.1 How can the District ensure that it can effectively manage its resources?

Health districts are complex organizations, requiring strong leadership to effectively address the sometimes competing issues of responding to health service delivery needs and being fiscally accountable to operate within available funding. Effective leadership requires a combination of a Board that understands its governance responsibilities and a senior management team that can assume responsibility for the day-to-day management of the organization.

a) Board Accountability

The Board of Directors of any Canadian health care organization is responsible for ensuring the delivery of appropriate and effective health services with the funds available to it. The Board also has the responsibility to work closely with the funding agencies to ensure that its needs are being properly represented and that as much funding as possible is being received. It is an ongoing challenge for governing bodies within the current health care system to "walk the fine line" between responding to the identified health care needs and being fiscally responsible.

Over the past year the Regina Health District Board approved a Health Plan and operating budget that, while responding to perceived needs in the community, resulted in the District incurring an enormous operating deficit and concurrent debt. In doing so, it failed to operate within the spirit of the current legislation requiring Boards to operate within the funds available. It did not exhibit proactive leadership in trying to address the service pressures within the District while recognizing the economic realities of the current situation. Nor did it make certain that the senior management team was properly advising it on the magnitude of the financial difficulties facing the District when the deficit was accumulating so rapidly.

The District does not currently have a planning process in place which can appropriately address the "competing" interests of responding to service needs versus maintaining fiscal accountability, or can determine, on an ongoing prioritized basis, the program/service needs within the District. It needs to ensure that such a process is implemented as part of its overall resource allocation process, and that it, as a Board, takes an active role in analyzing the various needs and makes considered decisions on the development of programs and services, and the corresponding allocation of funds.

The Board has been hampered in its attempt to understand and manage the financial situation of the District through delays in receiving from the Department of Health clearly delineated and timely statements of the funding base and any special funding available to it. It is imperative that the planning and funding allocation process initiated by the Department be advanced sufficiently to allow discussions on these matters to occur prior to the start of the fiscal year. This will facilitate the responsibility of the District Board to make informed and accountable budget decisions and to set the financial direction for the organization.

There is a need to ensure that the Board has the capability and willingness to assume strong leadership in undertaking its governance functions and in maintaining fiscal responsibility within the District. A significant change in composition of the Board is required to ensure that it has the skills and expertise necessary to fulfill its governance responsibilities and to establish a fiscally sound focus. It is important that the Board have members who have a strong business orientation, and a familiarity with accounting and financial reporting principles and practices.

The Board must also ensure that the management team, led by an experienced Chief Executive Officer, can provide coordinated leadership in directing the activities of the District. The Board must provide appropriate direction to the CEO and management team and must receive the reports and information required to allow it to effectively monitor the financial performance of the District.

b) Senior Management Responsibilities

The senior management team of a health care organization is responsible, on behalf of the Board of Directors, for all day-to-day operations. In addition, the team has a responsibility to work closely with the Board in ensuring that proper planning, financial and human resources management systems are in place and functioning properly. The senior management team also has a duty to report regularly to the Board on its activities and to alert the Board to issues or concerns that might require its attention.

The District Management Team at the RHD has been struggling over the past two years with trying to respond to workload pressures while dealing with the economic realities of the current situation. Unfortunately, they

have not had the financial planning and monitoring systems in place to support them, and as a result they have not given sufficient consideration to the financial ramifications of the program and service changes that they have made.

It is critical that the senior executive officers of the District, in fulfilling their functional responsibilities, strive to lead the organization in maintaining a balance between providing appropriate services and being fiscally responsible. The CEO must ensure that the District Management Team accepts this leadership responsibility, and acts accordingly.

c) Development of Financial and Human Resource Management Systems

The Regina Health District is a complex, multi-faceted organization requiring a strong financial management system to enable it to operate with effective fiscal accountability. The District's approach to financial management must include a number of key components, including:

- Delineation of the respective responsibilities of the Board and management for financial accountability.
- Determination of the roles of the program Vice-Presidents in being responsible to operate within approved funding while addressing the identified service needs.
- Determination of the role of the Vice-President Finance in monitoring the financial performance of all functional areas.
- Development of a funding allocation process that is coordinated by the District Management Team.
- Delineation of the role of the Human Resources Department in coordinating and monitoring the establishment of new positions and the hiring into these positions.
- Determination of the required working relationship between the Department of Health and the District to ensure that the District can fulfill its fiscal responsibilities.

There is a need for the District to review its current approach to financial management and to develop a system that would allow the Board and senior management team to provide strong financial leadership. The roles of the Finance Department, the reporting requirements throughout the organization, and the financial management responsibilities of the Vice-Presidents and Directors all need to be carefully assessed. The District has already taken steps to address many of these topics, through issuing a request for proposal to experienced health management professionals to work with them in establishing a financial management framework. The Review Team fully supports this initiative and believes that it will be an important "building-block" for the District in reestablishing fiscal stability.

It is also important for the District to develop the role of the Human Resources Department in monitoring the establishment of new positions throughout the organization. There is an important financial monitoring function that the Human Resources Department should accept through making certain that all positions being filled are assigned against approved budgetary positions. Adopting this monitoring approach within Human Resources provides another "check and balance" in the system to make certain that the proper controls are in place for staffing expenditures.

d) Utilization Management

Overall, utilization patterns of major programs offered by the Regina Health District have changed significantly over the past five years – and are generally in line with current trends nationally. Specifically, there has been:

- A reduction of acute inpatient admissions and inpatient days.
- An expansion of ambulatory care services and volumes.
- A change in the way in which institutional support facilities are utilized, to ensure services are available to those most in need.
- A change in the mix of services and range of options available in the community, to meet needs of clients, and to facilitate improved utilization of acute care facilities.

In the major "non-acute" programs, utilization gains have been impressive, both quantitatively and qualitatively. Although data is limited (which is an issue discussed later) utilization improvements in acute care have been more impressive in some areas (e.g. surgery) than in others (e.g. medicine).

Overall, utilization of Acute Care Services remains far from optimum. It is noted that:

- The SUR (standardized utilization rate) for acute care, incorporating both inpatient and day care surgery utilization, shows a rate of utilization by Regina residents at exactly the provincial average – and significantly higher than for Saskatoon residents. Across the country, urban areas generally have lower utilization rates than rural areas (note that the most recent data available is for the 1997/98 year).
- RHD reviews using the InterQual tool continue to show higher than expected numbers of admissions to several clinical services that do not meet admission criteria.

In our view, the RHD does not have a sufficient "organizational" commitment to effective Utilization Management (UM) in spite of excellent efforts of the UM Committee, some medical leaders, and staff in the ICS-A, ICS-B, and Medical Services portfolios. This lack of organizational commitment is evidenced by:

- an inadequate organization-wide database – hence, key utilization performance indicators are not routinely reviewed and acted upon.
- an absence of comparative data available to clinicians and program managers, against which utilization performance can be assessed. In particular, no efforts at benchmarking against "best practices" organizations are apparent.
- the fact there are virtually no Clinical Practice Guidelines – reviewed and accepted by the Medical Staff – in place, and therefore no monitoring or review of practices relative to Clinical Practice Guidelines.
- the fact that no Clinical Pathways have been introduced (although two are in progress). For high volume, and "routine" cases Clinical Pathways have been shown to significantly improve utilization.
- the wide variation in individual medical staff members' patterns of practice – and an apparent acceptance of "idiosyncratic" practice, even when it materially impacts on effective utilization. Admitting practices, and use of diagnostic testing and therapeutic services (e.g. drugs), are particularly obvious areas of concern.

Through the recently established System Wide Admission and Discharge Department (SWADD), the RHD has placed a major emphasis on facilitating patient/client "movement" through the system that is both efficient and seamless (from the clients' perspective) – and, we believe, has made significant gains in this respect. A formal evaluation process is underway, which will be helpful in assessing the impact of SWADD, and more importantly, in identifying possible avenues to further improve processes.

One component of the SWADD role is the related focus on "admission/discharge" screening, and on timely resolution of individual patient utilization issues - through the extensive use of Utilization Coordinators and Physician Screeners. While a valuable and important component of a broad-based UM program, the amount of resources committed to these activities is inordinately large. More importantly, these activities are unlikely to materially impact on "systemic" utilization issues, or make up for deficiencies in the overall organizational approach (and commitment) to UM.

There is a clear need for a re-focused and renewed approach to Utilization Management. This must be, and be seen to be, a priority of the Board and Senior Management. UM must be an integral part of the organizational structure, and headed by the most senior and influential staff in the organization. It should, as a minimum, incorporate the following features:

- The proposed Chief of Staff role should include a major focus on UM and on related Clinical Quality Assurance/Quality Improvement activities.

- Clearly establish accountability. Physicians, individually (and through the medical staff organization), as well as program managers are accountable for the effective use of resources.
- Establish a comprehensive UM database. Identify key utilization "performance indicators" that are monitored regularly. Take action to correct problems identified.
- Incorporate comparative data in the Review and monitoring process – with particular focus on benchmarking against "best practices" organizations.
- Review and approve Clinical Practice Guidelines – and, where required, assess actual practice patterns based on approved Clinical Practice Guidelines. Implement Clinical Pathways for selected high volume patient services.
- Review, as a priority, those clinical/diagnostic services where demand currently exceeds capacity (resulting in increasing wait lists, and/or excessive overtime costs). Ensure that indications for use (appropriate to the Saskatchewan environment) are communicated and understood. Develop strategies to manage wait lists.

It is noted that RHD staff is in the process of re-evaluating the District's overall UM program and a preliminary discussion paper on this topic is being prepared.

e) Human Resource Planning/Management

As noted in previous sections of this Review, the many organizational and service delivery changes requiring increased numbers of staff, and relocation of many staff, have seriously impeded the effective deployment of staffing resources over the past two years. The challenges have been greatly exacerbated by staffing shortages and difficulties recruiting appropriately trained staff members. While previous sections of this Review have focused primarily on nursing shortages, it is important to recognize that similar issues also apply to other professional staff groups. In virtually all cases, circumstances are projected to worsen over the next several years, unless specific actions are taken.

A major priority for the organization, both now and in the immediate future, will be to pursue a consistent strategy to stabilize and sustain the delivery of services for the next few years, so that the staff can focus their energies on the quality of their work rather than the reactive stance of surviving the changes.

An enhanced focus on quality improvement will facilitate this process, and may well enable the District to achieve greater efficiencies throughout the system.

Although this overall strategy incorporates a number of component strategies, there are two specific issues that need to be highlighted:

1. Ensuring that assigned staffing levels in all departments/programs are appropriate, and comparable to other organizations of similar size/operation in the province and nationally; and

2. Ensuring that the organization is able to retain professional staff and/or recruit adequate numbers of professional staff (in all categories) to meet current and projected needs.

For both of these issues, collaboration with the Department of Health – and active involvement of the Department – is critical to successful results.

Staffing Levels

During the conduct of this Review, it has been the consultants' impression that front line staffing levels are appropriate – and that staffing is generally at levels comparable to similar services in other organizations. However, it is emphasized that the mandate and scope of the current Review did not include an "operational review" – and no detailed assessment of front line staffing levels was undertaken.

It is suggested that a formal, and structured, review of front line staffing levels (including staffing mix) be undertaken, with comparisons to "peer" organizations of similar size and operation – including Saskatoon, and other organizations in other provinces. Participation of the Department of Health, in terms of setting criteria, and facilitating acquisition of data, would be helpful to the process – and would assist in ensuring that all parties have a level of confidence in the outcomes.

Recruitment/Retention

There is every indication that shortages in nursing, and, indeed, a number of health professional groups, will not ease in the next few years, but may even worsen. It is well recognized that Saskatchewan (and more specifically, Regina, and South Saskatchewan) is particularly vulnerable within the national context. Aggressive and proactive strategies are required to ensure an adequate supply of nurses (and others); to ensure that that they are appropriately trained; and to retain existing staff, if the high costs and service closures of the past year are to be averted in future.

The recruitment and retention issues are not unique to the RHD, but also exist, to a greater or lesser degree, throughout the province. Hence, it is suggested that the RHD collaborate in a joint effort to develop a human resource plan (for nursing, and where appropriate, for other health professionals) at the provincial level. In our view, it would be advantageous if collaboration extended to other Districts facing similar challenges, and to educational institutions responsible for training of health professionals.

We note, for example, that the Regina Health District has spent approximately $200,000 per annum over the past two years to train specialized nursing (OR nurses) – and may well be required to spend up to $500,000 more to train other nursing clinical specialists (Critical Care, Labour/Delivery, etc.) to meet their own needs. These "educational" costs might be better invested in some other venue – designed to help other Districts in South Saskatchewan meet their needs as well.

3.2 Given Regina Health District's responsibilities to respond to the health needs of the District's residents and to provide tertiary care for southern Saskatchewan, what would be required for the District to operate within available revenues and continue to provide quality services?

Over the past two years the District has made significant changes in its use of resources, both in staffing and non-staffing. As outlined previously, approximately $10 million of the budgeted changes could be considered to be outside the control of the District, with the remainder being the result of conscious decisions made by the District.

This section of the Review identifies a number of areas where there are opportunities for targeted savings within the District. The consultants believe that the District should be able to implement these savings, totaling approximately $12 million in annual savings, without any negative impact on quality of care, or the District's ability to provide timely access to appropriate care.

These opportunities for savings cover a wide range of activities throughout the District, with some being targeted in areas of utilization and provision of support to clinical activities, while others focus on corporate services and/or general administrative costs. Areas include:

- Utilization Management
- Organizational structure
- Physician remuneration
- Transitional costs
- Support to programs and services
- Utilization of staff resources
- General efficiencies
- Revenue enhancement

a) Utilization Management

Improved utilization management practices will undoubtedly result in cost savings. At this point, more important goals for the RHD are to:

1) Reduce current service pressures on acute inpatient services.

2) Address "barriers to access" issues (e.g. reduce waiting times for elective surgery).

Hence, for the short term, no specific savings targets resulting from improved UM have been suggested. At the present time, an acute care bed complement of 675 beds (including mental health beds) remains an appropriate level – although it is noted that, with improved utilization of acute care beds, and continuing technological advances, a valid goal would be a further reduction in acute care bed capacity.

However, within the broader ”utilization” context, there are some savings opportunities:

1) The Regina Health District should restructure physician participation in admission/discharge screening, and re-examine the roles of A/D Coordinators. A realistic expenditure reduction target is $700,000 per annum ($500,000 for physician participation, and $200,000 for A/D Coordinators).

2) As part of its overall commitment to improved utilization, the RHD should critically examine those clinical service activities where there are recognized inefficiencies, service duplication, and/or where expenditure levels are high relative to benefits achieved. In this regard, the acute care roles of rural facilities require reconsideration, especially related to their capacity to provide 24 hour “emergency” coverage. Costs are not the only issue, in that the ability to maintain quality services (for a number of low volume services) and continuity (due to limited staffing resources, including physician staffing) are also significant factors.

Some potential opportunities for review include:

- Role of, and scope of services offered by, the facility at Imperial.
- Role of, and scope of services offered by, the facility at Cupar.
- Clinics and other services that are duplicated in other settings.
- Services that can be provided in less expensive, but equally appropriate, settings.

Administrative and clinical staff will be able to identify additional opportunities for consideration. A realistic expenditure reduction target is in the order of $500,000 per annum.

In spite of significant improvements in accessing LTC Institutional Support services, the number of ALC patients (those not requiring acute care) is currently averaging 20-30. Not all these patients are awaiting LTC or residential placement, but may require additional physiotherapy or occupational therapy support in order to mobilize and return home. Some transitional beds are currently available within the Institutional Support system. Consideration should be given to establishing additional transitional beds, from within existing acute care resources. A small expenditure reduction can be expected – in the order of $200,000 per annum.

b) Review of Organizational Structure

Over the past number of years, there has been some streamlining of managerial roles and responsibilities, although overall, there has been significant additions of staff at the corporate level, and in individual portfolios.

- There appears to be inequitable distribution of responsibilities and workloads among administrative directors and managers, and a lack of consistency between and within portfolios with respect to span of control.

- There appears to be an inconsistent approach to the use of financial and human resource, and administrative support positions, with some functional areas making extensive use of such support. This has resulted in potential duplication and inefficiencies in the application of financial management and human resource management functions.

- The current structure includes both a Vice-president, Medicine and a Vice-president, Medical Operations, with separate spheres of activity and limited collaboration. The Medical Operations portfolio appears to have an extensive administrative structure that is considerably larger than that seen in equivalent sized organizations.

- Even with the proposed involvement of the Human Resources portfolio in position control and monitoring there is opportunity to consolidate departmental staffing.

- Corporate education resources, while possibly at desirable levels, are considerably more extensive than that seen in equivalent sized organizations.

There is an opportunity and need for the District Management Team to re-examine the organizational structure, in concert with strengthening corporate policies and systems in the financial management and human resource functions. This will require some level of investment in systems (e.g. computerized scheduling, financial and human resource reporting and monitoring systems, etc.

An expenditure reduction target of at least $1,000,000 would be anticipated. Some expenditure reductions can be implemented in the near future, while some will require implementation of improved systems (as noted above).

c) Physician Remuneration

In light of the current budgetary situation, it is recommended that consideration be given to the following:

1. Restructure physician involvement in admission/discharge screening. This is not to suggest that physician participation in A/D

screening (and in rapidly addressing utilization issues as they occur) is not a valid or useful function. However, the level of resources that are committed to this activity is inordinately high – and, generally, this utilization focus does not significantly contribute to the identification and resolution of systemic barriers to effective utilization (see comments on UM elsewhere in this Review).

2. Review the potential to increase revenue through fee-for-service billings for medical services provided by contracted physicians, where appropriate. Where opportunity exists, restructure contracts to facilitate revenue opportunities, and motivate contracted physicians to pursue fee-for-service billings. RHD officials have recognized the potential for enhancing revenue, and have made a significant start in this direction.

   It is important to note that this strategy has the potential to increase revenue to the RHD (and therefore, to contribute to the "bottom line"). However, except for revenues generated by providing services to non-residents of Saskatchewan, the overall impact on public health care expenditures is essentially unchanged by increasing fee-for-service billings for services provided to Saskatchewan residents.

3. Recognize that the current competitive environment, coupled with projected shortages of physicians in a number of specialties, strongly suggests that the existing difficulties in recruiting and retaining physicians will be exacerbated in future years. Strategies that rely on "reactive" responses to unsuccessful recruiting efforts, or to threatened resignation, will not suffice. Rather, collaboration with other health care authorities, and development of strategies at a provincial level, will be required, as a minimum. This will not have any specific impact on the RHD fiscal situation in the short-term, although could prevent further budgetary pressures, and service deficiencies, in the medium to longer term.

   No specific short-term savings targets have been identified for physician remuneration, generally, although enhanced revenue through increased fee-for-service billings by contracted physicians is a distinct possibility. Recognizing the current recruitment difficulties facing the District, it is highly likely that actual expenditures will be at least $500,000 less than "budget" in the next few years, simply because of unfilled vacancies.

d) Elimination of Transition Costs

The District has been required to respond to a number of major changes in its internal environment, as well as those imposed by external factors. Indeed, change has been the norm over the past six or seven years –

ever since the Regina Health District was created. Some of the most significant changes have occurred in the past two years, and include:

- Closure of the Plains Health Centre, and relocation/reconfiguration of acute care clinical programs.
- Significant shortages of nursing (and other professional) personnel.
- Implementation of major computer systems.

During such "transition" periods, additional costs are incurred – including "one-time" set-up costs, equipment costs, etc. Additional staffing costs can also be significant, and can include recruitment costs, staff training and orientation costs, and costs related to relocation of staff, and back-filling of positions when existing staff accept newly created positions. Less easily identified are costs due to reduced productivity of staff (and "systems") during transition periods.

Review of the RHD's incremental expenditures in 1999/00 identified at least $1.5 million of additional expenditures that are transitional in nature (not including overtime and orientation/training costs associated with these transitions). These expenditures should not be considered as part of the ongoing operational expenditure requirements – and plans need to be established to reduce or eliminate the expenditures within the next few months, or, as a minimum, over the next fiscal year.

A realistic expenditure reduction target for reduction or elimination of transitional costs is in the order of $1.5 million.

e) Reductions in Support to Programs and Services

The District's approved operating budget for the 1999/00 fiscal year included more than 170 additional positions to provide support to clinical programs and services – the majority of which are in the Acute Care Program. Some of the additional positions specifically support service enhancements, brought about by the additional ambulatory care facilities constructed as part of Project '98 and the other related capital projects.

Most of the additional staff have been professional staff (nurses, technologists, etc.), although a significant number represent additional staff in support areas to reduce nurses' workloads in the acute care setting (porters, dietary staff, service aids, etc.).

Given the current budgetary situation (and recognizing that overall Acute Care Service volumes are not increasing), a "balancing" of desirable program enhancements with fiscal capacity is required. The expansion of program support in 1999/00, while desirable, is simply not warranted at this point. The District should review all of the enhanced support that has been introduced in the current fiscal year, with targeted reductions of 50 - 60 positions, and resultant operating savings of approximately $2.0 million per year.

f) Improved Utilization of Staff Resources

Reduction of high turnover rates, combined with development of strategies to ensure adequate supply of appropriately trained professional staff will significantly reduce costs of current recruitment efforts, sick time and overtime, and orientation of new staff.

With respect to orientation, it is noted that the existing nursing orientation program is significantly more extensive than that seen in similar organizations. While this may be desirable, a redesigned program, targeting a one to two day reduction in orientation time should be considered.

Over the next three years, expenditure reductions in the order of $1.5 million should be achieved. It is noted that, with the recent recruitment efforts, expenditures are already stabilizing – and significant expenditure reductions should be seen in the next fiscal year.

Current specialized nursing training costs ($200,000) and anticipated future costs ($500,000) have been taken into account in developing the above expenditure reduction target. A provincial (or South Saskatchewan wide) approach to training specialized nursing funded partially by external funding sources would result in further expenditure reductions for the RHD.

g) General Efficiencies

Part of the successful financial management of any large complex organization involves an ongoing attitude of strong management of costs and constant identification of improved spending practices. Over the past few years the District, because of the lack of adequate financial controls and monitoring, has not had the opportunity to focus on general efficiency opportunities in the organization. This problem has been enhanced by the identified lack of a coordinated, collaborative approach to financial planning and monitoring by the District Management Team.

As identified elsewhere in this Review, the District must take steps to introduce a consistent, organization-wide approach to expenditure control. This should be accompanied by a review of all current expenditures with the goal of finding any areas of potential efficiencies, be they big or small. Since this focused approach to identifying efficiencies has not been in place recently, it should be possible to achieve a realistic efficiency savings target for each functional area of at least ½ to 1% of current expenditures. Therefore the District should introduce a targeted "general efficiency" reduction in operating expenditures of at least $2.0 million, which represents less than 0.75% of its operating budget.

h) Revenue Enhancement

The District has not, in the past, placed a high priority on maximizing revenue opportunities. A number of opportunities to increase revenues exist, including the following:

- Level 3,4 clients resident in WRC do not pay for consumables used – unlike all other Level 3,4 residents of other LTC facilities in the province (because WRC is operated under the *Hospital Standards Act*). A minor change in legislation (and/or regulations) would allow for this anomaly to be corrected.

- The District has increased expenditures in food services in anticipation of increasing non-patient cafeteria revenues. This has not occurred. Options are to either reduce costs, or more effectively generate appropriate revenue.

- As noted in a previous section of this Review, strategies to increase fee-for-service billings by contracted physicians represent a potential increase in revenue to the District. The RHD should review the policy implications of specific strategies with the Department of Health.

Other potential revenue generating opportunities need to be explored and pursued where appropriate. These include, but are not limited to:

- Existing revenue generating services where charges are inordinately low, or have not been changed to reflect increased costs (e.g. cafeteria prices, parking rates, etc..
- Preferred accommodations.
- Services provided to non-residents and/or to other health districts, where charges are allowed under current legislation (e.g. some referred-in laboratory services).

Additionally, the completion of Project '98 and other capital renovations incorporates further revenue opportunities and concerns. For example:

- Retail space was included in renovations at both Hospitals, which should positively enhance total revenues.
- Construction of the Doctors Office wing was based on the premise that this would be self-sufficient. It is imperative that expenditures/revenues be monitored to ensure that this is indeed the case.

Finally, it is noted that revenue from "Other Provincial Plans" is significantly less than previous years (and lower than budgeted) in 1999/00. Reasons for this shortfall need to be investigated. If this is a temporary phenomenon, then it would be reasonable to expect increased revenues from this source in future years.

Overall, revenue enhancement represents a significant opportunity, and an increased revenue "target" in the order of $1.5 million is achievable.

4. STRATEGIES TO RETURN TO FINANCIAL STABILITY

This Review has identified the following targeted reductions that should be implemented by the District over the next two years:

Focus for Operating Savings	Targeted Annual Savings
a) utilization management	$ 1,200,000
b) organizational restructuring	$ 1,000,000
c) physician remuneration	$ 500,000
d) elimination of transition costs	$ 2,000,000
e) reduction in service support to programs and services	$ 2,000,000
f) general efficiencies	$ 2,000,000
g) improved utilization of staffing resources	$ 1,000,000
h) enhanced revenues	$ (2,000,000)
Total Targeted Savings/Revenue Enhancement	**$ 11,700,000**

As noted previously, the Review Team is confident that these savings targets are achievable without negative impact on clinical service volumes, quality of service, and/or access to required services.

This Review has also identified that the District has incurred additional "non-controllable" operating costs of approximately $10 million. If the District is to maintain the core levels of service that it is currently providing to the residents of South Saskatchewan, it is imperative that these external costs be considered by the Department in its funding determinations.

In the event that the District is unable to achieve these targets, or, alternatively discussions between the District and Department conclude that additional savings are required, consideration should be given to closure of 25–30 acute care beds (one unit). Further savings in the order of $1.25 million could be realized. Although, at the outset, this may impede the District's ability to address some of the "barriers to access" issues, there is significant potential to improve acute care bed utilization – which could more than compensate for the reduced capacity. Indeed, reduced acute care bed capacity is a valid objective, and whether this occurs in the short term, or over a longer time frame, needs to be addressed jointly by the District and the Department

The District has recently indicated that its actual year-end operating position might exceed the $ 22.5 million targeted budget deficit by another $7-8 million. As part of the development of the financial recovery plan for the District it will be important for the Department and District to jointly review this projection and to agree upon the steps required to eliminate this overage.

Implementation Strategies

The Department and District need to agree upon a strategic financial plan designed to return the District to financial sustainability. This plan should include:

1. Development of strong leadership within the District, both at the Board and Senior Management levels, by:

- Making whatever changes are required in the composition of the Board to ensure that its members have the skills and expertise required to fulfill its governance mandate. Particular consideration should be given to Board members with a strong business orientation and a familiarity with accounting and financial reporting principles and practices
- Ensuring that the District recruits an experienced Chief Executive Officer who can provide strong leadership to the organization, particularly in maintaining a balance between the competing interests of responding to identified service needs while being fiscally responsible.
- Ensuring that the senior management team is actively involved in the decision making process and is taking a leadership role in the planning and resource allocation processes.
- Developing a financial management system that provides the proper controls and monitoring activities throughout the organization to ensure that there is proper fiscal accountability and to assist the Board and senior management team in fulfilling their fiscal responsibilities.

2. The establishment of a contract between the Department and the District outlining:

- A clear delineation of the financial sustainability that is to be achieved within the District over the next three years.
- The "terms and conditions" under which the Department is prepared to provide funding assistance.

These terms should include:

- Reconfiguration of the membership of the Board to strengthen its business and financial expertise (as noted above).
- Agreement by the Department on the proposed Officers of the Board of Directors.
- Involvement of the Department in the recruitment of a Chief Executive Officer for the District.
- A commitment by the District to develop a three year financial recovery plan to be approved by the Department.
- The establishment of a joint monitoring program designed to evaluate the success of the District in meeting its "financial sustainability plan".
- The creation of a "liaison officer" position by the Department, to whom is delegated by the Minister the responsibility to work with the District in the implementation of the financial plan, to liaise with the District and Department on outstanding issues as they arise, and to report regularly to the Minister on the District's progress in returning to financial sustainability.

3. The introduction of a three year financial recovery plan, that would include:

- A commitment by the District to implement a cost reduction plan to achieve the targeted annual savings of $12 million as identified in this Review.
- A commitment by the Department to include in its funding allocations consideration of the non-controllable operating expenses being incurred by the District.
- A detailed implementation plan developed by the District outlining the steps to be taken to implement the cost reduction strategies.

This financial plan must take into consideration the time that will be required by the District to fully implement its cost reduction strategies, and to realize the financial benefits. An appropriate target might be for the District to strive to achieve 50% of the targeted savings in the first year, and the balance in the second year. While this would mean that the total outstanding debt, and concurrent line of credit, of the District would continue to rise over the next two years, it would allow for an orderly introduction of the cost savings initiatives. It would also permit the District and the Department to discuss what strategies would be required in the final year of the recovery plan, to address this outstanding liability.

4. The development by the District of a strategic longer-term planning and resource allocation program that will ensure that the current financial difficulties are not repeated, through:

- Proactively identifying the ongoing service pressure and program development issues facing the District.
- Establishing a priority-setting process that can determine the most appropriate allocation of available funds.
- Developing an effective monitoring and evaluation process that can identify the effectiveness of the District in responding to identified needs, and in reallocating funds as required.

Longer Term Strategies

The major focus of this Report has been on the need for the District to return to financial stability, within a defined period of time. However there are a number of longer-term challenges, and opportunities, that also need to be considered within a context of future operational and financial sustainability.

Most of these longer-term challenges need to be addressed in a collaborative manner between Districts and with the Department of Health since similar challenges and opportunities face other Districts in the province. Leadership at the provincial level – by the Department and/or provincial associations – is essential in order to effectively deal with some or all of the following issue.

Physician Resource Planning

As previously noted in this Review, an increasingly competitive environment, coupled with projected shortages of physicians in a number of specialties, places the RHD (and other Districts) in a vulnerable position. The development of a province-wide physician resource plan, and provincial as well as local strategies to improve physician retention and recruitment, is urgently needed.

Revitalization of the existing Framework Committee (that includes participation of the Department of Health, SAHO and SMA) would be a positive step. Ultimately however, greater involvement by the Department in setting provincial guidelines and in putting a province-wide Physician Resource Planning process in place is required.

Nursing (and Other Health Care Professional) Resource Planning

Although the nursing "crisis" of last year is at least partially resolved, the District continues to carry vacant positions for nurses (especially nurses with specialty training), and several other professional groups. Planning, and development of recruitment and retention strategies, at the provincial, as well as local level, will be required to ensure longer-term stability. Since a number of other regions are facing problems similar to those in the RHD, collaboration in development of recruitment and educational initiatives, may benefit all parties.

Program Management Initiatives

Throughout the country, many health care organizations and facilities have adopted a "program management" approach to managing their core operations. While there seems to be an almost infinite number of variations on the program management theme, one constant has been the increased participation of physician leaders (Department Heads, or others) in program decision making. A more formal "program management" model, with program co-leadership by a physician and administrative team should at least be explored.

Capital Equipment Planning

The Regina Health District has a number of major equipment items that are in need of replacement (some urgently), and it is likely that other Districts have similar needs. A coordinated approach to tracking and prioritizing capital equipment needs (new and replacement) is required, along with stable multi year funding mechanisms. In Saskatchewan, as in other provinces, some deferral of capital replacement has occurred in recent years as a result of finding constraints; hence, it is likely that somewhat greater levels of funding dedicated to capital replacement will be required, overall.

Summary

This Review has identified the need for a number of actions to be taken to return the Regina Health District to financial sustainability. The Review Team is confident that, with strong leadership from the Board and senior management team, and with the ongoing support of the Department, the District will be able to continue to respond in a timely fashion to the health care needs of its community while acting in a fiscally responsible manner.

The proposed initiatives and actions being recommended in this Review must be considered as part of a total package, and not taken in isolation. Success in achieving financial sustainability will only be achieved if the parties work together in strengthening the organization, developing a viable financial plan, implementing realistic cost reduction initiatives, and providing transitional funding and operational support. Hopefully the conclusions and recommendations of this Review will provide support and directions in achieving these goals.

APPENDICES

Appendix A

Regina Health District – Selected Volumes of Clinical Data

some representative workload data for the past four years, as provided to the Review Team by the Regina Health District

Appendix B

Funding and Utilization Comparison – Regina and Saskatoon Health Districts

a summary comparative analysis of funding and utilization between the Regina and Saskatoon Health Districts

Appendix A

REGINA HEALTH DISTRICT
SELECTED VOLUMES – CLINICAL DATA

Acute Care Beds in Service
Regina Health District

	Psych	*All Other*	*Total*
Apr 1, 1996	64	696	799
Oct 1, 1996	64	667	731
Apr 1, 1997	64	667	731
Oct 1, 1997	54	625	679
Apr 1, 1998	54	625	679
Oct 1, 1998	50	612	662
Apr 1, 1999	50	566	616
Oct 1, 1999	50	595	645

Average Daily Census in Acute Care Beds
Regina Health District

1. Budget

	Level 6	*Level 3,4*	*Psych*	*Total*
1996/96	604.30	23.01	57.76	685.07
1997/98	590.92	23.01	57.76	671.69
1998/99	517.40	14.34	42.25	574.00
1999/00	505.56	10.00	46.31	561.87

2. Actual

	Level 6	*Level 3,4*	*Psych*	*Total*
1996/97 (Apr 1-Mar 31)	532.81	19.86	55.41	608.08
1997/98 (Apr 1-Mar 31)	524.00	13.85	51.04	588.89
1998/99 (Apr 1-Oct 31)	514.26	7.28	46.64	568.18
1998/99 (Nov 1-Mar 31)	524.54	8.89	47.36	580.79
1999/00 (Apr 1-Oct 31)	465.01	10.3	43.23	518.54
1999/00 (Oct only)	502.97	10.00	44.90	557.87

Admissions and Patient Days – Acute Care Facilities (excluding newborns)
Regina Health District

1. Budget

	Admissions	*Patient Days*
1996/96	37,210	250,051
1997/98	37,210	245,166
1998/99	32,232	209,510
1999/00	30,940	205,645

2. Actual

	Admissions	*Patient Days*
1996/97 (Apr 1-Mar 31)	33,928	221,946
1997/98 (Apr 1-Mar 31)	33,447	214,945
1998/99 (Apr 1-Oct 31)	18,963	121,590
1998/99 (Apr 1-Mar 31)	31,923	209,221
1999/00 (Apr 1-Oct 31)	17,169	110,968

Operating Room Cases – Acute Care Facilities
Regina Health District

1. Budget

	Inpatient	*Day Care*	*Total*
1996/97			29,283
1997/98			27,810
1998/99			27,594
1999/00			29,680

2. Actual

	Inpatient	*Day Care*	*Total*
1996/97	14,703	12,770	27,473
1997/98	14,239	12,625	26,864
1998/99 (Apr 1-Oct 31)	6,857	8,495	15,352
1998/99 (Apr 1-Mar 31)	12,301	13,111	25,492
1999/00 (Apr 1- Oct 31)	7,557	5,796	13,353
1999/00 (projected full year)	12,541	10,693	23,234

Wascana Rehab Centre – Beds in Service
Regina Health District

	Level 3,4	*Level 5*	*V. A.*	*Total*
Apr 1, 1996	191	66	54	311
Apr 1, 1997	191	66	54	311
Apr 1, 1998	197	56	54	307
Apr 1, 1999	197	56	54	307
Oct 1, 1999	197	56	54	307

Wascana Rehab Centre – Average Daily Census
Regina Health District

1. Budget

	Level 3,4	*Level 5*	*V. A.*	*Total*
1996/96	191	66	54	311
1997/98	197	56	54	307
1998/99	197	56	54	307
1999/00	197	56	54	307

2. Actual

	Level 3,4	*Level 5*	*V. A.*	*Total*
1996/97 (Apr 1-Mar 31)	190	54	53	297
1997/98 (Apr 1-Mar 31)	192	51	53	296
1998/99 (Apr 1-Mar31)	195	48	53	298
1999/00 (Apr 1-Oct 31)	197	41	53	291
1999/00 (Oct only)	197	44	53	294
1999/00 (Nov only)	196	46	54	296

Long Term Care Program
Regina Health District

1. Number of Beds in Service (operated by RHD and Affiliates)

	LTC Beds
Apr 1, 1996	1,535
Apr 1, 1997	1,504
Apr 1, 1998	1,504
Apr 1, 1999	1,500
Current (Nov 1, 1999)	1,500

2. Number of Admissions and Patient Days (in LTC beds operated by the RHD and Affiliates)

	Patient Days (1)	*Admissions*
1996/97	554,435	489
1997/98	548,960	599
1998/99	548,230	529
1999/00 (Apr 1- Oct 31)	321,000	306
1999/00 (projected full year)	549,000	539

(1) Based on the average Number of Beds during the year multiplied by the actual number of days in the year.

Home Care Program
Regina Health District
Selected Service Volumes – Home Care

1. Budget

	1996/97	*1997/98*	*1998/99*	*1999/00*
Admissions	N/A	N/A	N/A	N/A
Av. Monthly Clients	N/A	N/A	N/A	N/A
Nursing Hours	45,012	62,265	52,243	52,243
Homemaking Hours	186,000	213,667	204,143	204,143
Number of Meals	40,000	43,384	43,555	43,555

2. Actual

	1996/97	*1997/98*	*1998/99*	*1999/00 to Oct 31*	*1999/00 projected full year*
Admissions	3,010	3,062	3,997	2,437	4,178
Av. Monthly clients	2,428	2,436	2,573	2,575	N/A
Nursing Hours	45,933	53,558	57,857	33,108	56,756
Homemaking Hours	208,895	196,348	180,328	98,217	168,464
Number of Meals	43,852	43,602	44,558	26,992	46,272

Selected Clinic and Ambulatory Service Volumes

	1996/97	1997/98	1998/99	1999/00 Aug-99
Allan Blair Cancer Centre	13,829	11,243	10,291	4,857
Chemo/Pulse/pain Clinic/TPN**	1,566	1,097	1,101	686
Dietetics	1,195	1,106	623	274
Electrodiagnostic Lab	8,576	9,555	11,983	5,633
Enterostomal	495	459	447	176
Fetal Assessment	4,697	4,610	5,276	2,107
Haemodialysis	15,358	16,450	17,717	7,584
Infectious Diseases	N/A	N/A	372	373
L&D Outpt.	4,792	4,997	5,197	2,199
Laboratory	6,978	7,407	9,789	3,331
Maternal Medec	320	382	307	4,251
MEDEC	6,292	6,962	6,302	2,383
Mental Health Clinics	N/A	N/A	1,445	665
Methadone Clinic	5,087	4,957	4,352	1,531
Neurology Clinic	N/A	N/A	168	342
Nuclear Medicine	6,316	6,689	6,468	2,650
Orthopedic Clinic	14,460	13,203	13,886	5,648
Outpatients on Inpatient Units	500	358	411	108
Pacemaker Clinic	1,415	1,461	1,545	664
Pediatric Clinics	2,436	2,795	2,746	930
Perinatology	564	86	944	313
Pre-Admission Clinic	7,510	8,012	7,103	2,696
Psychiatry	1,592	1,405	0	0
Pulmonary Function	2,086	2,174	2,283	1,083
Radiology	17,231	18,899	19,175	9,040
Sleep Lab	642	1,245	1,236	738
Stroke Clinic	1,321	1,022	695	174
Therplasm Ex.	141	165	53	131
Tuberculosis	1,065	930	990	399
Ultrasound	3,548	3,106	3,087	1,215
Woman's Health	1,645	1,018	1,014	368

Selected Service Volumes in Other Services within LTC Program

Service/Program	1996-97	1997-98	1998-99	Apr-Oct99	1999–2000 (projected)
*** Convalescent Care**					
# Clients	58	97	119	58	125
Days Available	1,622	2,920	2,920	1,751	4,380
Days Utilized	1,622	2,752	2,839	1,704	
% Utilization	100%	94%	97%	97%	
Palliative Care					
# Clients	24	18	28	21	25
Days Available	1,460	1,460	1,460	856	1,460
Days Utilized	1,387	1,417	1,465	792	
% Utilization	95%	97%	100%	93%	
Quick Response					
# Clients	241	256	228	121	250
Days Available	2,190	2,190	2,190	1,284	2,190
Days Utilized	1,198	1,553	1,661	1,036	
% Utilization	55%	71%	76%	81%	
Respite Care					
# Clients	263	317	304	214	340
Days Available	5,110	5,110	5,110	2,996	5,110
Days Utilized	3,709	3,816	4,108	2,478	
% Utilization	73%	75%	80%	83%	
Transition Unit (operationalized Oct/97)					
# Clients		33	49	34	65
Days Available		2,184	4,380	2,568	4,380
Days Utilized		2,184	4,380	2,568	
% Utilization		100%	100%	100%	
**** Adult Day Support Program**					
# clients	244	237	183	195	230
# Spaces Available (Annually)	92	92	92	*** 114	114
# Days Available (Annually)	19,524	19,524	19,524	20,051	21,370
% Utilization	100%	100%	100%	100%	

Note:

*** The "Days Available" increase whenever additional beds are implemented for Convalescent Care.**

**** Access to all services/programs is based on the score obtained by applying Risk Indicator tool, e.g. a high-risk client in the Adult Day Support Program could be attending five days/week (i.e. 52 spaces annually). There is always 100% utilization of the Day Program spaces and the "waiting list" is closely monitored.**

***** The Adult Day Support Program spaces were increased from 92 to 114 on September 1, 1999.**

Diagnostic and Therapy Service
Regina Health District
Selected Service Volumes

	97/98	*98/99*	*99/00 (proj.)*
Laboratory (units 000's)	2,161	2,257	2,440
Diagnostic Imaging			
US (exams)	18,031	17,301	16,936
Radiology (exams)	118,529	114,983	112,326
CT (exams)	22,587	23,561	25,436
CNDS (proc.)	69,074	67,376	69,726
Cardiac Cath (proc.)	1,826	1,715	1,625
MRI (proc.)	-	-	4,680
Nuclear Medicine (proc.)	11,059	10,593	10,826
Respiratory Svces (units 000's)	3,648	3,518	3,623
Pulm. Function (units 000's)	213	242	293
Sleep Lab (visits)	1,245	1,236	1,927
Clinical Engineering (units 000's)	1,680	1,806	2,288

PUBLIC HEALTH SERVICES

IMMUNIZATIONS PROVIDED:

	Clinics/School	Travel	Flu	Total
1996-97	26,532	2,184	9,100	37,816
1997-98	39,439	1,879	10,008	51,326
1998-99	27,193	2,324	10,188	39,705
1999 to Oct	16,657	N/A	10,716	27,373
Projection to year-end	28,555	2,400	10,716	41,671

OTHER PROGRAM VOLUMES

COMMUNICABLE DISEASE SEXUAL HEALTH:

	Street Project Needle Exchange	Reportable Communicable Disease	HIV Testing	STD Counselling
1996-97	74,620	696	1,171	824
1997-98	114,883	686	1,140	677
1998-99	197,223	890	901	772
1999 to Oct	329,618	1,108	708	604
Projection to year-end	Jan-Dec/99 351,659	Jan-Dec/99	to Sept/99	725

HEARING HEALTH PROGRAM:

	Hearing Evaluations	Hearing Aid Fittings	Technical Services	Auditory Brain-stem Response
1996-97	4,248	1,445	7,801	
1997-98	4,665	1,835	9,196	544
1998-99	4,297	1,679	8,977	662
1999 to Oct	2,123	1,024	5,067	387
Projection to year-end	3,600	1,368	6,756	516

PODIATRY:

	Treatments	
1996-97	7,218	
1997-98	7,308	
1998-99	7,693	
1999 to Oct	4,594	Waiting list - 208
Projection to year-end	7,875	

ENVIRONMENTAL HEALTH:

	Food Premise Inspections	Other Inspections
1996-97	1,684	1,246
1997-98	1,616	1,128
1998-99	1,817	1,170
1999 to Oct	944	818
Projection to year-end	1,618	1,402

CALLS TO THE HEALTH INFORMATION/ADVICE LINE:

1996-97	8,325
1997-98	8,368
1998-99	7,696
1999 to Oct.(estimate)	4,457
Projection to year-end	7,630

HEALTH PROMOTION:

	Nurse Classroom Presentations	Dental Health Child Screenings	Nutrition Client Contacts	Health Promotion Group Presentation Attendance
1996-97	560	N/A	2,034	5,519
1997-98	515	2,619	2,281	5,751
1998-99	1,255	7,047	2,157	5,205
1999 to Aug only	222	1,801	831	2,822
Projection to year-end	1,110	6,003	1,994	5,644

AL RITCHIE COMMUNITY HEALTH CENTRE:

	Clients
1996-97	56
1997-98	2,747
1998-99	4,865
1999 to Oct.	1,915
Projection to year-end	3,283

FOUR DIRECTIONS COMMUNITY HEALTH CENTRE:

	Healthiest Babies Contacts
1996-97	4,632
1997-98	5,087
1998-99	5,718
1999 to Oct.	3,244
Projection to year-end	5,561

Appendix B

FUNDING AND UTILIZATION COMPARISON
REGINA AND SASKATOON HEALTH DISTRICTS

Concerns have been expressed by RHD Board members and staff, that the RHD may not be receiving an equitable share of provincial funding available for the provision of health services. More specifically, the concern is focused on whether RHD is receiving comparable funding levels relative to the Saskatoon Health District (SHD) – the only other district in the province that serves a similar population base and provides a similar range of services.

While not formally a part of the mandate of this Review, the questions regarding funding equity expressed by Board members and staff of the RHD (and the belief held by them that the RHD is "underfunded" relative to Saskatoon) are relevant to the outcome of the Review. Hence, this issue was examined – albeit at a high level only.

There are a number of ways in which the concept of funding "equity" can be considered. It is recognized that the majority of funding for the provision of health services in Saskatchewan is distributed on the basis of a "population based needs" resource allocation model. Implicit in such a model is that the definition of "equity" is based on the population served by health care providers, and the identified needs of that population.

There is much room for discussion, and debate, regarding the best way to account for a population's "needs" in such a model. However, the model currently used by Saskatchewan has presumably considered these issues – and it is not the intent of the external consultants to question the model (nor, to our knowledge, does this play a major role in the concerns of the RHD regarding the funding equity issue).

Some relevant comparative data is presented in the table below. While the table offers only some selected data – but it does indicate that, in general, Saskatoon provides services to a slightly larger population; provides more acute care services; and receives somewhat greater funding, than does Regina. It is important to note that:

1. SHD provides substantially more acute care service to "non-residents" of the District than does RHD.

2. Regina residents utilize acute care services (inpatient and day surgical care) – per capita – than do Saskatoon residents, based on 1997/98 utilization patterns of practice. In the absence of any information to suggest that, overall the acute care health needs of Regina residents is any different than Saskatoon residents, the higher acute care utilization rates may reflect on the efficiency and/or appropriateness of some of the services provided.

Selected RHD – SHD Comparative Data

	Regina	*Saskatoon*	*% Difference*
A. Population Served			
Population of District (1999)	215,820	242,049	12%
% population 75 years+	5.9%	5.5%	
% population 85 years+	1.6%	1.5%	
Population Growth (1991-1997)	2.44%	6.88%	
Population Growth (1997-2016) Projected	6.10%	24.83%	
Approximate Service Area Population	474,000	567,000	19%
B. Utilization Rates by residents			
(relative to provincial average)			
SUR (Acute Care) 1999-2000*	.9925	.8764	
C. Cross Boundary Service Flows			
(Acute Institutional Care)			
% of service that residents receive outside their home district (97/98) **	5.58%	4.79%	
Share of provincial need (inpatient cases adjusted for service intensity) (97/98)	28.18%	34.27%	
Total Weighted Cases Provided (97/98)	36,958	41,780	13%
Weighted Cases provided to non-residents of district (97/98)	13,795	19,597	42%
% Weighted Cases provided to non-residents	37.3%	46.9%	
D. Funding 1999/00***	$290.0 m	$308.4 m	6.3%

Notes: * Based on 1997/98 data applied to 1999/00 population.

**** Weighted Cases – All Weighted Cases data include acute inpatient and surgical day care cases, but exclude other ambulatory care.**

***** Funding from Saskatchewan Health per budget letter. Does not include other funding sources.**

Review of Funding Components – based on 1999/00 Budget Letter

The 1999/00 budget for each district breaks down the overall grant into a number of components – to demonstrate how the Department arrived at the total funding amount. The major components were briefly reviewed, and compared.

Acute Care

- By far, this is the largest component of the grant.
- The major portion of funding is based on the "population needs based resource allocation model" – and is accepted as being equitable (in that we have accepted the validity of the model).
- Funding for tertiary care equipment is equal in amount.
- Funding for identified special programs is based on service volumes – and therefore at least approximately equitable.
- Funding for some specialized programs that are unique to each district is based on historical funding.
- Funding for physician remuneration, identified within this "envelope" cannot be compared with the data available to the reviewers, and is discussed later.

Supportive Care Services

- Virtually 100% of funding is based on the "population needs based resource allocation model" – and is accepted as being equitable.

Home Based Services

- Funding is based on equal funding per capita (needs adjusted population).

Addiction Services

- For contracted services, RHD receives greater funding than does SHD. On the other hand, SHD operates a specialized addiction program, defined as a provincial program to serve residents of the entire province. There is no comparable program (or funding) in RHD.

Community Health

- Public Health is funded on an historical basis, and RHD receives more funding than does SHD.
- A substantial component of overall community health funding is based on a per capita funding grant.
- Smaller funding amounts for individual programs are based on volume of services provided.

Mental Health

- Overall, SHD receives substantially more funding than does RHD. This difference is likely understated because several psychiatrists in RHD are funded from this budget (compared with SHD where most psychiatrists are funded through fee-for service.
- Funding does not appear to be equitable.

Rehabilitation Services

- Overall, RHD receives substantially more funding than does SHD. This is mainly historical, and based on the number of beds at WRC and RUH respectively. At least some components of the rehabilitation provided at WRC represent "provincial" services, and are available to residents of the entire province.
- Funding does not appear to be equitable.

Other Programs

- There are a number of individually identified programs/grants – all of which receive relatively small funding allocations relative to larger programs noted above.
- The largest single item is the Urban Health Initiative, for which both districts receive exactly the same amount of funding ($1 million).
- Funding allocations for other programs are based on either per capita funding or on actual program volumes.

Additional Observations

The comparisons noted above are based on the Department of Health annual grant only. It is recognized that both districts receive significant revenues from other sources – that are beyond the scope of this Review.

One major factor that cannot be assessed is the impact of funding for the College of Medicine – the bulk of which is expended in Saskatoon. Medical educational activities (especially at the post-graduate level) are historically inter-woven with the provision of health services – so it is not surprising that funding is also linked.

In the Canadian context, the focus of concerns has been on the belief (supported by a number of studies) that the health care delivery system has been "subsidizing" the medical educational system. There is also a recognition that patient care costs in "academic" institutions are historically higher (even after adjusting for case mix and intensity), and therefore reflect an under recognized "cost" of medical education. Assuming that Saskatchewan experience is similar to other provinces, it is likely that the presence of the College of Medicine in Saskatoon (and associated funding) does not provide any financial advantage to SHD. In fact, the usual argument would be the reverse. There is one exception – and that is in the area of physician remuneration – recognizing that a number of the medical staff within SHD are "academic" physicians, and receive compensation from the College of Medicine. Very few medical staff in RHD are in the same position.

Physician Remuneration

On a comparison basis RHD receives substantially more funding for physician remuneration than does SHD (looking only at the annual budget letter). However, the two situations are simply not comparable – partly for reasons given above. For that reason, and based on the data available to the external consultants, a fair comparison cannot be made – and any judgement regarding funding "equity" related to this portion of the districts' funding allocations is simply not possible.

Summary

The high level review of comparative funding strongly suggests that overall (and for the majority of the total funding allocation), both RHD and SHD receive relatively comparable funding. However, the analysis conducted was limited by the following:

- The analysis was based only on the Department of Health annual budget allocation process as delineated in the 1999/00 budget letter.
- The analysis accepts the Department's population needs based resource allocation model as representing a reasonable process for allocating resources (i.e. the funding model has been accepted as being inherently equitable).

There are some significant exceptions. Funding for Mental Health Services and Rehabilitation Services are clearly not equitable (within the context of a population need based concept of equity). In one case SHD appears to be favorably treated. In another, RHD appears to be. In our view, the large differences raise questions about the respective roles of these important clinical programs, and about possible differences in accessing these services by residents relying on these services. Funding differences are secondary to these fundamental questions. As stated above, a comparison of funding equity for remuneration of physicians is simply not possible based only on examination of the Department's grant to each of the Districts.